STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

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F 000	INITIAL COMMENTS Correction date 6/13/19 The following deficiencies are the from the facility's annual health survey and investigation of the facility reported incident #83151-I completed May 13-16, 2019. Incident #83151-I was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	HEALTH FACILITIES JUN 21 2019	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

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

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident and staff interview, the facility failed to provide care for a resident in an environment that maintained or enhanced dignity for one of twenty-five residents observed (Residents #86). The facility reported a census of 115 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/14/19 identified Resident # 86 had diagnoses of Cerebrovascular Accident (stroke), chronic left femoral embolism (blood clot), and weakness. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS recorded the resident required the extensive assistance of two staff for toileting and transfers. The resident experienced frequent episodes of bladder and bowel incontinence. The MDS revealed the resident had no trial or current	F 550		

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F 550	Continued From page 2	F 550		

toileting program such as a scheduled toileting or bladder training since incontinence had been noted to manage the resident's urinary or bowel incontinence.

The care plan revised 2/13/19 revealed the resident had incontinence and an ADL (activities of daily living) deficit related to limited mobility and weakness. The care plan directives for staff included offer to toilet the resident upon rising, before/after meals, and bedtime, and PRN (as needed), use an EZ stand and two staff assistance for toileting, and provide good pericare after each incontinence episode.

The Admission Assessment dated 1/5/18 revealed Resident #86 had occasional bowel and bladder incontinence.

During observation and resident interview on 5/13/19 at 1:10 PM, Resident #86 sat in the wheelchair in the common area. The resident had a strong odor of urine. Resident #86 reported it took up to two hours before she received assistance from staff to take her to the bathroom. The resident reported she had frequent incontinence due to waiting for staff to take her to the bathroom, and she had gotten use to sitting in wet pants.

During observation and resident interview 5/14/19 at 12:47 PM, Resident #86 reported she needed to go to the BR, but required two staff assistance because they used a machine when she transferred. At the time, Resident #86 made Staff N, certified nursing assistant (CNA) aware she had to go to the bathroom. At 1:00 PM, Resident #86 sat in a wheelchair in front of the shower door and reported she continued to wait

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F 550	Continued From page 3 for staff assistance to take her to the bathroom. At 1:11 PM, Staff N, CNA, and Staff M, CNA, took Resident #86 into the shower room and used and EZ stand to transfer the resident onto the toilet. Staff O, Assistant Director of Nursing stood in the room and observed the cares. During an interview 5/14/19 at 1:48 PM, Staff N, CNA, reported Resident #86 had a wet brief.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

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F 580	Continued From page 4 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, family interview, and staff interview, the facility failed to notify a family and primary care physician a resident's decline in Activities of Daily Living (ADL) and deteriorating wound for 1 of 25 sampled residents (Resident #97). The facility reported a census of 115 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/13/19 for Resident # 97 identified a Brief Interview for Mental Status (BIMS) score of 12 without signs/symptoms of delirium. A score of 12 indicated moderate cognitive impairment. The resident required the extensive physical	F 580		

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F 580	Continued From page 5 assistance of 1 person for bed mobility, transfers, dressing, personal hygiene, 2 persons for toilet use, and independent with set up help only with eating. The resident walked once or twice with the assistance of 1 person in the room and corridor. The MDS documented diagnoses included Diabetes Mellitus, Alzheimer's disease, moderate recurrent Major Depressive Disorder, Morbid (severe) Obesity, Chronic Kidney Disease, stage 3 (moderate), and other skin changes. The MDS recorded the resident at risk of pressure ulcers/injuries but did not have any unhealed pressure sores. The Significant Change MDS assessment dated 4/21/19 documented the resident returned from the hospital on 3/29/19. The MDS identified a BIMS score of 09, which indicated moderate cognitive impairment. The resident required extensive physical assistance of 1 person for personal hygiene, 2 persons for bed mobility, dressing, toilet use, and supervision of 1 person for eating. The resident was totally dependent upon 2 persons for transfers and did not walk in room or corridor during the assessment period. The MDS record the presence of 1 Stage II, 2 Stage III, and 1 Unstageable Deep Tissue Injury pressure ulcers. The care plan revealed the following: a. On 2/11/19, a focus area identified an ADL (Activities of Daily Living) self-care performance deficit related to Alzheimer's disease. b. On 2/22/19 staff directed to provide assistance of 1 staff for dressing, 1 staff with gait belt for transfers, the use of the wheelchair to go to meals and back per resident preference, and to complete the restorative nursing program as ordered.	F 580		

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F 580	Continued From page 6 c. On 3/25/19 a new focus area identified an Unstageable pressure sore at the sacrum (located at the base of the lumbar vertebrae and connected to the pelvis) related to incontinent of bowel (diarrhea)/bladder, resistive to peri-care/repositioning, and poor nutritional intake. d. On 3/26/19 the care plan documented the resident non-complaint with cares, repositioning, and incontinence cares. e. On 4/1/19 new interventions directed staff to frequently turn and reposition the resident. f. On 4/9/19 staff directed to use the hoyer (mechanical) lift with 2 staff for transfers starting 4/8/19. g. On 4/11/19 the care plan again informed staff the resident non-compliant with repositioning and turns. h. On 5/2/19 staff advised the resident could sit up in the Broda chair (a type of reclining wheelchair) with Roho (pressure relief) cushion for meals up to 1 hour at a time as tolerated. The Restorative Nursing Program dated 1/2/19 documented the resident to ambulate approximately 50 feet with a 4 wheeled walker and contact guard assist or standby assist. The fax order dated 4/18/19 documented an order for PT/OT (Physical Therapy/Occupational Therapy) to update the RA (Restorative Aide) Program. The Therapy Communication dated 4/30/19 documented the resident could sit up in the Broda chair with the Roho cushion for meals up to 1 hour at a time as tolerated.	F 580		

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F 580	Continued From page 7 The Progress Notes revealed the following: a. On 1/11/19 at 9:48 p.m. a care plan charting note revealed the resident alert to self, transferred with assist of 1, mobility via wheelchair with frequently asking staff to propel but self-propelling encouraged, and the resident out in the dining room and able to feed self. b. On 3/25/19 at 1:46 p.m. the resident with generalized body weakness and found to have pressure sores to her bottom. A new order received to send the resident to the hospital and the ambulance service contacted. At 3:26 p.m. Staff P, Registered Nurse (RN)/facility wound nurse, documented a detailed Skin/Wound Note. Staff P recorded the resident had 4 areas of Unstageable pressure. The sacrum area measured 5.5 cm (centimeters) by 11.9 cm, the left gluteal fold measured 1.6 cm by 2.2 cm, the right gluteal fold measured 2.7 cm by 8.2 cm, and a Stage II pressure at the right buttock measured 2.7 cm by 8.2 cm. Staff P wrote the resident with impaired skin integrity related to incontinent of bowel due to diarrhea for 2 to 3 days, incontinent of bladder, and noted the C Diff test negative. Staff P documented the resident with generalized body weakness due to diarrhea, refused to be out of bed, non-compliant with cares, refused/resistive during peri-care and repositioning/turns while in bed. Staff P documented the resident with poor nutritional intake related to current illness and diagnosis of Diabetes Mellitus. Staff P wrote the nurse called the primary ARNP and received an order to send to the hospital for further evaluation and treatment. c. On 3/26/19 at 11:06 a.m. a call made to the hospital and informed the resident admitted for UTI (Urinary Tract Infection) and general body weakness.	F 580		

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F 580	Continued From page 8 d. On 3/29/19 at 10:09 p.m. the resident arrived back from the hospital at 5:25 p.m. The resident alert and oriented times 2 (person/place), assist of 1 with ADL's but uncooperative during care, and started on an antibiotic for UTI. e. On 3/30/19 at 2:39 a.m., the presence of open sores documented and eschar (dead tissue) to sacral area. At 1:05 p.m. the resident noted to be very uncooperative during cares, wound to buttock cleaned, treatment applied, and the resident refused to get out of the bed during the shift. At 9:02 p.m. documented the treatment continued to the buttock and the resident refused to get up that evening. f. On 4/1/19 at 1:56 p.m. the resident noted to spend time in room, refused to get up, but the resident being turned and changed as the resident was incontinent of both bowel and urine. At 10:18 p.m. the staff documented the resident needed fed during the shift. g. On 4/4/19 at 12:32 p.m. the resident documented to refuse to get up from bed, cares were provided, treatment to wounds completed, and the resident turned to sides to reduce pressure from her buttock. At 9:27 p.m. documented the resident stayed in bed all shift, checked, changed, and turned as needed. h. On 4/5/19 at 12:18 p.m. documented the resident stayed in bed all day and reposition on side at least every 2 hours. i. On 4/7/19 at 6:30 p.m. a post fall evaluation documented for a witnessed fall. The fall occurred in the resident's room while peri-care being done. The evaluation documented yes to change in mental status, change in behaviors, and change in mobility status. The evaluation documented a Stage I pressure issue on buttock with non-blanchable erythema. At 9:31 p.m. the incident note documented the resident lowered to	F 580		

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F 580	Continued From page 9 the floor as she was unable to bear weight when being cleaned up and the bedding being changed. j. On 4/8/19 at 9:15 p.m. a new order received from the primary ARNP to evaluate the resident to be a hoyer transfer and documented family notified. k. On 4/15/19 at 1:11 p.m. the resident repositioned but refused getting out of bed throughout the shift. l. On 4/20/19 at 3:05 p.m. the resident's son gave verbal authorization to see the wound doctor that week. m. On 4/22/19 at 11:05 a.m. an Activity Significant Change MDS progress note documented the resident recently laid in bed often. n. On 5/3/19 at 8:47 p.m. a Life Enrichment Note documented the resident now a 1 to 1 program but at times refusing visits and spending a lot more time in room. o. On 5/8/19 at 10:57 p.m. a new order received from the ARNP Wound Nurse to cleanse the coccyx with Vashe (intended for use in cleansing, irrigating, moistening and debriding acute and chronic wounds), a nickel thick layer of Santyl (a debriding agent) to the wound bed to slough covered area (have a layer of skin come off), loosely pack with fluff gauze to fill cavity, sprinkle collagen (a protein) powder to red granulation tissue (new growth of connective tissue associated with wound healing), cover with border gauze, and change daily. p. On 5/10/19 at 9:17 a.m. a Communication with Family documented by the Social Worker (SW). The entry recorded the resident's son came to discuss the resident's current state after being told by the nurses the resident refused a lot of cares, chose to stay in bed all day, and stated he felt like his mom may be giving up. The SW	F 580		

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F 580	Continued From page 10	F 580		

wrote she educated the son about hospice and palliative care and the son expressed interest in information on palliative care. The SW wrote she discussed options for the resident with the clinical team and would follow up with the son early the next week. At 12:27 p.m. the son went to Staff U, Licensed Practical Nurse (LPN), to request a UA (urinalysis) test. Staff U wrote the resident had been down, refusing to do things, incontinent of bowel and urine, and changed per staff. At 12:33 p.m. Staff U documented she sent a fax out to the physician requesting a UA per family request.

q. On 5/13/19 at 3:45 p.m., the son came to visit the resident and complained of the resident not able to stay awake, engage in conversation, or eat a meal. Staff A, LPN, wrote she tried to explain that aides help with the feeding in the room and the resident refused getting up. Staff A wrote the son requested a UA and palliative care evaluation. Staff A documented a fax had been sent to the primary ARNP and staff still waited for a response.

r. On 5/15/19 at 7:45 a.m. the resident red and flushed in the morning with a High FBS (fasting blood sugar reading), the on-call doctor notified, and temperature 99.4 degrees. At 7:58 a.m. the son updated on the resident's status and the daughter-in-law to be in the facility that day.

At 8:40 a.m. a Communication with Family documented by the SW. The SW wrote the daughter-in-law visibly upset and wanted to see the primary ARNP when she arrived to do rounds and wanted to ensure the resident on the list to be seen. The SW documented she apologized to the daughter-in-law that the family not aware of the resident's health decline. The SW recorded the daughter-in-law and son very upset the resident may be hospice appropriate.

At 8:57 a.m. Staff U documented the resident

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F 580	Continued From page 11 very sleepy during the shift barely opening her eyes. Staff U wrote she put the resident's dentures in her mouth, tried to feed her but the food spit out, and the resident refused medications. Staff U documented the physician aware, would be in to see the resident, and she repositioned the resident in the bed. At 11:20 a.m. Staff U documented the ambulance arrived, the resident transferred by assistance of 3 persons and a hoyer. Staff U wrote the daughter-in-law wanted to know how long the resident had been refusing meds and she informed her just that morning and the resident fed in room with very poor appetite. At 12:09 p.m., Staff U documented the daughter-in-law spoke to the physician regarding the resident decline, the recheck of the blood sugar at 10:00 a.m. 597, and the physician notified vital signs abnormal for the resident. Staff U wrote the facility still waited on the C&S (Culture & Sensitivity) report from the UA test. Staff U wrote she called for ambulance transport. The Facility Skin & Wound Evaluations revealed the following: Pressure sore Sacrum a. On 3/25/19 new Unstageable, in-house acquired, measured 5.5 cm by 11.9 cm, 100% eschar, surrounding tissue with erythema, excoriated, fragile, no treatment, progress new. b. On 4/1/19 measured 8.9 cm by 6.4 cm, 90% slough 10% eschar, light serosanguineous exudate, faint odor, progress improving. Noted resident sent to hospital with Unstageable pressure due to suspected deep tissue injury at the left rear thigh and readmitted with Stage II at the sacrum. Cleansed the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas, apply Calmoseptine to the	F 580		

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F 580	Continued From page 12 reddened areas on the buttocks and coccyx. c. On 4/9/19 measured 6.9 cm by 4.4 cm, 50% granulation tissue 50% slough, light purulent exudate (type of liquid that oozes from a wound that can be a sign of infection), progress deteriorating. Noted a depth of 0.5 cm, seen by the primary ARNP with treatment changed to cleanse site with normal saline, apply/pack with metahoney, covered with mepilex daily until healed, and continue all previous interventions. d. On 4/15/19 measured 10.0 cm by 6.6 cm, 40% granulation tissue 60% slough, moderate purulent exudate, progress deteriorating. Noted resident seen by the primary ARNP, noted a depth of 0.5 cm, treatment changed the previous week, would continue to apply and re-evaluate treatment effectiveness, and continue all previous interventions. e. On 5/7/19 measured 7.8 cm by 4.3 cm, 30% epithelial tissue 40% granulation tissue 30% slough, light serous exudate, progress deteriorating. Noted resident seen by ARNP Wound Nurse 5/7/19 with wound measurements of 8.5 cm by 3.6 cm by 1.6 cm, 25% slough, 10% partial thickness, 25% epithelial, 40% red granulation, epithelial islands, the bone palpable, moderate thin serous drainage with slight pain managed with pain medication. Started treatment of cleanse with Vashe, nickel thick layer Santyl to wound bed to slough covered areas, loosely pack with fluff gauze fill cavity, sprinkle with collagen powder to red granulation tissue, cover with border gauze, change daily and as needed. Observations revealed the following: a. On 5/13/19 at 11:32 a.m. Resident # 97 laid in bed positioned on her back. b. On 5/14/19 at 9:33 a.m. Resident # 97 positioned on her right side in bed with a pillow on	F 580		

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her left side of back to position. At 11:59 a.m. Resident # 97 laid in bed on her back, air pump in place on the bed, and functioning. Attempted conversation with the resident and not really responding.

c. On 5/14/19 at 1:32 p.m. the ARNP Wound Nurse, Staff P, and Staff A, entered the room to provide cares. Staff A and Staff P assisted the resident to roll onto her right side. The ARNP Wound Nurse unpacked the sacral wound, measured 5.5 cm by 5.3 cm by 2.4 cm straight depth, and stated some necrotic tissue present in the wound that needed removed. The ARNP Wound Nurse stated the wound bed 30% slough/necrotic tissue, 10% epithelial tissue, the rest granulation tissue; reported the wound areas pressure related. Observation revealed a foul odor coming from the unpacked wound. The ARNP Wound Nurse stated they were treating the wound with Santyl (a debriding agent) to get to the healthy tissue and that was why there was odor coming from the wound. The ARNP Wound Nurse debrided necrotic issue then re-measured 5.7 cm by 5.0 cm by 2.2 cm straight depth, 3.7 cm of tunneling at 9 o'clock, 1.7 cm of undermining at 11 o'clock to noon. The ARNP Wound Nurse stated the bone exposed and informed staff they needed to reach out to family to see how aggressive they wanted with treatment as bone exposure could mean possible osteomyelitis (bone infection). The ARNP Wound Nurse said if the family wanted aggressive treatment then infection control gets involved otherwise they would focus on keeping it from getting worse in the facility. Staff A washed hands, donned gloves, then cleansed the wound with normal saline, repacked the wound with Santyl gauze, then collagen powder on the outer skin areas where granulation tissue present, and

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F 580	Continued From page 14 a new foam dressing applied. Resident # 97 did moan at some points during the dressing change. Staff P responded the resident started with a decline overall, then had some loose stools, and a Stage II to III pressure area developed, and the resident went out to the hospital due to the decline. Staff P stated the depth of the wound new for the resident. d. On 5/15/19 at 8:35 a.m., Staff U reported she worked for the facility for a year and familiar with Resident # 97's cares prior to going to the hospital. Staff U stated prior to going to the hospital the resident used to be up talking and walking. Staff U responded the resident came from the hospital with the pressure sores. Staff U reported the resident had a pressure area that remained on the sacrum. Staff U attempted to rouse the resident to take drinks of water, drinks of Pepsi, and to attempt a bite of food. Resident # 97 slow to respond or open eyes, and moaned in response to being rubbed on the arm. Resident # 97 did take in dentures, but did not take a drink or meds. Staff U gave Resident # 97 a bite of food which the resident spit out. Staff U stated the resident not going to accept anything at that time so she would just wait for the doctor who was supposed to be coming. e. On 5/15/19 at 11:15 a.m., observation revealed paramedics arrived to the resident's room to assess and transport the resident to the hospital. Resident # 97's daughter-in-law at the resident's bedside with Resident # 97's son on the speaker phone. The daughter-in-law reported she spoke to the primary ARNP who had just been in the facility to assess the resident and the ARNP told her she had not been made aware the resident's condition that bad. Physician orders, primary ARNP visit, ARNP	F 580		

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F 580	Continued From page 15 Wound Nurse visits, revealed the following: The primary ARNP visit note dated 1/16/19 recorded the resident examined for a routine visit and noted all chronic conditions stable at that time. The primary ARNP visit note dated 3/13/19 recorded the resident examined for a routine visit and noted no acute concerns per nursing staff or family and all chronic conditions stable at that time. The ARNP Wound Nurse Wound Treatment Plan dated 5/14/19 documented the resident seen to assess the coccyx wound. The notes recorded the resident stayed in bed by choice due to sacral pain when sitting. The resident incontinent of bowel and bladder making gross contamination of wound problematic. A Broda chair with Roho cushion available for the resident however the staff report the resident no longer used the chair. The Skin Physical Examination section documented the following: Stage 4 pressure on coccyx measured 5.5 cm by 5.3 cm by 2.4 cm, 30% slough/necrotic 10% epithelial 60% red granulation, bone exposed, moderate thin serous exudate with slight odor. The Procedures/Services section documented the following: Excisional debridement done and measured after to be 5.7 cm by 5.0 cm by 2.2 cm, tunnel at 9 o'clock with depth of 3.7 cm, undermining from 11 o'clock to noon with depth of 1.7 cm, bone exposed. Plan Notes section documented the following: Skin nurse (Staff P) will discuss with family how aggressive they wish wound care to be and if they wish for full work up for potential osteomyelitis. If they do not wish aggressive work up, will focus	F 580		

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F 580	Continued From page 16 wound goal at pain control, odor management, and infection prevention while continued goal to promote healing. The primary ARNP visit note dated 5/15/19 recorded a routine visit. The notes included the following documentation: Staff related the resident refused morning meds, would not eat breakfast, and had eaten less the last 3 weeks, but did not refuse meals. That day, the staff informed the primary ARNP the coccyx wound much worse, the wound nurse debrided it that week, it was nearly to the bone, and the wound packed daily. Staff related the resident had not been getting up out of bed for about 3 weeks due to sore on coccyx and when the resident sat up in the wheelchair she scooted down so staff concerned the resident would fall out of the wheelchair and make her wound worse due to shearing. The resident appeared quite ill, ashen, diaphoretic (sweating heavily), hot, and recheck of vital signs showed hypotension (low blood pressure), febrile (elevated temperature). Discussed with family and the resident to be sent to the hospital for evaluation and treatment. The family stated in a care conference the previous week they were asked if they would like palliative care or hospice care due to the resident's coccyx wound. The ARNP wrote she was unaware this was being discussed. Interviews: On 5/15/19 at 9:06 a.m., the resident's daughter-in-law and son reported the resident initially went to the hospital (3/25/19) for bad pressure sores. The son reported the resident treated for UTI and high blood sugars at that time just like the resident had that morning. The son stated with the first hospitalization (3/25/19) the	F 580		

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facility told him the day his mother went his mother had some bed sores that were going to be looked at in the hospital; the son commented prior to that day, no call. The family reported the resident got better and was sent back to the facility. The son reported he went up in March and his mother appeared okay, a lot going on. The son stated his mother had a lot of fluid buildup in the legs and so started laying down to get rid of the fluid buildup and put on another medication. The son stated 2 to 3 weeks prior he was notified blood sugars high or changing meds, and usually the facility called about stuff like that, but never called to say his mother not eating or sleeping all the time. The son reported he went in to visit and seen his mother asleep when staff told him she was not eating. The son stated he asked how long it had been going on and told a couple weeks not eating as much, would drink, but not eating much breakfast and not lunch. The son reported the last time he visited his mother's lunch sat on the tray and she slept. The son stated the facility responded the nurse aide was in there and they go in to try to get her to eat but said the lunch tray sat untouched. The son stated the facility had a meeting with him on Friday (5/10/19) to tell him his mother should get palliative or hospice care in there so he said okay because his mom was going downhill. The family reported on 5/10/19 they visited the resident and she was sleeping and not aware of who the son was so he went to talk to the nurse. The son stated that was when the staff told him they turned her every 2 hours, told the sores better but still watching 1, and after 10 minutes of seeing his mother's condition, he went to talk to the SW. The family stated they asked the SW what they could do for the resident and the SW mentioned palliative or hospice to the family's surprise. The

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F 580	Continued From page 18 son stated he asked her to explain palliative care to which the SW explained his mother would get more care. The son stated the SW said she would have a team meeting that day and get back to them by Monday and the SW had a lot going on meeting wise. The son reported the facility told him the bed sores getting better on Friday when he called the facility to tell them to get a hold of the doctor as he wanted a UA test done to check for a UTI. The son reported on Saturday (5/11/19) Staff W, LPN, told him the resident not on hospice and they thought the SW had said the resident would be hospice. The son stated he felt a UA needed because maybe the same thing going on with UTI as it had the last time his mother was hospitalized. The son repeated he asked Friday morning for a UA and he had not heard anything as of Monday. The son reported when in the facility on 5/13/19 he asked about the results and the LPN there couldn't tell him anything and he felt he got different stories from everyone. The son responded he was not aware of anyone contacting him the day before to update him about the ARNP Wound Nurse's visit but the night nurse called that morning about the high blood sugar. The son stated he was bothered no one called yet as he would have said to get very aggressive with treatment. The daughter-in-law reported she spoke to the SW about their concerns regarding communication and not getting notified and told to go to the ADON to find out what she knew. On 5/15/19 at 10:25 a.m., Staff A recalled the ARNP wound nurse talking to Staff P the day before. Staff A stated she did call the son after the wound assessment completed the day before and notified the son the wound nurse had seen the resident. Staff A stated she thought she	F 580		

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called the son around 2:35 p.m. on 5/14/19. Staff A said she spoke to the son about palliative care and handed the phone to a hospice nurse who frequented the facility to explain to the son better what hospice care was after telling the hospice nurse the family looking in to hospice care. Staff A stated the hospice nurse talked to the son for a while and then Staff A contacted the doctor. Staff A clarified she did not talk to the son about the debridement of the wound that occurred on 5/14/19 as she felt the wound nurse Staff P more appropriate to explain what was going on. Staff A said she told the son the wound doctor there to see the resident and measured the wound and treatments done. Staff A stated the progress notes would be where the staff document family notifications. Staff A responded she did not know for sure how long the resident had been declining, not responding, or opening eyes. Staff A commented the resident did open and close eyes before when feeding the week before and would say yes, but no sentences used to communicate the day before.

