STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. BUILDING _____ B. WING _____	C 06/07/2021

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F 000	INITIAL COMMENTS Correction date: 6-24-21 The following deficiencies relate to the investigation of Complaints #94388 and #97430 conducted May 13, 2021 to June 7, 2021. Complaint #94338-C was substantiated. Complaint #97340-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Ridgewood Specialty Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide timely incontinence care, oral cares, and grooming to 1 of 3 residents (Resident #8) sampled for activities of daily living assistance. The facility reported a census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/28/21 listed diagnoses for Resident #8 of dementia, Parkinson's, and adjustment disorder with depressed mood. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, dressing, and personal hygiene, extensive assistance of 2 staff for transfers and	F 677	F 677: This is my credible allegation of compliance to F 677. This allegation does not constitute guilt but that the facility is in compliance to F 677. Resident #8 is receiving appropriate incontinence care, grooming, and oral care to meet their needs. All residents are receiving appropriate incontinence care, grooming, and oral car to meet their needs and per care plans Staff was educated on the standards for incontinence care, grooming and	6-24-21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 6-22-21

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F 677	Continued From page 1 toilet use, and depended completely on 1 staff for bathing. The MDS stated the resident was frequently incontinent of bladder and occasionally incontinent of bowel and listed the resident's Brief Interview for Mental Status (BIMS) score as 6 out of 15, indicating severely impaired cognition. During an observation on 5/20/21 at 6:40 a.m., Staff A (Certified Nursing Aide) and Staff B (Certified Nurse Aide) assisted the resident out of bed into a wheelchair. They then took the resident to the shower room and assisted the resident onto the toilet and changed the resident's incontinent brief. They then transferred the resident to a wheelchair. During the cares, the staff did not brush the resident's teeth or set up oral care supplies so she could brush her own teeth. Staff B then wheeled the resident to the dining room. The resident's hair was disheveled in the back. The surveyor remained in the area and the resident remained in the dining room until 9:05 a.m. when Staff C wheeled the resident to the shower room onto the scale to obtain her weight. At 9:13 a.m., Staff B and Staff C transferred the resident into a recliner in her room. At 9:32 a.m. Staff B and the Maintenance Supervisor went into the resident's room with a different recliner. They came out within 2 minutes and Staff B stated they transferred the resident to a different recliner because the original recliner's legs would not elevate. Staff B stated he did not assist the resident with any additional cares while in the room. The surveyor remained in the hallway area from this time until 11:30 a.m. During this time, no staff offered to take the resident to the bathroom or check and change the resident's incontinent brief. The surveyor asked the MDS Coordinator at 11:30 a.m. if she knew when the resident would be going to the	F 677	oral care on insert correct date. Residents will be observed by staff to ensure that proper grooming is maintained throughout the day to ensure residents are properly groomed. Grooming problems will be corrected as they are observed. Staff will be audited by nurse management for proper incontinence care techniques as well for oral care techniques. Problems will be corrected as they are observed during the audits with further education as needed for observed issues. Residents will be observed throughout the day for any incontinence care needs which includes toileting needs. Staff will be notified of resident needs for toileting, and further education will be provided as needed. Department Heads will monitor by means of their Stand Up meetings that grooming, incontinence care, and oral care are audited routinely as part of their Stand Up meetings and that appropriate corrective actions occur for observed problems. Further staff education will be provided as needed. F 684: This is my credible allegation of compliance to F 684. This allegation does not constitute guilt but that the facility is in compliance to F 684.	

