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F 000	INITIAL COMMENTS Correction date _____ The following deficiencies relate to the annual recertification and state licensure survey. See code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer 1 of 4 residents with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who were diagnosed with a possible serious Mental Disorder, Intellectual Disability, or	F 644		

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

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other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination (Residents #12). The facility reported a census of 54 residents.

Resident #12's annual Minimum Data Set (MDS) with a reference date of 2/26/19 identified the resident as NOT considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS also listed the following diagnoses: dementia, anxiety, depression, Post Traumatic Stress Disorder (PTSD) and, mood effective disorder.

Review of Resident #12's care plan, with a revision date of 3/20/19, revealed the resident received antidepressant medication therapy related to depression and PTSD. The care plan also indicated he used psychopharmacological medications related to his mood disorder.

Review of Resident #12's medical diagnoses tab in his Electronic Health Record (EHR) revealed the following diagnoses:
-major depressive disorder identified on 6/17/14
-depressive disorder identified on 6/17/14
-anxiety disorder identified on 6/19/14
-post-traumatic stress disorder identified on 6/7/14

Review of the clinical record revealed a Notice of Negative Level I Screen Outcome dated 6/23/14. The Level I screen documented "no" under question 1, does the individual have any of the following Major Mental Illnesses (MMI) which included major depression. The Level 1 screen documented "no" under question 2, does the individual have any of the following mental

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F 644	Continued From page 2 disorders which included anxiety disorder. The Level 1 screen form document was left blank under question 3a diagnosis 2 which asked if the resident had a diagnosis of a mental disorder that is not listed in #1 or #2. During a staff interview on 01/30/20 at 11:45 AM the Social Worker stated the PASRR was completed by a nurse that is no longer working in the facility. She stated she does the PASRR screenings and would resubmit the form to Ascend.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		

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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 interviews, the facility failed to implement care plan interventions for 1 of 20 residents (Resident #1). The facility reported a census of 54 residents.

Findings include:

The Minimum Data Set (MDS) dated January 8, 2020 for Resident #1 identified the resident with diagnoses that included: chronic obstructive pulmonary disease, arrhythmia and impaired cognitive functioning. The MDS showed that the resident scored 5 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive deficit. The MDS documented the resident required extensive assists with the help of one person for bed mobility, transfers and toileting.

According to a nurses note dated 1/19/2020 at

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F 656	Continued From page 4 6:50 PM, the resident had a cough for several days and her breathing was shallow. Oxygen saturation was 85% on room air. Supplemental oxygen was started at 2 liters per nasal cannula and the doctor was called. A follow up physicians order directed staff to supply oxygen as needed to keep oxygen saturation above 90%. The resident utilized supplemental oxygen on the 20th, 21st and 22nd. The care plan for Resident #1 last updated on 1/9/2020 lacked information or staff direction regarding oxygen use. The Director of Nursing stated on 1/30/2020 at 8:56 AM that Resident #1 had an order for supplemental oxygen as needed and the care plan should include this information.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		

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F 657	Continued From page 5	F 657		

and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to review and revise the residents care plans for 1 out of 20 residents (Resident #14). The facility reported a census of 54 residents.

Findings include:

The Minimum Data Set (MDS) dated January 21/2020 for Resident #14 indicated diagnoses that included: diabetes mellitus, hypertension, glaucoma and muscle weakness. The Brief Interview for Mental Status (BIMS) for the resident revealed that she had no cognitive impairment as evidenced by a score of 15 out of 15. The MDS showed the resident required extensive assistance with the help of 1 staff for bed mobility, dressing and toileting.