On 5/15/19 at 10:35 a.m., Staff V, LPN, reported she only worked with Resident # 97 a couple of times since starting work for the facility on 4/23/19. Staff V reported what she knew of the resident to be Resident # 97 slept a lot and family would come in and ask why the resident sleeping a lot and in the bed. Staff V stated one time the resident said no when had meals put to her mouth and pulled away.

On 5/15/19 at 10:40 a.m., Staff Y, CNA, reported she was familiar with Resident # 97's cares and worked for the facility for 3 years. Staff Y said sometimes the resident only up once a week. Staff Y stated after being in the hospital, Resident

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F 580	Continued From page 20 # 97 declined. Staff Y stated the resident may drink but had been a while that she kept her eyes closed while eating but still took food when put to her mouth. Staff Y responded she did assist the resident one day to sit up on the edge of the bed but got no further because she was too weak. Staff Y could not recall the day or how long ago that attempt to get up occurred. On 5/15/19 at 10:50 a.m., Staff P responded she had not yet reached out to the family regarding the ARNP Wound Nurse's directive 5/14/19 to ask about how aggressive family wanted to get with treatment. Staff P stated she had waited to receive the wound nurse's progress notes and orders which she just received via fax on 5/15/19. Staff P said she wanted to make sure she had all the orders and details to discuss with the family in order to answer any questions they may have. Staff P responded the resident had not been as declined the previous week. Staff P said after the resident got back from the hospital she noticed a decline. Staff P stated mostly the resident refused to get out of bed, just said no. Staff P commented times they could convince the resident to get out of bed and times she refused. Staff P responded they had been keeping the family notified of the decline. Staff P said the skin and wound assessments in the electronic record would contain documentation when the family and the doctor notified of changes if skin getting better. Staff P reported the ARNP Wound Nurse new to the facility and prior to her coming to do wound treatment, the facility communicated with the resident's primary doctor. On 5/15/19 at 11:10 a.m., Staff J, LPN, responded she was not sure how long the resident bed fast but she had not seen her out of	F 580		

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bed for a while, could be a week or weeks. Staff J said she used to see the resident up and about but not seen recently.

On 5/15/19 at 2:25 p.m., the primary ARNP reported she saw the resident as the primary care physician but not following the pressure sores. The primary ARNP reported the facility told her the ARNP Wound Nurse started following residents for pressure sores. The primary ARNP said she routinely examined the resident every other month and previously aware the resident had a Stage 2 pressure. The primary ARNP said she received a call 4/30/19 to inform her the resident had an elevated blood sugar reading and let her know the resident not laying down. The primary ARNP reported the on-call contacted at the end of the previous week. The primary ARNP confirmed staff to notify her with condition changes and in the evenings the staff can call the office answering service to speak to the on-call doctor. The primary ARNP confirmed she spoke with the family and told the resident not getting up for 3 weeks. The primary ARNP said she had been in the facility the previous week and heard the resident in her room during cares and asked what was going on. The primary ARNP said staff told her the resident had not been getting up for a few days due to her bottom. The primary ARNP stated the facility had not made her aware the pressure sore opened or got worse after return from the hospital. The primary ARNP stated she is usually made aware of changes from the facility but she had not been made aware of this resident's changes in conditions. The primary ARNP stated she would have wanted updated about the wound deterioration, the resident not eating as well, and the resident not getting out of bed for 3 weeks. The primary ARNP said she

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had been aware at that time in March the resident scooching in wheelchair, sliding down, and the facility got a bigger wheelchair. The primary ARNP stated the facility notified her on 3/23/19 the resident had 1 blood blister to her bottom that measured 6.0 cm by 6.0 cm, skin intact, raw, and resident turned side to side. The facility asked to be advised and a Duoderm treatment ordered and to change every 3 days. The primary ARNP stated after that she was not updated and then the resident went out to the hospital. The primary ARNP stated she was next notified in April the resident lowered to the floor and the staff asked if they could make the resident a hoyer transfer which she did order. The primary ARNP stated if a wound progressed or got worse she would have wanted the wound center brought in. The primary ARNP responded she was unaware that Staff A had the hospice nurse speak to the family the day before and said that would not be the proper technique for getting a hospice evaluation. The primary ARNP again stated she was not aware the pressure had gotten as big as it was. The primary ARNP reported March 2019 the last time she had seen the resident for a physical examination.

On 5/15/19 at 4:36 p.m. Staff W, LPN, reported he worked in the facility for a year. Staff W stated he was familiar with Resident # 97's care. Staff W stated since the resident returned from the hospital at the end of March, not get up from the bed. Staff W said therapy tried to work with the resident but it had been hard for them. Staff W stated when getting up the resident became dead weight not want to do anything so she didn't want up. Staff W commented they had to bribe the resident with diet Pepsi to try. Staff W responded the last time he recalled the resident out of bed,

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not that week or the week before. Staff W stated the thought the primary ARNP knew but then said wait, not sure if she knew. Staff W then stated the son came to check on the resident and upset his mom not getting up, but he saw she wasn't cooperating. Staff W responded he did not call the on-call doctor after speaking to the family; commented he waited for the fax to come back 5/13/19 for order for the UA. Staff W could not recall if he ever notified the family or the primary ARNP about the resident's decline or change post hospital.

On 5/15/19 at 5:19 p.m., Staff AA, Certified Medication Aide (CMA), worked for the facility for 3 years and familiar with Resident #97's cares. Staff AA responded she thought the resident had been in bed about 2 months. Staff AA said the resident had been up before the hospital and acknowledged the resident had declined a lot. Staff AA stated prior to hospitalization the resident fed herself and now ate only a little bit.

On 5/15/19 at 5:21 p.m., Staff X, CNA, reported she worked for 2 years at the facility and familiar with Resident # 97. Staff X responded staff got the resident up when she came back from the hospital for a couple of days but after that the bottom very bad so always made her lay down because of her bottom. Staff X stated sometimes they put the resident in her wheelchair to lay on her side, however, the resident still sat on her butt so they would lay her down in bed. Staff X recalled the resident used to stand up with walker to transfer, wouldn't stand up, so they began to use the hoyer.

On 5/16/19 at 12:40 p.m., the DON pointed out the facility skin assessments documented the

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F 580	Continued From page 24 primary ARNP had seen the resident on 4/10/19 and 4/15/19 and she wrote new orders each time. The DON confirmed the ARNP did not physically examine the resident. The DON said Staff P showed the ARNP the picture of the wound and the ARNP gave new orders.	F 580		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		

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F 582	Continued From page 25 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices for 2 of 3 residents reviewed for beneficiary notification protection. (Residents #38 and #61). The facility identified a census of 115 residents. Findings include: 1. Review of facility documentation for Resident #38 revealed the resident received Medicare benefits for skilled services from 2/27/19 to 3/18/19 and stayed in the facility for nursing services.	F 582		

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F 582	Continued From page 26 2. Review of facility documentation for Resident #61 revealed the resident received Medicare benefits for skilled services from 2/18/19 to 2/28/19 and stayed in the facility for nursing services. During an interview on 5/14/19, at 11:20 AM, the Director of Social Services confirmed the facility lacked documentation to support provision of the required CMS forms, "Notice of Medicare Non-Coverage" (CMS form 10123) and "Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage" (CMS form 10055) to the identified residents.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

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F 609	Continued From page 27 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy review and interviews, the facility failed to submit a report of the results of all allegations of abuse investigations to the State Survey Agency, within 5 working days of the incident for 1 of 2 current residents reviewed for allegations of abuse, (Resident #30). The facility identified a census of 115 current residents. Findings include: The Minimum Data Set (MDS) dated 12/9/18 documented the pertinent diagnoses of Non-Alzheimer's dementia, Anxiety and Depression for Resident #30. The MDS documented the resident's verbal communication is understood and usually understands what is communicated to her, hearing is adequate and wears glasses. The resident had a Brief Interview of Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. The resident experienced delusions and exhibited verbal behaviors 1-3 days of the 7 day assessment period. The resident required extensive assistance for transfer, bed mobility, ambulation, dressing, eating, toileting, and hygiene. Resident #30 had 2 or more falls without injury since the last MDS completed on 10/14/18.	F 609		

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F 609	Continued From page 28 The resident received scheduled pain, antianxiety and antidepressant medications for 7 of 7 days of the assessment period. A Care Plan problem dated 1/24/19 identified the resident was dependent upon staff for meeting emotional, intellectual, physical and social needs related to cognitive deficit and dementia disease process and directed staff to converse with resident while providing care. The Care Plan problem dated 2/10/19 identified the resident has an activities of daily living (ADL's) self-care deficit and directed staff to not leave the resident un-attended in the common area and utilizes a wheelchair as her primary mode of locomotion. The Care Plan identified the resident at high risk for falls related to confusion, history of falls and unawareness of safety needs and directed staff place a pressure pad alarm under the resident while seated in a chair. During interview on 5/15/19 at 3:15 PM the Director of Nursing (DON) stated she reviewed night shift camera surveillance of the Cedar hall common area on 2/20/19 because a certified nursing assistant (CNA), reported he fell during the night in this area shortly before midnight on 2/19/19 and she wanted to review his fall. The camera surveillance showed Staff E pushed Resident #30 back into the recliner in a very rough manner after she tried to stand and after the employee fell trying to respond to her. She reported this incident to DIA on 2/20/19 and suspended Staff E. Because of the concern she saw on the surveillance video of 2/19/19 she decided to review previous days of night shift camera surveillance of this area. On 2/22/19 she reviewed camera surveillance of Cedar hall common area during the night shift of 2/17/19.	F 609		

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F 609	Continued From page 29 She saw Staff F, Licensed Practical Nurse (LPN), placed a dining room chair under the extended footrest of the recliner where Resident #30 sat to restrict her from arising from the recliner. The DON stated she considered this an allegation of abuse due to restraint/unreasonable confinement so she reported it to DIA as an addendum to the previously filed report regarding Staff E and noted it in her 5 day summary submitted to DIA regarding investigation of the incident involving Staff E. The DON stated she did not file a 5 day summary of the incident investigation which involved Staff F to DIA. During interview on 5/15/19 at 3:45 PM Staff H and I, Human Resources representatives stated they met with Staff F on 2/22/19 and suspended his employment pending investigation of the incident observed on 2/17/19. Staff I stated after the investigation of the incident she, Staff H, the former administrator and the DON discussed what should be done regarding Staff F. The decision was made to assign Staff F to the 6:00 AM-2:00 PM shift on the 2nd floor so there would be more supervision of his performance and less temptation to use his cell phone while on duty as identified on video surveillance review of the night shift of 2/16/19. The facility's Abuse Prevention, Identification, Investigation and Reporting Policy revised 4/1/17 direct the following under Investigation: Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to DIA. This written report shall be forwarded to DIA within 5 days of the initial report.	F 609		
F 610	Investigate/Prevent/Correct Alleged Violation	F 610		

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F 610 SS=D	Continued From page 30 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and interviews, the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment while an alleged violation is awaiting investigation by the Iowa Department of Inspections and Appeals (DIA) for 1 of 2 residents reviewed for allegations of abuse. Resident #30. The total sample consisted of 25 current residents. The facility identified a census of 115 current residents. Findings include: The Minimum Data Set (MDS) dated 12/9/18 documented the pertinent diagnoses of Non-Alzheimer's dementia, Anxiety and Depression for Resident #30. The resident's	F 610		

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F 610	Continued From page 31	F 610		

verbal communication is understood and usually understands what is communicated to her, hearing is adequate and wears glasses. The resident had a Brief Interview of Mental Status (BIMS) score of 4 which indicated severe cognitive impairment. The resident experienced delusions and exhibited verbal behaviors 1-3 days of the 7 day assessment period. Resident #30 required extensive assistance for completion of transfer, bed mobility, ambulation, dressing, eating, toileting, and hygiene. The resident had 2 or more falls without injury since the last MDS completed on 10/14/18. The resident received scheduled pain, antianxiety and antidepressant medications for 7 of 7 days of the assessment period.

A Care Plan problem dated 1/24/19 identified the resident is dependent upon staff for meeting, emotional, intellectual, physical and social needs related to cognitive deficit and dementia disease process and directed staff to converse with resident while providing care. The Care Plan problem dated 2/10/19 identified the resident has an activities of daily living (ADL's) self-care deficit and directed staff to not leave the resident un-attended in the common area and utilizes a wheelchair as her primary mode of locomotion. The Care Plan identified the resident at high risk for falls related to confusion, history of falls and unawareness of safety needs and directed staff place a pressure pad alarm under the resident while seated in a chair.

During interview on 5/15/19 at 3:15 PM the director of nursing (DON) stated she reviewed night shift camera surveillance of the Cedar hall common area on 2/20/19 because Staff E, certified nursing assistant (CNA), reported he fell

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F 610	Continued From page 32	F 610		

during the night in this area shortly before midnight on 2/19/19 and she wanted to review his fall. The camera surveillance showed Staff E pushed Resident #30 back into the recliner in a very rough manner after she tried to stand and after the employee fell trying to respond to her. She reported this incident to DIA on 2/20/19 and suspended Staff E. Because of the concern she saw on the surveillance video of 2/19/19 she decided to review previous days of night shift camera surveillance of this area. On 2/22/19 she reviewed camera surveillance of Cedar hall common area during the night shift of 2/17/19. She saw Staff F, licensed practical nurse (LPN), placed a dining room chair under the extended footrest of the recliner where Resident #30 sat to restrict her from arising from the recliner. The DON stated she considered this an allegation of abuse due to restraint/unreasonable confinement so she reported it to DIA as an addendum to the previously filed report regarding Staff E.

During interview on 5/15/19 at 3:45 PM Staff H and I, human resources representatives stated they met with Staff F on 2/22/19 and suspended his employment pending investigation of the incident observed on 2/17/19. Staff I stated after the investigation of the incident she, Staff H, the former administrator and the DON discussed what should be done regarding Staff F. The decision was made to assign Staff F to the 6:00 AM-2:00 PM shift on the 2nd floor so there would be more supervision of his performance and less temptation to use his cell phone while on duty as identified on video surveillance review of the night shift of 2/16/19.

The facility's Abuse Prevention, Identification, Investigation and Reporting Policy revised 4/1/17

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F 610	Continued From page 33 direct the following under Initial /Immediate Protection During Facility Investigation: Following completion of the facility investigation if the facility concludes that the allegations of resident abuse are unfounded, the employee may be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility here no contact will be made between the accused employee and the resident alleged to have been abused. This separation must be maintained until the Department [DIA] concludes its investigation and issues the written results of its investigation. Note: if DIA determines there was abuse (even though the facility did not substantiate abuse) there is risk that DIA could cite the facility with immediate jeopardy for allowing an abuser to have access to other residents while the matter was being investigated. The investigation of the allegation of abuse #81668-M against Staff E and F was not initiated until 5/14/19. Review of the time clock record for Staff F revealed he returned to work on 2/27/19 and worked 6:00 AM-2:00 PM shifts on the following dates until his involuntary termination on 3/27/19 for an unrelated facility policy infraction: 2/27, 2/28, 3/1, 3/3, 3/4, 3/5, 3/8 through 3/16, 3/18 through 3/20 and 3/22 through 3/25/19.	F 610		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		

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F 644	Continued From page 34 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer one of three residents (Resident #110) who had a Level II Preadmission Screening and Resident Review (PASRR) when they had a significant change in mental health status and treatment to the appropriate state-designated authority for Level II PASRR evaluation and determination, and failed to incorporate PASRR recommendations for one of three residents reviewed (Resident #108). Findings include: 1. The annual Minimum Data (MDS) assessment dated 8/19/18 revealed Resident #110 had diagnosis of Alzheimer's Dementia, Anxiety Disorder, Delusional Disorder, intentional self-harm by sharp object, and Excoriation (skin picking) Disorder. The MDS documented the resident had a brief interview of mental status (BIMS) of 4, indicating severely impaired cognition. The resident not considered by the	F 644		

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F 644	Continued From page 35	F 644		

state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The assessment documented Resident #110 entered the facility on 10/16/17. The MDS documented the resident had no delirium. The resident took an antidepressant seven of the seven days during the look-back period,

The quarterly MDS dated 4/28/19 revealed the resident had no physical or verbal behaviors or delirium. The MDS revealed the resident took an antipsychotic and an antidepressant seven of seven days during the look-back period.

Review of the clinical record revealed a PASRR Notice dated 11/6/17. The PASRR documented Resident #110 had diagnoses of dementia. The PASRR documented the resident took antipsychotic medication. The PASRR documented no further PASRR screening required unless the resident had a suspected major mental illness of intellectual or developmental disability or had a significant change in behaviors or treatment needs.

The Diagnosis Report in the electronic health record documented Resident #110 had Dementia without behavioral disturbance (10/16/17), Excoriation (skin-picking) Disorder (10/16/17), Delusional Disorder (10/19/17), intentional self harm by unspecified object (10/20/17), and Anxiety Disorder (5/8/19).

