| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **155799** | A. BUILDING _____ B. WING _____ | **03/10/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **APERION CARE MARION LLC** | **614 WEST 14TH STREET MARION, IN 46953** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0686<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to provide interventions to prevent the development of pressure ulcers, provide treatment for [REDACTED]. This deficient practice resulted in Resident 17 developing an unstageable (full thickness skin or tissue loss with unknown depth) pressure ulcer which was not discovered by the facility. Findings include: 1. During an interview, on 3/2/20 at 9:34 a.m., Resident 17 was seated in her recliner in her room, with a blanket over her legs. She indicated she had some wounds to her lower legs. On 3/6/20 at 8:05 a.m., the resident was seated in her recliner, with a blanket rolled under her left lower leg, near the ankle. Resident 17's clinical record was reviewed on 3/3/20 at 3:06 p.m. [DIAGNOSES REDACTED]. Orders included, but were not limited to, sugar free protein supplement three times daily, [MEDICATION NAME] (insulin) 42 units daily, [MEDICATION NAME] (insulin) per sliding scale four times daily, elastic bandage wraps to bilateral legs twice daily for stasis [MEDICAL CONDITION], and oil [MEDICATION NAME] non-adherent wound dressings to bilateral lower extremities in the evening. A 1/14/20, quarterly Minimum Data Set (MDS) assessment indicated she was cognitively intact. She required extensive assistance with bed mobility, transfers, and ADLs. She was at risk for pressure injuries, and had an unhealed stage 2 pressure injury. She had a current, 2/20/20, care plan problem of a pressure ulcer of the left posterior calf related to immobility. Interventions included, but were not limited to, treatment as ordered, avoid positioning on posterior calf, and footboard to wheelchair. She had a current, 3/14/19 care plan problem of potential for impairment to skin integrity related to aging/disease process, decreased mobility, impaired mobility, incontinence, and fungal [MEDICAL CONDITION]. She had a current, 12/4/19, care plan problem of venous/stasis ulcers of the bilateral lower extremities. Review of a 12/22/19 Braden Skin Risk Assessment indicated she was at moderate risk for developing a pressure ulcer. The clinical record lacked any other skin risk assessments in the clinical record. Review of a 2/20/20 Nurse Practitioner (NP) progress note indicated the resident had a wound to her left posterior thigh. The wound was to be treated with [MEDICATION NAME] iodine and a foam bandage. She was to be followed by the wound nurse, and be provided with off-loading of the area and protein supplements. She had a pending appointment at the [MEDICAL CONDITION] (chronic swelling, usually in the arms and legs) clinic. Review of a 2/20/20 wound assessment indicated she had an in-house acquired, unstageable pressure ulcer to her left posterior calf. The wound measured 2.0 centimeters (cm) length (L) x 2.5 cm width (W) x no depth. It was 100 % covered with necrotic tissue/eschar (hardened dead tissue). The assessment indicated the wound was being treated with [MEDICATION NAME] iodine painting every shift and covered with a foam dressing with each left leg wrap daily. The order for the [MEDICATION NAME] iodine and foam pad was not implemented in the clinical record. Review of a 2/27/20 wound assessment indicated the pressure ulcer to her left posterior calf remained unstageable, measured 2.0 cm L x 2.5 cm W x no depth, and was 100 % covered with necrotic tissue/eschar. The assessment indicated the wound being treated with [MEDICATION NAME] iodine painting every shift. The order for the [MEDICATION NAME] iodine was not implemented in the clinical record. During an interview, on 3/4/20 at 9:35 a.m., Resident 17 indicated the Wound Nurse had done the treatment with [MEDICATION NAME] iodine when the wound was found, but it hadn't been done again. They had left it open at first, but that was uncomfortable, so she has had them put two ABD (gauze pads are used to absorb discharges from abdominal and other heavily draining ) pads on it for cushion. They change the wraps to her legs twice daily, usually around 5:00 a.m. and anytime after 8:00 p.m. They thought the pressure area was caused from the recliner, because it's right where the wound area met the leg rest. She was supposed to get some kind of board for her wheelchair legs, but hadn't gotten it yet. During