Observation showed on 1/29/2020 at 7:48 AM, CNA (certified nurse aide) Staff B in the resident's room while the resident was on the toilet. The sit-to-stand lift was in front of her with a harness around the upper portion of the resident's back. The harness remained attached to the mechanical lift with the loops fastened to the arm hooks. The resident held onto the handles of the

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machine and her feet rested on the platform of the sit-to- stand. At 7:51 AM Staff B indicated to the resident that she was going to lift her up and clean her bottom before moving her to the wheelchair. Staff B turned on the machine and elevated the resident off of the toilet without having her first stand on the platform and bear weight. The resident's toes were pushed against the front of the foot platform, she was bent at the hips with her knees locked and torso extended in a launched position. The shin strap was draped over the shin pad and not fastened around the resident's lower legs. The resident became frightened and said "that's high enough!" Staff B hurriedly wiped the resident's bottom, pulled up her briefs and pants and then left the bathroom while the resident was still in the air. Staff B locked the wheels on the wheel chair that sat right outside the bathroom door. She came back to the lift, elevated the resident higher and then maneuvered the lift out the bathroom door. The resident was still in the launched position, toes pressed up against the front of the foot platform. Staff B then lowered the resident into her wheelchair.

The care plan for Resident #14 last updated on 12/23/19 indicated she required one person assistance for ambulation and directed staff to use a gait belt when ambulating. The care plan lacked information or instruction regarding the use of the sit-to-stand lift.

A review of the facility policy title: Procedure Mobility Support and Positioning revealed direction to staff to check the care plan prior to transferring a resident. The document also indicated that staff should "never leave the resident unattended" while in the lift. The

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F 657	Continued From page 7 document stated that a calf strap is used when the resident requires additional lower extremity support or as a reminder not to step off the foot plate while the sit to stand is in motion. The policy stated staff are to direct or assist the resident to place the feet squarely on the footrest and advance the sit to stand until the shins rest against the shin pad. The policy stated; "if directed by the care plan, fasten the shin straps to keep shins and feet in place." In an interview on 1/30/2020 at 8:00 AM, the Director of Nursing stated that while the manufacturer did not mandate the use of the shin straps it seemed best practice to educate staff to use them to maintain resident safety. She acknowledged that the position of the resident as described seemed inappropriate and that before moving a resident with the sit-to-stand lift, staff should assure that the resident is actually standing with legs against the shin pad.	F 657		
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 by: Based on observations, record review, resident and staff interviews the facility failed to ensure services met professional standards of quality for 2 of 30 residents reviewed. (Resident #4 and Resident #13) The facility reported a census of 54 residents.	F 658		

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Findings include:

1. On 1/29/20 at 8:05 AM during medication administration, Staff C, LPN (licensed practical nurse) left Miralax (laxative) with Resident #4. The resident sat in the commons area with several other residents. The nurse told the resident to drink all of her water and then took the medication cart down the hall to the dining room. On 1/29/19 at 8:15 AM observed revealed Resident #4 assisted into the dining room via her wheelchair and she still had the glass half full with water and Miralax.

The quarterly Minimum Data Set (MDS) dated 1/7/20 documented Resident #4 as scoring 99, unable to complete the interview, and as moderately impaired for cognitive skills.

The Order Summary Report dated 1/29/20 documented the resident with an order for Miralax 17 grams daily.

The Director of Nursing stated on 01/29/20 at 09:08 AM, she expected the nurses to watch all medications administered and to never leave them with the resident.

2. The annual MDS dated 10/29/19 revealed Resident #13 with a BIMS score of "13". A score of 13 revealed no cognitive impairment.

The Medication Administration Record for the morning of 1/27/20 documented the resident received aspirin (blood thinner) 81 milligrams daily, cetirizine (antihistamine) 10 milligrams daily, ferrous sulfate (iron) 325 milligrams in the morning, hydrochlorothiazide (diuretic)12.5 milligrams daily and atenolol (blood pressure) 50

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milligrams ordered twice daily.

Observation showed on 1/27/20 at 10:10 AM, a medicine cup with 5 tablets of medicine in it next to Resident # 13's bed on her night stand. The resident stated staff leaves medication for her to take later when she is in the bathroom.

On 1/27/20 at 10:38 AM observation showed the resident in her wheelchair leaving with her grand daughter for the day. The medicine cup sat next to the bed with all 5 medication tablets still in it. Staff C, LPN (licensed practical nurse) stated on 1/27/20 at 10:50 AM it is common practice for staff to leave pills for the resident if she is in the bathroom and that she would give today's pills to the resident when she got back later today. She stated the resident only received them once a day so it would be okay.

The chart for Resident #13 lacked any documentation of a self medication safety assessment or a physician order to self medicate and the care plan lacked any documentation that she self medicates.