The care plan revised on 4/30/19 identified Resident #110 had diagnoses of Dementia, Depression and self-inflicted wounds on her face. The care plan directed staff to administer antidepressant and antipsychotic medications as

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F 644	Continued From page 36 ordered. The physician order summary revealed Zyprexa by mouth at bedtime for diagnoses of intentional self-harm by sharp object since 3/7/19, and Zoloft at bedtime for Depression since 3/4/19. During an interview 5/16/19 at 9:25 AM, the Social Worker reported she had not been trained to do PASRR's yet. During an interview 5/16/19 at 9:30 AM, the Admissions Director reported she only performed the PASRR's when a resident admitted from the community, and ensured the PASRR completed whenever a resident came from the hospital. During an interview 5/16/19 at 9:35 AM, Staff P, Registered Nurse, reported she had followed up on PASRR's the past year. Staff P stated the previous staff member who had completed the PASRR's no longer at the facility. Staff P reported if a resident had a change in mental health condition or had transferred to the hospital for a psychiatric condition, she made a referral to ASCEND to do a PASRR evaluation prior to the resident's readmission. 2. The MDS assessment dated 4/28/19 documented Resident #109 had diagnoses	F 644		

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F 644	Continued From page 37 including Thyroid Disorder, Osteoporosis, Alzheimer's disease, Parkinson's disease, Anxiety, Depression, and a Psychotic Disorder. The PASRR evaluation dated 3/4/18 documented the resident met the criteria for having a diagnosis of mental illness as defined by PASRR. The evaluation gave recommendations for specialized services. Recommendations included: a. Initial psychiatric evaluation to determine diagnosis and develop plan of care. b. Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. c. Obtain archived psychiatric records to clarify history and to provide to treating physicians. The Care Plan dated 2/6/19 did not include any of the recommendations.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental	F 645		

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F 645	Continued From page 38 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual	F 645		

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F 645	Continued From page 39 is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to submit a PASRR (Preadmission Screening and Resident Review) with a change in condition (Resident #46). The facility identified a census of 115 current residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/17/19 documented Resident #46 had diagnoses including high cholesterol, Dementia, Anxiety Disorder, Depression, Psychotic Disorder, and Lung Disease. A PASSR with assessment dated 9/23/08 instructed to complete an secondary assessment due to mental illness. A secondary assessment dated 6/24/10 documented a Delusional Disorder and Resident #46 took Prozac (antidepressant medication), Seroquel (antipsychotic medication), and Ativan	F 645		

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F 645	Continued From page 40 (antianxiety medication). The Medication Review Report dated 3/29/19 documented the resident had Vascular Dementia with behavioral disturbance, Anxiety Disorder, and Major Depression. The report documented the received Ativan, Seroquel, Trazadone (antidepressant medication), Effexor (antidepressant medication). The addition of diagnoses and medications required the facility to submit a new PASSR. The facility did not submit information for a new PASSR review until 5/14/19.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		

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F 656	Continued From page 41 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop a comprehensive care plan for psychotropic medications for 3 of 5 residents reviewed (Resident #1, #106, & #108). The facility reported a census of 115 residents. Findings include: 1. The Minimum Data Set assessment (MDS) dated 5/5/19 documented Resident #1 had diagnoses including Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Arthritis, Alzheimer's disease, Anxiety, and Psychotic disorder. The MDS documented the resident received an antipsychotic medication	F 656		

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F 656	Continued From page 42 daily and an antidepressant daily. The Care Plan dated 2/7/19 addressed the resident's mood. The Care Plan directed staff to administer medications as ordered and monitor for side effects as well as effectiveness. The Care Plan did not address the resident's use of antipsychotic medication and antidepressant medication use. The Care Plan did not list targeted behaviors and interventions for each psychotropic medication. 2. The MDS assessment dated 4/28/19 for Resident #106 documented diagnoses including Alzheimer's disease, Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. The MDS documented the resident received an antipsychotic medication daily, an antianxiety medication daily, and an antidepressant daily. The Care Plan dated 2/2/19 addressed the resident's antidepressant medication use but lacked any information on the resident's antipsychotic and antianxiety medication use. The Care Plan did not list targeted behaviors and interventions for each psychotropic medication. 3. The MDS assessment dated 4/28/19 documented Resident #108 had diagnoses including Hypertension, Renal Failure, Diabetes Mellitus, and Dementia. The MDS documented	F 656		

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F 656	Continued From page 43 the resident received an antipsychotic medication daily, an antianxiety medication daily, and an antidepressant daily. The Care Plan dated 2/13/19 addressed the resident's psychotropic drug use and listed adverse reactions. The care plan did not address the adverse effects of the antipsychotic medication, antianxiexty medication, and antidepressant medication. The Care Plan did not list targeted behaviors and interventions for each psychotropic medication. During an interview on 5/15/19 ay 10:37 a.m. Staff E, MDS and Care Plan Coordinator stated the Care Plan should address each class of psychotropic medication and adverse effects for monitoring.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

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F 657	Continued From page 44 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to update the comprehensive care plan for one of twenty-five residents reviewed (Residents #86). The facility reported a census of 115 residents. Findings include: The Minimum Data Set (MDS) assessment dated 4/14/19 documented Resident #86 had diagnoses of Cerebrovascular Accident (stroke), Anemia, and Chronic Deep Vein Thrombosis (blood clot). The MDS recorded the resident had a brief interview for mental status (BIMS) of 13, which indicated cognition intact. The care plan revised on 2/13/19 revealed the resident had a "Do Not Resuscitate" (DNR) advanced directive. The staff directives included do not initiate CPR (cardiopulmonary resuscitation) if they found the resident had no pulse or respirations. The Physician's Order Summary revealed Resident #86 a full code with an order date	F 657		

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F 657	Continued From page 45 3/22/2019. The electronic health record profile completed 1/5/18 revealed Resident #86 had a full code status. An Advanced Directive signed by the resident on 1/5/18, revealed the resident a full code. The facility failed to update or revise the care plan to reflect the resident's advanced directive for a full code status. In an interview 5/15/19 at 8:33 AM, Staff J, Licensed Practical Nurse (LPN) reported she looked at the profile screen to determine a resident's code status. In an interview 5/15/19 at 8:53 AM, Staff K, LPN, reported the nurse who had done the resident's admission initiated the initial care plan which addressed the resident's advanced directive or code status. Staff K stated he checked the electronic health record to determine if a resident had a full code or DNR status. During an interview 5/16/19 at 9:45 AM, Staff L, MDS Coordinator, reported the social worker (SW) updated the advanced directive section of the care plan. During an interview 5/16/19 at 10:05 AM, the SW reported she updated the advanced directive on the resident's care plan. The SW stated whenever the resident had a significant change MDS or annual MDS, she completed certain sections of the MDS, which triggered the CAA's (Care Area Assessment), and she updated the pertinent sections of the care plan. The SW	F 657		

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F 657	Continued From page 46 confirmed Resident # 86's care plan for advanced directive needed updated to reflect or coincide with the resident's desired advanced directive and physician orders.	F 657		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff	F 661		

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F 661	Continued From page 47 interview, the facility failed to complete a recapitulation for 1 of 3 closed record review (Resident #114). The facility reported a census of 115 residents. Findings include: Review of Resident #114's chart revealed the resident was admitted on 1/30/19 and discharged to the community on 2/13/19. The clinical record lacked a recapitulation of the resident's stay. During an interview on 05/16/19 07:43 a.m. the Director of Nursing stated the resident does not have a recapitulation in the clinical record.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, family interview, and staff interview, the facility failed to assess and intervene when a resident demonstrated a significant decline in Activities of Daily Living (ADLs) and failed to intervene in a timely manner to obtain a UA (urinalysis) for 1 of	F 684		

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F 684	Continued From page 48 25 sampled residents reviewed (Resident #97). The facility reported a census of 115 residents. Findings include: 1. The MDS assessment dated 1/13/19 for Resident # 97 identified a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, personal hygiene, 2 persons for toilet use, and independent with set up help only with eating. The MDS revealed the resident walked once or twice with the assistance of 1 person in the room and corridor. The MDS documented diagnoses that included Diabetes Mellitus, Alzheimer's Disease, moderate recurrent Major Depressive Disorder, Morbid (severe) Obesity, Chronic Kidney Disease stage 3 (moderate), and other skin changes. The MDS recorded the resident at risk of pressure ulcers/injuries but did not have any unhealed pressure sores. The Significant Change MDS assessment dated 4/21/19 documented the resident returned from the hospital on 3/29/19. The MDS identified a BIMS score of 09 which indicated moderate cognitive impairment. The resident required the extensive physical assistance of 1 person for personal hygiene, 2 persons for bed mobility, dressing, toilet use, and supervision of 1 person for eating. The resident was totally dependent upon 2 persons for transfers and did not walk in room or corridor during the assessment period. The MDS record the presence of 1 Stage II, 2 Stage III, and 1 Unstageable Deep Tissue Injury pressure ulcers.	F 684		

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F 684	Continued From page 49 The care plan revealed the following: a. On 2/11/19, a focus area identified an ADL self-care performance deficit related to Alzheimer's disease. b. On 2/22/19 staff directed to provide assistance of 1 staff for dressing, 1 staff with gait belt for transfers, the use of the wheelchair to go to meals and back per resident preference, and to complete the restorative nursing program as ordered. c. On 3/25/19 a new focus area identified an Unstageable pressure sore at the sacrum (located at the base of the lumbar vertebrae and connected to the pelvis) related to incontinent of bowel (diarrhea)/bladder, resistive to peri-care/repositioning, and poor nutritional intake. d. On 3/26/19 the care plan documented the resident non-complaint with cares, repositioning, and incontinence cares. e. On 4/1/19 new interventions directed staff to frequently turn and reposition the resident and to provide NIP supplement to promote wound healing. f. On 4/9/19 staff directed to use the hoyer (mechanical) lift with 2 staff for transfers starting 4/8/19. g. On 4/11/19 the care plan again informed staff the resident non-compliant with repositioning and turns. h. On 4/12/19 new focus areas identified an Unstageable pressure sore at the left gluteal fold, an Unstageable pressure sore at the right gluteal fold, and a Stage II pressure sore at the right buttock (fluid filled blister); all related to incontinent with bowel (diarrhea)/bladder, resistive to peri-care/repositioning, and poor nutritional intake. i. On 5/2/19 staff advised the resident could sit up	F 684		

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F 684	Continued From page 50 in the Broda chair (a type of reclining wheelchair) with Roho (pressure relief) cushion for meals up to 1 hour at a time as tolerated. The Restorative Nursing Program dated 1/2/19 documented the resident to ambulate approximately 50 feet with a 4 wheeled walker and contact guard assist or standby assist. The fax order dated 4/18/19 documented an order for PT/OT (Physical Therapy/Occupational Therapy) to update the RA (Restorative Aide) Program. The Therapy Communication dated 4/30/19 documented the resident could sit up in the Broda chair with the Roho cushion for meals up to 1 hour at a time as tolerated. The Progress Notes revealed the following: a. On 1/11/19 at 9:48 p.m. a care plan charting note revealed the resident alert to self, transferred with assist of 1, mobility via wheelchair with frequently asking staff to propel but self-propelling encouraged, and the resident out in the dining room and able to feed self. b. On 3/23/19 at 1:27 p.m. the resident refused to get out of bed so given a bed bath and the resident on contact precautions for loose stools and emesis. c. On 3/24/19 at 3:50 a.m. the resident's temperature 98.2 degrees, small amount of loose stool, Calmoseptine (a protective barrier) applied to buttock to prevent excoriation, and the resident remained on a pressure relief mattress with HOB (head of bed) elevated 30 degrees. At 12:28 p.m. the resident had a small amount of diarrhea,	F 684		

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F 684	Continued From page 51 refused to get up, refused cares, bed bath given, and the resident ate in room while in bed. At 6:25 p.m. the resident continued with diarrhea, refused cares including per-care, and assist of 4 utilized with a gait belt to transfer the resident to the wheelchair so the resident could get clean and the bed changed. d. On 3/25/19 at 2:00 a.m. dry excoriation observed on the left buttock with Calmoseptine documented as placed on the resident's buttock. At 12:03 p.m. the resident refused to get out of bed to check weight and at times refusing cares. At 1:46 p.m. the resident with generalized body weakness and found to have pressure sores to her bottom and documented the resident received cares and took all meds during that shift. A new order received to send the resident to the hospital and the ambulance service contacted. At 3:26 p.m. Staff P, Registered Nurse (RN)/facility wound nurse, documented a detailed Skin/Wound Note. Staff P recorded the resident had 4 areas of Unstageable pressure. Staff P documented the resident with generalized body weakness due to diarrhea, refused to be out of bed, non-compliant with cares, refused/resistive during peri-care and repositioning/turns while in bed. Staff P documented the resident with poor nutritional intake related to current illness and diagnosis of diabetes mellitus. Staff P wrote the nurse called the primary ARNP and received an order to send to the hospital for further evaluation and treatment. e. On 3/29/19 at 10:09 p.m. the resident arrived back from the hospital at 5:25 p.m. The resident alert and oriented times 2 (person/place), assist of 1 with ADL's but uncooperative during care, and started on an antibiotic for UTI. f. On 3/30/19 at 9:02 p.m. documented the treatment continued to the buttock and the	F 684		

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F 684	Continued From page 52 resident refused to get up that evening. g. On 4/1/19 at 1:56 p.m. the resident noted to spend time in room, refused to get up, but the resident being turned and changed as the resident was incontinent of both bowel and urine. At 10:18 p.m. the staff documented the resident needed fed during the shift. h. On 4/4/19 at 12:32 p.m. the resident documented to refuse to get up from bed, cares were provided, treatment to wounds completed, and the resident turned to sides to reduce pressure from her buttock. At 9:27 p.m. documented the resident stayed in bed all shift, checked, changed, and turned as needed. i. On 4/5/19 at 12:18 p.m. documented the resident stayed in bed all day and reposition on side at least every 2 hours. j. On 4/7/19 at 6:30 p.m. a post fall evaluation documented for a witnessed fall. The fall occurred in the resident's room while peri-care being done. The evaluation documented yes to change in mental status, change in behaviors, and change in mobility status. At 9:31 p.m. the incident note documented the resident lowered to the floor as she was unable to bear weight when being cleaned up and the bedding being changed. k. On 4/8/19 at 9:15 p.m. a new order received from the primary ARNP to evaluate the resident to be a hoyer transfer and documented family notified. l. On 4/15/19 at 1:11 p.m. the resident repositioned but refused getting out of bed throughout the shift. m. On 4/22/19 at 11:05 a.m. an Activity Significant Change MDS progress note documented the resident recently laid in bed often. n. On 5/3/19 at 8:47 p.m. a Life Enrichment Note documented the resident now a 1 to 1 program	F 684		

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F 684	Continued From page 53 but at times refusing visits and spending a lot more time in room. o. On 5/10/19 at 9:17 a.m. a Communication with Family documented by the Social Worker (SW). The entry recorded the resident's son came to discuss the resident's current state after being told by the nurses the resident refused a lot of cares, chose to stay in bed all day, and stated he felt like his mom may be giving up. The SW wrote she educated the son about hospice and palliative care and the son expressed interest in information on palliative care. The SW wrote she discussed options for the resident with the clinical team and would follow up with the son early the next week. At 12:27 p.m. the son went to Staff U, Licensed Practical Nurse (LPN), to request a UA (urinalysis) test. Staff U wrote the resident had been down, refusing to do things, incontinent of bowel and urine, and changed per staff. At 12:33 p.m. Staff U documented she sent a fax out to the physician requesting a UA per family request. p. On 5/13/19 at 3:45 p.m., the son came to visit the resident and complained of the resident not able to stay awake, engage in conversation, or eat a meal. Staff A, LPN, wrote she tried to explain that aides help with the feeding in the room and the resident refused getting up. Staff A wrote the son requested a UA and palliative care evaluation. Staff A documented a fax had been sent to the primary ARNP and staff still waited for a response. q. On 5/14/19 at 5:53 a.m. orders received for palliative care and UA with dysuria (painful urination); UA obtained without difficulty with cloudy yellow urine output. At 2:36 p.m. a fax sent to the primary ARNP with the UA results, son notified, and the wound doctor seen the resident with treatment done. r. On 5/15/19 at 7:45 a.m. the resident red and	F 684		

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F 684	Continued From page 54 flushed in the morning with a High FBS (fasting blood sugar reading), the on-call doctor notified, and temperature 99.4 degrees. At 7:58 a.m. the son updated on the resident's status and the daughter-in-law to be in the facility that day. At 8:40 a.m. a Communication with Family documented by the SW. The SW wrote the daughter-in-law visibly upset and wanted to see the primary ARNP when she arrived to do rounds and wanted to ensure the resident on the list to be seen. The SW wrote that she explained to the daughter-in-law she does not communicate directly with the ARNP but assured the resident would be seen. The SW wrote she referred the daughter-in-law to the ADON (Assistant Director of Nursing) who would be better equipped to answer nursing related questions. The SW documented she apologized to the daughter-in-law that the family not aware of the resident's health decline. The SW recorded the daughter-in-law and son very upset the resident may be hospice appropriate and the SW immediately notified the DON of the interaction. At 8:57 a.m. Staff U documented the resident very sleepy during the shift barely opening her eyes. Staff U wrote she put the resident's dentures in her mouth, tried to feed her but the food spit out, and the resident refused medications. Staff U documented the physician aware, would be in to see the resident, and she repositioned the resident in the bed. At 11:20 a.m. Staff U documented the ambulance arrived, the resident transferred by assistance of 3 persons and a hoyer. At 12:09 p.m., Staff U documented the daughter-in-law spoke to the physician regarding the resident decline, the recheck of the blood sugar at 10:00 a.m. 597, and the physician notified vital signs abnormal for the resident.	F 684		

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F 684	Continued From page 55 Staff U wrote the facility still waited on the C&S (Culture & Sensitivity) report from the UA test. Staff U wrote she called for ambulance transport. Observations revealed the following: a. On 5/13/19 at 11:32 a.m. Resident # 97 laid in bed positioned on her back. b. On 5/14/19 at 9:33 a.m. Resident # 97 positioned on her right side in bed with a pillow on her left side of back to position. At 11:59 a.m. Resident # 97 laid in bed on her back, air pump in place on the bed, and functioning. Attempted conversation with the resident and not really responding. c. On 5/14/19 at 1:32 p.m. the ARNP Wound Nurse, Staff P, and Staff A, entered the room to provide cares and assess the sacral wound. d. On 5/15/19 at 8:35 a.m., Staff U reported she worked for the facility for a year and familiar with Resident # 97's cares prior to going to the hospital. Staff U stated prior to going to the hospital the resident used to be up talking and walking. Staff U responded the resident came from the hospital with the pressure sores. Staff U attempted to rouse the resident to take drinks of water, drinks of Pepsi, and to attempt a bite of food. Resident # 97 slow to respond or open eyes, and moaned in response to being rubbed on the arm. Resident # 97 did take in dentures, but did not take a drink or meds. Staff U gave Resident # 97 a bite of food which the resident spit out. Staff U stated the resident not going to accept anything at that time so she would just wait for the doctor who was supposed to be coming. e. On 5/15/19 at 11:15 a.m., observation revealed paramedics arrived to the resident's room to assess and transport the resident to the hospital. Resident # 97's daughter-in-law at the resident's	F 684		

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F 684	Continued From page 56 bedside with Resident # 97's son on the speaker phone. The family relayed concerns the resident showed signs of dehydration with wrinkled skin and increased temperature above 100 degrees Fahrenheit. The daughter-in-law reported she spoke to the primary ARNP who had just been in the facility to assess the resident and the ARNP told her she had not been made aware the resident's condition that bad. The primary ARNP visit note dated 5/15/19 recorded a routine visit. The notes included the following documentation: Staff related the resident refused morning meds, would not eat breakfast, and had eaten less the last 3 weeks, but did not refuse meals. That day, the staff informed the primary ARNP the coccyx wound much worse, the wound nurse debrided it that week, it was nearly to the bone, and the wound packed daily. Staff related the resident had not been getting up out of bed for about 3 weeks due to sore on coccyx and when the resident sat up in the wheelchair she scooted down so staff concerned the resident would fall out of the wheelchair and make her wound worse due to shearing. The resident appeared quite ill, ashen, diaphoretic (sweating heavily), hot, and recheck of vital signs showed hypotension (low blood pressure), febrile (elevated temperature). Discussed with family and the resident to be sent to the hospital for evaluation and treatment. The family stated in a care conference the previous week they were asked if they would like palliative care or hospice care due to the resident's coccyx wound. The ARNP wrote she was unaware this was being discussed. The Hospital Progress Notes dated 5/16/19 at	F 684		

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F 684	Continued From page 57 6:59 a.m. documented the resident presented to the ED (Emergency Department) secondary to altered mental status and found to have osteomyelitis of the sacrum, renal failure, and UTI. The note recorded after long discussion with the family, the resident to be comfort cares only and hospice consult placed. The Impressions/Plan recorded a diagnosis of sepsis (a life-threatening illness caused by your body's response to an infection) secondary to osteomyelitis. Interviews: On 5/15/19 at 9:06 a.m., the resident's daughter-in-law and son reported the son went in to visit and seen his mother asleep when staff told him she was not eating. The son stated he asked how long it had been going on and told a couple weeks not eating as much, would drink, but not eating much breakfast and not lunch. The son reported the last time he visited his mother's lunch sat on the tray and she slept. The son stated the facility had a meeting with him on Friday (5/10/19) to tell him his mother should get palliative or hospice care in there so he said okay because his mom was going downhill. The family reported on 5/10/19 they called the facility to tell them to get a hold of the doctor as he wanted a UA test done to check for a UTI. The son stated he felt a UA needed because maybe the same thing going on with UTI as it had the last time his mother was hospitalized. The son repeated he asked Friday morning for a UA and he had not heard anything as of Monday. The son reported when in the facility on 5/13/19 he asked about the results and the LPN there couldn't tell him anything and he felt he got different stories from everyone. The son stated he thought his mother had a UTI when told the blood sugar reading over	F 684		

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600 and said he was told the preliminary report showed blood in urine, WBC (white blood cells) in urine, and showed the body fighting something. The son said he he felt his mother had an infection somewhere and something needed to be done before she turned septic. The son voiced he wanted his mom hospitalized immediately.

On 5/15/19 at 10:25 a.m., Staff A responded she did not know for sure how long the resident had been declining, not responding, or opening eyes. Staff A commented the resident did open and close eyes before when feeding the week before and would say yes but no sentences used to communicate the day before.

On 5/15/19 at 10:35 a.m., Staff V, LPN, reported she only worked with Resident # 97 a couple of times since starting work for the facility on 4/23/19. Staff V reported what she knew of the resident to be Resident # 97 slept a lot and family would come in and ask why the resident sleeping a lot and in the bed. Staff V stated one time the resident said no when had meals put to her mouth and pulled away. Staff V stated she knew the son in the day before and upset that no one got a UA done on the resident when he had asked a few days prior but she heard the order had not been received.

On 5/15/19 at 10:40 a.m., Staff Y, CNA, reported she was familiar with Resident # 97's cares and worked for the facility for 3 years. Staff Y said sometimes the resident only up once a week. Staff Y stated after being in the hospital, Resident # 97 declined. Staff Y stated the resident may drink but been a while that she kept her eyes closed while eating but still took food when put to

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her mouth. Staff Y responded she did assist the resident one day to sit up on the edge of the bed but got no further because she was too weak. Staff Y could not recall the day or how long ago that attempt to get up occurred.

On 5/15/19 at 10:50 a.m., Staff P, RN/Wound Nurse, said after the resident got back from the hospital she noticed a decline. Staff P stated mostly the resident refused to get out of bed, just said no. Staff P commented times they could convince the resident to get out of bed and times she refused.

On 5/15/19 at 11:10 a.m., Staff J, LPN, stated she had worked for the facility for 15 years and only worked on Resident # 97's hall when a medication aide assigned to pass medications there. Staff J responded she was not sure how long the resident bed fast but she had not seen her out of bed for a while, could be a week or weeks. Staff J said she used to see the resident up and about but not seen recently.

