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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165198	A. BUILDING ______ B. WING ______	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA CITY REHAB & HEALTH CARE	3661 ROCHESTER AVENUE IOWA CITY, IA 52245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
VKC 8/24/18	Correction date 08/26/18 The following deficiencies relate to the facility's annual health survey and investigation of facility reported incident #75956 & #76842 and complaint #75145, #75383, #75471, #75540, #75551, #75980, #76087, #76650, #76692, 76994, & #77039. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).			
F 578 SS=J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Berger — TITLE: Administrator — (X6) DATE: 8/26/18

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

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, physician, resident and staff interview, the facility failed to perform Cardio pulmonary resuscitation (CPR) for one of nine residents that requested full code status (Resident #269) and failed to formulate an advance directive for two residents without a code status (Resident #21 and #119). The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/15/18, documented Resident #269 had diagnosis of heart failure and non Alzheimer's dementia and required extensive assistance with eating, dressing, personal hygiene and toileting. The Care Plan dated 1/16/18, lacked any direction to staff for advanced directives. The Iowa Physician Order for Scope of Treatment	F 578		

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F 578	Continued From page 2 (IPOST) dated 1/18, directed staff to provide CPR. The Medication Administration Record (MAR) dated 3/18, directed the resident was a full code. The Daily Nursing Assignment sheet dated 3/24/18, listed Staff Z, Licensed Practical Nurse, LPN and Staff AA, Certified Nurse Aide, CNA working the 10 PM- 6 AM shift on the Hall the resident resided. The Daily Nursing Assignment sheet dated 3/25/18, listed Staff FF, LPN and Staff EE, CNA working the 6 AM - 2 PM shift on the Hall the resident resided. A Progress Note dated 3/25/18 at 10:19 a.m., documented a CNA alerted staff at 7:15 a.m., that the resident passed away. The resident was found in bed with the call light in reach, with no apical pulse, no respirations and no blood pressure detected. The Registered Nurse verified the condition and at 7:42 a.m., staff notified the on call Physician and the guardian and called the Medical Examiner at 7:46 a.m. Staff notified the funeral home at 10:00 a.m. and the CNA prepared the resident. Progress notes lacked identification of the resident's code status, lacked a description of the body temperature, description of the body color and description of the body tone. The Record of Death dated 3/25/18, documented the time of death as 7:15 a.m. During interview on 7/25/18 at 10:22 a.m., Staff AA, CNA confirmed working the 10 PM- 6 AM	F 578		

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F 578	Continued From page 3 shift on 3/24/18. Staff AA stated doing rounds every 2 hours and doing a visual check on all residents. Staff AA reported last rounds was completed at 5:30 a.m., and no concerns or problem was reported about the resident. During interview on 7/25/18 at 12:41 p.m., Staff Z, LPN verified working 10 PM -6 AM on 3/24/18. Staff Z stated the CNA's made the rounds and did not report anything abnormal about the resident. During interview on 7/23/18 at 7:07 p.m., Staff FF, LPN reported a CNA came and said the resident passed away. Staff FF revealed the resident lacked a pulse and lacked breathing. Staff FF reported getting Staff DD, Registered Nurse, RN in the building to double check the resident for a pulse and respirations. Staff FF stated the resident lacked any dependent lividity (purple/reddish skin coloring), or rigor (body stiffness). At 7:28 p.m., Staff FF reported the facility's CPR policy was if a resident was a full code then you do CPR. Staff FF continued to state letting the RN take over and that the resident was gone. Staff FF revealed not doing CPR on the resident. Staff FF reported a residents code status was found in the electronic health record and the paper record. Staff FF indicated as a newer employee letting the experienced RN take over the situation. During interview on 7/24/18 at 11:04 a.m., Staff EE, CNA reported coming in to work late at about 7:00 a.m., on 3/25/18. Staff EE reported finding the resident deceased. Staff EE revealed running to the nurse to report the death. Staff EE stated the nurse confirmed the resident passed away and the nurse directed the CNA's to continue	F 578		

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getting other resident up and then come back and prepare the resident for the funeral home transfer. Staff EE described the resident as pale, not stiff and with no mottling.

During interview on 7/24/18 at 4:33 p.m., Staff DD, RN reported not doing CPR on anyone for years, and nothing stands out as memorable on 3/25/18 during the 6-2 shift.

During interview on 7/25/18 at 2:08 p.m., Staff X, CNA reported not seeing the resident before they found the resident not breathing. Staff X stated the 10-6 staff reported all the residents were ok at the end of the 10-6 shift. Staff X reported helping clean the resident before the funeral home came. Staff X revealed the residents body was cool and limp, easy to move and the resident's skin lacked any reddish/purple skin discoloration.

During interview on 7/24/18 at 7:10 p.m., the Medical Director reported the facility left a message at about 11:00 a.m., on 3/25/18 that the resident passed away.

During interview on 7/25/18 at 8:15 a.m., Agency Staff CC, licensed practical nurse, LPN stated when a resident was found with no pulse and not breathing the first thing to do was check the resident's code status. If the resident wanted CPR, they would start CPR and have other staff call 911.

During interview on 7/25/18 at 8:49 a.m., Staff C, LPN, Unit Manager revealed they expected staff to start CPR on the resident and call the Physician or 911.

During interview on 7/25/18 at 8:55 a.m., Staff P,

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Regional Nurse Consultant stated if a resident was found with no breath or pulse staff was expected to check the code status and if they are a full code to started CPR and call 911.

During interview on 7/26/18 at 8:52 a.m., the Administrator stated all staff was educated on 7/25/18, in person, or over the phone and a plan was in place to educate all new agency staff.

The facility provided a policy titled Code Status Orders & Procedure dated 10/2017, directing the facility provides Basic Life Support (BLS) CPR only. The physician's order for full code or do not resuscitate (DNR) is written based on wishes of the resident/resident representative legally authorized party. Advanced Directives will be honored during the code process. Page 3 directs the 1st person on the scene:
1. confirm cardiac and or respiratory arrest.
2. Call for help.
3. Check the airway and pulse and connection to oxygen if available while awaiting the emergency cart.
4. Check the medical record for the code status.
5. Begin CPR and continue CPR while the AED is being set up for shock if the AED is assessable and utilized by the facility- ensure resident is on a firm surface.

The 2nd person role is to assist the 1st responder as necessary and be the coordinator of the event. The 2nd responder is directed at point #3 a. Notifies 911, 3 b. notifies the family and the Physician.

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F 578	Continued From page 6 2. The Admission Record Sheet dated 6/27/18, documented Resident #119 had diagnoses that included acute respiratory failure with hypoxia, paranoid schizophrenia and heart failure unspecified. The care plan dated 7/24/18, revealed the resident was a new admit to the facility and was alert and oriented to person, place and time and had some recall difficulty. The goal for the resident was to make his own choices as able. Nursing staff was directed to assist the resident as needed with decision making if the resident was unsure of what to do or asking for guidance. Offer the resident choices; allow him time to make his own decisions and respect his choices. Further review of the care plan revealed no documentation to indicate staff discussed with the resident the choice to have CPR done or not if found unresponsive. The Order Listing Report form contained orders for the resident to have activities as tolerated and admit to skilled nursing facility (SNF) level of care, medications to take and to continue orders for 90 days unless otherwise noted dated 6/27/18. No orders noted in regards to code status for the resident. Review of the July 2018 Medication Administration Record revealed the Advance Directive section blank with no indication if the resident was a Full Code/CPR status or a Do Not Resuscitate (DNR) status. The Social/Psychological Data Collection Tool dated 7/24/18, revealed an Advanced Directives section. The directions for the section was to	F 578		

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F 578	Continued From page 7	F 578		

check yes if completed and present in the medical record and reviewed with the resident/responsible party. All the areas under that section was marked no.

During an interview on 7/24/18 at 3:35 p.m., Staff R, Certified Nurse Aide (CNA) reported worked at the facility about one year. Staff R stated would look in the CNA electronic charting for the information to know if a resident is DNR or Full Code (CPR) status. Staff R stated she had not been educated on what to do if neither is documented for a resident and not sure what is to be done. Staff R reported to be CPR certified, but that not all CNA's are, more the Nurses are trained.

During interview on 7/24/18 at 4:01 p.m., the Social Services Director (SSD) reported they usually try to do an IPOST on admission for new residents and the admitting Nurse will also do a CPR/DNR Form when a resident is admitted. The SSD stated she was gone at the time of the resident's admit, but the Admitting Nurse would have been here to ask about CPR/DNR code status. The SSD indicated with no indication of code status for the resident, staff would treat the resident as a full code. The SSD further stated with no paperwork in the electronic file or on file in the resident's chart, it appears the CPR/DNR Form was not completed.

During interview on 7/24/18 at 3:53 p.m., the resident reported being asked at the local hospital about being a DNR or CPR code status. The resident stated they were not asked since coming to the facility. The resident stated he would want staff to try and resuscitate him if found unresponsive.

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3. The MDS assessment dated 4/30/18, documented Resident #21 had diagnoses of arthritis, Non - Alzheimer's dementia and depression and required extensive assistance for bed mobility, transfers and toileting.

The Social/Psychological Data Collection Tool dated 5/11/18, revealed the source of information came from other. The form noted to have an Advanced Directives section. The directions for the section was to check yes if completed and present in the medical record and reviewed with the resident/responsible party. The areas marked no were Health Care Surrogate, Living Will and IPOST which was completed to notify staff if a person is a CPR or DNR status.

The July 2018 Medication Administration Record revealed the Advance Directive section of the record to be blank with no indication if the resident was a Full Code/CPR status or a Do Not Resuscitate (DNR) status.

The Order listing Report dated 1/1/18- 7/31/18, did not list an order for Code/CPR status.

On 7/25/2018, the facility abated the Immediate Jeopardy by providing education to the professional nursing staff on appropriate resusitation policy. The scope and severity of the deficiency was lowered from a "J" to a "D" with the need for ongoing monitoring of facility's policy.