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

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F 677	Continued From page 2 bathroom and at 11:38 a.m. Staff A and Staff D (Certified Nurse Aide) transferred the resident to a wheelchair, took her to the shower room, and transferred her onto the toilet. The resident's incontinent brief was soiled in the back with feces and urine. Staff A and Staff D changed the resident's incontinent brief and provided perineal cares. During the period of 6:40 a.m. to 11:30 a.m. when the surveyor inquired, staff did not offer the resident the toilet or offer to provide oral cares. The resident's Kardex, dated 5/25/21, stated the resident required the assistance of 1 staff for oral care and directed staff to assist her to the toilet every 2 hours. The facility policy "Scheduled Toileting", dated January 2015, stated the purpose was to keep the resident dry and comfortable and to prevent skin breakdown. It listed an example of a toileting schedule as before and after all meals, at bedtime, and as needed. The facility policy "Oral Hygiene", dated January 2015, directed staff to offer oral hygiene at least daily and as needed. During an interview on 5/24/21 at 10:14 a.m., Staff D (Certified Nurse Aide) stated they tried to take every resident to the bathroom every 2 hours or sooner. During an interview on 5/24/21 at 10:42 a.m., Staff E (Certified Nurse Aide) stated recently the resident had a decline. She stated her care plan directed staff to take her to the bathroom every 2 hours and stated the resident would not ask to brush her teeth and would need cued by staff.	F 677	Residents #1, #2, and #5 are receiving appropriate diabetic management to assist in ensuring appropriate insulin administration is being followed and appropriate physician notification is occurring for oddities in their blood sugars and insulin needs. Resident's #1 and #2 wounds are being assessed per facility protocol and per physician orders. Physicians are being notified as needed related to their wounds for any changes in condition for appropriate treatment needs. Any residents with Diabetic needs are receiving appropriate care related to appropriate diabetic control which includes insulin needs as well as physician notification for changes and or additional interventions for low or high blood sugars. Any residents with wound care needs are receiving appropriate assessments, appropriate treatment, and physician notification in changed in wound condition for new treatment needs. Staff was educated on the importance of having blood sugar parameters on all diabetic residents on insert correct date along with physician notification of blood sugars outside of the blood sugar parameters. Facility obtained glucagon orders for diabetic residents and ordered glucagon for each resident. There is also glucagon	6-15-21 + 6-17-21

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F 677	Continued From page 3 During an interview on 5/24/21 at 2:37 p.m., the Director of Nursing stated in general staff should offer residents the bathroom several times per shift because the residents may not be able to communicate this. She stated staff should offer oral cares to residents.	F 677	available in the EKit. Facility reviewed diabetic residents and updated their MAR to reflect the established blood sugar parameters for physician notification. Staff was also educated on the facility wound care protocol on insert correct date. This	6-9-21 & 6-15-21
F 684 SS=J	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, policy review, and staff interview, the facility failed to provide accurate assessment and intervention for 3 of 5 sampled (Residents #1, #2 and #5). The facility failed to ensure residents consumed a meal after staff administered insulin for Resident #1 and Resident #2 and failed to recheck abnormal blood glucose levels for Resident #1, #2 and #5. On 10/17/21, Resident #2 did not eat lunch after the staff administered insulin and his blood glucose level dropped to 38 milligrams/deciliter (mg/dl). The facility lacked documentation staff offered the resident additional food to eat. On 5/11/21, Resident #1 did not eat breakfast or lunch and the nurse administered morning and noon insulin. Resident #1's blood glucose level dropped to 30 mg/dl and required two injections of glucagon.	F 684	education included proper wound assessments, treatment protocols, and physician's notification of changes in wounds and possible need for new treatment to meet the resident's wound needs. Facility nurse management will review blood sugars to ensure were obtained as ordered and were within parameters. If blood sugars were outside of parameters was the physician notified of the situation, and were appropriate nursing interventions implemented to assist in stabilizing the blood sugar pending return call from physician. Problems with blood sugars/physician notification/interventions will be corrected as they are observed. Facility's nurse management will review wounds for appropriate assessment and interventions which also include prompt physician notification if any change in condition or if a change in treatment is needed. Problems with wounds and assessment/physician	