On 5/15/19 at 2:25 p.m., the primary ARNP reported she saw the resident as the primary care physician but not following the pressure sores. The primary ARNP reported the on-call contacted at the end of the previous week. The primary ARNP confirmed she spoke with the family and told the resident not getting up for 3 weeks. The primary ARNP said she had been in the facility the previous week and heard the resident in her room during cares and asked what was going on. The primary ARNP said staff told her the resident had not been getting up for a few days due to her bottom. The primary ARNP stated she would have wanted updated about the wound deterioration, the resident not eating as well, and

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the resident not getting out of bed for 3 weeks. The primary ARNP stated there was a note on 5/10/19 from the on-call doctor the resident incontinent, refused to get out of bed, and the doctor advised to get a UA. The primary ARNP stated the UA documented as not collected till 5/13/19 and she knew of no reason why there should have been a delay in collecting the UA. The primary ARNP confirmed the delay in getting the UA may have changed the course of treatment decisions. The primary ARNP stated the bigger question she had that day when she assessed the resident was whether or not urine the issue or the wound. The primary ARNP said the urine results not horrific, the WBC 11 to 25,000, responded to the facility that afternoon, the results abnormal and would not treat with antibiotics but would take a look at the resident when she returned from the hospital. The primary ARNP stated the wound nurse debridement could have caused the blood sugars to elevate. The primary ARNP stated there was no excuse for not getting the UA Friday.

On 5/15/19 at 4:36 p.m. Staff W, LPN, reported he worked in the facility for a year. Staff W stated he was familiar with Resident # 97's care. Staff W stated since the resident returned from the hospital at the end of March, not get up from the bed. Staff W said therapy tried to work with the resident but it had been hard for them. Staff W stated when getting up the resident became dead weight not want to do anything so she didn't want up. Staff W commented they had to bribe the resident with diet Pepsi to try. Staff W responded the last time he recalled the resident out of bed, not that week or the week before. Staff W said the resident didn't want to do anything, the son wanted to get a UA test, a fax sent but he needed

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to wait for an okay. Staff W commented most times they had to wait 3 days to push fluids to wait to see if a resident complains before get UA; can't get UA have to push fluids first. Staff W stated the family requested it and he explained he needed to follow protocol first. Staff W confirmed if a doctor gave the order then they would need to follow the order. Staff W confirmed the son did want treatment for his mom as of 5/10/19 when he talked to him about it. Staff W reported on Saturday (5/11/19) the son's wife called again to ask about hospice option and not happy about it. Staff W stated he explained just because offered the option they didn't have to take it; said the wife wanted treatment for the resident and upset the UA test not done. Staff W said he informed the wife they had to wait for the fax to come back for an order. Staff W responded he did not call the on-call doctor after speaking to the family; commented he waited for the fax to come back 5/13/19 for order for the UA. Staff W confirmed before hospitalization the resident went to the bathroom, went to the dining room, but after came back, not wanting to do anything. Staff W could not recall if he ever notified the family or the primary ARNP about the resident's decline or change post hospital.

On 5/15/19 at 5:19 p.m., Staff AA, Certified Medication Aide (CMA), worked for the facility for 3 years and familiar with Resident #97's cares. Staff AA responded she thought the resident had been in bed about 2 months. Staff AA said the resident had been up before the hospital and acknowledged the resident had declined a lot. Staff AA stated prior to hospitalization the resident fed herself and now ate only a little bit.

On 5/15/19 at 5:21 p.m., Staff X, CNA, reported

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F 684	Continued From page 62 she worked for 2 years at the facility and familiar with Resident # 97. Staff X responded staff got the resident up when she came back from the hospital for a couple of days but after that the bottom very bad so always made her lay down because of her bottom. Staff X stated sometimes they put the resident in her wheelchair to lay on her side, however, the resident still sat on her butt so they would lay her down in bed. Staff X recalled the resident used to stand up with walker to transfer, wouldn't stand up, so they began to use the hoyer. On 5/16/19 at 12:40 p.m., the DON stated the staff did not get the UA on 5/10/19 because they faxed out for the UA 5/10/19 and the ARNP did not answer back on the fax until 5/13/19.	F 684		
F 686 SS=G	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, observation, family interview, and staff interviews, the facility	F 686		

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F 686	Continued From page 63 failed to prevent the development of pressure sores, failed to complete wound assessments, failed to communicate decline in residents condition and deterioration of sacrum wound that developed osteomylitis and failed to complete wound treatments as ordered for 2 of 4 residents reviewed for pressure sores, (Resident #97 and Resident #9). The facility reported a census of 115 residents. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is 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. Unstageable Ulcer: inability to see the wound bed.	F 686		

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F 686	Continued From page 64 Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. The Minimum Data Set (MDS) assessment dated 1/13/19 for Resident # 97 identified a Brief Interview for Mental Status (BIMS) score of 12 without signs/symptoms of delirium. A score of 12 indicated moderate cognitive impairment. The MDS documented the resident displayed no behaviors during the 7 day look-back period which included no rejection of cares. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, personal hygiene, 2 persons for toilet use, and independent with set up help only with eating. The MDS revealed the resident walked once or twice with the assistance of 1 person in the room and corridor. The MDS documented diagnoses that included Diabetes Mellitus, Alzheimer's disease, moderate recurrent Major Depressive Disorder, Morbid (severe) Obesity, Chronic Kidney Disease, stage 3 (moderate), and other skin changes. The MDS recorded a weight of 329 pounds. The MDS recorded the resident at risk of pressure	F 686		

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F 686	Continued From page 65 ulcers/injuries but did not have any unhealed pressure sores. The Discharge Return Anticipated (DRA) MDS assessment dated 3/25/19 documented the resident went to the hospital on 3/25/19. The MDS documented the resident displayed verbal behaviors directed toward others on 1 to 3 days of the 7 day look-back period but did not display rejection of cares. The MDS revealed the presence of unhealed pressure ulcers/injuries but failed to document the number or types. The Significant Change MDS assessment dated 4/21/19 documented the resident returned from the hospital on 3/29/19. The MDS identified a BIMS score of 09 without signs/symptoms of delirium which indicated moderate cognitive impairment. The MDS documented the resident rejected cares on 1 to 3 days of the 7 day look-back period. The MDS revealed the resident required the extensive physical assistance of 1 person for personal hygiene, 2 persons for bed mobility, dressing, toilet use, and supervision of 1 person for eating. The MDS revealed the resident totally dependent upon 2 persons for transfers and did not walk in room or corridor during the assessment period. The MDS record the presence of 1 Stage II, 2 Stage III, and 1 Unstageable Deep Tissue Injury pressure ulcers. The care plan revealed the following: a. On 1/23/19 a new problem onset identified a potential for altered skin integrity due to history of irritation of skin and resident scratched, picked her skin. A blister present on the coccyx upon admit and excoriation to the perineal area. The resident chooses to lay in recliner most of the day, eating meals in room and watching TV. The	F 686		

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F 686	Continued From page 66 interventions included: the nurse to assess skin twice weekly and notify the doctor as needed; treat skin issues as ordered; NIP (nutritional supplement) due to pressure areas; peri-care per staff; gel cushion and dicem (anti-slip mat) in recliner; moisture barrier cream twice a day and as needed as resident allows; and standard pressure reducing mattress. b. On 2/11/19 a new intervention started for an alternating air mattress. c. On 2/11/19, a focus area identified the resident sometimes resistive to care and staff direction related to adjustment to nursing home and dementia. Another focus area identified an ADL (Activities of Daily Living) self-care performance deficit related to Alzheimer's disease. d. On 2/22/19 staff directed to provide assistance of 1 staff for dressing, 1 staff with gait belt for transfers, the use of the wheelchair to go to meals and back per resident preference, and to complete the restorative nursing program as ordered. e. On 3/25/19 a new focus area identified an Unstageable pressure sore at the sacrum (located at the base of the lumbar vertebrae and connected to the pelvis) related to incontinent of bowel (diarrhea)/bladder, resistive to peri-care/repositioning, and poor nutritional intake. The new interventions directed staff to: apply treatment per order; encourage good nutrition and hydration in order to promote healthier skin; and keep the skin clean and dry. f. On 3/26/19 the care plan documented the resident non-complaint with cares, repositioning, and incontinence cares. g. On 4/1/19 new interventions directed staff to frequently turn and reposition the resident and to provide NIP supplement to promote wound healing.	F 686		

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F 686	Continued From page 67 h. On 4/1/19 and revised 5/3/19 an entry directed staff to monitor and document location, size, and treatment reporting abnormalities, failure to heal, signs/symptoms of infection, maceration (softening skin) etc. to the doctor. i. On 4/9/19 staff directed to use the hoyer (mechanical) lift with 2 staff for transfers starting 4/8/19. j. On 4/11/19 the care plan again informed staff the resident non-compliant with repositioning and turns. k. On 4/12/19 new focus areas identified an Unstageable pressure sore at the left gluteal fold, an Unstageable pressure sore at the right gluteal fold, and a Stage II pressure sore at the right buttock (fluid filled blister); all related to incontinent with bowel (diarrhea)/bladder, resistive to peri-care/repositioning, and poor nutritional intake. l. On 5/2/19 staff advised the resident could sit up in the Broda chair (a type of reclining wheelchair) with Roho (pressure relief) cushion for meals up to 1 hour at a time as tolerated. The January, February, and March 2019 Treatment Administration Records (TARs) documented an entry for the administration of Calmoseptine ointment to be applied topically to the coccyx every shift as a preventative treatment to maintain skin integrity. The TARs documented the Calmoseptine treatment routinely completed 3 times a day at 5:30 a.m., 1:30 p.m., and 9:30 p.m., every day of the month with only 2 exceptions. The staff visualized the resident's buttocks approximately every 8 hours. The April 2019 TAR contained an entry to apply metahoney to the pressure sacrum, bilateral	F 686		

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F 686	Continued From page 68 gluteal fold, right buttock, and cover with mepilex daily until healed. The TAR reflected 4/17 and 4/22 left blank indicating the treatment not completed. The progress notes lacked documentation of any refusals to complete the treatment on those days. The Progress Notes revealed the following: a. On 1/11/19 at 9:48 p.m. a care plan charting note revealed the resident alert to self, transferred with assist of 1, mobility via wheelchair with frequently asking staff to propel but self-propelling encouraged, and the resident out in the dining room and able to feed self. b. On 3/22/19 at 9:23 a.m. the resident's blood sugar reading high at 516 and staff updated the primary ARNP (Advance Registered Nurse Practitioner). At 1:43 p.m., the resident noted to continue with some watery loose stools but none since 9:30 a.m. that day. The resident complained she didn't feel good, and orders to obtain specimen for C Diff test (type of infection that causes diarrhea). c. On 3/23/19 at 1:27 p.m. the resident refused to get out of bed so given a bed bath and the resident on contact precautions for loose stools and emesis. d. On 3/23/19 at 8:27 p.m., the nurse observed a pre-existing bloody blister to the left side of the resident's buttock getting bigger and tender. Peri care provided, barrier cream applied, and fax sent out to physician about condition as resident refusing to lay in bed on her side to reduce pressure to her bottom. e. On 3/23/19 at 8:46 p.m. the C Diff test results reported as negative and a fax request sent to the physician to discontinue the Miralax order due to diarrhea.	F 686		

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F 686	Continued From page 69 f. On 3/24/19 at 3:50 a.m. the resident's temperature 98.2 degrees, had a small amount of loose stool, Calmoseptine (a protective barrier) applied to buttock to prevent excoriation, and the resident remained on a pressure relief mattress with HOB (head of bed) elevated 30 degrees. At 12:28 p.m. the resident had a small amount of diarrhea, refused to get up, refused cares, bed bath given, and the resident ate in room while in bed. At 6:25 p.m. the resident continued with diarrhea, refused cares including per-care. Resident assisted by 4 staff and a gait belt to transfer to the wheelchair so the resident could get clean and the bed changed. g. On 3/25/19 at 2:00 a.m. dry excoriation observed on the left buttock with Calmoseptine documented as placed on the resident's buttock. At 12:03 p.m. the resident refused to get out of bed to check weight and at times refusing cares. At 1:46 p.m. the resident had generalized body weakness and found to have pressure sores to her bottom. The resident received cares and took all meds during that shift. A new order received to send the resident to the hospital and the ambulance service contacted. At 3:26 p.m. Staff P, Registered Nurse (RN)/facility wound nurse, documented a detailed Skin/Wound Note. Staff P recorded the resident had 4 areas of Unstageable pressure. The sacrum area measured 5.5 cm (centimeters) by 11.9 cm, the left gluteal fold measured 1.6 cm by 2.2 cm, the right gluteal fold measured 2.7 cm by 8.2 cm, and a Stage II pressure at the right buttock measured 2.7 cm by 8.2 cm. Staff P wrote the resident with impaired skin integrity related to incontinent of bowel due to diarrhea for 2 to 3 days, incontinent of bladder, and noted the C Diff test negative. Staff P documented the resident had generalized body weakness due to diarrhea, refused to be out of	F 686		

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F 686	Continued From page 70	F 686		

bed, was non-compliant with cares, refused/resistive during peri-care and repositioning/turns while in bed. Staff P documented the resident had poor nutritional intake related to current illness and diagnosis of Diabetes Mellitus. Staff P wrote the nurse called the primary ARNP and received an order to send to the hospital for further evaluation and treatment.

h. On 3/26/19 at 11:06 a.m. a call was made to the hospital and informed the resident admitted for UTI (Urinary Tract Infection) and general body weakness.

i. On 3/29/19 at 10:09 p.m. the resident arrived back from the hospital at 5:25 p.m. The resident was alert and oriented times 2 (person/place), assist of 1 with ADL's but uncooperative during care. The resident was started on an antibiotic for UTI.

j. On 3/30/19 at 2:39 a.m., the presence of open sores and eschar (dead tissue) to sacral area, area cleansed and Calmoseptine applied. The resident was on a pressure relief mattress. At 1:05 p.m. the resident noted to be very uncooperative during cares, wound to buttock cleaned, treatment applied. The resident refused to get out of the bed during the shift. At 9:02 p.m. documented the treatment continued to the buttock and the resident refused to get up that evening.

k. On 4/1/19 at 1:56 p.m. the resident noted to spend time in room, refused to get up. The resident had been turned and changed as the resident was incontinent of both bowel and urine. At 10:18 p.m. the staff documented the resident needed fed during the shift.

l. On 4/4/19 at 3:33 a.m. the resident on a pressure relief mattress. At 12:32 p.m. the resident refused to get up from bed, cares were

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F 686	Continued From page 71 provided, treatment to wounds completed, and the resident turned to sides to reduce pressure from her buttock. At 9:27 p.m. documented the resident stayed in bed all shift, checked, changed, and turned as needed. m. On 4/5/19 at 12:18 p.m. documented the resident stayed in bed all day and reposition on side at least every 2 hours. n. On 4/7/19 at 6:30 p.m. a post fall evaluation was documented for a witnessed fall. The fall occurred in the resident's room while peri-care being done. The evaluation documented yes to change in mental status, change in behaviors, and change in mobility status. The evaluation documented a Stage I pressure issue on buttock with non-blanchable erythema. At 9:31 p.m. the incident note documented the resident lowered to the floor as she was unable to bear weight when being cleaned up and the bedding being changed. The incident note recorded a scant amount of blood noted from the existing wound on buttock, the wounds cleaned, treatment completed, and weekend supervisor made aware. o. On 4/8/19 at 9:15 p.m. a new order received from the primary ARNP to evaluate the resident to be a hoyer transfer and documented family notified. p. On 4/10/19 at 11:29 p.m. a new order received from the primary ARNP to apply metahoney (treatment designed for wounds that have difficulty healing on their own) to the pressure area on the sacrum and cover with mepilex (self-adherent, soft silicone foam dressing) daily until healed; documented family notified. q. On 4/15/19 at 1:11 p.m. the resident repositioned but refused getting out of bed throughout the shift. r. On 4/20/19 at 3:05 p.m. the resident's son gave	F 686		

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F 686	Continued From page 72	F 686		

verbal authorization to see the wound doctor that week.
s. On 4/22/19 at 11:05 a.m. an Activity Significant Change MDS progress note documented the resident recently laid in bed often.
t. On 4/30/19 at 8:20 a.m. the resident's blood sugar level high at 530 and the primary ARNP and family notified.
u. On 5/3/19 at 8:47 p.m. a Life Enrichment Note documented the resident now on a 1 to 1 program but at times refusing visits and spending a lot more time in room.
v. On 5/8/19 at 10:57 p.m. a new order received from the ARNP Wound Nurse to cleanse the coccyx with Vashe (intended for use in cleansing, irrigating, moistening and debriding acute and chronic wounds), a nickel thick layer of Santyl (a debriding agent) to the wound bed to slough covered area (have a layer of skin come off), loosely pack with fluff gauze to fill cavity, sprinkle collagen (a protein) powder to red granulation tissue (new growth of connective tissue associated with wound healing), cover with border gauze, and change daily.
w. On 5/10/19 at 9:17 a.m. a Communication with Family note, documented by the Social Worker (SW), recorded the resident's son came to discuss the resident's current state after being told by the nurses the resident refused a lot of cares and chose to stay in bed all day. He stated he felt like his mom may be giving up. The SW wrote she educated the son about hospice and palliative care and the son expressed interest in information on palliative care. The SW wrote she would discuss options for the resident with the clinical team and would follow up with the son early the next week. At 12:27 p.m. the son went to Staff U, Licensed Practical Nurse (LPN), to request a UA (urinalysis) test. Staff U wrote the

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F 686	Continued From page 73 resident had been down, refusing to do things, incontinent of bowel and urine, and changed per staff. At 12:33 p.m. Staff U documented she sent a fax out to the physician requesting a UA per family request. x. On 5/13/19 at 3:45 p.m., the son came to visit the resident and complained of the resident not able to stay awake, engage in conversation, or eat a meal. Staff A, LPN, wrote she tried to explain that aides help with the feeding in the room and the resident refused getting up. The son requested a UA and palliative care evaluation. Staff A documented a fax had been sent to the primary ARNP and staff still waiting for a response. y. On 5/14/19 at 5:53 a.m. orders received for palliative care and UA with dysuria (painful urination); UA obtained without difficulty with cloudy yellow urine output. At 2:36 p.m. a fax was sent to the primary ARNP with the UA results and son notified. The wound doctor saw the resident and treatment done. z. On 5/15/19 at 7:45 a.m. the resident was red and flushed, her temperature was 99.4 degrees. The resident had a High FBS (fasting blood sugar reading), the on-call doctor was notified. At 7:58 a.m. the son updated on the resident's status and the daughter-in-law to be in the facility that day. At 8:40 a.m. a Communication with Family, documented by the SW, noted the daughter-in-law visibly upset and wanted to see the primary ARNP when she arrived to do rounds and wanted to ensure the resident on the list to be seen. The SW explained to the daughter-in-law she does not communicate directly with the ARNP but assured the resident would be seen and she referred the daughter-in-law to the ADON (Assistant Director of Nursing) who would be better equipped to	F 686		

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F 686	Continued From page 74 answer nursing related questions. The SW apologized to the daughter-in-law that the family not aware of the resident's health decline. The SW recorded the daughter-in-law and son very upset the resident may be hospice appropriate and the SW immediately notified the DON of the interaction. At 8:57 a.m. Staff U documented the resident was very sleepy during the shift, barely opening her eyes. Staff put the resident's dentures in her mouth and tried to feed her but she spit out the food. The resident refused medications. Staff U documented the physician was aware and would be in to see the resident. The resident had been repositioned in bed. At 9:19 a.m. Staff P documented she tried to talk to the son to give update related to the wound as the ARNP Wound Nurse would like to know if family wanted aggressive treatment to the wound, and if they did, a referral to infectious specialist would be given. The son did not answer the call so she spoke to the daughter-in-law and gave updates of wound care plan. Staff P documented the daughter-in-law got a hold of the son and reported he wanted to be as aggressive as possible with treatment. At 11:20 a.m. Staff U documented the ambulance arrived and the resident transferred by 3 persons and a hoyer. The daughter-in-law wanted to know how long the resident had been refusing meds and Staff U informed her just that morning and the resident was fed in her room with very poor appetite. At 12:09 p.m., Staff U documented the daughter-in-law spoke to the physician regarding the residents decline. A recheck of the blood sugar had been done at 10:00 a.m., BS 597. The physician was notified of vital signs abnormal for the resident. The Physician stated the resident	F 686		

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F 686	Continued From page 75 will be sent to the hospital per family request. The facility still waiting on the C&S (Culture & Sensitivity) report from the UA test. Staff called for ambulance transport. The Facility Skin & Wound Evaluations revealed the following: The clinical record lacked documentation of pressure sore Skin & Wound Evaluations for any areas dated prior to 3/25/19. The care plan identified a blister to the coccyx 1/23/19 and the Progress Notes identified a pre-existing bloody blister to the left side of the resident's buttock getting bigger and tender on 3/23/19. Pressure sore Right Buttock a. On 3/25/19 the resident had a new intact serum filled blister that measured 2.7 cm by 8.2 cm. The surrounding tissue had erythema (redness of the skin), was excoriated and fragile. The blister was in-house acquired. b. On 4/1/19 the blister measured 1.6 cm by 1.5 cm with100% granulation and light serosanguinous exudate (bloody, watery fluid drainage), progress improving. The resident had been sent to the hospital with a Stage II pressure at the right buttock (blister) and the resident readmitted with the blister broke open. Staff were directed to cleanse the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas and apply Calmoseptine to the reddened areas on the buttocks and coccyx. Education included; alternating air mattress in place, NIP supplement to promote wound healing, frequent turn and repositions, keep skin dry and clean, and wheelchair cushion in place. c. On 4/9/19, the area to the right buttock was marked a Stage III pressure area. The area measured 1.5 cm by 1.4 cm with100%	F 686		