The Order Summary Report dated 1/29/20 documented the resident with active orders for aspirin, cetirizine, ferrous sulfate, hydrochlorothiazide and atenolol. The Order Summary Report dated 1/29/20 documented the resident with orders to receive the ferrous sulfate in the morning and an order to receive the atenolol twice a day.

Facility policy on Medications documented staff should administer medications to the resident according to the six rights. The procedure identified the six rights as: right medication, right

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F 658	Continued From page 10 dose, right resident, right route, right time and right documentation. The Director of Nursing stated on 1/29/20 at 9:06 AM, she expected nurses to take the medication back with them and place them in the medication cart until the resident is ready to take them and if they are ordered in the morning or twice daily staff needed to administer them per the order. She also stated that the facility never assessed residents for self medication.	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews the facility failed to provide care to prevent a pressure ulcer and failed to provide care to prevent deterioration of pressure ulcers for 1 of 3 residents reviewed. (Resident #54) The facility reported a census of 54 residents.	F 686		

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Findings include:

The Face Sheet for Resident #54 documented diagnoses to include left femur fracture, heart failure, anemia and stage 3 pressure ulcer dated 10/17/19.

The resident's Care Plan contained an update on 8/12/19 following a fall with fracture from independent in room to needing staff assist of 2 and the total lift.

The significant change Minimum Data Set (MDS) dated 8/19/19 documented Resident #54 did not have any pressure ulcers but was at risk of developing pressure ulcers. It coded her as needing extensive assist of 2 staff for bed mobility and total care of 2 staff for transfers. She scored 11/15 on her Brief Interview of Mental Status (BIMS) which indicated moderate cognitive impairment. The resident utilized an indwelling foley catheter and was always incontinent of bowel.

The Braden Assessment on 8/19/19 documented she scored at 16 for being at mild risk for pressure related breakdown.
The Braden Assessment on 9/27/19 documented she scored at 13 for being at moderate risk for pressure related breakdown.
The Braden Assessment on 11/12/19 documented she scored 15 for being at mild risk for pressure related breakdown.
The Braden Assessment on 1/21/20 documented she scored 11 for being at high risk for pressure related breakdown.

The quarterly MDS dated 9/25/19 documented

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the resident did not have any pressure ulcers but was at risk of developing pressure ulcers. It coded her to require extensive assist of 2 staff for bed mobility and total care of 2 staff for transfers. She scored 9/15 on her BIMS indicating moderate cognitive impairment. the MDS identified the resident as always incontinent of urine and frequently incontinent of bowel. It also coded her as having a significant weight loss.

The Progress Note dated 10/2/2019 at 11:59 AM documented the resident returned from a medical appointment accompanied by her son with an order to remove the sling when the resident is in her wheelchair and that the care plan was updated.

The Wound Data Collection Tool dated 10/17/19 documented the resident with a red moist area to her coccyx. The Wound Data Collection Tool dated 10/22/19 documented no rash noted.

The Skin Observation form dated 10/30/19 documented the right buttock with a red open area measuring 2cm (centimeters) by 1cm and covered with border foam dressing.

The Order Summary Report dated 10/17/19-1/31/20 lacked any documentation of the order for border foam dressing or any other orders for the open area to the right buttock until 11/3/19. The Progress Notes lacked documentation of physician notification until 11/2/19.

The Wound Data Collection form dated 11/5/19 documented the resident with a stage 3 area to her coccyx measuring 2cm in length by 0.7cm in width by 0.2cm in depth. Wound characteristics

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documented 80 percent granulation, 10 percent slough and 10 percent eschar.
The Skin Observation form dated 11/5/19 documented the resident with an open area to her right buttock measuring 2.5cm by 1.1cm, an open area to her lower left buttock measuring 2.5cm by 1cm and an open area to her upper left buttock measuring 2cm by 2.5cm. The form indicated the facility faxed the physician for an order for Allevyn wound dressing.

There was no further documentation regarding the left upper and lower buttock areas.

The Progress Note dated 11/5/19 at 10:58 AM documented the dietician recommended Prostat nutritional supplement twice daily. The chart lacked any documentation of requesting that supplement until she seen by her physician on 11/12/19.