F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in

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F 582	Continued From page 9 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. (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	F 582		

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F 582	Continued From page 10 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 clinical record review and staff interview, the facility failed to adequately inform residents of their right to appeal the decision for discontinuation of skilled services for 3 of 3 residents reviewed (Residents #369, #370 & #371). The facility census was 64 residents. Findings include: 1. Clinical record review revealed Resident #369 discharged from skilled care on 3/13/18. The facility issued a notice of medicare technical denial on 3/9/18. The facility did not issue a Notice of Medicare Non Coverage (NOMNC) Centers for Medicare Services (CMS) Form 10123. 2. Clinical record review revealed Resident #370 was discharged from skilled coverage on 5/30/18. The facility did not issue a NOMNC, CMS Form 10123. 3. Clinical record review revealed Resident #371 was discharged from skilled care on 3/27/18. The facilty did not issue Notice of Non medicare coverage or Skilled Nursing Facility Advance Beneficiary Notice. (SNF ABN, CMS Form 10055)	F 582		

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F 582	Continued From page 11 During interview on 7/25/18 at 10:05 a.m., the social worker stated she was not sure why the forms were not given to residents or families to notify of non coverage. She was told in March she only had to give the advanced beneficiary notice. During interview on 7/26/18 at 8:57 a.m., the Administrator expect notices to be completed in a timely manner and correctly. Going forward management team will be meeting daily to discuss and ensure things are being completed on time.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

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and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to maintain a homelike and sanitary resident environment.

Findings include:

1. On 7/12/18 at 1:00 p.m., rooms 13, 15, 19, 21, 23, 25, 42, 44, 45, 46 & 48 had floors with a heavy amount of dirt, grime and dead flies present.

The door jams of rooms 15, 19, 21, 23 & 25 had a large amount of paint chipped throughout one fourth of the lower area.
The bathroom floors in rooms 19, 23, 42, 45 & 48 had a large amount of dirt and grime present.

The floor between room 15 and the bathroom

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F 584	Continued From page 13 lacked the transition piece, leaving a dirt filled, uneven space. Room 36 had window curtains that were shear and therefore prohibiting total privacy. The Lumex stand up lift in the East Hall had a large amount of missing paint and dirt on the platform. During interview on 7/13/18 at 9:00 a.m., the Housekeeping Supervisor indicated environmental staff were directed to clean each room on a daily basis. These tasks included mopping the floors, wiping every surface down and collecting garbage, The housekeeping department had a staffing issue, but they scheduled three housekeepers seven days a week for 8 hours a day and one person assigned to buffing floors and one staff in laundry. A review of the facility housekeeping schedule revealed all areas were to be cleaned on a daily basis that included emptying trash, cleaning restrooms and moping floors.	F 584		
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	F 609		

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F 609	Continued From page 14 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. §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 and staff interview, the facility failed to report an injury of unknown origin to the department for one of four residents reviewed. The facility census was 64 residents. Findings include: 1. The Admission Record documented Resident #13 had diagnosis of repeated falls. The Fall report sheet dated 6/30/18, revealed staff found the resident on the floor bleeding profusely from a laceration to the forehead. Staff called for medics to transport the resident to the hospital. The Discharge Summary dated 7/6/18 revealed the resident was hospitalization from 6/30/18 to	F 609		

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F 609	Continued From page 15 7/6/18, for a right distal tibia and medial malleolus fracture with extension into the ankle joint, a 6 centimeter facial laceration and acute blood loss. During interview on 7/18/18 at 8:15 a.m., the Interim Administrator reported they initially thought the resident had an old fracture and did not make a report to the department. Staff D reported the facility made a report last evening.	F 609		
F 636 SS=F	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		

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F 636	Continued From page 16 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interview, the facility failed to complete timely minimum data set (MDS) assessments as required for 46 current residents. The facility census was 64 residents.	F 636		

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F 636	Continued From page 17 Findings include: 1. The facility supplied a report of incomplete Minimum Data Set (MDS) assessments. The report revealed 46 residents that had MDS assessments due 7 or more days prior to the day the report was printed. During interview on 7/24/18 at 2:22 p.m., Staff Q, Registered Nurse (RN) MDS Coordinator from another facility reported the reason MDS assessments were not being completed was they do not have an MDS coordinator and she had been asked to come help two days a week to get them caught up. During interview on 7/26/18 at 10:48 a.m., Staff P, RN, Regional Nurse Consultant stated they have regional MDS nurses working on getting the MDS assessments up to date. According to the Resident Assessment Instrument/Minimum Data Set policy from the facilities Clinical Programs Manual dated 7/15, staff was to complete MDS assessments and electronically encode them into the facility's MDS software system and transmit to the State database according to current CMS regulations as outlined in the current MDS/RAI Instruction Manual.	F 636		
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	F 656		

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F 656	Continued From page 18 §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). (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 interviews, the facility failed to ensure the resident	F 656		

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centered plan of care for three of seven residents reviewed included all services provided to the resident. (Resident#28, #38 & #8) The facility census was 64 residents.

Findings include:
1. The Minimum Data Set (MDS) assessment dated 7/5/18, documented Resident #28 had diagnoses that included chronic kidney disease, Non-Alzheimer's dementia and diabetes mellitus required extensive assistance for all activities of daily living (ADL's) and utilized a indwelling catheter.

The Care Plan indicated the resident had an ADL deficit related to disease process with a date initiated of 7/18/18. The care plan addressed bathing for the resident with no entry in the care plan addressing the residents indwelling catheter.

During interview on 7/26/18 at 9:05 a.m., Staff P, Registered Nurse, RN stated the care plan needed to include the catheter and direct nursing staff on catheter care, problems to look for, and possible signs and symptoms of infection.

2. The MDS assessment dated 6/11/18, documented Resident #38 had diagnoses of anemia, heart failure and Alzheimer's disease and required extensive assistance for bed mobility, transfers and toileting and received dialysis.

The Care Plan dated 6/25/18, failed to identify dialysis as a problem. The care plan lacked direction to staff for monitoring dialysis port for signs and symptoms of infection or to monitor resident for side effects from dialysis.

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3. The Minimum Data Set (MDS) assessment dated 5/30/18, documented Resident #8 had diagnoses of diabetes mellitus, Schizophrenia and muscle weakness and required supervision for transfers, walking and limited assistance for toilet use and extensive assistance for dressing and eating. The resident had a BIMS (Brief Interview for Mental Status) score of 10, indicating moderate cognitive ability.

Review of the care plan initiated on 12/19/17 and revised on 7/5/18, the care plan directed the staff to encourage the resident to ask for help and wait for assistance before ambulating independently. The resident frequently decided to ambulate independently and encourage him to accept use of walker and use the walker.

Incident report dated 5/10/18 at 11:14 a.m., revealed the resident fell in their room and was found with a bleeding laceration on the chin. The resident's left side of the face was swollen with dark purple bruising and swollen left hand. The resident was sent to the hospital. The incident report indicated the predisposing factors for the fall was poor lighting and gait imbalance.

Incident report dated 5/19/18 at 1:48 p.m., revealed staff witnessed the resident get up from the chair and fall to their knees. The resident went to the hospital. The incident report indicated the predisposing factors for the fall is gait imbalance.

Incident report dated 6/26/18 at 6:45 p.m., revealed the resident fell while ambulating in the hall, the staff indicated the resident was not

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F 656	Continued From page 21 compliant with his walker. The incident report indicated the predisposing factor for the fall is gait imbalance. Incident report dated 7/5/18, revealed the resident had a fall in the lobby. The resident fell to his knees and hit head on the floor. The incident report indicated the resident had on improper footwear. Review of a local hospital admission note dated 5/19/18, Resident #8 arrived to the emergency room due to a fall. The notes revealed the resident also seen in the emergency room on 5/10/18 after experiencing a fall. A workups completed and the resident at that time only facial bruising. The assessment on 5/19 revealed the resident has had falls the past few weeks and has a decline in functional status. The resident had a hospitalization from 5/19-5/21/18 reason for admission is altered mental status, fall and low blood sugar. During interview on 7/19/18 at 11:29 a.m., Staff K, registered nurse, RN revealed staff failed to put any fall interventions in place for the 5/10, 5/19, 6/21 falls. Staff K stated they put an intervention in place to ambulate the resident with assistance on 6/26 but failed to add it to the care plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		

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by:
Based on observation, clinical record review and staff interview, the facility failed to obtain/follow physician orders as directed for two of five residents. (Resident #35 & #14) The facility census was 64 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 5/10/18, documented Resident #35 had diagnoses of cellulitis, muscle weakness and severe obesity with alveolar hypoventilation (respiratory insufficiency) and was on oxygen therapy.

Observation on 7/23/18 at 10:13 a.m., revealed the resident in bed with oxygen on at per 2.5 liters per nasal cannula via an oxygen concentrator.

Observation on 7/24/18 at 7:08 a.m., revealed the resident in bed with the oxygen on at 2.5 litters per nasal cannula.

Clinical record review lacked an order for the residents oxygen on a continuous bases.

During interview on 7/25/18 at 10:31 a.m., Staff X, Certified Nurse Aide, CNA reported the resident had oxygen on at night only, but has had the oxygen on all the time since being on bedrest a couple of months ago.

During interview on 7/25/18 at 10:43 a.m., Staff P, Nurse Consultant reported she could not find an order for the oxygen.