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F 686	Continued From page 76 granulation tissue and light serosanguineous exudate. The surrounding tissue was eczematous. The area was deteriorating. The resident was seen by the primary ARNP on 4/10/19 and the treatment changed to cleanse site with normal saline, apply/pack with metahoney, cover with mepilex daily until healed. Continue all previous interventions. Education included; the resident non-compliant for turning and repositioning, encourage to turn frequently, appetite poor and diagnosed with Diabetes Mellitus type 2 with blood sugar uncontrolled despite medications, all the factors affect wound healing process. d. On 4/15/19 the area measured 1.5 cm by 1.6 cm with100% epithelial tissue (thin tissues that cover all the exposed surfaces of the body) and light sanguineous exudate (bloody drainage). Noted wound healing well. e. On 4/22/19 the area measured 1.1 cm by 1.4 cm and was resolved. Pressure sore Right Thigh (Rear) a.k.a. Right Gluteal Fold a. On 3/25/19 a new Unstageable pressure area measured 1.8 cm by 2.3 cm with 100% eschar (dead tissue). The surrounding tissue had erythema was excoriated and fragile. b. On 4/1/19 the area measured 1.4 cm by 2.4 cm, 80% epithelial tissue and 20% slough (a layer or mass of dead tissue separated from surrounding living tissue in a wound), light serosanguineous exudate. The resident sent to hospital with Unstageable pressure due to suspected deep tissue injury at the right rear thigh and readmitted with Stage II at the right rear thigh. Staff directed to cleanse the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas and apply	F 686		

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F 686	Continued From page 77 Calmoseptine to the reddened areas on the buttocks and coccyx. c. On 4/9/19 the area measured 2.1 cm by 1.7 cm with100% granulation tissue. Had light serosanguineous exudate and the surrounding tissue had erythema. The area was deteriorating. The resident was seen by primary ARNP 4/10/19 and treatment changed to cleanse site with normal saline, apply/pack with metahoney, covered with mepilex daily until healed. Continue all previous interventions. d. On 4/15/19 the area measured 1.6 cm by 1.0 cm with100% epithelial tissue. Pressure sore Left Thigh (Rear) a.k.a. Left Gluteal Fold a. On 3/25/19 a new Unstageable pressure area measured 1.6 cm by 2.2 cm with 100% eschar. The surrounding tissue with erythema, excoriated and fragile. b. On 4/1/19 area measured 1.8 cm by 1.6 cm with 20% epithelial tissue and 80% slough. The area had serosanguineous exudate. Resident #97 sent to hospital with Unstageable pressure due to suspected deep tissue injury at the left rear thigh and readmitted with Stage II at the left rear thigh. c. The clinical record lacked an assessment completed on 4/9/19. d. On 4/15/19 area measured 1.4 cm by 1.4 cm with 100% epithelial tissue. It had light sanguineous exudate. e. On 4/22/19 area measured 0.9 cm by 0.1 cm and was resolved. Pressure sore Sacrum a. On 3/25/19 a new Unstageable pressure area measured 5.5 cm by 11.9 cm, with 100% eschar. The surrounding tissue had erythema and was	F 686		

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F 686	Continued From page 78 excoriated and fragile. The pressure area was in house acquired. b. On 4/1/19 the area measured 8.9 cm by 6.4 cm with 90% slough and 10% eschar. It had light serosanguineous exudate with a faint odor. The resident was sent to hospital with Unstageable pressure due to suspected deep tissue injury at the left rear thigh and readmitted with Stage II at the sacrum. Treatment to the area included to cleanse the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas, apply Calmoseptine to the reddened areas on the buttocks and coccyx. c. On 4/9/19 the area measured 6.9 cm by 4.4 cm with 50% granulation tissue and 50% slough. It had light purulent exudate (type of liquid that oozes from a wound that can be a sign of infection), progress deteriorating. The area had a depth of 0.5 cm. The resident was seen by the primary ARNP with treatment changed to cleanse site with normal saline, apply/pack with metahoney, cover with mepilex daily until healed, and continue all previous interventions. d. On 4/15/19 the area measured 10.0 cm by 6.6 cm with 40% granulation tissue and 60% slough. It had moderate purulent exudate, progress deteriorating. Noted resident seen by the primary ARNP, noted a depth of 0.5 cm, treatment changed the previous week, would continue to apply and re-evaluate treatment effectiveness, and continue all previous interventions. e. The residents clinical record lacked an assessment of the wound for the week of 4/22/19. f. The residents clinical record lacked an assessment of the wound for the week 4/29/19. g. On 5/7/19 the area measured 7.8 cm by 4.3 cm with 30% epithelial tissue, 40% granulation tissue and 30% slough. It had light serous	F 686		

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F 686	Continued From page 79 exudate. The area was deteriorating. The resident was seen by ARNP Wound Nurse on 5/7/19 with wound measurements of 8.5 cm by 3.6 cm by 1.6 cm. The area was 25% slough, 10% partial thickness, 25% epithelial and 40% red granulation. It had epithelial islands and the bone was palpable. There was moderate thin serous drainage with slight pain, managed with pain medication. Started treatment of cleanse with Vashe, nickel thick layer Santyl to wound bed to slough covered areas, loosely pack with fluff gauze fill cavity, sprinkle with collagen powder to red granulation tissue, cover with border gauze, change daily and as needed. Observations revealed the following: a. On 5/13/19 at 11:32 a.m. Resident # 97 laid in bed positioned on her back. b. On 5/14/19 at 9:33 a.m. Resident # 97 positioned on her right side in bed with a pillow on her left side of back to position. At 11:59 a.m. Resident # 97 laid in bed on her back, air pump in place on the bed, and functioning. Attempted conversation with the resident and she did not really respond. c. On 5/14/19 at 1:32 p.m. the ARNP Wound Nurse, Staff P, and Staff A, entered the room to provide cares. Staff A and Staff P assisted the resident to roll onto her right side. The ARNP Wound Nurse unpacked the sacral wound, measured 5.5 cm by 5.3 cm by 2.4 cm straight depth, and stated some necrotic tissue present in the wound that needed removed. The ARNP Wound Nurse stated the wound bed was 30% slough/necrotic tissue, 10% epithelial tissue, the rest granulation tissue. The ARNP Wound Nurse reported the wound areas were pressure related. Noted a foul odor coming from the unpacked wound. The ARNP Wound Nurse stated they	F 686		

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were treating the wound with Santyl (a debriding agent) to get to the healthy tissue and that was why there was odor coming from the wound. The ARNP Wound Nurse debrided the necrotic issue then re-measured. The measurements were 5.7 cm by 5.0 cm by 2.2 cm straight depth with 3.7 cm of tunneling at 9 o'clock and 1.7 cm of undermining at 11 o'clock to noon. The ARNP Wound Nurse stated the bone was exposed and informed staff they needed to reach out to family to see how aggressive they wanted with treatment as bone exposure could mean possible osteomyelitis (bone infection). The ARNP Wound Nurse said if the family wanted aggressive treatment then infection control gets involved otherwise they would focus on keeping it from getting worse in the facility. Staff A washed hands, donned gloves, then cleansed the wound with normal saline, repacked the wound with Santyl gauze, then collagen powder on the outer skin areas where granulation tissue present, and a new foam dressing applied. Resident # 97 did moan at some points during the dressing change. Staff P stated the resident started with a decline overall, then had some loose stools, and a Stage II to III pressure area developed. Staff P stated the depth of the wound was new for the resident.
d. On 5/15/19 at 8:35 a.m., Staff U attempted to rouse the resident to take drinks of water, drinks of Pepsi, and to attempt a bite of food. Resident # 97 was slow to respond or open eyes and moaned in response to being rubbed on the arm. Resident # 97 did take in dentures, but did not take a drink or meds. Staff U gave Resident # 97 a bite of food which the resident spit out. Staff U stated the resident was not going to accept anything at that time so she would just wait for the doctor who was supposed to be coming. Staff U reported she worked for the facility for a year and

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F 686	Continued From page 81 was familiar with Resident # 97's cares prior to going to the hospital. Staff U stated prior to going to the hospital the resident used to be up talking and walking. Staff U responded the resident came from the hospital with the pressure sores. Staff U reported the resident had 2 pressure areas on the gluteal folds that healed up and the other pressure area remained on the sacrum. Staff U stated when the resident went to the hospital her bottom just red and the wound nurse saw the resident before she went to the hospital. Staff U again clarified she had never seen the pressure areas on the resident's bottom before the hospitalization, the sacral area was just red. e. On 5/15/19 at 11:15 a.m., observed paramedics arrive to the resident's room to assess and transport the resident to the hospital. Resident # 97's daughter-in-law at the resident's bedside with Resident # 97's son on the speaker phone. The family relayed concerns the resident showed signs of dehydration with wrinkled skin and increased temperature above 100 degrees Fahrenheit. The daughter-in-law reported she spoke to the primary ARNP who had just been in the facility to assess the resident and the ARNP told her she had not been made aware the resident's condition that bad. Physician orders, primary ARNP visit, ARNP Wound Nurse visits, revealed the following: The primary ARNP Routine Visit note dated 1/16/19 recorded the resident examined for a routine visit and noted all chronic conditions stable at that time. The primary ARNP Routine Visit note dated 3/13/19 recorded the resident examined for a routine visit and noted no acute concerns per nursing staff or family and all chronic conditions	F 686		

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F 686	Continued From page 82 stable at that time. The fax order sheet dated 3/23/19 documented the resident had 1 blood blister to her left bottom/groin that measured 6.0 by 6.0 cm, the skin intact but raw, cream applied, and requested treatment for the blister. The fax recorded the resident being turned to her side but non-compliant. A new order given for Duoderm to open area on the buttocks and change every 3 days. The hospital Discharge Summary dated 3/29/19 documented the resident admitted to the hospital on 3/25/19 for increased confusion, urinary tract infection, and AKI (Acute Kidney Injury). The discharge orders included treatment to coccyx/buttock of: clean with cleansing spray or soap and water; apply thick layer of Z-guard 3 times a day; cover open areas; do not wipe to skin level; specialty mattress; side to side turns only; and foam wedge pillow. The discharge instructions included to follow up with the primary care physician in 1 week. The clinical record lackedevidence the resident seen by the primary care physician after return from the hospital. The ARNP Wound Nurse, Wound Treatment Plan dated 5/14/19, documented the resident was seen to assess the coccyx wound. The notes recorded the resident stayed in bed by choice due to sacral pain when sitting. The resident incontinent of bowel and bladder making gross contamination of wound problematic. A Broda chair with Roho cushion available for the resident however the staff report the resident no longer used the chair. An air mattress overlay in place	F 686		

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F 686	Continued From page 83 and appropriately inflated to reflect current body weight. No concerns voiced by staff related to current wound treatment. The Skin Physical Examination section documented the following: Stage 4 pressure on coccyx measured 5.5 cm by 5.3 cm by 2.4 cm. The wound tissue was 30% slough/necrotic, 10% epithelial and 60% red granulation. Bone was exposed. A moderate thin serous exudate present with slight odor. The Procedures/Services section documented the following: Excisional debridement done and wound measurements after were 5.7 cm by 5.0 cm by 2.2 cm, tunnel at 9 o'clock with depth of 3.7 cm, undermining from 11 o'clock to noon with depth of 1.7 cm, bone exposed. Plan Notes section documented the following: Skin nurse (Staff P) will discuss with family how aggressive they wish wound care to be and if they wish for full work up for potential osteomyelitis. If they do not wish aggressive work up, will focus wound goal at pain control, odor management, and infection prevention while continued goal to promote healing. The primary ARNP Routine Visit note dated 5/15/19 included the following: staff related the resident refused morning meds, would not eat breakfast, and had eaten less the last 3 weeks, but did not refuse meals. Today staff informed me the coccyx wound much worse. The wound nurse debrided it this week and it was nearly to the bone. Staff are packing the wound daily. Staff related the resident had not been getting up out of bed for about 3 weeks due to sore on coccyx and when the resident sat up in the wheelchair she scooted down. Staff concerned the resident would fall out of the wheelchair and make her	F 686		

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F 686	Continued From page 84 wound worse due to shearing. The resident laid in bed during visit and appeared quite ill, ashen, diaphoretic (sweating heavily) and hot. A recheck of vital signs showed hypotension (low blood pressure) and febrile (elevated temperature). Discussed with family and the resident to be sent to the hospital for evaluation and treatment. The family stated in a care conference the previous week they were asked if they would like palliative care or hospice care due to the resident's coccyx wound. The ARNP wrote she was unaware this was being discussed. The ARNP felt the resident appeared septic and sent the resident to the hospital for evaluation and treatment. The Hospital Progress Notes dated 5/16/19 at 6:59 a.m. documented the resident presented to the ED (Emergency Department) secondary to altered mental status and found to have osteomyelitis of the sacrum, renal failure, and UTI. The note recorded after long discussion with the family, the resident to be comfort cares only and hospice consult placed. The Impressions/Plan recorded a diagnosis of sepsis (a life-threatening illness caused by your body's response to an infection) secondary to osteomyelitis. Interviews: On 5/15/19 at 9:06 a.m., the resident's daughter-in-law and son reported the resident initially went to the hospital (3/25/19) for bad pressure sores. The son reported the resident treated for UTI and high blood sugars at that time just like the resident had that morning. The son stated with the first hospitalization (3/25/19) the	F 686		

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facility told him the day his mother went his mother had some bed sores that were going to be looked at in the hospital; the son commented prior to that day, no call. The daughter-in-law reported she observed the resident's buttocks in the hospital on the first day she went (3/25/19) and recalled the skin looked purple with no skin missing or open on the part she observed, but she did not see the skin folds. The family reported the hospital wound doctor saw the resident. The residents blood sugar went down and the resident got better and was sent back to the facility. The son reported he went up in March and his mother appeared okay, a lot going on. The son stated his mother had a lot of fluid buildup in the legs and so started laying down to get rid of the fluid buildup and put on another medication. The son stated 2 to 3 weeks prior he was notified blood sugars high or changing meds, and usually the facility called about stuff like that, but never called to say his mother not eating or sleeping all the time. The son reported he went in to visit and saw his mother asleep and staff told him she was not eating. The son stated he asked how long it had been going on and told a couple weeks of not eating as much, she would drink, but not eating much breakfast and not lunch. The son reported the last time he visited, his mother's lunch sat on the tray and she slept. The son stated the facility responded the nurse aide was in there and they go in to try to get her to eat but said the lunch tray sat untouched. The son stated the facility had a meeting with him on Friday (5/10/19) to tell him his mother should get palliative or hospice care in there. He said okay because his mom was going downhill. The family reported on 5/10/19 they visited the resident and she was sleeping and not aware of who the son was so he went to talk to the nurse. The son

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stated that was when the staff told him they turned her every 2 hours, he was told the sores better but still watching 1, and after 10 minutes of seeing his mother's condition, he went to talk to the SW. The family stated they asked the SW what they could do for the resident and the SW mentioned palliative or hospice to the family's surprise. The son stated he asked her to explain palliative care to which the SW explained his mother would get more care. The son stated the SW said she would have a team meeting that day and get back to them by Monday and the SW had a lot going on meeting wise. The son reported the facility told him the bed sores getting better on Friday when he called the facility to tell them to get a hold of the doctor as he wanted a UA test done to check for a UTI. The son reported on Saturday (5/11/19) Staff W, LPN, told him the resident not on hospice and they thought the SW had said the resident would be hospice. The son stated he felt a UA needed because maybe the same thing going on with UTI as it had the last time his mother was hospitalized. The son repeated he asked Friday morning for a UA and he had not heard anything as of Monday. The son reported when in the facility on 5/13/19 he asked about the results and the LPN there couldn't tell him anything and he felt he got different stories from everyone. The son stated he thought his mother had a UTI when told the blood sugar reading over 600 and said he was told the preliminary report showed blood in urine, WBC (white blood cells) in urine, and showed the body fighting something. The son said he he felt his mother had an infection somewhere and something needed to be done before she turned septic. The son voiced he wanted his mom hospitalized immediately. The son responded he was not aware of anyone contacting him the day

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before to update him about the ARNP Wound Nurse's visit but the night nurse called that morning about the high blood sugar. The son stated he was bothered no one called yet as he would have said to get very aggressive with treatment. The daughter-in-law reported she spoke to the SW about their concerns regarding communication and not getting notified and told to go to the ADON to find out what she knew.

On 5/15/19 at 10:25 a.m., Staff A responded she worked as PRN only on weekends. Staff A stated she worked for the facility for longer than a year and floated around the facility assigned to different halls. Staff A stated she did not recall the resident having pressure sores prior to going to the hospital. Staff A stated the resident had loose stools and around that time she had not been taking care of the resident. Staff A responded no one had told her before the hospitalization of any pressure areas. Staff A recalled the ARNP Wound Nurse talking to Staff P the day before. Staff A stated she did call the son after the wound assessment completed the day before and notified the son the wound nurse saw the resident. Staff A stated she thought she called the son around 2:35 p.m. on 5/14/19. Staff A said she spoke to the son about palliative care and handed the phone to a hospice nurse who frequented the facility to explain to the son better what hospice care was after telling the hospice nurse the family looking in to hospice care. Staff A stated the hospice nurse talked to the son for a while and then Staff A contacted the doctor. Staff A clarified she did not talk to the son about the debridement of the wound that occurred on 5/14/19 as she felt the wound nurse Staff P more appropriate to explain what was going on. Staff A said she told the son the wound doctor there to

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see the resident and measured the wound and treatments done. Staff A stated the progress notes would be where the staff document family notifications. Staff A responded she did not know for sure how long the resident had been declining, not responding, or opening eyes. Staff A commented the resident did open and close eyes before when feeding the week before and would say yes but no sentences used to communicate the day before.

On 5/15/19 at 10:35 a.m., Staff V, LPN, reported she only worked with Resident # 97 a couple of times since starting work for the facility on 4/23/19. Staff V reported what she knew of the resident was Resident # 97 slept a lot and family would come in and ask why the resident slept a lot and in the bed. Staff V stated one time the resident said no when had meals put to her mouth and pulled away. Staff V stated she knew the son was in the day before and upset that no one got a UA done on the resident when he had asked a few days prior but she heard the order had not been received.

On 5/15/19 at 10:40 a.m., Staff Y, CNA, reported she was familiar with Resident # 97's cares and worked for the facility for 3 years. Staff Y said sometimes the resident only up once a week. She did not recall if the resident's pressure sore present prior to going to the hospital but knew it was there after her return from the hospital. Staff Y stated after being in the hospital, Resident # 97 declined. Staff Y stated the resident may drink and still took food when it was put up to her mouth. It had been a while that she kept her eyes closed while eating. Staff Y responded she did assist the resident one day to sit up on the edge of the bed but got no further because she was too

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F 686	Continued From page 89 weak. Staff Y could not recall the day or how long ago that attempt to get up occurred. On 5/15/19 at 10:50 a.m., Staff P responded she had not yet reached out to the family regarding the ARNP Wound Nurse's directive 5/14/19 to ask about how aggressive family wanted to get with treatment. Staff P stated she had waited to receive the wound nurse's progress notes and orders which she just received via fax on 5/15/19. Staff P said she wanted to make sure she had all the orders and details to discuss with the family in order to answer any questions they may have. Staff P responded the resident had not been as declined the previous week. Staff P said after the resident got back from the hospital she noticed a decline. Staff P stated mostly the resident refused to get out of bed, just said no. Staff P commented times they could convince the resident to get out of bed and times she refused. Staff P responded they had been keeping the family notified of the decline. Staff P said the skin and wound assessments in the electronic record would contain documentation when the family and the doctor notified of changes if skin getting better. Staff P reported the ARNP Wound Nurse new to the facility and prior to her coming to do wound treatment, the facility communicated with the resident's primary doctor. Staff P stated prior to the resident going to the hospital 3/25/19, the resident already identified to have pressure sores caused by moisture associated skin damage related to incontinence of bowel. Staff P stated she felt the pressure sores got worse while the resident in the hospital. Staff P said her process for skins was the nurses called her for any critical wounds. She first observed the resident's wounds on 3/25/19. Staff P reported the resident assessed on 3/25/19 to have 4 areas; 1 blister on	F 686		

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the buttock, 1 pressure in the right gluteal crease, 1 pressure in the left gluteal crease, and 1 pressure area on the sacral area. Staff P reported the blister and left, right gluteal pressures healed and only the sacral pressure sore remained. Staff P provided picture documentation of her weekly assessments and said the sacral wound did not open up until 4/19/19. The review of the picture showed a lot of yellow slough present on 4/19/19. Staff P stated the staff performed skin checks on residents every shower day, 2 times a week and documented the checks in the electronic clinical record. Staff P commented the resident had not been compliant with diet and not wanting to get repositioned. Staff P stated the resident had been on a turn and reposition program, tracked for high risk potential for skin impairment, and they had protocols in place before the development of the pressure sores preventatively. Staff P stated the information also on the Kardex and staff aware as it had been on the care plan. Staff P stated they also talked in shift huddles to keep up to date on skin changes.

On 5/15/19 at 11:10 a.m., Staff J, LPN, stated she had worked for the facility for 15 years and only worked on Resident # 97's hall when a medication aide assigned to pass medications there. Staff J stated she was familiar with the resident's pressure on her bottom and thought it happened suddenly. Staff J responded she was not sure how long the resident bed fast but she had not seen her out of bed for a while, could be a week or weeks. Staff J said she used to see the resident up and about but not seen recently.