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F 684	Continued From page 4 The facility lacked documentation of physician notification following the glucagon injections. Resident #1's blood glucose level dropped again in the evening and required Emergency Medical Services to intervene as the facility lacked additional glucagon. This resulted in Immediate Jeopardy. The facility failed to provide adequate assessments and intervene for Resident #1 and Resident #2's wounds. The facility reported a census of 41 residents. Findings: 1. The Minimum Data Set (MDS) assessment dated 3/24/21 listed diagnoses for Resident #1 of dementia, diabetes, and cerebrovascular accident (stroke). The MDS stated the resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, toilet use, and personal hygiene, and depended completely on 1 staff for bathing. The MDS listed the resident's cognition as severely impaired. The Care Plan dated 2/8/18 documented Resident #1 had diabetes and received insulin and directed the staff to administer diabetes medication and monitor for side effects and effectiveness. The May 2021 Medication Administration Record (MAR) listed an order for Novolin R Solution (short acting insulin), inject 10 units if blood glucose level greater than 300 mg/dl. The May 2021 MAR entry dated 5/8/21 4:51 p.m., revealed Resident #1 had a blood glucose level of 504 mg/dl and received 10 units of Novolin insulin. The record lacked documentation to reflect the staff rechecked Resident #1's blood	F 684	notification/treatment will be corrected as they are observed. Facility's management team will monitor that blood sugars, wound care, physician notification for both, and that appropriate interventions were initiated as part of their Stand Up Meetings. . Problems will be corrected as they are observed. Further staff education will be performed as needed in relation to problems that the management team identifies. F 686 This is my credible allegation of compliance to F 686. This allegation does not constitute guilt but that the facility is in compliance to F 686. Resident #4 is receiving appropriate treatment for their pressure injuries per their physician's orders and with current standards of practice. Facility residents with pressure injuries are receiving treatment for the pressure injuries per their physician's orders and with current standards of practice. Staff was educated on insert correct date on the standard of practice of providing all treatments to pressure injuries per the resident's physician's orders. This education included the importance of providing the treatment	6-9-21 & 6-15-21

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F 684	Continued From page 5 glucose level to determine the effectiveness of the insulin. The Weights and Vitals Summary dated 5/11/21 6:21 a.m., revealed Resident #1 had a blood glucose level of 103 mg/dl. The May 2021 Documentation Survey Report V2 documented Resident #1 consumed 0-25% of her food at breakfast and lunch. The May 2021 MAR listed an order for Levemir (long acting insulin) 64 units three times a day and documented the resident received the Levemir in the a.m. and at midday. The Progress Notes dated 5/11/21 revealed the following: a. At 1:15 p.m., Resident #1 in bed sleepy, not talking to staff, and had a blood glucose level of 30 mg/dl. Staff administered glucagon (injectable medication treat low blood glucose levels). b. At 12:45 p.m., Resident #1 had a blood glucose level of 30 mg/dl. c. At 1:00 p.m., blood glucose level of 37 mg/dl. Staff administered a second dose of glucagon due to the blood glucose level not increasing above 40. d. At 1:30 p.m., Resident #1 had a blood glucose level of 67 mg/dl. e. At 3:15 p.m., Resident #1 sleepy, blood glucose level 82 mg/dl, and she took a few sips of liquacel (nutritional supplement).	F 684		

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F 684	Continued From page 6 f. At 6:00 p.m., Resident #1 had a blood glucose level of 27 mg/dl and the facility obtained an order from the Nurse Practitioner to transfer Resident #1 to the Emergency Room. g. At 6:38 p.m., an ambulance arrived and treated Resident #1 for low blood glucose level. Resident #1 had a blood glucose level of 164 mg/dl and transferred to the hospital. The Clinical Record lacked documentation to reflect the staff notified the Physician of Resident #1's low blood glucose levels and Resident #1 received glucagon from 3:15 p.m. until 6:00 p.m. The Discharge Summary (Hospital) dated 5/21/21 documented Resident #1 had a blood glucose level of 26 mg/dl at the facility and Emergency Medical Services treated and transferred to the Emergency Room. Resident #1 lethargic and barely communicative. The undated Summary Chart for Treatment of Hypoglycemia policy listed guidelines for residents with a blood sugar of 20-50 mg/dl and directed staff to give glucagon intramuscularly, call the physician, monitor the resident and check the blood sugar after 15 minutes, and follow any new orders. The procedure directed staff to provide a snack once the blood sugar was 100 mg/dl or higher. During a phone interview on 6/2/21 at 4:04 p.m., the Director of Nursing (DON) stated on the morning of 5/11/21, Staff G cared for Resident #1 and Resident #1 had a blood glucose level of 100 mg/dl. Staff G administered Resident #1's	F 684		

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F 684	Continued From page 7	F 684		

morning Levemir (64 units) and noon Levemir (64 units). The DON stated there was a concern because Resident #1 did not eat very much and Staff G administered Resident #1's insulin in the morning and again at noon. The DON stated if the resident's blood glucose level was 100, even though that was not really low, if the resident did not eat, she would have held her morning insulin. She stated the nurse received education and the facility set parameters for giving insulin so this did not occur again.