a interview, on 3/4/20 at 9:55 a.m., the Wound Nurse indicated she had already completed her wound rounds for the week earlier that morning. The resident usually had her treatment done between 5:30 a.m. and 6:30 a.m. and late at night. She received a [MEDICATION NAME] iodine paint to her left leg and wraps bilaterally daily. During an interview, on 3/4/20 at 9:58 a.m., the Wound Nurse indicated she had not yet completed the resident's assessment or treatment for [REDACTED]. During the wound observation, on 3/4/20 at 11:20 a.m., accompanied by the Wound Nurse, she indicated the following: The resident had elastic wraps to her bilateral lower legs, with petroleum dressings sticking out of the top, to her shins. The wound was 2.0 cm L x 2.5 cm W, and had softened and opened, but had lots of drainage. She lowered the wrap on the resident's left lower leg and lifted the leg to make the back of her calf visible. A wound, slightly larger than a quarter, was observed to the back of her calf. The edges were attached from 12 o'clock to 3 o'clock (if the wound was the face of a clock), to a solid, dark brown/black piece of tissue covering the wound bed. The skin surrounding the wound was intact, with a purple discoloration at the edges. She wasn't able to determine if there was tunneling, due to the eschar cap. The wound nurse indicated there had not been a treatment in place, other than off-loading, because she already had her lower legs wrapped daily. The Wound Nurse indicated the [MEDICATION NAME] iodine and foam hadn't been continued, because the resident was scared it would hurt. The resident indicated during the observation, she had minimal pain at the time, but had more at night, which was why she had them add abdominal (ABD) pads under the wraps to cushion the area. She would see if the NP would order a treatment to help debride it. Review of a 3/4/20 wound assessment indicated the pressure ulcer to her left posterior calf remained unstageable, measured 2.0 cm L x 2.5 cm W x no depth, and was improving, but still covered 100% with eschar. There was moderate serous drainage, and the eschar had softened. There were no signs or symptoms of infection and no odor. The edges were well-defined, and she had no pain. A treatment was ordered for medical grade honey and [MEDICATION NAME] gel with foam dressing to be changed every Tuesday and Friday morning, and as needed. Review of 3/5/20 NP progress note indicated the resident reported pain to her posterior left thigh. She denied fever, nausea, vomiting or chills. The wound to her posterior thigh presented with eschar and slough to the surrounding edges, and a moderate discharge with odor. She had an infection of the wound to her left posterior thigh and was to start [MEDICATION NAME] (antibiotic) twice daily for seven days. She was to continue wound care with the wound nurse, continue off loading the area, and protein supplements. During an interview, on 3/5/20 at 9:02 a.m., the resident indicated the facility staff took the pedals off of her wheelchair the day before, which seemed to help the pain when she was up. She never did get the foot board for the wheelchair, they kept talking about it, but never got one. There was nothing added to her recliner, and nothing to her legs other than the two ABD pads under the wraps. She stayed in her recliner throughout the day, after getting up out of bed around 5:30 or so in the morning. She would get up in her wheelchair late in the afternoon or early evening, depending on what activities were going on, and stayed up for supper. During an interview, on 3/5/20 at 9:29 a.m., the NP indicated she had discovered the pressure wound while doing wound rounds with the Wound Nurse. The resident was complaining of pain to the back of her leg while she assessed her lower legs, and the wound was found. She was supposed to be having [MEDICATION NAME] iodine applied to the area, with a foam dressing. She was not aware the treatment was not being completed, and had not seen the wound yet for the week. Wound rounds were usually completed on Thursdays, but the Wound Nurse had completed them the day before for some reason, and she had not been made aware. The NP did not usually come in on Wednesdays. Review of a 3/9/20 at 12:21 p.m. progress note indicated the resident had complained of severe pain to her left lower extremity. A muscle relaxer had been administered, but was not effective. A doppler study and blood work was ordered, and the resident was referred to the wound clinic. She received a |