On 5/15/19 at 12:05 p.m., the Director of Nursing (DON) reported the facility recently updated their

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F 686	Continued From page 91 skin policies and procedures in April 2019. On 5/15/19 at 12:43 p.m. the family reported the hospital doctor confirmed the bone exposed in the wound, the wound bad, called it nasty, and would be admitted to complete more blood testing as well as discussing possible surgery to close the wound. On 5/15/19 at 2:25 p.m., the primary ARNP reported she saw the resident as the primary care physician but not following the pressure sores. The primary ARNP reported the facility told her the ARNP Wound Nurse started following residents for pressure sores. The primary ARNP said she routinely examined the resident every other month and previously aware the resident had a Stage 2 pressure. The primary ARNP said she received a call 4/30/19 to inform her the resident had an elevated blood sugar reading and let her know the resident not laying down. The primary ARNP reported the on-call contacted at the end of the previous week. The primary ARNP confirmed staff to notify her with condition changes and in the evenings the staff can call the office answering service to speak to the on-call doctor. The primary ARNP confirmed she spoke with the family and told the resident not getting up for 3 weeks. The primary ARNP said she had been in the facility the previous week and heard the resident in her room during cares and asked what was going on. The primary ARNP said staff told her the resident had not been getting up for a few days due to her bottom. The primary ARNP stated the resident historically refused to get out of her chair, refused to take food in room, and cycled between eating and not eating. The primary ARNP stated the resident played possum at times during her examinations. The primary	F 686		

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ARNP stated when she assessed the resident earlier in the day 5/15/19, she had to instruct the resident to speak up to let her know if she was sick and needed to go to the hospital. The primary ARNP said the resident answered her and said okay to go to hospital. The primary ARNP reported the resident sometimes yelled at her to leave her alone during examinations. The primary ARNP stated the facility had not made her aware the pressure sore opened or got worse after return from the hospital. The primary ARNP stated she is usually made aware of changes from the facility but she had not been made aware of this resident's changes in conditions. The primary ARNP stated she would have wanted updated about the wound deterioration, the resident not eating as well, and the resident not getting out of bed for 3 weeks. Discussion of the measurements documented on 3/25/19 and The primary ARNP responded the pressure areas could show up quickly within 10 to 12 hours in the elderly. The primary ARNP said she had been aware at that time in March the resident scooching in wheelchair, sliding down, and the facility got a bigger wheelchair. The primary ARNP stated the facility notified her on 3/23/19 the resident had 1 blood blister to her bottom that measured 6.0 cm by 6.0 cm, skin intact, raw, and resident turned side to side. The facility asked to be advised and a Duoderm treatment ordered and to change every 3 days. The primary ARNP stated after that she was not updated and then the resident went out to the hospital. The primary ARNP stated she was next notified in April the resident lowered to the floor and the staff asked if they could make the resident a hoyer transfer which she did order. The primary ARNP stated if a wound progressed or got worse she would have wanted the wound center brought in. The primary

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F 686	Continued From page 93 ARNP stated there was a note on 5/10/19 from the on-call doctor the resident incontinent, refused to get out of bed, and the doctor advised to get a UA. The primary ARNP stated the UA documented as not collected till 5/13/19 and she knew of no reason why there should have been a delay in collecting the UA. The primary ARNP confirmed the delay in getting the UA may have changed the course of treatment decisions. The primary ARNP stated the bigger question she had that day when she assessed the resident was whether or not urine the issue or the wound. The primary ARNP said the urine results not horrific, the WBC 11 to 25,000, responded to the facility that afternoon, the results abnormal and would not treat with antibiotics but would take a look at the resident when she returned from the hospital. The primary ARNP stated the wound nurse debridement could have caused the blood sugars to elevate. The primary ARNP responded she was unaware that Staff A had the hospice nurse speak to the family the day before and said that would not be the proper technique for getting a hospice evaluation. The primary ARNP again stated she was not aware the pressure had gotten as big as it was. The primary ARNP stated there was no excuse for not getting the UA Friday. The primary ARNP reported March 2019 the last time she had seen the resident for a physical examination. On 5/15/19 at 4:36 p.m. Staff W, LPN, reported he worked in the facility for a year. Staff W stated he was familiar with Resident # 97's care. Staff W stated since the resident returned from the hospital at the end of March, not get up from the bed. Staff W said therapy tried to work with the resident but it had been hard for them. Staff W stated when getting up, the resident became	F 686		

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dead weight not want to do anything so she didn't want up. Staff W commented they had to bribe the resident with Diet Pepsi to try. Staff W responded the last time he recalled the resident out of bed, not that week or the week before. Staff W stated the thought the primary ARNP knew but then said wait, not sure if she knew. Staff W stated the son came to check on the resident and upset his mom not getting up, but he saw she wasn't cooperating. Staff W said the resident didn't want to do anything. The son wanted to get a UA test, a fax sent but he needed to wait for an okay. Staff W commented most times they had to wait 3 days to push fluids to wait to see if a resident complains before get UA; can't get UA have to push fluids first. Staff W stated the family requested it and he explained he needed to follow protocol first. Staff W confirmed if a doctor gave the order then they would need to follow the order. Staff W confirmed the son did want treatment for his mom as of 5/10/19 when he talked to him about it. Staff W reported on Saturday (5/11/19) the son's wife called again to ask about hospice option and not happy about it. Staff W stated he explained just because offered the option they didn't have to take it; said the wife wanted treatment for the resident and upset the UA test not done. Staff W said he informed the wife they had to wait for the fax to come back for an order. Staff W responded he did not call the on-call doctor after speaking to the family; commented he waited for the fax to come back 5/13/19 for order for the UA. Staff W first recalled the resident having pressures before she went to the hospital (3/25/19). Staff W could not recall the sores or when they started but stated they were not open and on the sacral area. Staff W stated he thought he recalled the area looking like a red spot. Staff W recalled a treatment to

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Calmoseptine on it. Staff W recalled the treatment of putting Calmoseptine on the buttocks 3 times a day and responded he was not sure how he would not have seen the sores. Staff W said he did know of a blister the resident had in January 2019. Staff W confirmed before hospitalization the resident went to the bathroom, went to the dining room, but after came back, not wanting to do anything. Staff W could not recall if he ever notified the family or the primary ARNP about the resident's decline or change post hospital.

On 5/15/19 at 5:19 p.m., Staff AA, Certified Medication Aide (CMA), worked for the facility for 3 years and familiar with Resident #97's cares. Staff AA responded she thought the resident had been in bed about 2 months. Staff AA said the resident had been up before the hospital and acknowledged the resident had declined a lot. Staff AA commented she seen the pressure sore the day before but did not recall if the sores present before the hospital. Staff AA stated prior to hospitalization the resident fed herself and now ate only a little bit.

On 5/15/19 at 5:21 p.m., Staff X, CNA, reported she worked for 2 years at the facility and familiar with Resident # 97. Staff X responded staff got the resident up when she came back from the hospital for a couple of days but after that the bottom very bad so always made her lay down because of her bottom. Staff X stated sometimes they put the resident in her wheelchair, however, the resident still sat on her butt so they would lay her down in bed. Staff X recalled the resident used to stand up with walker to transfer, wouldn't stand up, so they began to use the hoyer.

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F 686	Continued From page 96 On 5/16/19 at 8:30 a.m. the DON confirmed the photos from the skin assessments on 3/25/19 showed 4 skin areas caused by pressure. In a follow-on 5/16/19 at 9:18 a.m., Resident # 97's family reported the resident remained at the hospital and the family would be pursuing comfort cares. The family stated the doctors said there would be a high risk for the resident's kidneys to go into failure and need dialysis if they tried to attempt a surgical fix for the pressure area. The family stated the resident more alert that day and voiced being in pain, therefore, they just wanted to pursue comfort cares. The facility reported on 5/16/19 at 9:30 a.m. the previous electronic software system utilized January 2019 thru the beginning of March 2019 lacked documentation of any skin assessments. On 5/16/19 at 12:30 p.m., Staff B, CNA, recalled her witness statement from 3/22/19 re: Staff F, LPN, refusing to help clean up Resident # 97 when she had incontinent stools. Staff B stated she was literally brand new to the facility and could not recall specifics about how the resident's bottom looked. Staff B reported she and another aide who was pregnant assisted the resident to try to stand to get cleaned. Staff B said she recently had surgery so neither aide felt she should do heavy lifting and the resident a bigger lady. Staff B stated when they stood the resident, Resident # 97 slipped in the poop because it was loose stool that just kept falling out of her. The resident had trouble standing and not really bearing weight Staff B stated they couldn't get the loose stools under control and had been in the resident's room multiple times. Staff B stated they asked the ADON for help and she made	F 686		

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F 686	Continued From page 97 Staff F go in the room to help. Staff B said Staff F entered the room with the resident's insulin shot, gave it, commented his job done, he's not an aide, and left the room. Staff F reported she told the ADON again and she made Staff F go back in but as soon as she left, he left again stating he was out of there. On 5/16/19 at 12:40 p.m., the DON presented a timeline of the resident's pressure sore measurements and assessments. The DON pointed out the facility skin assessments documented the primary ARNP saw the resident on 4/10/19 and 4/15/19 and she wrote new orders each time. The DON confirmed the ARNP did not physically examine the resident. The DON said Staff P showed the ARNP the picture of the wound and the ARNP gave new orders. The DON stated the ARNP Wound Nurse first saw the resident on 4/22/19. The DON stated the staff did not get the UA on 5/10/19 because they faxed out for the UA 5/10/19 and the ARNP did not answer back on the fax until 5/13/19. 2. The MDS assessment dated 2/17/19 for Resident #9 identified a BIMS score of 00 without signs/symptoms of delirium. A score of 00 indicated severe cognitive impairment. The resident required the extensive physical assistance of 1 person for bed mobility, totally dependent upon 2 persons for transfers, and the resident did not walk in room or corridor during the 7 day look-back period. The MDS coded a functional limitation in range of motion on 1 side of the body, both upper and lower extremity. The MDS documented diagnoses Peripheral Vascular Disease (PVD), non-Alzheimer's dementia,	F 686		

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F 686	Continued From page 98 hemiparesis/hemiplegia (paralysis/weakness on 1 side of the body), and generalized muscle weakness. The resident at risk of pressure ulcers/injuries but did not have any unhealed pressure sores. The care plan revealed the following: a. On 12/5/18, a focus area identified a self-care deficit due to diagnoses of dementia, hemiparesis/hemiplegia, muscle weakness, and unaware of needed cares to maintain quality of life. The care plan identified a potential for altered skin integrity due to incontinent of bowel and bladder, the resident preferred to stay in bed most of the day, and the resident needed assist with repositioning. The care plan approaches included: nurse will do twice weekly skin assessments and notify doctor as needed; treat skin issues as ordered; alternating air mattress; avoid skin to skin contact with pillows; skin assessment daily; lotion to BLE (bilateral lower extremity) and BUE (bilateral upper extremity) 2 times a day; and encourage frequent turns and reposition. b. On 3/19/19, a focus area identified 2 Stage II pressure areas at the right knee and left knee, 1 Stage III pressure area on the left shin, and 1 Unstageable pressure area on the dorsal right foot related to contracture, decreased bed mobility, and poor nutrition. The care plan interventions included: apply pillows between BLE to alleviate pressure; encourage good nutrition and hydration in order to promote healthier skin; frequent reposition and turns; keep skin clean and dry, use lotion on very scaly skin; and treatment of pressure areas per physician order. c. On 3/20/19, the care plan directed staff to avoid skin to skin contact by placing pillows as	F 686		

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F 686	Continued From page 99 needed, keep pillow between knees in bed, and place body pillow along the wall in bed. d. On 4/1/19, staff directed to administer NIP (nutritional supplement). e. On 4/11/19, a new focus area identified a Stage II pressure sore at the left shin related to contracture and poor nutrition. The care plan interventions initiated included: apply pillows between BLE to alleviate pressure; NIP supplement; apply treatment as ordered; frequent repositioning and turns; weekly treatment documentation to include measurement of each area of skin cellulitis (inflammation of the skin) width, length, color and exudate (drainage) and any other notable changes or observations; and record observations of the site with wound dressing change. f. On 4/22/19 identified a Stage III pressure sore at the left great big toe related to contracture. The care plan interventions initiated included: NIP supplement; apply treatment as ordered; and encourage good nutrition and hydration in order to promote healthier skin. g. On 5/13/19 an intervention for the wound doctor to assess every week. The Progress Notes revealed the following: a. On 3/7/19 at 12:12 p.m. a Restorative Program Note related to March Contracture Charting. The entry recorded limited range of motion in the following: right wrist extension 30 degrees flexion to 60 degrees; right shoulder abduction 70 degrees; right elbow flexion 90 degrees, extension 50 degrees; right knee extension 60 degrees; and right hip abduction 12 degrees. b. On 3/19/19 at 4:47 a.m. resident assisted by 2 persons to change position and 2 blisters noted where the resident's legs laid together to the medial aspect of the left calf and right inner knee.	F 686		

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F 686	Continued From page 100 Staff placed a pillow between the legs for abduction (movement of a limb away from the midline of the body) and a fax notification sent to the primary ARNP (Advanced Registered Nurse Practitioner). At 12:47 p.m. skin follow up, blister to knee and calf, and pillow in place as an intervention. At 2:26 p.m. a Stage II pressure sore at the right knee measured 1.3 cm (centimeters) by 0.9 cm, the left knee measured 1.8 cm by 1.9 cm with 100% granulation tissue (new growth of connective tissue associated with wound healing), and a Stage II pressure sore of a fluid filled blister at the left shin measured 2.5 cm by 5.0 cm. The predisposing factors mostly likely to contribute to the development of pressure sores: the resident had contractures on the BLE and hips; the resident unable to independently change position while in bed; poor nutrition intake as the resident only liked to consume house supplement for most meals; and the resident incontinent for bowel and bladder. The entry documented prior to the pressure sore development the resident identified as a high risk for pressure sores and preventative measures in place included: monitored pre-albumin (protein) level every 3 months (which was low at 18.8 mg/dl (milligrams per deciliter, low levels an indicator for malnutrition); administered prosource no -carb (supplement) 30 ml (milliliter) daily; restorative nursing program; air mattress; frequent reposition and turns thru the shift, and pillows between knees to alleviate pressure. c. On 3/20/19 at 1:00 a.m. the CNA (Certified Nurse Aide) called the nurse to the resident's room and the resident was turned toward the wall with lateral left knee against wall and a 2.0 cm by 2.0 cm abrasion present. The note recorded if staff positioned the resident on his right side he	F 686		

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F 686	Continued From page 101 would reposition self to left side. A body pillow was placed against the wall to prevent recurrence and a fax sent to the ARNP to request treatments. The blistered areas to the medial aspect (inside) of left calf and left knee superficial and open to air. At 1:42 p.m. the (primary) ARNP in the facility and new orders received for Duoderm (a protective bandage) on bilateral knees to be changed every 5 days, betadine on the blister located on shin, and Decubivite (multivitamin) for skin break down. d. On 3/26/19 at 9:14 a.m. iodine to the blister on the left shin discontinued and a new order received for Duoderm to the left shin and bilateral knees, change every 3 days. e. On 4/20/19 at 3:01 p.m. a verbal okay received forthe resident to be seen by the wound doctor. f. On 5/1/19 at 11:38 p.m. resident was seen by the ARNP Wound Nurse and a new order received to apply foam border dressing to the left lower extremity, change twice a week and as needed. g. On 5/6/19 at 10:38 p.m. resident assist of 1 with ADL's (Activities of Daily Living), assist of 2 for transfers via hoyer (mechanical lift), and the resident spent most of the time in bed. The entry documented the resident did use a wheelchair propelled by staff for mobility. h. On 5/12/19 at 9:32 p.m., resident pleasant and cooperative with cares, unable to make needs known, staff needed to anticipate his needs, and the resident stayed in bed at all times. i. On 5/15/19 at 8:55 a.m. a Long Term Evaluation completed. The notes recorded an ability to move left upper extremity, impairment in ROM (range of motion) on one side of upper body (right), and impairment in ROM on both sides of lower body.	F 686		

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F 686	Continued From page 102 The Facility Skin & Wound Evaluations revealed the following: Pressure sore Right Knee a. On 3/19/19 Stage II pressure area measured 1.3 cm by 0.9 cm. The wound bed was 100% granulation tissue with light serosanguineous exudate (bloody, watery fluid drainage). The pressure area was in house required. b. On 3/25/19 area measured 3.0 cm by 2.6 cm with 50% epithelial tissue (thin tissues that cover all the exposed surfaces of the body) and 50% slough (a layer or mass of dead tissue separated from surrounding living tissue in a wound). It had light seropurulent exudate (drainage often a sign of infection), the peri-wound (around the wound) had non-attached (edges appear as a cliff). The treatment was povidone iodine with hydrocolloid dressing (a non-breathable dressing that adheres to the skin so no separate taping is needed). The wound bed improved with no signs of infection, continue to put pillow between knees to alleviate pressure, apply Duoderm to wound c. On 4/1/19 area measured 2.2 cm by 3.1 cm with 90% epithelial tissue and 10% slough. It had light serosanguineous exudate, peri-wound had epithelialization. d. On 4/9/19 area measured, 0.6 cm by 0.6 cm with100% epithelial tissue. e. On 4/15/19 area measured 1.4 cm by 0.1 cm, resolved. Will continue to monitor for 2 weeks. f. On 4/22/19 noted resolved, will continue to monitor in case it reopened g. On 4/29/19 area measured 0.7 cm by 0.5 cm with100% granulation tissue. Noted on 5/1/19 the resident was seen by ARNP Wound Nurse, for a Stage III pressure area. The area measured 0.8 by 1.1 cm by 0.1 cm with100% hypergranulation (formation of excessive granulation tissue) It had	F 686		

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F 686	Continued From page 103 moderate thin serous exudate (watery fluid drainage). Staff were directed to discontinue current treatment, start cleanser of choice, apply foam border dressing, change twice weekly and as needed. Pressure sore Left Knee a. On 3/19/19 a Stage II pressure area measured 1.8 cm by 1.9 cm with 100% granulation tissue. It had light serosanguineous exudate. The pressure area was in house aquired. b. On 4/29/19 the area was noted resolved, wound healed. Pressure sore Left Shin a. On 3/19/19 - no assessment b. On 3/25/19 documented 1 week old pressure area. No stage status assessed. The area measured 4.9 cm by 2.4 cm with 50% granulation tissue and 50% slough. It had light seropurulent exudate. Noted blister at the left shin broke open. A fax sent to primary ARNP to change the betadine treatment to apply Duoderm c. On 4/1/19 area measured 1.8 cm by 3.7 cm with10% epithelial tissue and 90% slough. Area had light serosanguineous exudate, the peri-wound had epithelialization. d. On 4/9/19 area measured 3.3 cm by 1.7 cm with 40% epithelial tissue and 60% slough. Area had light serosanguineous exudate. e. On 4/15/19 area marked as Stage II. It measured 3.0 cm by 1.4 cm with 20% epithelial tissue and 80% slough. The wound had light purulent exudate (type of liquid that oozes from a wound that can be a sign of infection). Documentation noted initially the area a Stage II blister that progressed to Stage III. Apply Duoderm to site change every 3 days and continue to apply pillow in between legs to	F 686		

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F 686	Continued From page 104 alleviate pressure. f. On 4/22/19 area measured 1.7 cm by 2.3 cm with 80% granulation and 20% slough. The area had moderate purulent exudate. g. On 4/29/19 area measured 1.5 cm by 2.3 cm with 100% granulation tissue. It had light sanguineous (bloody) exudate. treatment hydrocolloid dressing, progress improving. Referred to wound care specialist for evaluation and treatment. Documented on 5/1/19 Resident #9 was seen by ARNP Wound Nurse. A Stage III area measured 2.8 cm by 1.9 cm by 0.1 cm with 100% hypergranulation. The area had moderate thin serous exudate. Discontinue current treatment and start cleanse with cleanser of choice, apply foam border dressing, change twice a week and as needed. h. On 5/9/19 area measured 2.0 cm by 2.9 cm with 100% hypergranulation tissue. The area had moderate serosanguineous exudate. The resident was seen by wound specialist on 5/7/19, continue to cleanse with cleanser of choice, apply foam dressing twice weekly and as needed Pressure sore Right Foot, 5th digit lateral side On 5/7/19 documented an Unstageable pressure sore on dorsum right foot. The area measured 1.5 cm by 1.3 cm with 100% granulation tissue. The area had serosanguineous exudate. The pressure area was in house acquired. Pressure sore Left Foot, medial side The clinical record lacked documentation of skin assessments for the pressure sore on the left medial foot first identified on the care plan 4/22/19 and by the ARNP Wound Nurse during her visit on 5/1/19.	F 686		

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F 686	Continued From page 105 Observations revealed the following: a. On 5/13/19 at 12:45 p.m. Resident # 9 laid in bed in room with eyes closed. Staff Y, CNA, reported Resident #9 typically did not come out of his room for lunch; said they take it in to him and sometimes he refuses. b. On 5/14/19 at 8:55 a.m. Resident # 9 rested in bed. c. On 5/14/19 at 11:21 a.m. the room lights on and family present to visit with resident at bedside. At 12:10 p.m. the resident's family gone. Resident # 9 remained in bed. At 1:14 p.m. the ARNP Wound Nurse prepared to assess the resident's pressure sores with Staff P, Registered Nurse (RN)/facility wound nurse. Noted pillows were between the residents legs. The ARNP Wound Nurse exposed the pressure sore on the left medial foot below the great toe and measured 1.5 cm by 1.1 cm with purulent drainage present. The ARNP Wound Nurse then exposed the pressure sore on the left shin, measured 2.5 cm by 1.8 cm, and stated the wound with all red granulation tissue, area improved. The ARNP Wound Nurse exposed the pressure area on the right inner knee and measured the area. The ARNP Wound Nurse then cultured the area on the left medial foot to test for infection. Staff P cleansed the areas and the ARNP Wound Nurse assisted to help hold the resident's legs apart. The ARNP Wound Nurse stated because the facility said the resident crosses his legs the areas came from pressure. d. On 5/15/19 at 4:36 p.m. Resident # 9 laid in bed. Physician orders, primary ARNP visit, ARNP Wound Nurse visits, and Treatment Administration Records revealed the following:	F 686		