A Health Status Note dated 6/25/18, from the

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F 658	Continued From page 23 Physician directed the resident was required to remain on bed rest with check and change every 1 hour until her posterior right thigh open areas were resolved. 2. The MDS assessment dated 1/30/18, documented Resident # 14 required extensive assistance for toilet use and utilized an electric wheelchair for mobility. The Care Plan dated 4/12/18, directed staff to administer medications as ordered, monitor and document for medication side effects. A Progress Note dated 3/8/18, documented the resident returned from the wound clinic with the new order for Augmentin 875-125 milligrams twice daily by mouth for 10 days. The local wound clinic notes dated 3/8/18, indicated the resident had a wound to the right gluteus with neurotic tissue. The Wound clinic directed staff to administer Augmentin 875-125 milligrams, twice daily by mouth for 10 days. During interview on 7/24/18 at 4:30 p.m., Staff C, licensed practical nurse, LPN stated on March 8 a newly hired nurse incorrectly noted the antibiotic order and the resident did not receive the medication as ordered.	F 658		
F 677 SS=E	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;	F 677		

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This REQUIREMENT is not met as evidenced by:

Based on observation, clinical record review and staff interviews, the facility failed to ensure eight of 10 residents reviewed received personal care as planned to maintain good grooming. (Residents #7, #43 & #35, #2, #15, #16, #17 & #18). The facility census was 64 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 5/10/18, documented Resident #35 had diagnoses of cellulitis, muscle weakness and severe obesity with alveolar hypoventilation (respiratory insufficiency), required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene and was frequently incontinent of bowel and bladder.

During observation on 7/23/18 at 1:40 p.m., Staff W, Certified Nurse Aide, CNA and Staff I, CNA placed supplies on the bed side table as the resident laid in bed. Staff W used washcloths with sooth & cool nonrinse foam to cleansed the resident of bowel movement that was visible on the wash cloth. Without completing frontal peri care Staff W turned the resident to the left side and continued to cleanse loose bowel movement from the residents rectal area. Staff W failed to cleanse the residents right hip. Staff I placed the soiled linen on the floor and observation revealed the mattress was saturated with urine. Staff did not sanitize the mattress. Staff I cleansed the residents left gluteal area and without changing gloves, applied Calazime to the residents gluteal area.

2. The MDS assessment dated 3/21/18, documented Resident #7 had diagnoses of

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Alzheimer's disease and cerebrovascular accident (CVA) and required extensive assistance with transfers, toileting and personal hygiene.

The Care Plan dated 1/16/18, directed staff to provide incontinence care as needed.

During observation on 7/23/18 at 2:44 p.m., Staff T, CNA and Staff R, CNA transferred the resident into bed. Observation revealed the residents pants and the seat in the wheelchair was wet with a urine odor. Staff T removed the soaked brief from the resident. Staff T used a wipe to wash the tip of the residents penis and the top of the scrotum while the resident laid on his right side. Staff T used a new wipe to wash the resident's rectum, but failed to wash the entire penis, scrotum and buttocks that were wet from urine.

During interview on 7/26/18 at 8:35 a.m., the Assistant Director of Nursing (ADON) reported expecting staff to wash all skin areas that came in contact with urine or bowel material.

The Facility provided a policy titled Perineal Care with a revision date of 4/13, and a purpose statement to promote cleanliness and prevent infection. The procedure directing at point # 13 wash the rest of the penis, using downward strokes towards the scrotum. Point # 15 directed staff to clean the top and sides of the scrotum gently. Point # 16 directed staff to position resident to expose, clean the bottom of the scrotum and the anal area.

During observation on 7/24/18 at 8:04 a.m., the resident sat at the table in the Dining Room with facial hair to his cheeks, chin and neck.

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F 677	Continued From page 26 During observation on 7/24/18 at 2:47 p.m., the resident was in bed awake and continued to have facial hair. During observation on 7/26/18 at 7:05 a.m., the resident sat in the wheelchair in the front lounge with 1/4 inch long facial hair. 3. The MDS assessment dated 6/29/18, documented Resident #43 had diagnoses of Alzheimer's dementia and lack of coordination and required extensive assistance for personal hygiene needs. The Care Plan dated 6/15/18, directed staff to provide assistance for dressing and grooming. Encourage the resident to participate as much as possible. During observation on 7/23/18 at 12:27 p.m., the resident's cheeks and neck contained facial hair. During observation on 7/24/18 at 9:01 a.m., the resident sat in the lounge next to the fish tank with long facial hair. During observation on 7/24/18 at 2:49 p.m., the resident remained in the lounge by the fish tank with long facial hair. During observation on 7/25/18 at 7:49 a.m., the resident was not shaven. During observation on 7/26/18 at 7:05 a.m., the resident was in the recliner chair in the lobby next to the fish tank with long facial hair.	F 677		

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During interview on 7/26/18 at 7:14 a.m., Staff W, CNA reported men are shaven daily or with their bath. Staff W stated Resident #43's facial hair was about 1/4 inch long or little longer. Staff W reported Resident # 7's facial hair was a little less than 1/4 of an inch long.

During interview on 7/26/18 at 8:35 a.m., the assistance director of nursing, ADON reported expecting staff to ask and try to shave residents daily.

The facility provided a procedure entitled Shaving dated 1/13, directing at point # 20 to assist with shaving daily, per resident preference.

4. The MDS assessment dated 3/14/18, documented Resident #15 had intact cognition and required extensive assistance for bathing.

The Care Plan documented the resident requested showers on Tuesday, Friday and Saturday on the evening shift.

Bath documentation revealed no showers in May, three showers in June and one shower in July, 2018.

During interview on 7/12/18 at 10:15 a.m., the resident stated they do not get showers when staff was pulled or when there was not enough staff.

5. The MDS assessment dated 5/26/18, documented Resident #16 had modified cognitive skills.

Bath documentation revealed the resident

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F 677	Continued From page 28 received two baths in May, June and July, 2018. During interview on 7/12/18 at 10:15 a.m., the resident stated they did not always get a shower when the facility was short staffed. 6. The MDS assessment dated 5/25/18, documented Resident #17 had intact cognition and required total assistance for bathing. The Care Plan directed staff to offer two showers a week and as necessary. Bath documentation revealed the resident received seven baths in May, six baths in June and no baths between July 1 - 11, 2018. During interview on 7/12/18 at 10:15 a.m., the resident stated when the facility was short of staff they did not get showers as planned. 7. The MDS assessment dated 5/24/18, documented Resident #18 had intact cognition and required extensive assistance for bathing. The Care Plan revealed the resident preferred showers on Wednesday and Saturday on the day shift. Bath documentation revealed the resident received seven showers in May, seven showers in June and no showers between July 1 - 11, 2018. During interview on 7/12/18 at 10:15 a.m., the resident stated when the facility was short of staff they did not get showers as planned.	F 677		

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F 677	Continued From page 29 8. The MDS assessment dated 4/6/18, documented Resident #2 had modified cognition. The Care Plan determined the resident preferred showers on Wednesdays and Saturdays on the evening shift. Bath documentation revealed the resident received one bath in May, two in June and two in July, 2018. During interview on 7/12/18 at 10:00 a.m., the resident reported not recalling if they received two baths a week and stated at times staff offered baths too late at night. During interview on 7/13/18 at 8:00 a.m., the Director of Nursing, DON reported the facility scheduled five aides on the day shift and no bath aides. The DON knew baths were not being done and put a new schedule in place. Staff was to notify the nurse if a resident refused his/her bath. Aides were to complete a bath sheet after completing the bath that included a skin assessment.	F 677		
F 684 SS=G	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.	F 684		

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F 684	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to ensure residents received accurate assessments and timely interventions. Resident #4, #6, #10, #12 and #19. The facility reported a census of 64. Findings include: 1. According to the Admission Record dated 7/10/18 Resident #4 had diagnoses of colon cancer and peripheral vascular disease. The Minimum Data Set (MDS) dated 3/21/18 revealed Resident #4 at risk for skin break down. The MDS revealed Resident #4 had no wounds, ulcers or skin problems. The MDS revealed Resident #4 at risk for pressure ulcer development. The Braden Scale dated 3/14/18 revealed Resident #4 low risk for skin break down. The Plan of Care failed to reflect Resident #4 had skin impairments. The Nursing Admission Data Collection dated 3/14/18 revealed the Admission Skin Sweep revealed no skin impairments present. The Skin Grid for All "Other" Skin Impairments sheet dated 3/14/18 revealed Resident #4 had an excoriation above the rectum on admission. The sheet directed the staff to complete weekly assessments. The sheet revealed one assessment dated 6/12/18. The sheet revealed the area healed.	F 684		

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F 684	Continued From page 31 The Skin Grid for All "Other" Skin Impairments sheet dated 3/14/18 revealed Resident #4 had a bleb with an open area. The sheet revealed one assessment dated 6/5/18. The sheet revealed the area healed. The Progress Notes dated 5/4/18 at 10:40 revealed a nurse aide reported Resident #4 had an open area on his/her buttocks and two areas of excoriation. One area Stage III. The wound started bleeding and pressure applied. Resident #4 transferred to the emergency room. The May 2018 May Treatment Administration Record sheet revealed an order dated 5/9/18 to apply Aquacele AG to sacrum wound every other day. The sheet revealed omissions in the treatment on 5/9, 5/17 and 5/21. 2. The Admission Record dated 7/24/18 revealed Resident #6 had diagnoses of heart disease and diabetes. The Plan of Care directed the staff to encourage resident to report changes in his/her skin, observe skin during cares for signs of breakdown and weekly skin sweeps. Observation on 7/10/18 at 2:15 p.m. revealed Resident #6 had a dressing on the left forearm dated 7/7. The July 2018 Medication Administration Record sheet revealed an order dated 6/20/18 to apply mepilex one time a day every three days. The staff documented the treatment competed on 7/6 and 7/9. An interview on 7/11/18 at 9:20 a.m. the Assistant	F 684		

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Director of Nurses (ADON) reported he/she observed Resident #4's dressing yesterday and noted it was dated 7/7. The ADON reported the treatment was signed out as completed but it doesn't look like it was changed as it was dated 7/7.

An interview on 7/11/18 at 1:32 p.m. Resident #6 reported the staff changed his/her dressing this morning and prior to that it was four days ago.

3. The Admission Record dated 5/14/18 revealed Resident #10 had diagnoses of Parkinson's disease and diabetes.

The Progress Note dated 3/29/18 at 10:14 p.m. revealed Resident #10's right great toe had dark brown discoloration, some breakdown, swelling, redness and warmth. The staff left a note for the Physician to look at the toe in the morning.

An interview on 7/20/18 at 1:30 p.m. revealed Staff P (Nurse Consultant) reported Resident #10 had an area on the right great toe. Staff P reported a skin sheet could not be located for the right great toe. Staff P reported Resident #10 received antibiotic treatment in June. Staff P reported the facility had incomplete assessments for the other areas of Resident #10's.