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

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

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F 0686

**Level of harm -** Actual harm

**Residents Affected -** Few

(continued... from page 1)

one time additional dose of [MEDICATION NAME] for the pain. During an interview, on 3/10/20 at 12:48 p.m., the resident indicated she had not refused the [MEDICATION NAME] treatment, the nurses just hadn't ever done it.

2. During a wound observation with LPN (Licensed Practical Nurse) 28, on 3/5/20 at 10:39 a.m., Resident 38's second toe on her right foot was swollen twice the size of her second toe on her left foot and slightly purple below the knuckle. A cranberry sized opened area was observed to the second toe on her right foot with a dark pink wound bed to the knuckle area. During an interview, on 3/5/20 at 10:58 a.m., LPN 28 indicated the resident's second toe of the right foot had a wound approximately the size of a dime with minimal slough noted at the bottom right base of the wound site. She indicated the resident's entire toe was reddened and swollen. During an interview, on 3/5/20 at 3:24 p.m., LPN 28 indicated the wound on the resident's second toe of the right foot was a pressure ulcer rather than a skin tear. During an interview, on 3/5/20 at 10:39 a.m., Certified Nurse's Aide (CNA) 20 indicated the resident's family bought the resident some new slippers. An observation of the slippers indicated a hard/firm seam to the area lining up with her toe. CNA 20 indicated the wound had been present the entire month she worked at the facility. The resident was observed wearing new thinner slippers without a seam at the toe. Resident 38's clinical record was reviewed on 3/5/20 at 11:00 a.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, aspirin 81 milligram (mg) once daily, [MEDICATION NAME] 40 mg once daily, [MEDICATION NAME] (blood pressure) 5 mg once daily, glimepiride (diabetic) 8 mg once daily, [MEDICATION NAME] (depression) 25 mg once daily, Pro-Stat Sugar Free (supplement) 30 milliliters (ml) twice daily, [MEDICATION NAME] (pain) 50 mg every four hours as needed, and Xeroform Oil [MEDICATION NAME] (wound) every two days for open wound on bilateral second toes. A quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely cognitively impaired. She required extensive assistance for bed mobility, transfers, dressing, and toileting. The MDS indicated the resident was at risk for pressure ulcers and no pressure ulcers were noted. Skin interventions included, but were not limited to, an application of dressings to the feet. A current care plan for a skin tear, dated 2/15/20, indicated the resident had a skin tear to the right second toe. Interventions included, but were not limited to, the resident needed footwear on while up and awake. The clinical record lacked a care plan for pressure ulcers or impaired skin integrity. Review of a physician progress notes [REDACTED]. The note indicated the resident's wound was still open with no eschar or slough. Review of a weekly skin sheet, dated 2/15/20 at 3:23p.m., indicated the skin tear to the resident's second toe on the right foot measured 1 centimeter (cm) x 1 cm x 0.3 cm, the wound was worsening, and no new skin concerns were noted that required physician notification. Review of the clinical record indicated a lack of physician notification on 2/15/20 for the resident's worsened pressure ulcer. Review of a weekly skin sheet, dated 2/20/20 at 10:40 a.m., indicated the skin tear to the second toe on the right foot was improved and measured 0.8 cm x 1 cm x 0.3 cm. Review of a weekly skin sheet, dated 2/27/20 at 1:41 p.m., indicated the skin tear to the resident's second toe on the resident's right foot measured 0.8 cm x 1 cm x 0.3 cm. Review of a weekly skin sheet, dated 3/4/20 at 8:08 a.m., indicated the resident had an open lesion to the second toe on the right foot. The open lesion measured 0.8 cm x 0.8 cm x 0.2 cm and had no signs or symptoms of infection noted. Review of a Braden Assessment, dated 1/24/20 at 8:19 p.m., indicated the resident was not at risk for pressure ulcers. During an interview, on 3/5/20 at 4:07 p.m., the Director of Nursing (DON) indicated the clinical record lacked care plans for a pressure ulcer or impaired skin integrity. During an interview, on 3/10/20 at 9:40 a.m., the DON indicated any change in the appearance or documentation that referenced a worsened wound should have been reported to the physician immediately. She indicated the Wound Nurse is not certified. 