During a phone interview on 6/2/21 at 4:17 p.m., Staff G (Licensed Practical Nurse) stated on 5/11/21, the Nurse Aides did not inform her that Resident #1 did not eat breakfast and stated she administered her morning Levemir and her noon Levemir. She stated after the noon dose of Levemir, her blood sugar was subsequently 30 mg/dl so she received glucagon. She stated the Nurse Aides documented meal intakes and she did not realize Resident #1 did not eat.

During a phone interview on 6/3/21 at 8:29 a.m., the DON stated she did not see documentation of physician notification in Resident #1's chart regarding the administration of the glucagon on 5/11/21. She stated the earliest note she saw was at 5:30 p.m. She stated the staff should notify the physician of the administration of glucagon. She stated the facility had 2 doses of glucagon and the resident utilized them both but stated in the future, the facility planned to stock glucagon for all residents. She stated she did not know if anyone notified the pharmacy of the need to replenish the glucagon after staff administered it on 5/11/21 but stated she would check.

According to the Medication Administration

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F 684	Continued From page 8 Record dated 5/21/21 6:15 p.m., revealed Resident #1 had blood glucose reading of 471 mg/dl and received 10 units of Novolin. The clinical record lacked documentation to reflect the staff rechecked Resident #1's blood glucose reading and if the insulin was effective. The State Agency informed the facility of the Immediate Jeopardy on June 6/3/21 at 10:00 a.m. The facility removed the Immediate Jeopardy on June 3, 2021 by providing staff education on insulin administration parameters for diabetic residents for physician notification, implemented a system for establishing blood glucose parameters for newly admitted diabetic residents, reviewed all diabetic residents for appropriate blood glucose parameters, pharmacy to provide additional education for insulin administration, and staff education for use of glucagon including physician notification and follow up. The scope lowered from "J" to "D" at the time of the survey after ensuring the facility implemented their policy and procedure. 2. DIABETIC CARE: The MDS assessment dated 9/20/21, listed diagnoses for Resident #2 included diabetes, heart failure, and anxiety. The MDS stated the resident required extensive assistance of 2 staff for bed mobility, transfer, dressing, toilet use, and personal hygiene, and depended completely on 1 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score of "11", indicating moderately impaired cognition. Care Plan dated 9/14/20 documented Resident	F 684		

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F 684	Continued From page 9 #2 utilized insulin related to diabetes and directed staff to monitor for side effects and effectiveness. The Progress Note dated 10/17/20 9:08 a.m., revealed Resident #2 refused the facility breakfast and his wife was bringing him 2 breakfast sandwiches. The Progress Note dated 10/17/21 10:04 a.m. revealed Resident #2 ate 1 plain biscuit. The October 2020 MAR documented the resident received Novolog Mix 70/30 (a type of insulin) 30 units midday on 10/17/21. The Progress Noted dated 10/17/21 2:06 p.m., documented Resident #2 refused lunch because he didn't like it. The facility lacked documentation staff offered the resident something different to eat and lacked documentation of a blood sugar check completed after the resident refused to eat after he received insulin. The Progress Note dated 10/17/21 3:02 p.m., document Resident #2's wife called and stated the resident had slurred speech and requested a blood glucose check. Resident #2 had a blood glucose level of 38 mg/dl at 2:45 p.m. and the nurse gave the resident orange juice and a peanut butter sandwich. At 3:00 p.m., Resident #2 had a blood glucose level of 64 mg/dl. The Progress Note dated 10/17/21 4:15 p.m., revealed the resident told the nurse not to give insulin to someone until after they ate. 3. DIABETIC CARE: The MDS assessment dated 5/13/21 listed diagnoses for Resident #5	F 684		

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F 684	Continued From page 10	F 684		

included diabetes, anxiety disorder, and non-Alzheimer's dementia. The MDS stated the resident required limited assistance with dressing and toilet use and listed the resident's BIMS score as 14 out of 15, indicating intact cognition.