The Skin Care & Wound Management policy dated 6/2015 revealed the components of the skin care program include, but are not limited to, the following: identification of residents at risk for developing pressure ulcers, implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues, weekly monitoring of resident skin status, daily monitoring of existing wounds, application of

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treatment protocols based on clinical "best-practice" standards for promotion of wound healing, interdisciplinary review of identified skin impairments, monitoring for consistent implementation of interventions and effectiveness of interventions, review of modification of treatment plans as applicable and analysis of facility pressure ulcer data for quality improvement opportunities.

4. According to the Minimum Data Set (MDS) dated March 27, 2018 Resident #19 has diagnoses which included Peripheral Vascular Disease, Diabetes, Stroke and heart disease. The MDS revealed the resident independent in transfers, walking, dressing and toilet use. The resident had a BIMS score of 11 which indicated moderately impaired cognitive ability. The resident did not have any skin impairments.

Review of Resident #19's care plan revised on 1/9/18 indicated the resident had a skin tear to their hands but were resolved. The care plan failed to identify the resident had a wound to their feet and failed to direct staff in the care of the foot wound.

Review of a Nursing Home visit note dated March 9, 2018, the resident's physician indicated the resident had cellulitis on his left great toe which developed some evidence of gangrene on the end of the toe. The physician transferred the resident to the local hospital and diagnosed for infection and vascular disease involving his left great toe. The hospital evaluated the wound and performed a left femoral endarterectomy for peripheral vascular disease. The notes indicate the resident returned to the facility but needed close follow up with Vascular Surgery as he may

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need amputation of the left great toe in the future.

Review of the Progress Notes dated 4/27/18 the resident returned from the hospital after left great toe amputation, his toe is bandaged. A progress note dated 5/1/18 indicated the nursing staff received a new order from the local hospital surgical department to pack the resident's left great toe with a Dakins solution and wrap with a bandage. On 5/2/18 the resident transported to the local emergency with high temperatures and infection in left foot. The resident admitted to the hospital for antibiotic therapy and subsequently was discharged from the facility due to a prolonged hospitalization.

Review of the Order Listing Report for Resident #19, it indicated the resident had an order for the staff to complete wound care once daily to the left great toe amputation site, to pack the toe with a small piece of Dakins gauze and then wrap with Kerlix. The physician ordered the wound treatments on 5/1/18.

Review of the March 2018 Treatment Administration Records directed the staff to complete weekly skin checks, which were not completed as ordered. The treatment records directed staff to paint the left dorsal great toe with betadine twice daily with a start date of 2/26/18, was on hold from 3/4-3//18. The staff failed to complete the treatments as ordered.

Review of the March, April and May Treatment Administration Records revealed under the section, unscheduled other orders, it stated wound care to left great toe, keep wound clean and dry and may shower. Review of the 3 treatment records failed to reveal a specific place

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F 684	Continued From page 35 for this order to be signed off as completed. The electronic treatment record failed to prompt to staff to complete the treatment. During an interview with Staff L-RN on 7/18/18 at 10:00 a.m. Staff L reviewed the treatment records for Resident #19. Staff L stated the orders for the wound care were not transcribed appropriately and were omitted from the treatment records for March, April and May 2018. Review of the treatment records revealed the staff failed to complete treatments for the resident's left great toe. During an interview Resident #19's family member on 7/18/18 at 1:26 p.m., the family member shared the resident remains in the hospital and has had three surgical amputations on their left leg. During an interview with Resident #19's physician on 7/18/18 at 11:18 a.m. the physician stated he was aware the staff were not completing the wound dressings as ordered, he stated he directed them to complete the dressings but they didn't comply. He stated the resident had vascular disease and had gangrene to their left great toe and said the lack of wound care did not help the resident's situation. 5. According to the Admission Record dated 6/6/18, Resident #12 had a admission date of 6/6/18 and discharged on 6/9/18. Review of the June 2018 Medication Administration record revealed the resident had diagnoses which included muscle weakness and abnormal gait.	F 684		

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F 684	Continued From page 36 Review of the Progress Notes revealed a late entry dated 6/9/18 at 1:00 a.m., the agency nurse charted the aide called her into the resident's room and found the resident laying on the floor on her left side. The aide said the resident threw a shoe at her, lost her balance and fell to the floor. The nurse asked the aide if she felt the resident fell or the resident lowered herself to the floor. The nurse indicated the resident lowered self to the floor. The aide and the nurse assisted the resident to her feet and placed her back into bed. Review of a Progress Note dated 6//9/18 at 8:50 a.m. the former Director of Nurses stated she was told by the night aide that the resident fell during the night. The former D.O.N. completed an assessment and found abnormalities and the resident complained of severe left leg pain. The staff called 911 and the resident transferred to a local emergency room. Review of a Progress Note dated 6/10/18 revealed the resident admitted to a local hospital with a left hip fracture. During an interview with Staff O-CNA, she said she worked the night shift with Resident #12. She reports the resident became upset with her about 12:30 a.m., stood up and threw a shoe at the aide. The resident lost her balance and fell on the floor, hitting her head on the floor. Staff O contacted the agency nurse on duty. The agency nurse came into the room, stood over the resident and stated" she looks fine to me" the agency nurse and C.N.A. got her up off the floor and into bed, the aide indicated the resident had a limp when they walked her back to be. The aide stated the nurse failed to assess the resident prior to getting her off the floor. Staff O stated in	F 684		

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F 684	Continued From page 37 the morning the resident requested help getting out of bed, when she provided assistance the resident was unable to stand, complained of severe leg pain and bear weight on her left leg. The aide clocked out and called the Director of Nurses to report the fall and lack of interventions. An Interview with Staff F-RN on 7/17/18 at 1:52 p.m. revealed the staff failed to formulate an initial care plan upon admission to the facility. During an interview with Staff D-Interim Administrator on 7/17/18 at 12:35 p.m. she indicated she was called on 6/9/18 about 10:00 a.m. by the former D.O.N. She reported they sent out Resident #12 to the hospital after a fall. The former D.O.N. called the agency nurse to return to document the fall. Staff D stated the agency nurse failed to assess the resident after the fall on 6/9/18. Review of a Fall Risk Reduction and Management Policy dated April 2013 directed the staff to provide immediate care and services to the resident with a fall to identity and treat any injuries. To avoid moving the resident until injury evaluation is completed and evaluate for additional injuries. The policy directed the staff to review the care plan and update with any new or revised interventions as indicated.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		

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F 686	Continued From page 38 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 record review, observations and interviews the facility failed to ensure residents received appropriate treatment and care in healing and preventing infection of pressure sores. Resident #1, #13, #8, and #35. The facility reported a census of 64. 1. The Admission Record dated 7/10/18 revealed Resident #1 had a diagnosis of paraplegia. The Minimum Data Set (MDS) assessment dated 5/10/18 revealed Resident #1 had no cognitive impairments. The MDS revealed Resident #1 required extensive assistance of two staff with bed mobility, transfers and bathing. The MDS revealed Resident #1 had one Stage I Pressure Ulcer and one unstageable Pressure Ulcer. The Braden Scale dated 5/24/17 revealed Resident #1 scored "13". The scored placed the resident at moderate risk. The Plan of Care revealed Resident #1 had an ulcer on the left medial heel on admit. The Plan	F 686		

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F 686	Continued From page 39 of Care directed the staff to off-load Resident #1's heels when in bed, mechanical lift for transfers, inspect skin daily, keep skin clean, apply moisturizing lotion, provide incontinence care as needed, can leave the premises without supervision, provide supervision with smoking. The Progress Note dated 4/24/18 revealed Resident #1 had a shallow open area to the right buttock caused by moisture and shearing. The area measured 4.0 centimeters (cm) (length) by 2.0 cm (width) by 0.1 cm (depth). The center dark pink/red and open. The wound nurse will evaluate today and suggest treatment. Currently on Ensure, alternating air low air loss mattress, pressure reducing chair cushion, frequent turns and incontinence care including application of barrier cream. Will discuss with doctor after wound nurse makes recommendation. The Skin Grid for All "Other" Skin Impairments dated 4/24/18 revealed Resident #1 had a moisture shear area to the right buttock. The sheet revealed the area not present on admission, pink and red in color and had granulation present. The sheet directed the staff to complete weekly. The sheet contained no weekly assessments after 4/24/18. The Treatment Administration Record sheet from 1/4/18 at 4/30/18 revealed an order dated 4/25/18 to cleanse the right buttock with normal saline, dry, apply collagen and cover a dressing one time a day. The Treatment Record sheet revealed an order dated 4/27/18 to increase the treatment to twice a day. The sheet revealed omissions in the treatment on 4/27, 4/28, 4/2 and 4/3.	F 686		

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F 686	Continued From page 40 The Treatment Administration Record sheet from 5/1/18 to 5/31/18 revealed omissions in the treatment on 5/1, 5/4, 5/7, 5/10, 5/13, 5/14, 5/17, 5/19, 5/20, 5/22, 5/23, 5/25, 5/26, 5/28, 5/29, 5/30. The Initial Wound Clinic Progress Note dated 5/18/18 revealed Resident #1 had an unstageable Pressure Ulcer to the right gluteus that measured 4.1 cm (length) by 3.5 cm (width) by 1.2 cm (depth). The note revealed the pressure ulcer had a large amount of drainage with a relatively strong odor. The entire wound bed is covered with necrotic tissue, adherent slough and eschar. Resident #1 had an excisional debridement of the wound. The Treatment Administration Record dated 6/1/18 to 6/30/18 revealed the omissions in the treatment on 6/1, 6/3, 6/5, 6/6, 6/7, 6/8, 6/9, 6/12, 6/13, 6/14, 6/15, 6/16, 6/17 and 6/18. The Wound Clinic Progress Note dated 6/19/18 revealed Resident #1's Stage IV Pressure Ulcer measured 6.0 cm (length) by 6.0 cm (width) by 3.0 (depth). The sheet revealed the staff able to probe down in at least two different areas. The wound had a large amount of serous sanguineous drainage with a strong odor and wound bed covered with necrotic tissue. The Wound Clinic Staff consulted the Hospitalist who admitted Resident #1 to the hospital for further work up. The Nursing Assessment dated 6/27/18 revealed an Admission Skin Sweep with no documented skin concerns. The Progress Notes dated 6/27/18 at 11:44 p.m.	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 41
revealed Resident #1 returned to the facility with a wound vac.