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F 686	Continued From page 106 The Fax Order Request sheet dated 3/25/19 documented the resident was seen by the (facility) wound nurse. A blister to left shin had opened, and request for change of treatment to Duoderm to left shin and to bilateral knees approved. The primary ARNP Routine Visit progress notes dated 3/27/19 included: skin review positive for wound on right inner knee and left calf; exhibits deformity/contracture of right arm, bilateral lower extremities; and pressure ulcers on bilateral knees due to contractures. The report documented the plan to continue Duoderm and pillow between the knees to offload pressure. The ARNP Wound Nurse, Wound Treatment Plan dated 5/1/19, documented the resident was seen to assess multiple areas of concern. The resident very contracted, lying in the fetal position, and laid on left side toward the wall. Staff attempt to keep a pillow between the knees however he frequently removed it. When staff positioned the resident on his right side he repositioned himself to the left side. The Skin Physical Examination section documented the following: a. Unstageable pressure ulcer right lateral foot, 5th digit; measured 0.8 cm by 0.7 cm by 0.1 cm with100% eschar (presence of dead tissue). Unable to assess wound bed. b. Unstageable pressure ulcer to the medial; measured 1.2 cm by 1.2 cm by 0.1 cm with 100% stable eschar. Slightly boggy wound bed. c. left knee, trauma resurfaced -intact d. Stage III pressure ulcer to medial right knee. Area measured 0.8 cm by 1.1 cm by 0.1 cm with hypergranulated wound bed and moderate, thin, serous drainage.	F 686		

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F 686	Continued From page 107 e. Stage III pressure ulcer to LLE (left lower extremity). Area measured 2.8 cm by 1.9 cm by 0.1 cm with hypergranulated wound bed and moderate, thin, serous drainage. Wound Treatment Plan section documented the following: a. right lateral foot, 5th digit - discontinue current treatment and cleanse with cleanser of choice, apply skin prep daily b. left medial foot - discontinue current treatment and cleanse with cleanser of choice, apply skin prep daily c. left knee - discontinue current treatment d. right medial knee- discontinue current treatment and cleanse with cleanser of choice, apply foam border dressing, change dressing twice a week and as needed e. left lower extremity - discontinue current treatment and cleanse with cleanser of choice, apply foam border dressing, change dressing twice a week and as needed The ARNP Wound Nurse Wound Treatment Plan dated 5/7/19 documented the resident was seen to assess multiple areas of concern. The Skin Physical Examination section documented the following: a. Location - right foot, 5th digit, lateral; Etiology - pressure ulcer, unstageable; Measurement - 0.0 cm by 0.0 cm by 0.0 cm; Wound status - resurfaced; Tissue - 100% epithelial; Wound bed - epithelialized b. Location - left foot, medal; Etiology - pressure ulcer, unstageable; Measurement - 1.2 cm by 1.1 cm by 0.1 cm; Wound status - not healed; Tissue - 100% red granulation; Wound bed - granulation; Exudate - moderate, thin, serosanguineous c. Location - right knee, medial; Etiology -	F 686		

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F 686	Continued From page 108 pressure ulcer, Stage III; Measurement - 0.3 cm by 0.6 cm by 0.1 cm; Wound status - improved; Tissue - 100% hypergranulation; Wound bed - hypergranulation; Exudate - moderate, thin, serous d. Location - left lower extremity; Etiology - pressure ulcer, Stage III; Measurement - 2.9 cm by 2.0 cm by 0.1 cm; Wound status - not healed; Tissue - 100% hypergranulation; Wound bed - hypergranulation; Exudate - moderate, thin, serous Procedures/Services section documented: Chemical Cauterization - silver nitrate to hypergranulation tissue to left lower extremity wound bed Wound Treatment Plan section documented the following: a. right foot, 5th digit, lateral - discontinue current treatment and start cleanse with cleanser of choice, skin prep daily x 14 days then discontinue b. left foot, medial - discontinue current treatment and start cleanse with cleanser of choice, apply foam border dressing, change twice weekly and as needed c. right knee, medial - continue current treatment of cleanser of choice, apply foam border dressing, change twice a week and as needed e. left lower extremity - continue current treatment of cleanser of choice, apply foam border dressing, change twice a week and as needed The May 2019 Treatment Administration Record reflected the facility failed to discontinue treatment to the left knee as ordered on 5/1/19. The TAR documented the treatment of cleanse the left knee daily with cleanser of choice and apply skin prep daily; completed 5/4/19 thru	F 686		

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F 686	Continued From page 109 5/16/19. The TAR documented the treatment of foam dressing bordered pad, apply to left knee topically in the morning every 3 days for pressure ulcer; completed 5/2/19 and discontinued 5/3/19. The TAR lacked an entry to indicate the treatment to the left foot completed as ordered on 5/1/19 or on 5/7/19. Staff Interviews: On 5/15/19 at 10:50 a.m., Staff P stated she believed 3 pressure areas occurred at the same time 3/19/19; the left and right knees and left shin. Staff P said she thought if the care plan had a different date it would have been an input error as they switched electronic software systems in March 2019. On 5/15/19 at 5:30 p.m, Staff P acknowledged the resident's contractures were present for a long time. Staff P acknowledged the care plan entry 2/20/19 of a pillow between the legs a preventative intervention to protect against pressure sores. On 5/16/19 at 10:33 a.m., the Director of Nursing, (DON), acknowledged the resident's pressure sores on his legs would be consider avoidable. The DON commented she would look in the clinical record for documentation of any refusals to place a pillow between his knees as the resident could be non-compliant. The clinical record lacked documentation of the resident's refusals to keep a pillow between his legs or if refused, attempts at other interventions to keep legs separated.	F 686		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689 SS=D	Continued From page 110 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to provide adequate supervision to prevent a resident to exit a locked dementia unit for one resident, (Resident #116). The facility reported a census of 115. Findings include: 1. An admission record revealed Resident #116 admitted on 5/10/19. The Care Plan dated 5/10/19 revealed the resident had activities of daily living (ADL) self-care performance deficit related to Alzheimer's and is able to ambulate independently. Observation on 05/13/19 at 10:27 a.m., revealed Resident #116 standing next to the exit door holding a pillow and blanket dressed in white jeans and a white jean jacket. An Incident Report dated 5/13/19 revealed the resident followed a visitor out of the unit onto another unit. There were several attempts made to place a wander guard on the resident but the resident kept refusing. After the elopement	F 689		

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F 689	Continued From page 111 another staff member was able to place a wander guard on the resident's right wrist without difficulty. Progress notes dated 5/13/19 revealed Staff IP made a late entry indicating the resident was seen at 9:15 a.m., walking towards the door and wandering. Staff P instructed Staff Q LPN to do another elopement risk due to exit seeking. After speaking to Staff Q around 9:30 a.m., Staff P approached the resident to apply the wander guard but the resident adamantly refused to put it on. Certified Nurses Aide was instructed that resident will be on one on one because she is at risk for elopement, will reapproach to put wander guard on resident. Progress note dated 5/13/19 revealed around 11:15 a.m., this morning the resident followed a visitor out of Birch Blvd unit onto Cedar Court unit, this was her first attempt of eloping. A wander guard was attempted several times prior to this incident occurring due to the resident knocking on the double doors to the hallway this morning. An interview on 05/16/19 at 10:04 a.m., Staff P Registered Nurse stated she was in Birch Blvd and saw the resident coming down the hallway carrying things. The resident was redirected back to the lounge area in which she sat down in the recliner. Staff P stated she attempted to place a wander guard on the resident but the resident refused. Staff P stated she approached Staff R, Certified Nurses Aide and instructed to keep an eye on the resident. An interview on 5/16/19 at 9:16 a.m., Staff R stated the resident was packing her things up and	F 689		

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F 689	Continued From page 112 going back and fourth to double doors and exit door. She stated there was no direction from staff to keep an eye on Resident #116. Staff R stated she was standing post keeping an eye on the resident's when she went to break without telling anyone. In an interview on 5/16/19 at 09:12 a.m., Staff T, House Hold Coordinator stated the resident was recently admitted on 5/10/19. She stated she was standing outside the Director of Nursing office between Birch Blvd and Cedar Court when she was asked to assist another resident to Aspen. At that time, Staff T stated, she saw Resident #116 come around the corner out of Birch Blvd and continued to keep her eyes on the resident until she entered Cedar Court. She then preceded to take the other resident to Aspen and then went to Cedar Court to get Resident #116. In an interview on 5/16/19 at 12:52 p.m., the DON and Quality Assurance Nurse stated if Staff R would have communicated with her co-workers that she was going on break they could have been more aware of Resident #116's wandering. They both verified if other staff on the unit were aware, the elopement may have been prevented.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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F 690	Continued From page 113 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff interviews the facility failed to provide services to maintain continence for 1 of 4 resident reviewed (Resident # 65) and failed to complete a bladder assessment for 1 of 4 residents review (Resident #86). The facility reported a census of 115 during the time of the survey. Findings include: 1.The 3/31/19 quarterly Minimum Data Set (MDS)	F 690		

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F 690	Continued From page 114	F 690		

for Resident #65 revealed she had severely impaired cognition for daily decisions making and never or rarely made decisions and required extensive assistance of 2 staff for bed mobility, transfers, walking in room, toilet use and personal hygiene. The MDS included diagnosis of Alzheimer's, Psychotic Disorder and Stage 3 Chronic Kidney Disease.

Resident #65's Care Plan included at risk for urinary tract infection and incontinence and included and intervention for staff to prompt to use the bathroom several times a day.

Resident #65's Bladder Elimination record during 5/1/19 - 5/15/19 included she had been continent 24 times and incontinent 20 times during the period. The 5/15/15 included documentation at 4:40 AM continent at that time.

Continuous observation on 5/15/19 from 7:35 to 11:19 revealed the following:

On 5/15/19 at 7:35 AM Resident # 65 in her recliner with feet up in pink top and blanket on her lap eyes closed. This surveyor proceeded to nurse's station standing with direct vision to Resident # 65's room and entered each time staff entered.

On 5/15/19 at 8:39 AM Staff D, Certified Nursing Assistance (CNA) took Resident #65's breakfast tray into her room placed tray onto the over bed table. Staff D sat Resident #65 up in her recliner she had on pink top and black pants. Staff D washed his hands and left room.

On 5/15/19 at 9:13 AM Staff D, CNA went into Resident # 65's room and took her room tray and

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F 690	Continued From page 115 moved the over bed table from in front of her and left. She ate 100%. The resident seemed pleasant with Staff D. On 5/15/19 at 9:38 AM Staff A, Licensed Practical Nurse (LPN) took Resident #65's medications into her room, set them down, washed hands and moved the over bed table. Staff A sat Resident #65 straight up with feet on the floor. Staff A sat beside her to give medication. Resident #65 refused the medication. Staff A waited a few minutes and asked again to take medication, resident refused again and Staff A labeled the medications and left the room. Staff A explained she would try again later. On 5/15/19 at 9:52 AM Staff A, LPN knocked on the door to give Resident #65 medication. The nurse asked if she was in pain. Resident #65 replied she was okay and refused to take medication so nurse left room to try later. On 5/15/19 at 10:09 AM Staff B, CNA was in the dining room by the nurses station charting on Resident #65. This surveyor at the nurse's station with direct view of Resident # 65 room. This surveyor continued to go into the residents room every time someone went to the room. On 5/15/19 at 10:32 AM Staff B and Staff D, CNA's left to go to lunch. They notified the other 2 CNA's they were going. On 5/15/19 at 10:59 AM Resident #65 sat in her recliner in her room with feet down and watching TV. On 5/15/19 at 11:04 AM Staff B and Staff D, CNA's came back from lunch.	F 690		

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F 690	Continued From page 116 On 5/15/19 at 11:15 AM observed Staff C, CNA charting on paper. When asked, Staff C, explained they mark on a sheet who they have taken to the bathroom so they know if someone else had taken residents to the bathroom while not in the area. On 5/15/19 at 11:17 AM this surveyor looked at the paper charting that revealed Resident # 65 had been done.The charting did not reveal a time. On 5/15/19 at 11:19 AM Resident # 65 sat in her recliner watching TV. During an observation on 5/15/19 at 12:34 PM Resident # 65 sat in her room in the recliner with curtain pulled and tray table in front of her with lunch on top of the tray table. During an observation on 5/15/19 at 1:04 PM Staff B took lunch tray away only dessert eaten. During an observation on 5/15/19 at 1:08 PM Staff B, CNA, Staff C, CNA and Staff E, Registered Nurse all knocked on the door to enter Resident #65's room. Staff B washed her hands and Staff C used hand sanitizer both donned gloved. Staff B tried to move blanket. Resident #65 unhappy with aids and refused to go to bathroom. Staff C explained she gets like this if she does not need to use the bathroom. During an interview on 5/15/19 at 1:14 PM Staff B, CNA explained she had taken Resident #65 to the bathroom right after breakfast. When asked her at what time, Staff B replied 8:30 AM or 9:00 AM and that's when they got her dressed for the day. The surveyor had observed the resident	F 690		

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F 690	Continued From page 117 already dressed in a pink top and black pants prior to that time. During an interview on 5/15/19 at 1:55 PM with Director of Nursing (DON) acknowledged she would have expected them to have toilet her during the time the surveyor observed Resident #65's room and not to chart if they did not take her. 2. The Minimum Data Set (MDS) assessment dated 4/14/19 identified Resident # 86 had diagnoses of Cerebrovascular Accident (stroke), chronic left femoral embolism (blood clot), and weakness. The resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. Resident #86 required the extensive assistance of two staff for toileting and transfers. The resident experienced frequent episodes of bladder and bowel incontinence. The MDS revealed the resident had no trial or current toileting program such as a scheduled toileting or bladder training since incontinence had been noted to manage the resident's urinary or bowel incontinence. The Care Plan revised 2/13/19 revealed the resident had incontinence and an ADL (activities of daily living) deficit related to limited mobility and weakness. The Care plan directives for staff included offer to toilet the resident upon rising, before/after meals, and bedtime, and PRN (as needed), use an EZ stand and two staff assistance for toileting, and provide good peri-care after each incontinence episode.	F 690		

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F 690	Continued From page 118 The Admission Assessment dated 1/5/18 revealed resident had occasional bowel and bladder incontinence. The clinical record lacked documentation of ongoing bowel/bladder assessments or interventions for the resident to prevent or reduce incontinence episodes. During observation and resident interview on 5/13/19 at 1:10 PM, Resident #86 sat in the wheelchair in the common area. The resident had a strong odor of urine. Resident #86 reported it took up to two hours before she received assistance from staff to take her to the bathroom. The resident reported she had frequent incontinence due to waiting for staff to take her to the bathroom, and she had gotten use to sitting in wet pants. During observation on 5/14/19 at 12:47 PM, Resident #86 reported she needed to go to the BR and required two staff assistance because they used a machine when she transferred. At the time, Resident #86 made Staff N, Certified Nursing Assistant (CNA) aware she had to go to the bathroom. At 1:00 PM, Resident #86 sat in a wheelchair in front of the shower door and reported she continued to wait for staff assistance to take her to the bathroom. At 1:11 PM, Staff N, CNA, and Staff M, CNA, took Resident #86 into the shower room and used an EZ Stand to transfer the resident onto the toilet. During an interview on 5/14/19 at 1:48 PM, Staff N, CNA, reported Resident #86 had a wet brief.	F 690		

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F 690	Continued From page 119 During an interview on 5/15/19 at 1:59 PM, the Director of Nursing (DON) reported an admission assessment is performed when a resident admitted to the facility. The DON reported the admission assessment included a bowel/bladder assessment. The DON acknowledged no other bowel / bladder assessments completed.	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		

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F 756	Continued From page 120 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and consultant pharmacist interview, the facility failed to document an appropriate diagnosis for psychotropic medication and failed to report irregularities to the physician for 3 of 5 residents reviewed (Resident #1 #106, and #108). The facility reported a census of 115 residents. Findings include: 1. The Minimum Data Set assessment (MDS) dated 5/5/19 documented Resident #1 had diagnoses including Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Arthritis, Alzheimer's disease, Anxiety, and Psychotic Disorder. The MDS documented the resident received an antipsychotic medication daily and an antidepressant daily. The Physician Orders dated 11/2/18 and The Medication Review Report dated 4/25/19 listed the resident received Trazodone (antidepressant) daily, started 2/14/18, Zoloft (antidepressant) daily, started 5/18/18, and Zyprexa (antipsychotic) daily, started 9/17/18. The Medication Regimen Review lacked documentation the pharmacist reported the	F 756		

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irregularities of duplicate antidepressants to the physician.

The Medication Administration Record for April 2019 had documentation to monitor for side effects of antidepressant but did not list any side effects.

The Medication Administration Review for May 2019 had documentation to monitor for side effects of antidepressant but did not list any side effects.

2. The MDS assessment dated 4/28/19 for Resident #106 documented diagnoses including Anemia, Hypertension, Alzheimer's disease, Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. The MDS documented the resident received antipsychotic, antianxiety, and antidepressant medication daily.

The Physician Orders dated 1/18/19 and The Medication Review Report dated 3/29/13 listed the resident received Zyprexa (antipsychotic) daily, Buspar (antianxiety) twice a day,started 1/5/19, Ativan (antianxiety) three times a day, started 5/11/18, Zoloft (antidepressant) daily, started 7/20/18, and Trazadone (antidepressant) twice daily, started 9/20/18.

The Medication Regimen Review lacked documentation the pharmacist reported the irregularities of duplicate antianxiety medication and antidepressant therapy to the physician.

The Medication Administration Review For April 2019 had documentation to monitor for side effects of the antidepressant, antipsychotic, or

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F 756	Continued From page 122 antianxiety medication but did not list any side effects. The Medication Administration Review for May 2019 had documentation to monitor for side effects of the antidepressant, antianxiety, or antipsychotic medication but did not list any side effects. 3. The MDS assessment dated 4/28/19 documented Resident #108 had diagnoses including Hypertension, Renal Failure, Diabetes Mellitus, and Dementia. The MDS documented the resident received antipsychotic, antianxiety, and antidepressant medication daily. The Physician Orders dated 1/18/19 and The Medication Review Report dated 3/28/19 listed the resident received Ativan (antianxiety), started 7/12/17, Buspar (antianxiety), started 2/19/19, Prozac (antidepressant), started on 12/5/18, and Nuplazid (antipsychotic), started 2/19/19. The Medication Regimen Review lacked documentation the pharmacist reported the irregularities of duplicate antianxiety medication. The Medication Administration Record for April 2019 had documentation to monitor for side effects of the antidepressant , antianxiety,or antipsychotic medication but did not list any side effects. The Medication Administration Record for May 2019 lacked documentation monitoring the antianxiety, antidepressant, or antipsychotic medication but did not list any side effects.	F 756		

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F 756	Continued From page 123 During an interview on 5/15/19 at 10:40 a.m. the Consultant Pharmacist stated she did consider duplicate medication an irregularity. She is in the process of getting appropriate diagnoses for psychotropic medications.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		

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F 758	Continued From page 124 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, web-site information, and staff interview, the facility failed to ensure each resident had an appropriate diagnosis for psychotic medication use for 2 of 5 residents reviewed (Resident #106 and #108) The facility reported a census of 115 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/28/19 for Resident #106 documented diagnoses including Anemia, Hypertension, Alzheimer's disease, Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. The MDS documented the resident received an antipsychotic, antianxiety, and antidepressant medication daily. The Physician Orders dated 1/18/19 and The Medication Review Report dated 3/29/19 listed	F 758		

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	165612	A. BUILDING _____ B. WING _____	05/16/2019

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F 758	Continued From page 125 the resident received an antipsychotic (Zyprexa) daily, an antianxiety(Buspar) twice a day, started 1/5/19, an antianxiety (Ativan) three times a day, started 5/11/18, an antidepressant (Zoloft) daily, started 7/20/18, and an antidepressant (Trazodone)twice daily, started 9/20/18. The Medication Review Report dated 3/29/19 listed an antipsychotic medication, Nuplazid, started 2/19/19 used for Parkinson's dementia. Review of the website nuplazidhcp.com revealed the medication is used for Parkinson's disease related delusions and hallucinations and shows the medication increased mortality in the elderly. It should not be used for dementia related psychosis. The clincal record lack a diagnosis of Parkinson's disease. 2. The MDS assessment dated 4/28/19 documented Resident #108 had diagnoses including Hypertension, Renal Failure, Diabetes Mellitus, and Dementia. The MDS documented the resident received an antipsychotic, antianxiety, and antidepressant medication daily. The Physician Orders dated 1/18/19 and The Medication Review Report dated 3/28/19 listed the resident received an antianxiety (Ativan), started 7/12/17, an antianxiety medication (Buspar), started 2/19/19, an antidepressant medication (Prozac), started on 12/5/18, and an antipsychotic (Nuplazid) started 2/19/19. The Medication Review Report 3/28/19 listed a diagnosis of demenetia for the Buspar not an	F 758		

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F 758	Continued From page 126 anxiety disorder, a diagnosis of hypertension for the Prozac not depression, and a diagnosis of dementia for the Nuplazid not a psychotic disorder. During an interview on 5/15/19 at 10:40 the Consultant Pharmacist stated she is in the process of getting appropriate diagnoses for psychotropic medications.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to administer medications according to physician orders leading to a 7.41% medication error rate occurrence during administration of 27 medications. The facility reported a census of 115 residents. Findings include: 1. The Medication Review Report signed by the physician 3/29/19 for Resident #53 documented an active order for Levemir (insulin medication) FlexTouch Solution Pen-Injector 100 unit/ml (milliliter); Inject 20 units subcutaneously (under the skin) 2 times a day for diabetes. Observation on 5/15/19 at 7:40 a.m. revealed Staff V, Licensed Practical Nurse (LPN), dialed	F 759		