The May 2021 MAR listed an order for Regular Human Solution (a type of insulin), inject 10 units for blood sugars above 300 mg/dl. The MAR documented staff administered the insulin at the following times:

a. On 5/7/21, the resident's blood sugar was 491 mg/dl at 4:11 p.m.

A 5/7/21 5:43 p.m. nursing note stated the resident's blood sugar was 332 mg/dl. The facility lacked further documentation of an additional blood sugar check completed.

b. On 5/8/21, the resident's blood sugar was 386 mg/dl at 4:13 p.m. and the entry on the MAR stated the insulin was "I"(Ineffective). The facility lacked documentation of an additional blood sugar check completed.

c. On 5/11/21, the resident's blood sugar was 425 mg/dl at 4:28 p.m. and 7:35 p.m..

A 5/11/21 10:29 p.m. nursing note stated the resident's blood sugar was 375 mg/dl. The facility lacked further documentation of an additional blood sugar check completed.

d. On 5/12/21 at 4:29 p.m., the resident's blood sugar was 483 mg/dl and at 7:53 p.m., it was 425 mg/dl.

A 5/1/21 10:18 p.m. nursing note stated the

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F 684	Continued From page 11 resident's blood sugar was 342 mg/dl. The facility lacked further documentation of an additional blood sugar check completed. Care plan entries, dated 6/28/18, stated the resident had diabetes and received insulin. The entries stated the resident would have no complications related to diabetes and directed staff to monitor for and document the side effects and effectiveness of the medication. The facility policy "Blood Glucose Monitoring", dated January 2015, stated each resident should have individualized high and low parameters designated for physician notification. The facility policy "Change of Condition/Hot Chart Protocol", dated January 2015, stated a condition change was a change from normal status and directed staff to notify the physician as appropriate The facility policy "General Wound and Skin Care Guidelines" dated January 2015, directed staff to carry out wound treatments and inform the physician of any changes in wound status. During an interview on 5/24/21 at 11:22 a.m., Staff H RN stated she would always recheck a blood sugar if it was over 400 mg/dl. During an interview on 5/24/21 at 2:37 p.m. the DON stated staff should notify the physician if they administered sliding scale insulin and the blood sugar did not decrease to under 300 mg/dl. She stated if a resident did not eat after giving insulin, staff should follow up. She stated staff should ensure residents ate when they received insulin.	F 684		

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F 684	Continued From page 12 During an interview on 5/25/21 at 11:20 a.m., the DON stated she did not locate any additional documentation regarding assessment and intervention of the above resident's abnormal blood sugars or skin treatments. The Nurse Consultant was present during this interview and stated the facility created parameters for all residents on insulin for staff to follow. During an interview on 6/1/21 at 12:17 p.m., the DON stated it was her expectation staff should complete wound care per the orders and document this. 4. WOUND CONCERN: A Skin Evaluation: Non-Pressure sheet dated 4/13/21 revealed Resident #1 had a wound on the back of the right ankle which measured 5.6 cm(centimeters) x 4.8 cm x 0.2 cm(length x width x depth). The April 2021 MAR listed a 4/13/21 order for Keflex (antibiotic) 250 mg(milligrams) 1 capsule by mouth twice daily for cellulitis(an infection of the tissues) of the right lower limb. A 4/15/21 physician's visit note stated the resident went to the ER due to pain associated with RLE (Right Lower Extremity) arterial disease. A 4/16/21 10:27 a.m. nursing note stated the resident had odorous green/brown drainage to the RLE. A 4/20/21 Wound Evaluation stated the resident had an area on the right heel 5.03 cm x 4.7 cm x 0.5 cm and it was "deteriorating".	F 684		