Review of the Progress Notes from 4/24/18 to 6/19/18 revealed Resident #1 refused his/her treatment on 5/15/18.

An interview on 7/12/18 at 8:48 a.m. Staff G reported Resident #1's pressure ulcer started as a scratch. Staff G reported he/she is aware of the omissions on the treatment records.

An interview on 7/18/18 at 2:50 p.m. Staff J (Charge Nurse) reported the nurses work 8 hour shifts. Staff J reported at times the nurse cannot get all of the treatments completed and pass them on to the next shift. Staff J reported at times he/she can stay late to get the treatments completed. Staff J reported Resident #1 goes out to of the facility at times and refuses to lay down.

An interview on 7/13/18 at 1:20 p.m. Wound Clinic Clinical Manager reported Resident #1 does not staff comply with staying off his/her pressure area and is not a candidate for a skin flap.

2. The Admission Record dated 7/19/18 revealed Resident #13 had diagnoses of heart failure, obesity, diabetes and kidney disease.

The Minimum Data Set (MDS) assessment dated 6/10/18 revealed Resident #13 cognitively intact.

The MDS dated 6/10/18 revealed Resident #13 required extensive assistance of one staff with bed mobility, dressing and hygiene.

The MDS dated 6/10/18 revealed Resident #13

F 686

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F 686	Continued From page 42 had no pressure ulcers. The Plan of Care revealed no skin impairments. The Braden Scale dated The Progress Notes dated 4/10/18 revealed Resident #13 continued with an open area to the left heel. The note revealed the open area circular and moist with a loose flap of skin attached to the lower part of the wound. Gauze applied to wound and Resident #13 complained of pain to the area. Soft boot placed on left foot and Tramadol administered. The Progress Note dated 4/25/18 revealed the left heel wound measured 3.5 cm by 4.0 cm by undetermined. The physician wrote an order to cleanse the wound with normal saline, apply skin prep around the wound, apply calcium alginate AG to wound bed and cover with semiperiable dressing. The Nursing Admission Data Collection sheet dated 5/8/18 revealed Resident #13 had a Stage I pressure area to the left heel that measured 4.2 cm (length) by 3.4 cm (width). The Skin Grid for All "Other" Skin Impairments sheet dated 5/22/18 revealed an area on the left heel not present on admission. The area measured 3.0 cm (length) by 2.0 cm (width) by 0.3 cm (depth). The sheet revealed assessments dated 6/5/18, 6/12/18, 6/21/18, 6/25/18, 7/2/18, 7/6/18 and 7/8/16. The April 2018 Treatment Administration Record revealed an order dated 4/25/18. The order directed the staff to cleanse the left heel with	F 686		

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F 686	Continued From page 43 normal saline, dry, apply skin prep around the wound, apply calcium alginate AG to the wound and cover. The May 2018 Treatment Administration Record revealed the order changed on 5/8/18. The order directed the staff to apply Silvadene cream to the left heel and cover. The Treatment Record revealed omissions in the treatment on 5/7, 5/9, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/22, and 5/23. The June 2018 Treatment Administration Record revealed the order changed on 6/15/18. The order directed the staff to cleanse the left calcaneus with normal saline, apply skin prep, apply Medihoney Wound/Burn dressing pad to wound and change every three days. The Treatment Record revealed omissions in the treatment on 6/1, 6/6, 6/7, 6/9, 6/11, 6/12, 6/13 and 6/14. The Wound Clinic note dated 6/26/18 revealed Resident #13 had an unstageable pressure ulcer to the left heel. The area measured 3.5 centimeters (cm) (length) by 2.8 cm (width) by 0.1 cm (depth). Observation on 7/20/18 at 2:10 p.m. revealed Staff G removed the dressing to Resident #13's left heel. The dressing had a moderate amount of serous drainage. Staff G measured the wound. The wound measured 4.2 cm (length) by 4.7 cm (width) by 0.2 cm depth. Staff G cleansed the wound and applied Mepilex AG foam and secured with gauze. An interview on 7/20/18 at 9:34 a.m. Staff L reported he/she noted the first nursing	F 686		

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F 686	Continued From page 44 assessment for Resident #13's heel on 5/8/18. Staff L reported treatments started on 4/25/18. Staff L reported concerns with weekly assessments not being completed and documentation of treatments being completed. Staff L reported Resident #13's pressure ulcer was not identified on list of pressure ulcers and that was updated. The Skin Care & Wound Management policy dated 6/2015 revealed the components of the skin care program include, but are not limited to, the following: identification of residents at risk for developing pressure ulcers, implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues, weekly monitoring of resident skin status, daily monitoring of existing wounds, application of treatment protocols based on clinical "best-practice" standards for promotion of wound healing, interdisciplinary review of identified skin impairments, monitoring for consistent implementation of interventions and effectiveness of interventions, review of modification of treatment plans as applicable and analysis of facility pressure ulcer data for quality improvement opportunities. 3. According to the Minimum Data Set dated May 30, 2018 Resident #8 had diagnoses which included Diabetes, Schizophrenia, difficulty walking and muscle weakness. The resident required supervision of 1 person for transfers, walking and limited assistance for toilet use and extensive assistance for dressing and eating. The resident had a BIMS (Brief Interview for	F 686		

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F 686	Continued From page 45 Mental Status) of 10 which indicated moderate cognitive ability. The assessment revealed the resident did not have pressure sores but had skin tears. Review of the care plan revised on 7/5/18 the staff failed to formulate a specific care plan for the prevention and care of the resident's pressure sore. The facility staff failed to update the residents care plan after the discovery of an open area on 712/18. Review of the care plan dated 7/18/18 indicated the resident had actual skin impairments related to fragile skin and impaired mobility with an acquired area on the left buttock. The plan directed the staff to monitor/document location and size, pressure relief mattress on bed and padding to chairs complete treatments of the left buttock as ordered and use caution during transfers and bed mobility. Review of a Skin Grid for Other Skin impairments dated 7/12/18 Staff G-RN record Resident #8 had an abrasion to the left buttock measuring 4 centimeters by 4 centimeter and appeared superficial. Review of the Skin Grid for Other Skin impairments dated 7/18/18, Staff G-RN recorded Resident #8 had a pressure sore to their left buttocks which measured 2.2 x 3 centimeters and with a depth of 0.3 centimeters. During the assessment of the left buttock wound on 7/18/18 at 2:00 p.m. an additional area noted directly below the original pressure sore which measured 0.5 x 0.5 centimeters and described as superficial. Staff G indicated the original pressure sore which started as an abrasion is now	F 686		

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F 686	Continued From page 46 progressed to a pressure sore and she did not know the resident had an additional open area on the left buttock. Review of the Progress Notes dated 7/18/18 at 10:50 p.m. Staff H-RN noted the resident had a Stage 11 pressure ulcer to the left inner buttocks which measured 2.0 x 1.0 x depth of 0.1 centimeters and the current Mepilex treatment is unchanged. Review of Resident #8 July 2018 Treatment Record the resident had an order for twice daily left buttock wound care which started on July 13th. Review of the Treatment Record from July 13 until July 18 revealed the staff failed to complete 5 of 11 ordered dressing changes. Observation on 7/18/18 at 7:05 a.m. with Staff C-LPN she stated the resident refused the treatment earlier today and told her to get out. At this time she reattempts to complete the dressing, the resident at this time was compliant with the dressing change. Staff C had the resident roll to their right side, the area on the left buttock did not have a dressing in place and noted to have white exudates on and surrounding the wound. The resident is noted to have on 2 incontinence briefs. The staff completed the dressing change and provided incontinence cares. During this process of wound care and provision of cares Resident #8 was complaint and cooperative with staff assistance. Review of the Progress Notes from July 13-July 18, 2018 revealed the resident refused his treatment on July 14 at 10:20 a.m. but no further refusals noted in the notes.	F 686		

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F 686	Continued From page 47 During an interview with Staff I- CNA on 7/17/18 at 8:43 a.m. the staff indicated they didn't know the resident had wounds but thought he had an reddened area on his buttock they apply cream to and stated she didn't think he had any dressings to buttocks area. During an interview with Staff G-RN on 7/18/18 at 7:05 a.m. Staff G stated she assessed the buttock wounds yesterday and they are considered pressure areas. She discovered a new area directly below the original pressure sore and stated she didn't know it was there. Staff G stated the wound to buttocks is worse than last week when she measured it. During an interview with Staff F-RN on 7/19/18 at 10:35 a.m. Staff F stated the second open area discovered yesterday is described as a pressure sore. 4. The Quarterly Minimum Data Set (MDS) Resident Assessment dated 5/10/18 documented that Resident#35 had scored a 14 out of 15 on the Brief Interview for Mental Status questions. The MDS documented that the resident required extensive assistance of two staff members for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS documented that the resident had been frequently incontinent of bowel and bladder. The MDS documented that the resident had diagnoses of cellulitis to part of an unspecified limb, muscle weakness, diabetes, edema, and severe obesity with alveolar hypoventilation (respiratory Insufficiency). The MDS documented that the resident had unhealed pressure areas, and that included three unstageable areas due to non-removable dressings.	F 686		