3. During a wound observation on 3/5/20 at 2:35 p.m., LPN 28 indicated the Resident 41 had a stage three pressure ulcers to the Achilles region of the right foot which measured 5.7 cm x 2.1 cm x 0.2 cm. LPN 28 described the wound as an open wound with scant slough along the edge of the wound and granulation surrounded the entire wound. The resident's wound had serosanguinous drainage. During the observation, the resident did not have a wound located on the right heel. Resident 41's clinical record was reviewed on 3/03/20 at 4:10 p.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, [MEDICATION NAME] (antipsychotic) 5 mg daily, [MEDICATION NAME] 15 mg daily, sodium chloride (supplement) 1 gram twice daily, Promod Liquid (supplement) 30 ml three times daily, [MEDICATION NAME] 20 mg (diuretic) twice daily, [MEDICATION NAME] acid (supplement) 500 mg daily, zinc sulfate (supplement) 225 mg once daily, and calcium alginate (wound) every shift. A quarterly MDS, dated [DATE], indicated the resident was not cognitively impaired. The resident required supervision for bed mobility and transfers. He is independent with locomotion on and off the unit. The resident was at risk for pressure ulcers and had stage 3 pressure ulcer present on admission. Skin interventions included nutrition to manage skin problems and an application of dressings to the feet. The clinical record indicated the wound was documented as being on the right heel rather than the right foot Achilles region. The clinical record lacked care plans for pressure ulcers and impaired skin integrity. Review of a weekly skin assessment, dated 2/6/20 at 6:39 a.m., indicated the stage three pressure ulcer to the resident's right heel measured 3.8 cm x 1.3 cm x 0.1 cm. Review of a weekly skin assessment, dated 2/15/20 at 3:00 p.m., indicated the resident's stage three pressure ulcer to the right heel measured 3.6 cm x 1.2 cm x 0.1 cm. The documentation indicated the physician was last notified on 2/13/20 and the family was last updated on 2/15/20. Review of a weekly skin assessment, dated 2/20/20 at 10:03 a.m., indicated the resident's stage three pressure ulcer to the right heel measured 3.6 cm x 1.1 cm x 0.1 cm. Review of a weekly skin assessment, dated 2/27/20 at 9:03 a.m., indicated the resident's stage three pressure ulcer to the right heel measured 3.6 cm x 1.1 cm x 0.01 cm. The skin assessment indicated the wound improved, edges were rolled, and tissue was 95 percent granulation with 5 percent [MEDICATION NAME]. Review of a weekly skin assessment, dated 3/4/20 at 7:28 a.m., indicated the resident's stage three pressure ulcer to the right heel measured 3.6 cm x 1.1 cm x 0.01 cm with moderate serosanguinous drainage. The assessment indicated wound status improved with 10 percent granulation and 90 percent slough. Review of a Braden Assessment, dated 3/06/20 at 4:16 p.m., indicated the resident was at risk for pressure ulcers with a score of eighteen. During an interview, on 3/5/20 at 3:14 p.m., LPN 28 indicated the clinical record lacked a pressure ulcer or skin integrity care plans. LPN 28 indicated the wound measurements were significantly larger on her assessment dated [DATE] compared to the wound measurements documented by RN 9 on the skin assessment dated [DATE]. During an interview, on 3/5/20 at 4:19 p.m., the DON indicated Resident 41's clinical record lacked care plans for impaired skin integrity and pressure ulcers.