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F 684	Continued From page 13 A 4/24/21 9:56 a.m. nursing note stated the resident had an Unna boot(a compression dressing made of layers of gauze) in place to the RLE and stated staff changed the boot due to multiple wounds draining green drainage. A 4/27/21 Wound Evaluation stated the right heel wound was 5.83 cm x 6.06 cm x 0.3 cm. A 5/4/21 Wound Evaluation stated the right heel wound was 6.79 cm x 6.7 cm x 0.4 cm and was "deteriorating". A 5/9/21 9:40 a.m. nursing note stated the resident's RLE had a large amount of green drainage and a foul odor. A 5/11/21 Wound Evaluation stated the right heel wound was 6.81 cm x 5.27 cm x 0.5 cm and had exposed tendon. The facility lacked documentation of physician notification of the drainage and foul odor to the RLE on 4/16/21, 4/24/21, and 5/9/21 and lacked documentation of physician notification of the wound increasing in size and "deteriorating" during the time frame of 4/13/21-5/11/21. A 5/11/21 6:38 p.m. nursing note stated the resident went to the emergency room for low blood sugar. A 5/12/21 hospital Consultation report stated the resident's right lower extremity had necrotic(dead) tissue as well as maggots within the wound itself. A 5/21/21 hospital discharge summary stated the resident was septic (having harmful	F 684		

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microorganisms in the blood) and had wounds to the RLE positive for proteus mirabilis and citrobacter (types of bacteria). The note stated the resident's wounds were debrided (the removal of tissue or foreign objects from a wound) by surgery and the resident received antibiotics.

A 2/9/18 care plan entry stated the resident had a pressure injury to her right lower extremity previously diagnosed as peripheral arterial disease. A 2/4/8 entry stated the resident's skin integrity would improve and an 11/2/17 entry directed staff to monitor the resident's skin and report any concerns to the nurse.

During an interview on 5/24/21 at 11:22 a.m., Staff H RN (Registered Nurse) stated Resident #1's wounds had dark green and brown drainage and an odor. She was not sure if the physicians knew about this but stated they should have.

During an interview on 5/24/21 at 2:37 p.m., the DON stated if a resident's wound had green drainage, staff should notify her or the physician.

During an interview on 5/25/21 at 11:46 a.m., Staff A (Nurse Aide) stated Resident #1's leg wounds would leak through the bandage every day to her bed. He stated the drainage smelled and was greenish yellow.

During a phone interview on 6/2/21 at 8:35 a.m., the surveyor requested the DON provide all provider notifications of Resident #1's wound status for April and May 2021.

On 6/2/21 at 3:11 p.m. and 4:38 p.m., the DON sent the surveyor documents via email regarding Resident #1 including physician progress notes

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and hospital notes. The documents did not include physician notification of the wound increasing in size and "deteriorating" during the time frame of 4/13/21-5/11/21.

During a phone interview on 6/3/21 at 12:21 p.m., Staff I (Doctor of Osteopathic Medicine) stated he would want to know if a wound had green drainage and if staff did not notify the physician, it could cause more of an infection.

5. WOUND CONCERN:

Nursing Skin Evaluation: Non-Pressure sheet dated 9/30/20, revealed Resident #2 had 1 centimeter (cm) by 1 cm area of moisture induced excoriation with a pink/red wound bed on the left side of his anus.

A 10/6/20 Nursing Skin Evaluation: Non-Pressure, stated excoriation to the left buttock remained.

A 10/13/20 Nursing Skin Evaluation: Non-Pressure stated excoriation to the left buttock remained and the current treatment would continue.

A 10/20/20 Nursing Skin Evaluation: Non-Pressure stated excoriation to the left buttock remained and the current treatment would continue.

The October 2020 Treatment Administration Record (TAR) listed a 9/30/20 order for Cavilon barrier film to the left side of the anus twice daily and prn until healed. The TAR documented the resident received the medication until 10/13/20 but lacked documentation of a treatment to the

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F 684	Continued From page 16 area carried out from 10/14/20-10/22/20(the resident's discharge). The facility lacked documentation the resident received any additional medication to the anal/buttock area from 10/14/20 until his discharge on 10/22/20. A 10/22/21 nursing note stated the resident discharged from the facility. Care plan entries, dated 9/30/20, stated the resident had an open area near the anus and directed staff to apply barrier cream to the buttocks/ anus as needed due to incontinence related excoriation.	F 684		
F 686 SS=D	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 observation, record review, and interview, the facility failed provide care consistent with professional standards of practice	F 686		