The Progress Note dated 11/7/19 at 11:16 AM documented her appetite was less with intake of meals at 25 to 50 percent. The Progress Note dated 11/10/19 at 2:59 PM documented her appetite was still poor.

The Progress Note dated 11/12/19 at 10:14 AM documented the dietician continues to recommend Prostat.

The Clinic Note dated 11/12/19 documented the physician order for the Prostat.

The Wound Data Collection form dated 11/12/19 documented the dressing was not present and the resident with a stage 3 area to her coccyx measuring 2cm in length by 1.3cm in width by 0.2 cm in depth. Wound characteristics documented

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100 percent slough.
The Skin Observation form dated 11/12/19 documented the resident had a open area to her right upper buttock measuring 2cm by 0.9cm by 0.1cm.

The Progress Note dated 11/13/19 at 12:59 PM documented the resident experienced pain with dressing changes and the facility would request stronger pain medication from the physician. The Progress Note dated 11/15/19 at 1:08 AM documented the physician ordered Tylenol (analgesic) 500 milligrams every 6 hours for 7 days and then to report back to the physician.

The significant change MDS dated 11/12/19 documented the resident at risk for pressure ulcer development with one stage 3 pressure ulcer. The MDS coded the resident to require extensive assist of 2 staff for bed mobility and total care of 2 staff for transfers. She was unable to complete the BIMS and was documented as having modified independence for cognitive skills. It coded her as always incontinent of bowel and bladder.

The Wound Data Collection form dated 11/19/19 documented the dressing as not present and the resident had a stage 3 area to her coccyx measuring 2.5cm in length by 2cm in width by 0.7cm in depth. It also documented a stage 2 area on the residents right buttock measuring 2cm by 1cm by 0.2cm in depth. The facility faxed the physician to request a treatment change and to request an indwelling urinary catheter due to "large amount of urinary incontinence".

A care plan with revision on 11/6/19 identified the resident with a pressure sore related to

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hypertension, anemia and decreased mobility. The care plan contained the intervention to avoid positioning on back with initiation date and revision dates of 11/6/19. The care plan directed staff to provide pressure reduction mattress to bed with initiation and revision dates of 11/23/18. On 1/30/20 at 10:47 AM the Director of Nursing (DON) described this pressure reduction mattress as the same mattress provided to all residents.

The care plan did not contain every 2 hour repositioning interventions until 11/26/19 when it directed staff to turn and reposition the resident every 2 hours when in bed. The care plan directed staff to leave the sling under the resident until canceled on 6/17/19. (A physician note 10/2/19 identified sling as under the resident). The care plan did not identify pressure reduction for the wheelchair or recliner until date initiated 11/26/19 and revision on 12/17/19. The care plan ientified low air loss mattress date initiated 11/16/19 and revision 12/17/19.

The Care Plan lacked any revisions or updates prior to 11/26/19 except for the intervention to avoid positioning resident on her back. It was added on 11/6/19 after the sores developed.

The Wound Data Collection form dated 11/26/19 identified the wound dressing not present and the current treatment as collagen/hydrogel and border foam. The form identified the resident with an unstageable pressure ulcer on her sacrum measuring 3cm in length by 4cm in width by 2cm in depth. Wound characteristics documented 25 percent slough and 75 percent eschar with a foul odor present. The wound appeared reddened with purulent drainage. The second Wound Data Collection form dated 11/26/19 documented the

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resident had a stage 2 pressure area on her right buttock measuring 1.4cm in length by 0.9cm in width by 0.1cm in depth. The form identified a large pressure ulcer next to this sore with possible infection. The resident grimaced and flinched with pain.

A physician order dated 11/28/19 revealed an order for levofloxacin (antibiotic) 750 milligrams (mg.) daily every other day for coccyx wound until 12/9/19.

A wound care specialist started seeing the resident 11/28/19.