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F 759	Continued From page 127 the Levemir Flex-pen to 20 units, attached a needle, and without priming the needle first, administered the insulin. Staff V stated they only prime the pens if it is a new pen. Staff B commented the pharmacy told them they only have to prime if a brand new pen. On 5/15/19 at 7:55 a.m., Staff Z, LPN, responded the process of using an insulin Flex-pen included to attach a needle then prime the needle with 2 units of insulin, then inject the desired dose. On 5/15/19 at 8:17 a.m., Staff U, LPN, responded the process of giving insulin via Flex-pen included to wipe pen with alcohol, attach the needle, prime the needle with 2 units, then dial the desired amount of insulin. By failing to prime the needle, Staff V failed to inject the entire 20 units of insulin. 2. The hospital discharge orders dated 5/10/19 for Resident #61 included an active order for the following medication: calcium 600 mg (milligrams)/vitamin D 400 IU (International Units) tablet; take 1 tablet by mouth 2 times daily. Observation on 5/15/19 at 8:47 a.m. revealed Staff J, LPN, prepared medication for Resident #61. Staff J obtained a stock bottle medication labeled calcium 600 mg plus vitamin D3 200 IU tablets. Staff J removed 1 tab from the bottle and administered the medication with the resident's other morning pills. Staff J failed to give the correct dose of vitamin D 400 IU as ordered by the hospital.	F 759		

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F 759	Continued From page 128 27 opportunities of medication administration were observed and 2 of the 27 medications not administered in accordance with physician's orders, resulting in a medication error rate of 7.41%.	F 759		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the	F 801		

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F 801	Continued From page 129 services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations	F 801		

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F 801	Continued From page 130 from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility failed to ensure a qualified person served as the director of food and nutrition services. The facility identified a census of 115 residents. Findings include: During an interview on 5/13/19, at 8:40 AM, the Director of Ancillary Services reported their previous dietary manager left facility employment on 4/26/19 and the Assistant Dietary Manager will be stepping into the role but acknowledged she is not a certified dietary manager (CDM). He reported the facility plans to enroll the Assistant Dietary Manager in the CDM classes. He confirmed the facility does not have a full-time dietitian. Their current consultant dietitian comes weekly and will end services next week and they have a contracted dietitian that started last week and will provide approximately 16 to 24 hours weekly. During a follow-up interview on 5/14/19, at 8:00 AM, the Director of Ancillary Services reported he is currently in charge of the department with a background and degree in hotel/restaurant management, and is ServSafe certified, however, acknowledged the facility currently does not meet the federal regulation for a qualified foodservice director. He reported they began to develop a plan to cover the position when the previous manager submitted her resignation. He confirmed their plan is to promote the Assistant Dietary Manager into the manager position once she becomes a CDM.	F 801		

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F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

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F 842	Continued From page 132 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, family and staff interviews the facility failed to provide complete documentation related to the use of merry walkers for 4 of 4 Residents (Resident #18, #21, #54 and # 56). The facility reported a census of 115 during the time of the survey. Findings include: 1. The 3/24/19 quarterly Minimum Data Set	F 842		

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

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F 842	Continued From page 133 (MDS) for Resident #54 revealed she had severely impaired cognition for daily decisions making and never or rarely made decisions. The resident required extensive assistance of 2 staff for walking in and out of her room. The MDS included diagnosis of Non-Alzheimer's Dementia and Depression. Resident #54 had used other restraint daily during the 7 day look back period. Resident #54's Care Plan included the use of a merry walker and to document usage and release. The May Restraint Form for Resident #54 lacked documentation. During an observation on 5/14/19 at 9:32 AM, Resident # 54 used a merry walker. During an interview, Resident #54's spouse explained they were very happy having his wife use the merry walker. He further explained she is able to walk around safely. 2. The 3/24/19 quarterly Minimum Data Set (MDS) for Resident #56 revealed she had severely impaired cognition for daily decisions making and never or rarely made decisions. The resident required extensive assistance of 1 staff for walking in and out of her room. The MDS included diagnosis of Non- Alzheimer's Dementia and Depression. The resident had used other restraint daily during the 7 day look back period. Resident #56's Care Plan included the use of a merry walker to increase mobility and independence. The March and May Restraint Form for Resident	F 842		

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F 842	Continued From page 134 #56 lacked documentation. During an observation on 5/13/19 at 9:59 AM, Resident #56 was in merry walker looking out the window. During an interview on 5/15/19 at 3:20 PM, the Director of Nursing (DON) explained the only documentation for Resident #54 the facility had is for May and Resident #56 is March and May with lots of missing documentation on each form. 3. The quarterly MDS dated 2/24/19, identified diagnosis for Resident #18 included Non-Alzheimer's Dementia, Psychotic Disorder, and Hypertension. The MDS revealed the resident severely cognitively impaired. According to the MDS the resident required extensive assist of two staff for transfer and toilet use. The MDS revealed physical restraints used daily. The Care Plan with a focus area dated 2/19/19 revealed the resident used a merry walker to promote independent ambulation and directed staff to make frequent checks and to release for activity and toileting. A Fax Order Request/Communication dated 8/17/16 noted resident doing well in merry walker and an order received for the merry walker use for independent ambulation. Review of February, March, April, and May 2019 Restraint Form revealed incomplete documentation.	F 842		

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F 842	Continued From page 135 4. The quarterly MDS dated 2/24/19 identified diagnosis for Resident #21 included Alzheimer's Disease, Anxiety Disorder, and Psychotic Disorder. The MDS revealed the resident severely cognitively impaired. The resident required extensive assist of one staff for bed mobility, transfers, dressing, and toilet use. The MDS revealed physical restraints used daily. The Care Plan with a focus area dated 2/8/19 revealed the resident used a merry walker to promote independent ambulation and directed staff to make frequent check and release for activity and toileting when in merry walker. A Fax Order Request/Communication dated 4/9/19 revealed Physicial Therapy (PT) to evaluate appropriateness of merry walker with a response indicating okay. Review of February, March, April, and May 2019 Restraint Form revealed incomplete documentation. In an interview on 05/15/19 at 1:53 p.m., the Director of Nursing (DON) verified there are gaps and incomplete documentation in merry walker restraints. She would expect staff to document not applicable (n/a) if the resident was not in the merry walker.	F 842		

Trinity Center at Luther Park

1555 Hull Ave

Des Moines, Iowa 50316

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F550

The resident has a right to toileting assistance when requested of staff to be performed in a timely manner. The facility will provide care for the resident in an environment that will maintain and enhance dignity.

Corrective action taken for residents found to have been affected by deficient practice

Resident #86 has been put on a toileting program, after a bowel and bladder assessment were completed. Resident's care plan has been updated.

How the center will identify other residents having the potential to be affected by the same deficient practice

The clinical team will identify all residents residing in this facility who require assistance with ADL's and complete a bowel/bladder assessment, and it will be determined if they are appropriate for a bowel/bladder program.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Staff will be re-educated on the Dignity/Confidentiality Policy on or before 6/13/19, and will not be allowed to work until education is completed.
- ADON or designee will complete Random audits on 5 residents weekly x1 month with random audits to be incorporated into the routine QA audits occurring no less than quarterly.
- Bowel/Bladder assessments to be conducted Upon Admission, Annual/Quarterly/Sig change MDS' and PRN.
- Review of Bowel/Bladder assessments with Annual/Quarterly/Sig Changes on a routine basis

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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Identified concerns shall be reviewed by the facility's AQQ Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

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F580

It is the practice of the facility to notify the doctor and family of any changes in condition including ADLs and deteriorating wounds.

Corrective action taken for residents found to have been affected by deficient practice

Resident #97 was sent to the hospital for further evaluation. Resident passed away while at the hospital.

How the center will identify other residents having the potential to be affected by the same deficient practice

All residents who have displayed a change in their normal condition for greater than 24 hours will have full assessment completed by nurse and notify family & physician (FYI) so as to inform them a change has been noticed and is being monitored

All current residents who reside at the facility and have a change in condition or decline in ADL's.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Licensed/Registered nurses will be educated on the requirements of Assessments and notifications when there is a change in condition
- DON, ADON, Overnight Supervisor & Weekend Supervisor and Clinical team will do daily review on all residents with changes in condition to ensure compliance with physician and family notifications.
- ADON will randomly audit residents with changes in condition weekly x 4 weeks to ensure physician and family notification is completed
- Resident will be added to "Hot Charting" for next 72 hours or until the condition is resolved.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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F582

It is the practice of the facility to notify residents of the Medicaid/Medicare coverage/liability notice.

Corrective action taken for residents found to have been affected by deficient practice

Resident #38 has been notified.

Resident #61 has been notified.

How the center will identify other residents having the potential to be affected by the same deficient practice

All residents discharging from skilled therapy.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Director of social services has been re-educated on the notification process.
- Residents on skilled nursing will be reviewed at the weekly Medicare meeting and residents identified who have upcoming discharges.
- Random audits to be conducted on all resident discharging from skilled therapy weekly x 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

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Des Moines, Iowa 50316

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F609

It is the practice of the facility to report abuse allegation as per the DIA requirements.

Corrective action taken for residents found to have been affected by deficient practice

Social services will assess resident # 30 for psycho-social well-being.

How the center will identify other residents having the potential to be affected by the same deficient practice

Audit of steps taken, timeline r/t compliance in reporting alleged abuse cases will be conducted on all reports submitted to the state r/t abuse allegations.

All residents who reside at the facility are at risk for abuse.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- HR will re-educate DON on the abuse reporting policy.
- Audits to be completed weekly x 4 weeks to ensure all abuse allegations have been reported to the DIA in a timely manner.
- QA will review submissions on a routine basis.
- Abuse policy is currently under review and will be revised and updated.

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F610

The facility always strives to investigate all abuse allegations and submit five-day investigation summary per DIA regulations. The facility will prevent further potential abuse, neglect, exploitation or mistreatment while an alleged violation is awaiting investigation by the DIA.

Corrective action taken for residents found to have been affected by deficient practice

Social services will assess the resident for psycho-social well-being.

How the center will identify other residents having the potential to be affected by the same deficient practice

The facility identifies all residents who reside at the facility are at risk for abuse allegation.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- HR to re-educate the DON on abuse follow up process.
- The facility will review and revise the abuse policy.
- Weekly audits to be conducted on all reportables from the facility to ensure a five-day investigative summary is submitted.
- Audit of steps taken, time line r/t compliance in reporting alleged abuse cases will be conducted to include the five-day report submitted to the state on all alleged abuse cases.
- Abuse policy is currently under review and will be revised and updated.

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F644

The facility always strives to ensure proper coordination of PASRR and assessments.

Corrective action taken for residents found to have been affected by deficient practice

Resident #110 has been re-assessed for a new PASRR and care plan updated

Resident #108 has been re-assessed for a new PASRR and care plan updated

How the center will identify other residents having the potential to be affected by the same deficient practice

The center will identify residents by ensuring any new admit or current resident who resides in the facility and receives a new mental health diagnosis, a change in condition (which could include a new or worsening behavior), and the addition or discontinuation of psychotropic medication(s) will be required to have a new PASRR.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Educate nursing leadership on PASRR coordination process.
- A complete house audit of all residents in the facility has been completed to ensure PASRR compliance, and care plans have been updated.
- All new admits and 5 residents will be audited weekly x 4 weeks for PASSR compliance.
- Interdisciplinary team members which include; Director of Social Services and Director of Admissions will be responsible for completion of new and revised PASRRs.

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F645

The facility will strive to ensure PASRR screening for MD and ID.

Corrective action taken for residents found to have been affected by deficient practice

Resident # 46 has had a new PASRR submitted, the family declined mental health services d/t resident being on Hospice cares, he has since passed away.

How the center will identify other residents having the potential to be affected by the same deficient practice

An audit of all residents residing in the facility has been conducted to see that PASRR is current and in chart/on care plan. New admits will be audited for correct diagnoses, medications, and PASRR.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Educate nursing leadership team on PASRR screening for MD and ID
- All current residents and new admits will be screened for PASRR MD and ID.
- Social services will complete random audits on 5 residents to ensure compliance weekly x 4 weeks, and then added to the QA process of routine auditing.
- Interdisciplinary team members which include; Director of Social Services and Director of Admissions will be responsible for completion of new and revised PASRRs.

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F656

The facility strives to develop a comprehensive care plan for all residents on psychotropic medications.

Corrective action taken for residents found to have been affected by deficient practice

Care plans for resident #1 - Care plan was reviewed and updated

Resident #106 – Care plan was reviewed and updated

Resident # 108 - Care plan was reviewed and updated.

How the center will identify other residents having the potential to be affected by the same deficient practice

A review of all residents in the facility and their diagnoses will be conducted to identify residents that are currently taking psychotropic medications.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- All residents on psychotropic meds will have their care plans reviewed and updated.
- ADON will conduct random audit on 5 residents with psychotropic meds weekly x 4 weeks for compliance. Audits will be added to the QA process on a routine basis.
- Care Plan Templates have been created in the E.H.R. for antidepressants, anxiolytics, antipsychotics, and hypnotics in order to identify potential side effects unique to the individual resident's therapeutic response to treatment.

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F657

The facility strives to revise and update care plans in a timely manner.

Corrective action taken for residents found to have been affected by deficient practice

Resident # 86 had advance directives revised and updated on the care plan.

How the center will identify other residents having the potential to be affected by the same deficient practice

A review of all residents advanced directives will be conducted throughout the facility to ensure that appropriate directives are clearly identified both in chart and on care plans.

All new admits and residents who reside at the facility.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Advance directives of all residents who currently reside in the facility, and new admits have been reviewed and updated in the physician orders and on the resident's care plan.
- ADON will conduct random audits on 5 residents weekly x 4 weeks to ensure compliance with the advance directives.
- Social Services reviews advance directives at every care conference with resident and or power of attorney.

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F661

The facility strives to provide a discharge recapitulation to all residents who discharge from the facility.

Corrective action taken for residents found to have been affected by deficient practice

Resident #114 no longer resides at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

On-going audits will be conducted to ensure all resident both new and current have discharge planning in place, and any resident who has been discharged from the facility has the appropriate discharge recapitulation form completed.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- All departmental heads and licensed staff will be educated on the discharge process.
- Social services or designee will complete random audit on all discharges weekly x 5 weeks for compliance.
- Social Services initiates discharge recapitulation process and has interdisciplinary team members will complete their section during daily clinical meeting.

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F684

The facility strives to ensure timely interventions will be put in for all physician orders and residents who experience a change in condition.

Corrective action taken for residents found to have been affected by deficient practice

Resident # 97 was assessed and sent to the Hospital for evaluation, resident passed away.

How the center will identify other residents having the potential to be affected by the same deficient practice

Any resident who is noted to have had a change in their baseline health status or routine behavior, will be assessed. After a 24-hour period with no signs of improvement, the physician and family will be notified unless acute signs and symptoms warrant immediate notification.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Staff education has been completed for all nurses on how to recognize a change in condition and notification of the physician.
- All residents having a change in condition will be placed on alert charting until resolved.
- Education to nurses regarding notification of change in condition should not be faxed to a closed office, but rather called into the physician on call promoting immediate initiation of treatment.
- Random audits will be conducted on residents having changes in condition weekly x 4 weeks to ensure compliance with timely intervention.
- We now have an in-house nurse practitioner in the building three day per week, to allow for immediate follow up and intervention.

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F686

The facility strives to ensure residents receive proper care for prevention of pressure ulcers and provide interventions to treat and prevent development/deterioration of pressure ulcers. The facility will also complete physician orders and notify respective family members for any changes in condition.

Corrective action taken for residents found to have been affected by deficient practice

Resident # 97 was assessed by the wound doctor and treatment was in place. Resident was sent to the ER, passed away while at the hospital.

Resident #9 has also since passed away.

How the center will identify other residents having the potential to be affected by the same deficient practice

Area of concern was identified on 4/19/19 to include wound documentation and an entire sweep of building, skin inspections on all residents was conducted on 4/22/19, new incident reports and skin sheets were started, Skin Policy review and education with staff started on 4/30/19. This is an area we are currently working on. Documentation will be submitted however incomplete d/t ongoing status of process to improve this are of concern.

All residents who reside at the facility have contractures or at risk for development of pressure ulcers.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Skin policy was reviewed and subsequent education has been provided to nursing staff and is ongoing.
- A wound doctor has been hired to do rounds weekly on all residents with pressure ulcers and complicated skin issues.

- DON will conduct weekly audits on all residents with pressure ulcers and new wounds to ensure treatment is in place weekly x4 weeks then monthly by QA.
- Daily audits of Mars & Tars to confirm compliance with documentation.

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F689

The facility strives to ensure there is adequate supervision to meet resident needs.

Corrective action taken for residents found to have been affected by deficient practice

Resident # 116 was assessed for elopement, physician orders obtained for a wander-guard.

How the center will identify other residents having the potential to be affected by the same deficient practice

Elopement assessments will be conducted on all residents who reside in the facility that are ambulatory or considered as high risk for elopement.

All new admits and residents who reside in the facility, are ambulatory and are at high risk for elopement.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Elopement education initiated and in progress.
- Elopement assessment will be completed on all new admits.
- All residents who are at high risk for elopement will be given wander-guard. (If staff is unable to secure a wander-guard onto the resident's person, 1:1 staff supervision will be put into place until a wander-guard is secured.
- A binder with information (including a photo of the resident) who is a high risk for elopement has been placed at the reception area/desk and all nurses' stations and will be updated as needed.
- Weekly random audits will be conducted on five residents who are high risk for elopement, for a duration of four weeks. A physician's order, placement, and function of the wander-guard will be confirmed and added to the resident's care plan and elopement binder.

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F690

The facility will strive to provide assessment for bowel and bladder function on all residents

Corrective action taken for residents found to have been affected by deficient practice

Resident # 65 was added to a toileting program.

Assessment for bowel/bladder continence has been completed on resident # 86 and care plan updated.

How the center will identify other residents having the potential to be affected by the same deficient practice

All new admits and residents who reside at the facility have been identified through a bowel and bladder assessment.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Education has been provided to the licensed nursing staff and is on-going.
- ADON will conduct Random audits on residents on toileting program weekly x 4 weeks to ensure compliance.
- Facilities contracted therapy provider is able to provide treatment modality that will address resident's incontinence through the stimulation of pelvic muscle strengthening.
- Toileting program has been added to the E.H.R. library. Residents who can participate on this program will be identified and added to the program.

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F756

The facility strives to complete drug regimen review and report duplicate medications to the doctor, to ensure psychotropic medications have appropriate diagnoses.

Corrective action taken for residents found to have been affected by deficient practice

Med-review will be conducted on residents # 46, # 108, #1.

#1-Pharmacy consultant reviewed residents meds, made recommendations to the physician, recommendation addressed

#106- Pharmacy consultant reviewed residents meds, made recommendations to the physician, recommendation addressed

#108- Pharmacy consultant reviewed residents meds, made recommendations to the physician, recommendation addressed

How the center will identify other residents having the potential to be affected by the same deficient practice

Review of all medications classified as psychotropic. Residents who take this class of medication will be identified upon admission, quarterly, annual, and significant change assessments.

All residents who admit and reside in the facility and are on psychotropic meds.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Audit of all residents who are currently residing in the facility, on psychotropic medications, and have duplicate therapies will be identified and reported to the physician.
- DON or Designee will conduct random audits on 5 residents weekly x 4 weeks to identify if they have duplicate therapies.
- Pharmacy consultant reviewed all residents; all residents with duplicate therapies were identified, and recommendations were made to the physician. All recommendations have been addressed.

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F758

The facility will consistently strive to review unnecessary psychotropic medication use, and ensure proper diagnosis for psychotropic medications are in place.

Corrective action taken for residents found to have been affected by deficient practice

Resident #108 Diagnoses have been reviewed and updated

Resident #106 Diagnoses have been reviewed and updated

Psychotropic meds will be reviewed by the pharmacist for psychotropic meds use.

How the center will identify other residents having the potential to be affected by the same deficient practice

A review of all residents who admit or reside in the facility and are on scheduled or PRN psychotropic medications will be identified to be at risk for above mentioned deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- The pharmacist will conduct a monthly review of patients on psychotropic med use and make recommendations to the pharmacist for those who are due for GDR.
- DON or designee will conduct an audit on 5 residents weekly x4 weeks to ensure compliance with psychotropic med use and proper diagnosis.

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F759

The facility strives to ensure residents are free from medication errors.

Corrective action taken for residents found to have been affected by deficient practice

Incidents reports for med error have been completed on resident #53 and resident #61 for med errors.

Resident #53 Medication error report and resident assessed for ASE from error. Resident is doing well post med error.

Resident #61 Medication error report and resident assessed for ASE from error. Resident is doing well post med error.

How the center will identify other residents having the potential to be affected by the same deficient practice

All residents that reside in the facility and require staff to administer medications are identified as potential candidate for the above-mentioned deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Education will be conducted on all nursing staff on safe med pass process.
- DON, ADON or designee will conduct random audits on 5 residents weekly x 4 weeks to ensure compliance.

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F801

The facility always strives to ensure there is qualified staff personnel with certification.

Corrective action taken for residents found to have been affected by deficient practice

All residents in the facility were likely to be affected. The original plan to have the current assistant dietary supervisor complete the CDM class is no longer valid. Please see the below changes for the new plan of correction.

How the center will identify other residents having the potential to be affected by the same deficient practice.

All residents living in the facility are identified as candidates that could experience this deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Director of Ancillary Services will work in conjunction with Luther Park's HR department to fulfill state requirements r/t the hiring of a certified dietary manager.
- Advertisement for permanent CDM currently running on multiple job sites.

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F842

The facility strives to ensure documentation for merry walker use is completed as per the facility policy.

Corrective action taken for residents found to have been affected by deficient practice

Residents # 56, #21, # 18, # 54 will be assessed for adverse effects related to no documentation on merry walker use.

How the center will identify other residents having the potential to be affected by the same deficient practice

Identification for all residents who reside in the facility and utilize a merry-walker for independent ambulation.

What changes will be put into place to ensure that the problem will be corrected and will not recur?

- Education will be completed to the licensed staff about merry walker documentation
- Audit will be conducted on all residents with merry walker to ensure they have physician orders and in compliance as per the merry walker policy.
- DON, ADON or Designee will conduct random audits on all residents with merry- walkers weekly x 4 weeks to ensure documentation compliance.
- Restraint documentation has been added to the E.H.R. Library and is on the Kardex for residents who currently utilize merry walkers.
- The position for full-time CDM is currently being advertised for the facility.

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