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F 686	Continued From page 17 for 1 of 2 residents sampled (Resident #4) for pressure ulcers. The facility reported a census of 41 residents. Findings: 1. The Minimum Data Set (MDS) assessment dated 4/27/21, listed diagnoses for Resident #4 included diabetes, pressure ulcer, and hemiplegia (one-sided paralysis). The MDS stated the resident required the limited assistance of 1 staff for dressing, extensive assistance of 1 staff for bed mobility and personal hygiene, extensive assistance of 2 staff for transfers and toilet use, and depended completely on 1 staff for eating and bathing. The MDS listed the resident's Brief Interview for Mental Status score as 13 out of 15, indicating intact cognition. During an observation on 5/19/21 at 10:12 a.m. the Director of Nursing (DON) measured an open area with a pink and white wound bed on the resident's hip as 9 cm x 9.5 cm(length x width) with a depth of 1.6 cm with 3.5 centimeters of tunneling. During an observation on 5/19/21 at 2:32 p.m., the DON measured a wound on the resident's right inner heel at 3.5 cm x 3 cm x 0.5 cm. The wound had a black center with yellowish edges. The April and May 2021 Treatment Administration Records (TAR) listed the following orders: On 4/23/21-5/13/21 order for the left hip: Apply Kerracel (gel dressing). Cover with dry dressing, change every 3 days and as needed. The TAR lacked documentation of the dressing change from 4/23/21 until 4/26/21.	F 686		

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F 686	Continued From page 18 On 5/15/21-5/19/21 order for the left hip: Cleanse wound with Dakins 0.25% soaked gauze for wet to dry dressing, cover with 2 layers of abdominal pads, every day and evening shift. The TAR lacked documentation of the completion of the treatment on the evening shift of 5/16/21 and 5/18/21. A 5/18/21 Progress Note documented the resident restless in the morning and then asleep after lunch so the nurse informed the second shift the dressing needed completed. On 4/21/21-5/19/21 order for the right heel: Cover wound with Betadine and cover with a dry dressing, change twice daily. The TAR lacked documentation of completion of the treatment on the morning shifts of 4/23/21 and 4/26/21 and the evening shifts on 4/29/21, 5/2/21, 5/6/21, 5/12/21, and 5/16/21. Care plan entries, dated 4/21/21, stated the resident had a pressure injury which would show signs of healing and remain free from infection. The facility policy "General Wound and Skin Care Guidelines" dated January 2015, directed staff to carry out wound treatments. On 6/1/21 at 12:17 p.m., the Director of Nurses stated it was her expectation staff should complete wound care per the orders and document this.	F 686	as scheduled and documenting that the treatment was provided on the resident's treatment administration record. If treatment was not provided due to resident refusal then that refusal must be documented on the resident's Treatment Administration Record. Nurse management will monitor treatments to ensure that they are provided per physician's orders. Problems with treatment administration will be corrected as they are observed with further staff education as needed which may include staff discipline. Facility's management will ensure treatments are monitored and that appropriate corrective actions take place in a timely manner. Problems will be corrected as they are observed.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804	F 804: This is my credible allegation of compliance to F 804. This allegation does not constitute guilt but that the facility is in compliance to F 804. Resident #3 is receiving their food at appropriate temperatures per food code guidelines. All residents are receiving their food at appropriate temperatures per food code guidelines.	