The Wound Data Collection form dated 12/3/19 documented the resident had an unstageable pressure ulcer on her sacrum measuring 3.8cm in length by 3.7cm in width and no depth measured. Wound characteristics documented 95 percent slough and 5 percent eschar with tunneling. Mechanical debridement scheduled for the pressure sore that day. The form identified the resident with continuous pain to the area, The physician ordered hydrocodone (narcotic) for the pain. The description of the wound was listed as possible worsening of infection, increased size/drainage and worsening pain. The wound had a foul necrotic odor. he second Wound Data Collection form dated 12/3/19 documented the resident had a stage 2 pressure area on her right buttock measuring 1.5cm in length by 1.6cm in width by 0.2cm in depth. The form identified the resident with dull achy pain from the wound that worsened while sitting and caused the resident to flinch/grimace. Staff placed the resident in bed between meals.

The Wound Data Collection form dated 12/10/19

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documented the resident had an unstageable pressure ulcer on her sacrum measuring 5.2cm in length by 6.2cm in width and 3.4 cm in depth. Wound description documented possible worsening of infection, increased size and drainage and worsening pain. The resident grimaced with light touch and laid down after meals. The resident utilized Fentanyl (narcotic) and hydrocodone for pain. Wound characteristics documented 80 percent slough and 20 percent eschar with a foul necrotic odor present. Tunneling was present. The treatment was Santyl in wound bed covered with border foam. Mechanical debridement at the bedside was scheduled. The second Wound Data Collection form dated 12/10/19 documented the resident had a stage 2 pressure area on her right buttock measuring 1.5cm in length by 01.6cm in width by 0.2cm in depth.

A physician fax dated 12/12/19 identified a treatment change for the sacral pressure wound. The new order directed staff to apply wet to dry packing, using Dakins solution .0125 daily and PRN (as needed) and cover with foam dressing.

The Wound Data Collection form dated 12/17/19 documented the resident had an stage 4 pressure ulcer on her sacrum measuring 6.1cm in length by 4.2cm in width and 4.2 cm in depth. Wound description documented resident hollering out and grimacing in pain. Staff administered pain medication prior to the treatment change. Wound characteristics documented 90 percent slough and 10 percent epithelization and a foul odor in her room. Staff documented dressing and treatment as Dakins gauze in wound bed, covered with border foam, diathermy, pressure reduction mattress on bed and cushion on chair,

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repositioning and pain management. The second Wound Data Collection form dated 12/17/19 documented the resident had a stage 2 pressure area on her right buttock measuring 1.5cm in length by 0.9cm in width by 0.2 cm in depth.

The quarterly MDS dated 12/18/19 documented the resident was at risk for pressure ulcer development and had one Stage 4 pressure ulcer. It coded her as needing extensive assist of 2 staff for bed mobility and transfers, having an indwelling catheter and always incontinent of bowel.

The Wound Data Collection form dated 12/24/19 documented the sacral wound measured 5.9 cm in length by 5 cm in width and 4.2 cm in depth. Wound characteristics documented 60 percent granulation 20 percent slough and 20 percent eschar with a strong four odor. The second Wound Data Collection form dated 12/24/19 documented the resident had a stage 2 pressure area on her right buttock measuring 1 cm in length by 0.8 cm in width by 0.2cm in depth.

A fax to the physician dated 12/28/19 revealed an update of the coccyx wound. The wound previously contained pink edges on exterior opening and those edges now appear green/black. The resident is totally dependent with cares in bed and doesn't reposition on own. Staff turns every 2 hours and transfers the resident with a hoyer lift. The whites of the resident's eyes appear yellow and the resident's stomach remains distended.

The Wound Data Collection form dated 12/31/19 documented the sacral wound measured 6.5 cm in length by 6.5 cm in width and 4 cm in depth.

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Wound characteristics documented 75 percent granulation 25 percent slough with a strong four odor. Current wet to dry dressing being used until the wound vac arrives.

The Wound Data Collection forms dated 1/6 and 1/7/20 did not include measurements. Tunneling was described as 4.8 cm. ay 10-12 o'clock. there were no other measurements. No other wound assessments found for the right buttock.

The Wound Data Collection form dated 1/14/20 documented the stage 4 pressure ulcer on her sacrum measured 5.9 cm in length by 5.4 cm in width and 4 cm in depth. Resident described to be in pain continuously with movement. Wound characteristics documented 92 epithelized and 8 percent slough with a mild four odor. Apiece of bone was removed from the wound bed. Documentation of conversation with family about hospice. The dressing/treatment listed: LALAP mattress, high protein diet, shakes/Prostat, NWPT-60mmhg (wound vac) and talked with family about hospice.