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F 686	Continued From page 48 The Braden Scale (Skin Risk Assessment) dated 6/7/18 documented that the resident had been chairfast, slightly limited with mobility, occasionally moist skin, and had potential problems for friction and shear. A Skin Grid for Pressure Ulcers documented that a right posterior thigh skin concern had the identification date of 2/22/18. The clinical record lacked an assessment until the date 5/29/18. A Skin Grid for Pressure Ulcer documented that the tip of the right third toe skin concern had the identification date of 4/12/18. The clinical record lacked an assessment until the date of 5/22/18. A Skin Grid for Pressure Ulcer documented that the right foot arch skin concern had the identification date of 4/12/18. The clinical record lacked an assessment until the date of 5/22/18. A Skin Grid for Pressure Ulcer documented that the right fourth toe tip skin concern had the identification date of 4/12/18. The clinical record lacked an assessment until the date 5/22/18. A Skin Grid for Pressure Ulcer documented that the right posterior heel skin concern had the identification date of 4/12/18. The clinical record lacked an assessment until the date of 5/22/18. The Nurses Note Dated 4/12/2018 at 1:21 p.m. documented that a wound nurse entered the residents room to assess skin areas, measurements completed and weekly assessments for each area initiated. The residents doctor had been notified and treatment orders received. Areas were documented as	F 686		

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F 686	Continued From page 49 follows: right 5th toe- dark purple scare (eschar) measured 0.3x0.4 centimeters (cm) with no depth, right great toe-under tip dark purple eschar measured 1x1cm with no depth, right 2nd toe tip measured 1x1.5cm with no depth purple intact blister-fluid filled, right post heel brown eschar 1.2x1.2cm 0 depth, right great toe and knuckle measured 0.7x0.5cm with no depth dark brown eschar, right 4th toe tip dark purple escahr measured 1x1cm with no depth, right 3rd toe tip stage 3 measured 1.5x1.3cm with 0.1cm depth- wound bed left pink tissue with 0.3x0.6cm yellow slough to center and flap of skin attached to inferior aspect of wound coming up over about 0.2cm of open area- edges defined and attached no visible drainage, to plantar surface of right foot in center of the arch- upon initial observed area is 7.5x5cm dark brown/purple with 0 depth with a flap of dead calloused skin in the center measured 5x1.7cm; the flap and remainder of skin uniform in color and tissue type, able to remove flap by gently pulling. Flap of dead tissue separated from foot fairly easily leaving intact lighter colored skin roughly 5x1.7cm. Remainder of thick dry brown/purple tissue attached to foot at this time. No complaints of pain when the tissue had been removed. This area non-pressure. All remaining areas are skin deep tissue injury except the area to 3rd toe which is a stage 3 pressure area. Treatment orders as follows: To all areas on toes except 3rd toe stage 3, apply skin prep twice a day, to area on 3rd toe apply silvadene and cover daily, and to area on right plantar surface- apply hydrogel and cover daily with gauze. Nurses Notes reviewed from 4/12/18 to 7/24/18 lacked documentation of complete assessment of the residents pressure areas, and other skin	F 686		

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F 686	Continued From page 50 concerns that had been documented on for the date 4/12/18. The Treatment Administration Record (TAR) dated 4/1/18 to 4/30/18 directed the staff with a physicians order start date of 4/12/18 as follows: apply Skin Prep Wipes topically to the pressure ulcers on the right great toe, second toe, fourth toe, fifth toe, and the posterior right heel twice a day. The TAR lacked documentation that these treatments had been completed twice a day for the following dates; 4/18/18, and 4/21/1. The TAR also directed the staff with a physicians order start date of 11/30/17 as follows; apply Aquaphilic cream to both lower legs twice a day. The TAR lacked documentation that these treatments had been completed twice a day for the following dates; 4/9/18, 4/17/18, 4/18/18, 4/19/18, and 4/29/18. The TAR directed staff with a physicians order start date of 4/13/18 as follows; Apply Betadine to the right foot and wrap with gauze daily for wound management. The TAR lacked documentation that this treatment had been completed on 4/24/18. The TAR directed staff with a physicians order start date of 11/08/17 as follows; Waffle cushion to chair at all times every shift for off load pressure. The TAR lacked documentation of this intervention being completed every shift on the following dates; 4/9/18, 4/17/18, 4/18/18 and 4/29/18. The TAR dated 5/1/18 to 5/31/18 directed staff with a physicians order start date of 11/08/17 ; Waffle cushion to chair at all times every shift for off load pressure. The TAR lacked documentation of this intervention being completed every shift on the following dates; 5/3/18, 5/7/18, 5/8/18, 5/11/18, 5/13/18, 5/16/18, 5/17/18, 5/20/18, 5/22/18, 5/25/18, 5/26/18, 5/27/18, and 5/28/18.	F 686		

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The TAR directed the staff with a physicians order start date of 4/12/18 as follows: apply Skin Prep Wipes topically to the pressure ulcers on the right great toe, second toe, fourth toe, fifth toe, and the posterior right heel twice a day. The TAR lacked documentation that these treatments had been completed twice a day for the following dates; 5/3/18, 5/8/18, 5/11/18, 5/12/18, and 5/17/18. The TAR directed the staff with a physicians order start date of 11/30/17 as follows; apply Aquaphilic cream to both lower legs twice a day. The TAR lacked documentation that these treatments had been completed twice a day for the following dates; 5/3/18, 5/7/18, 5/8/18, 5/11/18, 5/14/18, 5/16/18, 5/17/18, 5/20/18, 5/22/18, 5/26/18, and 5/28/18. The TAR directed staff with a physicians order start date of 4/12/18 as follows; clean the right third toe pressure ulcer,apply Silver Sulfadiazine Cream 1% topically and cover daily. The TAR lacked documentation that the treatment to the third toe had been completed daily on the following dates; 5/3/18, 5/11/18, and 5/16/18. The TAR directed staff with a physicians order start date of 4/13/18 as follows; apply Betadine to the right foot and wrap the with gauze for wound management daily. The TAR lacked documentation that the Betadine treatment had been completed on the following dates; 5/3/18, 5/10/18, 5/18/18, and 5/26/18.

The TAR dated 6/1/18 to 6/30/18 lacked documentation the physicians order for the waffle cushion had been in place every shift 15 out of 90 shifts. The TAR also lacked documentation that the treatment to the residents right toes had been completed 3 out of the 60 times required. The TAR also lacked documentation that the Aquaphilic treatment had been completed 16 out of the 60 times required. The TAR lacked

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documentation that the Silver Sulfadiazine Cream treatment to the right third toe had been completed 3 out of 30 times. The TAR lacked documentation that the Betadine treatment to the right foot had been completed 2 out of the 30 times required.

The TAR dated 7/1/18 to 7/23/18 lacked documentation the physicians order for the Betadine treatment to the right foot had been completed 4 out of the 24 required times. The TAR lacked documentation that the Silver Sulfadiazine Cream treatment had been completed to the third right toe three of the 24 required times. The TAR lacked documentation that the Skin Prep treatments had been completed 3 of the 48 times required.

During an observation on 07/23/18 at 1:04 p.m. Staff Y, R.N. (Grapetree Staffing) placed dressing supplies directly on the bedside table after removing the residents lunch tray from the bedside table. She then washed her hands and put on gloves then opened Betadine swabs wrapper. She then cleaned the right foot on the lateral area (side of foot) and the mid arch with the Betadine. She then covered the area cleaned with the Betadine with two by two inch gauze pads, and then wrapped it with a Kling dressing that had been laying directly on the bedside tab. The staff member did not complete any dressings to the residents toes. The tops of the toes appeared tan in color and dry to the right foot.

During an interview on 7/23/18 Staff Y, Register Nurse reported that the treatment record reported there had been an order for a third toe dressing, but she did not see any questionable area, and had never done a treatment to the residents third

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toe to either foot.

During clinical record review on 7/24/18 the nurses notes lacked documentation that the nurse had contacted the physician to change or discontinue the treatment to the residents toes for the date of 7/24/18 or 7/25/18.

During an observation on 7/23/18 at 1:40 p.m Staff W, Certified Nurses Aide (C.N.A) and Staff I C.N.A provided the resident with incontinence care. Staff W, C.N.A applied Calazime cream to the residents mid upper posterior thigh that had a quarter sized open area with a beefy red center that had a circular shape.

During an Interview on 7/23/18 at 1:40 p.m. Staff W, CNA and Staff I CNA both reported that they were directed to put Calazime on it. Both staff also reported that the resident had been on bed rest for treatment of her sore on the back of her leg, because she use to sit in her wheel chair a lot of the time.

Upon clinical record review there lacked documentation of an open area to the right posterior thigh.

During an interview on 07/25/18 at 7:58 a.m. Staff P, Nurse Regional Consultant reported that there are several system failures at the facility. She also reported that she could not find all the documentation for the residents skin Issues.

A Health Status Note dated 6/25/18 from the Physician directed that the resident had been required to remain on bed rest with check and change every 1 hour until her posterior right thigh open areas were resolved.