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F 804	Continued From page 19 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to serve foods at adequate minimum hot holding temperatures for 1 of 1 meal observed. The facility reported a census of 41 residents. Findings: 1. During an interview on 5/18/21 at 7:36 a.m., Resident #3 stated the food was not hot at the facility. It was lukewarm and the plates were always cold. 2. During an observation on 5/19/21 at 12:07 p.m., the Dietary Manager served the first lunch plate in the dining room. At 12:30 p.m., the surveyor entered the kitchen and Staff G Cook continued to serve residents in the dining room. At 12:40 p.m., the Dietary Manager stated they were getting ready to plate room trays and the surveyor requested staff place a test plate of food and a thermometer on the room tray cart. Staff G prepared the test plate, placed it on the cart and then prepared 4 additional room trays and placed those on the cart. Staff G finished these at 12:45 p.m. and the Dietary manager immediately began passing out the trays and finished distributing the last room tray at 11:51 a.m. Immediately after the Dietary	F 804	Dietary and other staff was educated on the importance of maintaining food temperatures on room trays on insert correct date. Facility ordered dome inserts on insert correct date to assist in maintaining food temperatures. Facility also limited the amount of room trays sent out at one time to assist in maintaining food temperatures. Management team is also to assist with passing of room trays during meal service. Test trays are to be sent with carts so that temperatures can be checked after room trays are delivered. Temperatures are to be logged so that problems can be corrected to assist in maintaining room tray temperatures. Problems are to be corrected as they are observed. Dietary staff will monitor food temps and log food temps per facility protocols this also includes room tray test tray temps. This is to be brought into facility Stand Up Meetings to discuss the temps and potentially problem solve food temp issues. Management team will monitor that food temps are brought to stand up for discussion and problem solving if there are issues identified. Problems will be corrected as they are observed. F 812:	6-7-21 6-2-21

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F 804	Continued From page 20 Manager distributed the 4th and last room tray, the surveyor obtained the following temperatures utilizing the thermometer provided by the facility: a. Hamburger patty 120 degrees Fahrenheit b. Shredded pork 123 degrees Fahrenheit c. French fries 111 degrees Fahrenheit d. Ground pork 97 degrees Fahrenheit e. Beets(cubed) 112 degrees Fahrenheit The surveyor then tasted the food and it tasted lukewarm. The facility policy "Food Temperature", February 2016 Edition, stated the facility would hold and serve hot food at a temperature of at least 140 degrees Fahrenheit. During an interview following the distribution of the room trays on 5/19/21, the Dietary Manager stated food hot holding temperatures should be a minimum of 141 degrees Fahrenheit.	F 804	This is my credible allegation of compliance to F 812. This allegation does not constitute guilt but that the facility is in compliance to F 812. The facility kitchen and whole facility has been fully treated for pests by licensed exterminator on insert correct date. The facility is now on a routine treatment plan to assist in pest prevention. The exterminator is treating for all pests which includes cockroaches, bed bugs, and other pests that may try to inhabit the facility. The exterminator now leaves his treatment records in the facility for facility to be able to track treatments provided. The facility management will continue to monitor for pests such as bed bugs,	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	cock roaches, and any other pests so that if any are seen the exterminator can be notified, so that they can come and treat the facility. The facility will continue to notify the exterminator of any pest sightings so that pests can be treated. the facility's management team will discuss pests as part of their Stand Up meeting to ensure that exterminator is notified of any pest sightings so that prompt treatments can be administered to get rid of the pests.	6-2-21 6-3-21 6-8-21 6-11-21 6-21-21

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F 812	Continued From page 21 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain a pest free kitchen and dining area. The facility reported a census of 41 residents. Findings include: 1. During a tour of the Kitchen on 5/25/21 at 9:09 a.m., revealed 15 dead insects and 1 live insect on the floor between the dishwashing area and the wall. The Dietary Manager reported the insects were most likely cockroaches. She stated they had been good "lately" but were "terrible" approximately a month ago. She stated when she walked in the kitchen and turned the lights on, she would see 3-5 cockroaches. During an interview on 5/25/21 at 11:08 a.m., Staff F (Housekeeper) stated she saw a couple cockroaches in the dining room about a month ago. During an interview on 5/25/21 at 11:46 a.m., Staff A (Certified Nurse Aide) stated he saw cockroaches all the time and just saw some in the dining room "last week". During an interview on 5/25/21 at 12:15 p.m., the Administrator stated she had not seen any cockroaches in the facility and was not aware there were any in the dining room or kitchen	F 812		

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F 812	Continued From page 22 currently. She stated the facility would hire a new pest control company to take care of the problem. During an interview on 5/26/21 at 2:40 p.m., the Director of Nursing stated they did not have a policy for pest control.	F 812		