The Order Summary Report dated 1/14/20 documented an order for hospice level of care.

A physician order dated 1/16/20 revealed the physician discontinued the wound vac and directed staff to use saline gauze with foam for dressings. Change 3 times a week and PRN.

A clinic note dated 1/16/20 revealed the resident is 95 years old and was seen for follow up. The resident admitted to hospice due to decline in function and nonhealing and worsening wound. The family requests discontinuation of wound vac. The physician documented the resident did

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not appear ill and rested peacefully in bed. The resident did not respond to commands appropriately.

The Wound Data Collection form dated 1/21/20 documented the stage 4 pressure ulcer on her sacrum measured 6 cm in length by 5.4 cm in width and 5.3 cm in depth. The evaluation of the wound included the comment "increased bone". Resident described as moaning in pain during bed checks. Wound characteristics documented a piece of bone removed from the wound bed during cares.

The Wound Data Collection form dated 1/28/20 documented the stage 4 pressure ulcer on her sacrum measured 6.5 cm in length by 6 cm in width and 5.5 cm in depth.

Observations showed on 1/29/20 at 9:45 AM LPN Staff F and CNA (certified nurse aide) Staff G present to help with the bed mobility. The resident laid on the right side on an alternating air mattress. Both staff washed their hands and donned gloves. Staff G held the resident in place on her right side while Staff F removed an old dressing exposing an open wound approximately the size of a baseball. Staff F identified tunneling present. She removed her gloves and used hand sanitizer, she then applied clean gloves and used saline soaked gauze to clean the wound and also used saline spray to flush the wound. Staff G removed her dirty gloves, used hand sanitizer and applied clean gloves. She used 3M skin prep spray and sprayed around the edge of the wound and then packed it with 2 wet 4x4 gauze pads that she fluffed. She then covered it with a foam dressing. The resident grimaced and said ouch several times during cares.

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F 686	Continued From page 21 Observation on 1/27/20 at 2:40 PM of the resident in bed laying on her back. Observation on 1/28/20 at 10:40 AM of the resident in bed laying on her back asleep. Observation on 1/30/20 at 10:45 AM of the resident in bed laying on her back asleep with no pillows found in her bed for positioning. The resident's daughter in law stated on 1/28/20 at 10:41 AM that she and her husband are concerned with how the pressure ulcer developed here. The physician told them last fall at a doctor appointment that the blue sling should not be left under the resident because it contributed to the breakdown. She stated it took the facility quite awhile before they started removing it from under her. The DON stated on 1/30/20 at 10:47 AM she expected nurses to notify the physician immediately with any new open areas and then update the care plan. She also expected staff to update the care plan ongoing with changes and also expected initiation of dietician recommendations immediately.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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by:
Based on clinical record review, observation, facility policy review and staff interviews, the facility failed to assure each resident received adequate supervision and assistance to prevent accidents for 2 of 20 residents reviewed (Resident #5, and Resident #14). The facility reported a census of 54 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 1/14/2020 for Resident #5 indicated the resident required extensive assistance of one staff with bed mobility, transferring, dressing and toileting. The Brief Interview for Mental Status (BIMS) assessment indicated severe cognitive deficit as evidenced by a score of 8 out of 15. The care plan for Resident #5 last updated on 11/15/19 identified the resident with impaired thought processes, macular degeneration, and limited physical mobility and self-care deficits.

Observation showed on 1/27/2020 at 12:20 PM the resident seated at a dining table with two other residents in the South East corner of the dining room. After taking a couple of bites of her meal, Resident #5 started coughing. The coughing continued for a couple of minutes and one of the residents at her table stated: "she always starts coughing." Staff in the dining area did not take notice of the on-going coughing. At 12:24 PM she continued to struggle, her eyes watered and she sneezed. At that time the surveyor alerted staff to the resident's situation and Staff D, Certified Med Aide, who previously assisted feeding residents on the North West corner of the room came to assist Resident #5. At 12:27 PM the coughing subsided and at 12:33

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PM staff wheeled the resident back to her room.