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F 686	Continued From page 54 Upon Clinical record review of the nurses notes dated 6/25/18 to current the nurses notes lacked documentation that the resident refused to be repositioned. The Care Plan with initiated date of 4/14/17 documented that the resident had the potential and actual skin impairment related to fragile skin, diabetes, and obesity. The Care Plan directed staff to complete skin treatments as ordered. The Care Plan further directed the staff to identify, document location, size and treatment of skin injury, and report abnormalities, and failures to heal, signs and symptoms of infection to the doctor. On 7/19/2018, the facility abated the Immediate Jeopardy by providing education to the professional nursing staff on appropriate pressure sore assessments. The facility also assessed all resident's skin to ensure all current assessments were updated. The scope and severity of the deficiency was lowered from a "K" to a "E" with the need for ongoing monitoring of facility's took for weekly monitoring of pressure sores.	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review,	F 698		

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F 698	Continued From page 55 resident and staff interview, the facility failed to consistently complete nursing assessments and monitoring of one resident on dialysis before and after outpatient dialysis was completed. (Resident #38) The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/11/18, documented Resident #38 had diagnoses of anemia, diabetes mellitus and hyperlipidemia and required extensive assistance for bed mobility, transfers and toileting and received dialysis. On 7/23/18 at 3:03 p.m., observation revealed the residents port for dialysis was on her right chest area covered with clear occlusive dressing. The resident stated she goes to dialysis on Tuesday, Thursday and Saturday. Review of residents medication and treatment administration records for the month of June and July reveal no documentation was done regarding dialysis or the dialysis port. Review of nurse progress notes revealed entries 16 times regarding the dialysis port, dressing and signs and symptoms of infection from 5/17/18 through 7/24/18. During interview on 7/25/18 1:05 p.m., the Assistant Director of Nursing, ADON stated there should be documentation on a facility dialysis communication form kept in the chart. She was unable to locate any form for the resident. She stated staff should be checking the dialysis port and documenting it on the treatment record daily.	F 698		

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F 698	Continued From page 56 Clinical Programs Manual with revision date of 8/15 provided by the facility directed staff fill out Dialysis Communication form that included Resident room number, transportation and phone number, Vital signs, departure time, last blood sugar if applicable, Dietary concerns, medications given pre dialysis and medications to be taken at dialysis, any change since last dialysis, special instructions to dialysis if any.	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on employee record review, facility policy review and staff interview, the facility failed to ensure nurse aides completed 12 hours of in-service training on an annual basis for three of three Certified Nurse Aides, CNA reviewed. The facility census was 64 residents. Findings include: 1. An Active Employees form revealed the following CNA's began employment at the facility as follows: a. Staff U on 2/7/2000 b. Staff V on 9/28/2005	F 730		

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F 730	Continued From page 57 c. Staff W on 7/20/2016 On 7/25/18 at 8:52 a.m., Staff P , Nurse Consultant stated she was unable to produce any records of staff hours of in-service. She had looked and stated the records are not there. Staff P was able to produce minimal hours of in-service training but stated it was not the required twelve hours needed. A facility document titled Iowa City Rehab and Healthcare Facility Assessment revealed nurse aides were required to attend no less than twelve hours of in-service per year.	F 730		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		

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F 761	Continued From page 58 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility failed to safeguard medication for one of three residents reviewed. (Resident #10) The facility census was 64 residents. Findings include: 1. The Intake Information sheet submitted by the facility on 5/12/18, documented Resident #10 had a liquid narcotic missing. During interview on 7/1/18 at 10:18 a.m., the Nurse Consultant reported Resident #10's liquid morphine count was off by 8 milliliters. The Nurse Consultant investigated and found staff failed to check the actual amount in the bottle when they completed the narcotic count. The Nurse Consultant determined staff were not completing a narcotic count when taking over the medication cart, therefore all staff received training on how to properly count narcotics and document the counts.	F 761		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		

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F 809	Continued From page 59	F 809		

§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.
This REQUIREMENT is not met as evidenced by:
Based on resident council minute review, resident and staff interviews, the facility failed to ensure residents were offered a bedtime snack for five of five residents interviewed. The facility census was 64 residents.

Findings include:

1. During group interview on 7/23/18 at 1:30 p.m., five of five residents present reported not being offered bedtime snacks every night and stated they used to get snacks offered after supper but have not for quite some time now.

Documentation from 4/10/18, resident council minutes revealed several residents reported no evening snacks were being passed after dinner.

Documentation from 5/08/18, resident council minutes revealed several residents reported no evening snacks were being passed after dinner.

During interview on 7/25/18, the dietician and the

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F 809	Continued From page 60 dietary manager stated snacks have not been passed for a while. During interview on 7/25/18 at 1:27 p.m., the Nurse Consultant stated it would be an expectation that resident's be offered snacks after supper.	F 809		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		

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F 880	Continued From page 61 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility policy review, facility document review and	F 880		

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F 880	Continued From page 62 staff interview, the facility failed to maintain proper infection control procedures for one of three residents reviewed with catheters and failed to ensure soiled linens were handled appropriately for one resident (Resident #28 & #35) and failed to have an Infection Control Procedure to include an Antibiotic Stewardship Program. The facility census was 64 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/5/18, documented Resident #28 had diagnoses that included chronic kidney disease, Non-Alzheimer's dementia and diabetes mellitus and had an indwelling catheter. On 7/23/18 at 11:58 a.m., observation revealed the resident in the assisted dining room (ADR) in his wheelchair with the catheter bag under the seat of the wheelchair with the bag and tubing dragging on the floor. At 12:43 p.m., observation revealed the resident propelling self down the hall as the catheter bag drug along with the tubing under the wheel chair seat. On 7/24/18 at 7:52 a.m., observation revealed Staff C, Certified Nurse Aide, CNA pushing the resident down the hallway with the catheter bag dragging along the floor. At 8:05 a.m., the resident was sitting in his wheel chair with the catheter touching the floor while hanging under the wheelchair seat. At 8:54 a.m., the resident propelled self to his room with the catheter bag dragging on the floor. At 12:12 p.m., Staff T, CNA pushed the resident	F 880		

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F 880	Continued From page 63	F 880		

out of the room with the catheter bag dragging on the floor.

During observation on 7/24/18 at 7:25 a.m., Staff C, CNA and Staff T, CNA assist the resident out of bed. Staff C placed the graduated cylinder on the bedside nightstand with no barrier while she went through the drawers of the nightstand for alcohol pads. No alcohol pads found so Staff C left the room to get some while the graduated cylinder remained on the top of the bedside dresser sitting next to resident's water pitcher/glass on the table.
At 7:29 a.m., Staff C placed the graduated cylinder on the bare floor with no barrier, opened the spout and emptied the urine out and alcohol wiped the end of the spout and laid the catheter bag on the floor.

During interview on 7/26/18 at 8:59 a.m., Staff C, CNA said the bag and tubing should not be touching the floor and the bag can be put in a dignity bag under the wheelchair to prevent that.

During interview on 7/26/18 at 9:02 a.m., the Assistant Director of of Nursing (ADON) stated the expectations for the nursing staff in regards to assisting a resident with a indwelling catheter who utilizes a wheelchair for mobility is to make sure the catheter bag and tubing remains off the floor. The ADON commented a barrier needs to be in place when emptying the catheter bag.

2. During observation on 7/23/18 at 1:40 p.m., Staff I, CNA and Staff W, CNA provided Resident #35 with peri care after an incontinent episode. Observation revealed urine had saturated the linen down to the mattress. Staff I placed the soiled linen directly on the floor. Staff failed to

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F 880	Continued From page 64	F 880		

sanitize the mattress prior to placing a clean sheet on the residents bed.

During observation on 7/24/18 at 8:11 a.m., soiled linen was on the floor.

During interview on 7/26/18 at 8:13 a.m., Staff G, registered nurse, RN expected staff not to place soiled linen on the floor, but in a plastic bag.

The facility Policy for Linen Handling dated 3/2015 documented that overview as follows; The facility strives to reduce the risk of infection to the resident/patient and employees. Linens will be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and person handling the linen. All soiled linen will be bagged and/or placed in containers at the location where it is to be used. Linen heavily contaminated with blood or other body fluids will be bagged and transported in a manner that will prevent leakage.

3. Record Review of the Annual Nonsocomial Infection Rate Summary lacked complete documentation for the months of May and June.

The facility Infection Prevention and Control Program with the original date of 3/2015 documented the overview as follows: The facility strives to prevent transmission of infections and communicable diseases, development of nosocomial infection, and effectively treat and manage nosocomial and community acquired infections, The goal of the program is to identify and reduce the risks of acquiring and transmitting infections among residents/patients, employees, volunteers, and visitors. The program includes a

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F 880	Continued From page 65 system to monitor and investigate infections trends. The program is developed based on nationally recognized organizational standards and procedures. A coordinated process is established to reduce the risks of nosocomial infections in resident/patients and employees. The infection prevention and control process is directed at lowering risk, and improving trends and rates of epidemiological significant infections. During interview on 7/26/18 at 9:42 a.m., the Nurse Consultant reported the infection control manual would get reviewed as soon as possible, and revised. During interview on 7/26/18 at 11:01 a.m., the Administrator confirmed the Infection Control program and the Antibiotic Stewardship program needed some revisions and more follow through. The Policy and Procedure for Antibiotic Stewardship with effective date of March 2017 documented the individuals accountable for the antibiotic stewardship activities include the following: Medical Director, Director of Nursing, Consultant Pharmacist, Infection Preventionist, Consultant Laboratory, and local health departments, if indicated. The policy documented the responsibilities for each team member.	F 880		

F 578

Resident #269 was discharged from the center on 3/25/18.
An audit of resident code status was completed on 7/25/18 by the Director of Social services.
Code cart audits were completed on 7/25/18 by the Regional Clinical Consultant to validate that supplies for a code were available to staff.
Facility staff will be re-educated by the Director of Nursing regarding resident advance directives and the centers CPR policy. Education will begin 7/25/18 and continue until all center staff have been re-educated. Staff members will not work without first receiving the above education prior to the start of their shift. A roster of resident wishes regarding CPR/Advanced Directives will be developed and maintained by the Social Service Director.
Audits of advanced directives will occur daily for 7 days, 3 times weekly for 3 weeks and weekly for 2 months to validate staff continue to follow resident wishes for advanced directives, provide immediate emergency assistance, and maintain a roster of resident CPR/Advanced Directives.
Results of these audits will be brought to the monthly QA meeting for 3 months and as needed.
The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 582

Resident #369 was discharged from the center on 5/22/18. Resident #370 will be screened by the therapy department to assess therapy needs on or before 9/12/18. Physician orders for therapy will be obtained as needed. Resident #371 was discharged from the center on 3/27/18.
An audit of the last 30 days of therapy discharges will be completed by the Social Service Director on or before 9/12/18 to validate the Notice of Medicare Non-Coverage form was provided to residents as required. Concerns identified will be addressed as needed.
The Interdisciplinary Team will be re-educated by the Administrator regarding the requirements of issuing the Notice of Medicare Non-coverage on or before 9/12/18. This re-education will include center requirements at the time of admission and the centers responsibility to inform residents of their rights regarding appeal.
Audits will be completed weekly for 12 weeks by the Administrator to validate the Interdisciplinary Team continues to issue the Notice of Medicare Non-coverage as required.
The results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Administrator of responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 584