Observation showed on 1/29/2020 at 12:31 PM the resident feeding herself at the same table as 1/27/20 observation, in the South East corner of the room and she faced the corner. She received ground meat and a baked potato with skin still on. Four feeding assistant staff assisted residents on the other side of the room in the North West corner. At 12:46 PM the resident finished she was done eating and hadn't eaten any of the potato skin.

A review of the clinical record revealed that the MDS dated 7/30/19 identified the resident with some choking incidents. The MDS documents from 1/14/2020, 10/22/19 and 5/14/19 indicated no swallowing issues.

The care plan last updated on 6/3019 for Resident #5 indicated the resident ate independently and directed staff to encourage the resident to main upright while eating and 30-45 minutes after meals. The care plan also directed staff to encourage the resident to take small bites/sips and to check the right side of the mouth for pocketed food.

The clinical record revealed a swallow study completed on 7/11/19. The recommendations were to use nectar thickened liquids and mechanical soft solids. The therapist also recommended direct supervision when eating.

A review of the nursing notes reveled on 9/14/19 the facility called the residents daughter to update the family regarding a choking incident related to eating corn at dinner. The resident coughed it out at that time and asked staff to place her on the

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list for no corn.

A nutrition note from 10/22/19 identified the resident as independent with eating but needed supervision. The resident received a regular diet with ground meat, no raw fruits/vegetables except bananas and no hard/crunchy foods and nectar think liquids.

On 1/28/20 at 10:55 AM observation revealed the daughter of Resident #5 in the room getting her mother up for the day. The daughter indicated she knew her mother chokes on her food at times and stated they did some swallow tests and she understood staff needed to watch the resident closely at meals.

The Director of Nursing (DON) stated on 1/29/20 at 1:10 PM she expected restorative nurses to be in the dining room area and supervise residents at risk for choking.

2. The MDS dated 1/21/2020 for Resident #14 indicated diagnoses that included: diabetes mellitus, hypertension, glaucoma and muscle weakness. The Brief Interview for Mental Status (BIMS) revealed the resident without cognitive impairment as evidenced by a score of 15 out of 15. The MDS showed the resident required extensive assistance with the help of 1 staff for bed mobility, dressing and toileting.

Observation showed on 1/29/2020 at 7:48 AM CNA (certified nurse aide) Staff B in the resident's room while the resident used the toilet. The sit-to-stand lift was in front of her with a harness around the upper portion of the resident's back. The harness remained attached to the mechanical lift with the loops fastened to the arm

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hooks. The resident held onto the handles of the machine and her feet rested on the platform of the sit-to- stand. At 7:51 AM Staff B indicated to the resident that she planned to lift her up and clean her bottom before moving her to the wheelchair. Staff B turned on the machine and elevated the resident off of the toilet without having her first stand on the platform and bear weight. The resident's toes pushed against the front of the foot platform, The resident's body appeared bent at the hips with her knees locked and torso extended in a launched position. Observation revealed the shin strap draped over the shin pad and not fastened around the resident's lower legs. The resident became frightened and said "that's high enough!" Staff B hurriedly wiped the resident's bottom, pulled up her briefs and pants and then left the bathroom while the resident was still in the air. Staff B locked the wheels on the wheel chair that sat outside the bathroom door. She came back to the lift, elevated the resident higher and then maneuvered the lift out the bathroom door. The resident remained in the launched position with toes pressed up against the front of the foot platform. She was then lowered to her wheelchair.

The care plan for Resident #14 last updated on 12/23/19 indicated she required one person assistance for ambulation and directed staff to use a gait belt when ambulating. The care plan lacked information or instruction regarding the use of the sit-to-stand lift.

A review of the facility policy title: Procedure Mobility Support and Positioning revealed direction to staff to check the care plan prior to transferring a resident. The document also stated

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staff should "never leave the resident unattended" while in the lift. The document stated to use a calf (shin) strap when the resident required additional lower extremity support or as a reminder not to step off the foot plate while using the sit to stand lift. The policy stated staff are to direct or assist the resident to place the feet squarely on the footrest and advance the sit to stand until the shins rest against the shin pad. The policy stated; "if directed by the care plan, fasten the shin straps to keep shins and feet in place."

According to the manufacturer recommendations on the use of the sit-to-stand lift, from Tollos Technologies, copyrighted 2014, staff are to move the lift close enough to the resident so that both knees come into contact with the padded knee support.

On 1/30/2020 at 8:00 AM, the Director of Nursing (DON) stated that while the manufacturer did not mandate the use of the shin straps, it seemed best practice to educate staff to use them to maintain resident safety. She acknowledged that the position of the resident as described seemed inappropriate and before moving a resident with the sit-to-stand lift, staff should assure the resident actually stood with legs against the shin pad.

On 1/29/20 at 1:09 PM the DON stated that according to the Safe Resident Handling Equipment Competency checklist used to train staff, staff are taught the use of the shin/calf strap on the sit-to-stand lift as directed by the care plan. She said that when a resident required additional lower extremity support, a nurse should assess the resident and determine if the resident can bear weight and if the shin strap should be

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SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

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F 689	Continued From page 27 used. The DON stated that the front of the residents leg should always be up against the padded shin guard.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to ensure an as needed (PRN) Xanax (antianxiety) order was reviewed 14 days after it started for 1 of 1 resident (Resident #39) reviewed for PRN psychotropic medications use. The facility reported a census of 54 residents.

Findings include:

According to Resident #39's quarterly MDS (Minimum Data Set) with a reference date of 12/10/19 revealed he had a BIMS (Brief Interview of Mental Status) score of 12, moderate cognitive impairment. The MDS listed the following diagnoses for Resident #39: anxiety and depression. The MDS indicated he received an antianxiety and antidepressant for 7 days during the 7 day review period.

Review of Resident #39's care plan, with a revision date of 9/3/19 revealed the resident with impaired cognitive function related to his depression. The care plan also indicated use of

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antidepressant medication.

Review of Resident #39's Electronic Health Record (EHR) revealed the following diagnoses:
-major depressive disorder
-anxiety disorder
-adjustment disorder

Review of Resident #39's order summary report, signed by the physician on 12/10/19 revealed the following order:
-Xanax Tablet 0.5 milligrams (mg) by mouth every 6 hours as needed for anxiety & agitation

Review of Resident #39's Medication Administration Records revealed the resident received his PRN Ativan 4 times in June of 2019, none in July of 2019, once in August, September, October, November and December of 2019, and 2 times in January of 2020.

Record review revealed a facsimile sent to the physician on 12/25/19 to renew the Xanax order. The physician's response was yes but included no end date.

Record review revealed Resident #39's Electronic Health Record (EHR) lacked documentation to continue the PRN Xanax order after the continuation order received on 12/25/19, until present date of 1/30/2020.

On 01/30/20 at 10:21 AM the Director of Nursing (DON) stated they could not find an order to continue the PRN Xanax after the 12/25/19 continuation order.

During a staff interview with the DON on 01/30/20 at 11:24 AM, she stated their process is to have

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F 758	Continued From page 30 the overnight nurses send notifications to the doctors about continuing the PRN orders so that way it is taken care of during the day. She believes the new overnight nurse sent the notification to the doctor without knowing there needed to be a 14 day review which would explain why they got missed after 12/26/19.	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide each resident with food at a safe and appetizing temperature for 2 of 20 residents (Resident #12, Resident #54). The facility reported a census of 54 residents. A review of the clinical record identified Resident #12 with an order for regular diet and Resident #54 with a doctor's order for pureed texture diet. Observation of the noon meal process on 1/28/20 revealed meal service began at 11:50 AM. Staff took temperatures of all the hot foods with no concerns. Staff kept the hot foods in the steam table as they served the residents in the main dining room. At 12:38 PM dietary aide Staff E	F 804		

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F 804	Continued From page 31 began to serve room trays. At that time temperatures of the food revealed the following: ground chicken was 130 degrees, pureed chicken meat was 130 degrees and cauliflower was 127 degrees. Staff did not reheat the food and served the pureed chicken to Resident #54 and served the cauliflower to Resident #12. The dietary manager stated on 1/29/20 at 2:00 PM she understood the food temperatures were below the recommended standards. She said she should have reheated the food before serving it to the residents.	F 804		