Rooms 13, 15, 19, 21, 23, 25, 42, 44, 45, 46, and 48 were deep cleaned by the housekeeping staff. The chipped paint identified on the door jams of rooms 15, 19, 21, 23, and 25 were scraped and repainted by the Maintenance Director. Bathrooms in rooms 19, 23, 42, 45, and 48 were deep cleaned by the housekeeping staff. The missing transition piece in room 15 has been replaced by the Maintenance Director. The curtains in room 36 were replaced by the housekeeping staff. The Lumex stand up lift was cleaned and repaired by the Maintenance Director.
An observational audit will be conducted by the Administrator, Housekeeping Supervisor and the Maintenance Director to identify areas requiring repair or cleaning. Areas identified will be

scheduled to be addressed in a punch detail with responsible staff member identified as well as dates of completion.
Center staff will be re-educated regarding the requirements of maintaining the center in a clean homelike environment This re-education will include housekeeping, preventative maintenance requirements and responsibilities to communicate needed cleaning and repairs.
Observational audits will be completed 5 times weekly by the Administrator to validate staff continue to maintain the center in a clean homelike manner. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Administrator is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F609

The injury of unknown origin was reported by the Administrator on _____.
An audit of the last 30 days of nursing documentation, event reports and grievances were completed by the Administrator and the Director of Nursing to validate events meeting criteria for reporting are reported as required. Events will be reported as needed.
Center staff will be re-educated regarding the requirements of reporting on or before 9/12/18. This re-education will include reporting guidelines and timelines as well as the abuse policy.
Audits will be completed weekly for 12 weeks by the Administrator and the Director of Nursing to validate reportable events continue to be reported as required. The results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as required. The Administrator is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 636

MDS assessments will be completed per the RAI manual and submitted per the time guidelines required.
An audit of resident MDS assessment completion will be completed by the Director of Nursing/designee to identify assessments requiring completion. MDS assessments identified as outside of the required submission timeline will be completed and submitted.
The Interdisciplinary team will be re-educated on or before 9/12/18 by the Regional MDS Coordinator regarding the requirements of completing and submitting MDS assessments per federal guidelines.
An audit of MDS completion will be completed weekly for 12 weeks to validate the Interdisciplinary Team continue to complete and submit MDS assessments per the federal timelines. The Director of Nursing will complete these audits. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 656

The comprehensive care plan for Resident #28 was reviewed and revised by the Director of Nursing. Resident #38 was discharged from the center on 7/31/18. The comprehensive care plan for Resident #8 was reviewed and revised by the Director of Nursing.
An audit of resident care plans was completed by the Interdisciplinary Team on or before 9/12/18 to validate they reflect the current needs of the residents. Revisions will be made as needed.

The Interdisciplinary Team was re-educated by the Director of Nursing/designee regarding the requirement to maintain the care plans in comprehensive manner that reflects the needs of the residents.
Weekly audits of 10 resident care plans will be completed for 12 weeks by the Director of Nursing to validate the Interdisciplinary Team continues to maintain resident care plans in a comprehensive manner. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 658

Resident #35's orders for oxygen were clarified by the Licensed Nurse. Resident #14's antibiotic orders were clarified by the Licensed Nurse.
An audit of the last 30 days of physician orders was completed on or before 9/12/18 by the Director of Nursing/designee to validate staff follow physician orders as required.
Nursing staff will be re-educated on or before 9/12/18 regarding the requirement to follow physicians' orders. This education will include the transcription of physician orders.
Audits will be conducted weekly for 12 weeks by the Director of Nursing/designee to validate nursing staff continue to follow physician orders as required. Audits will include transcription of new orders. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 677

Residents will be provided personal care per their plan of care.
An observational audit of personal care provided to residents will be completed on or before 9/12/18. Focus areas of the audit will include perineal care/incontinence care, linen handling, environmental cleaning of soiled items, shaving and bathing.
Nursing staff will be re-educated regarding the requirement to provide personal care to residents per the resident's plan of care. This education will focus on incontinence care, linen handling, environmental cleaning post soiling, shaving and bathing as well as the documentation of care provided.
Observational audits will be completed 5 times weekly for 12 weeks to validate nursing staff continue to provide personal care as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 684

A skin assessment for Resident #4 was completed by the Licensed Nurse and documented in the medical record. A skin assessment for Resident #6 was completed by the Licensed Nurse and documented in the medical record. A skin assessment for Resident #10 was completed by the Licensed Nurse and documented in the medical record. Resident #19 was discharged from the center on 5/2/18. Resident #12 was discharged from the center on 6/9/18.
An audit of skin assessment completion was conducted on or before 9/12/18 by the Director of Nursing/designee to validate licensed nursing staff assess and document skin assessments and complete treatments as required. An audit of fall risk assessment was conducted on or before

9/12/18 by the Director of Nursing/designee to validate licensed nursing staff complete fall risk assessments as required. Skin or fall assessments identified as requiring completion will be completed as needed.
Nursing staff will be re-educated on or before 9/12/18 by the Director of Nursing regarding the requirement to complete and document assessments for skin and fall risks. This education will include completion of the assessments, documentation of the assessments and development of a plan of care based on assessment results.
Audits will be completed 5 times weekly for 12 weeks by the Director of Nursing/designee to validate nursing staff continue to complete and document assessments for skin and fall risks as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 686

Skin assessments were completed for residents residing in the center. Residents identified with skin conditions had entries made into their medical record to reflect the results of the skin assessments, notification of change as required and the plan of care for each resident with skin conditions was reviewed and revised to reflect current condition and care.
A house wide skin sweep will be completed by the Nurse Management Team to validate all residents with skin impairments have current treatments in place as required. An audit of resident's medical records will be completed to validate treatment orders for wound care are flowing to the Treatment Administration Record as required. An audit of residents with current wounds will be completed to validate wound assessments are in place and documented as required. An audit of resident care plans and CNA Kardex's will be completed to validate interventions for the treatment and prevention of wounds are in place.
Nursing staff will be re-educated by the Regional Nurse Consultant/designee regarding the requirement to assess residents for risk of pressure ulcer development, the care and treatments of pressure ulcers, the implementation of interventions to treat and prevent pressure ulcers and the requirement to document care provided.
Audits will be completed daily for 7 days, 5 times weekly for 3 weeks and weekly for 8 weeks to validate nursing staff continue to assess, treat, care plan and document care provided to residents with wounds. Results of these audits will be brought to the monthly QAPI meeting for 3 months and as needed for review and recommendations. The Director of Nursing is responsible for ongoing compliance.
Date of compliance: 08/26/2018

F 698

Resident #38 was discharged from the center on 7/31/18.
An audit of physician orders for residents requiring dialysis treatments was completed on or before 9/12/18 to validate orders for monitoring dialysis site are in place. Orders requiring clarification will be completed at the time of identification.
Licensed nursing staff will be re-educated regarding the requirement to assess and document the dialysis site of residents requiring dialysis. This will include the requirement to complete a dialysis communication form when residents receive dialysis.
Audits will be completed weekly for 12 weeks by the Director of Nursing to validate staff continue to assess and document the dialysis site for residents receiving dialysis. The results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.

Date of Compliance: 08/26/2018

F 730

Certified Nursing Assistant staff will be provided with the required 12-hour annual training.
An audit of CNA annual training will be completed by the Human Resource Director to identify staff requiring annual training. Training will be provided to the CNA staff identified.
The Interdisciplinary Management Team will be re-educated by the Administrator on or before 9/12/18 regarding the annual requirements of training for Certified Nursing Assistant staff.
Audits will be completed weekly for 12 weeks by the Human Resource Director to validate the Interdisciplinary Management Team continue to provide the required annual training for CNA staff as required. The results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Administrator is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 761

Licensed Nursing staff will account for controlled medications and document the count as required. A pain assessment was completed and documented for Resident #10.
An audit of the controlled substances will be completed by the Director of Nursing and a second Licensed Nurse to validate the documented count of controlled medications is accurate. An observational audit of licensed nurse-controlled medication reconciliation will be completed by the Director of Nursing on or before 9/12/18.
Licensed Nursing staff will be re-educated regarding the requirement to reconcile the controlled medication count at the time of administration and at the time of shift change. This re-education will include reconciliation of liquid controlled medications.
Unannounced observational audits of controlled medication count will be completed 3 times weekly by the Director of Nursing to validate nursing staff continue to reconcile controlled medications as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 809

Residents will be provided a bedtime snack as required.
An audit of bedtime snack provision and documentation will be completed on or before 9/12/18 by the Administrator/designee. Concerns identified will be corrected as identified.
Dietary and nursing staff will be re-educated on or before 9/12/18 by the Administrator regarding the requirement to proceed residents with a bedtime snack.
Audits will be completed weekly for 12 weeks by the Administrator/designee to validate staff continue to provide bedtime snacks to residents as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Administrator is responsible for ongoing compliance.
Date of Compliance: 08/26/2018

F 880

Resident #28 was assessed for signs or symptoms of infection with no change of condition identified. Resident #35 was assessed for signs or symptoms of infection with no change of condition identified.
An observational audit of infection control practices was completed on or before 9/12/18 by the Director of Nursing. Identified concerns will be addressed at the time of identification. The Antibiotic Stewardship program policy was revised.
Center staff will be re-educated regarding the requirements to maintain required infection control practices on or before 9/12/18 by the Director of Nursing. This education will include care and maintenance of an indwelling urinary catheter, linen handling and cleaning of solid equipment.
The centers appointed infection preventionist was re-educated by the Regional Nurse Consultant regarding the requirements of the Antibiotic Stewardship program including tracking, trending and documentation.
Audits will be completed weekly for 12 weeks by the Director of Nursing to validate staff continue to adhere to infection control practices as required. These audits will include linen handling, indwelling urinary catheter care and maintenance and cleaning of equipment. A monthly audit will be completed by the Director of Nursing for 3 months to validate the infection control documentation remains complete as required. Results of these audits will be brought to the monthly QA meeting for review and recommendations for 3 months and as needed. The Director of Nursing is responsible for ongoing compliance.
Date of Compliance: 08/26/2018