4. Resident 19's clinical record was reviewed on 3/4/20 at 9:29 a.m. [DIAGNOSES REDACTED]. Her physicians orders included, but were not limited, prostat sugar free liquid (Amino Acids-Protein Hydolys) 30 ml (milliliter) twice daily, vitamin C 500 mg (milligram) daily for wound healing, zinc sulfate 220 mg daily for wound healing, skin inspection/nursing weekly assessment every nightshift every Monday complete weekly skin observation and wash and pack with CA (Calcium Alginate) rope and cover with dry dressing daily every day shift for wound care. A quarterly MDS (Minimum Data Set), dated 1/22/20, indicated the resident was severely cognitively impaired. She required extensive assistance with bed mobility, dressing, toilet use, personal hygiene. She was totally dependent with two staff members for transferring. She was at risk for developing pressure ulcers/injuries, she had one Stage 2 pressure ulcer that was present upon admission to the facility. She had a pressure reducing device for bed. She received pressure ulcer/injury care. She had a focus care plan, initiated on 9/26/19, indicated she had an open wound under her abdominal fold as well as a large hernia. Her goal was for her wound to heal without complications. Interventions were monitor site for signs and symptoms of infection (ie; increased drainage, foul odor, redness, warmth, etc) initiated on 9/26/2019 and treatment as ordered initiated 9/26/2019. A Braden (pressure ulcer risk assessment) observation indicated the following: a. 9/23/19, she was at risk for pressure ulcer development. b.10/21/19, she was at risk for pressure ulcer development. c. 1/21/20, she was at moderate risk for pressure ulcer development. d. 3/6/20, she was at high risk for pressure ulcer development. A skin and wound evaluation, dated 10/1/19, indicated the resident had an open lesion to her lower right abdomen, it was present on admission and measured 0.8 cm (centimeter) x 1.7 cm x 0.6 cm, there was granulation tissue, light amount of serous exudate, wound edge appeared flush with wound bed or as a sloping edge, surrounding tissue was normal in color, area was improving, no infection was suspected to area. Area looks good and wound edges were clean and normal skin color. The resident was educated on the importance of attending physical and occupational therapy to promote strengthening and to take the pressure off of her body from lying in bed. On 11/8/19 the [MEDICAL CONDITION] measurements were 1.0 cm x 0.7 cm x 1.9 cm. The skin-pressure/diabetic/venous/arterial wound report indicated the following: a. The resident admitted with a stage 2 pressure ulcer. b. On 12/16/19 the measurements were 2.0 cm x 2.0 cm x 2.0 cm. c. On 12/27/20 the measurements were 2.0 cm x 2 cm x 1.5 cm. d. On 1/9/20 the measurements were 0.3 cm x 0.3 cm x <0.1 cm. e. On 1/23/20 the measurements were 0.5 cm x 0.5 cm x 0.1 cm, the wound was unchanged, there was 100% granulation tissue, there was no drainage, the treatment was collagen powder and foam. f. On 2/6/20 the measurements were 0.4 cm x 0.4 cm x 0.1 cm. g. On 2/20/20 the measurements were 1.0 cm x 0.8 cm x 0.5 cm, the wound was improving with 100% granulation tissue, there was small bloody drainage. h. On 2/27/20 the measurements were 0.8 cm X 0.8 cm X 0.4 cm. i. On 3/4/20 she was admitted with a wound to her right abdominal fold and was a stage 2 pressure injury measuring 0.8 cm X 0.8 cm X 0.4 cm, the wound status was unchanged, tissue type was 100% granulation, there was bloody drainage, wound edges were well defined. Interventions were nutrition or hydration intervention to manage skin problems, supplements, predisposing risk factors were immobility and diabetes. A skin - other skin condition report dated 3/6/20 indicated the resident had pressure, to her lower abdomen measuring 2.0 cm x 0.7 cm x 0.4 cm, it was worsening, area measured larger than prior measurements. The treatment was wash and pack with calcium alginate rope and cover with dry dressing daily, the resident had complaints of pain, [MEDICATION NAME] was given and no change was needed to her care plan. During an observation of Resident 19's abdominal wound, on 3/5/20 at 10:54 a.m. with LPN 71 and QMA 79. QMA 79 was holding the resident's large abdominal hernia up, under the hernia located in the middle of the residents abdomen in the resident abdominal fold. Serous drainage was visible on the old dressing. The area was nickel size, with granulation tissue and depth visible. LPN 71 cleansed wound with wound spray and 4 x 4 gauze pad, cut a 1 inch of calcium alginate rope and packed the wound with the rope using a cotton tipped applicator. LPN 71 indicated the wound was pressure related due to the resident's hernia was lying on top of it and it was a stage 3. During a wound measurement observation with the Interim DON and QMA 79 on 3/06/20 at 12:01p.m., the wound measured 2 cm x 0.7 cm x 0.4 cm, the DON indicated she thought the wound was a stage 2, after reviewing the NPUAP (National Pressure Ulcer Advisory Panel) pressure injury staging definitions on Point Click Care, she indicated it would be a stage 3. NPUAP pressure injury staging definition on Point Click Care indicated the following: Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated [MEDICAL CONDITION] (IAD), intertriginous [MEDICAL CONDITION] (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss

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| | this is an Unstageable Pressure Injury. Review of a current facility policy, titled Skin Condition Assessment & Monitoring - Pressure and Non-Pressure, dated 6/8/18 and provided by the Interim DON on 3/5/20 at 12:21 p.m., indicated the following: .Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented .A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified .Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment .Wound Assessment/Measurement: .2. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. Physician and responsible party notification will be documented in the clinical record. These changes include, but are not limited to: a. new onset of purulent drainage b. new onset of odor .6. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care .7. Physician ordered treatments shall be initiated by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses notes. 3.1-40(a)(1) 3.1-40(a)(2) |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** |

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to provide supervision for 3 of 3 residents reviewed for smoking safety (Resident 23, Resident 25, Resident 41). Findings include: 1. On 3/4/20 at 9:33 a.m., Resident 23 ambulated with her walker to Resident 25's room and asked for a cigarette to smoke. The resident proceeded to the Nurse's station and signed her name in the leave of absence binder. Review of the binder indicated the resident did not write the date and time she left the facility. On 3/4/20 at 9:34 a.m., Resident 23 left the exit door between D wing and E wing to smoke. She stopped and sat on her rollator seat halfway between the building and the designated smoking area and lit her cigarette. She was not accompanied by any staff members. On 3/4/20 at 9:52 a.m., Resident 23 returned to the facility. Review of the leave of absence binder indicated dates and times were not logged since 2/19/20. On 3/6/20 at 11:44 a.m., the resident was observed smoking within 4 feet of the exit door. Resident 23's clinical record was reviewed on 3/5/20 at 8:56 a.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, [MEDICATION NAME] ([MEDICAL CONDITION]) 300 milligrams (mg) twice daily, risperdone microspheres (antipsychotic) 25 mg intramuscularly every 14 days, [MEDICATION NAME] (pain) 5-325 mg three times daily, [MEDICATION NAME] (anxiety) 0.5 mg three times daily, and vitamin D (supplement) 1000 units daily. A quarterly Minimum Date Set (MDS) assessment, dated 1/26/20, indicated the resident's cognitive status was mildly impaired. She required supervision for bed mobility, transfers, locomotion on and off the unit, dressing, and toileting. The MDS lacked information regarding tobacco use for Resident 23. A current care plan for smoking, dated 2/20/20, indicated the resident was a smoker and will not smoke on facility grounds or in the facility. Interventions included but were not limited to, the resident will participate in smoking assessments as needed and the resident can smoke unsupervised. A current care plan for impaired cognitive function, dated 2/20/20, indicated the resident had short term memory impairment. Interventions included but were not limited to, cue the resident, reorient, and supervise as needed. Review of a Social Services Note, dated 12/13/19 at 11:56 a.m., indicated the resident met with social services to review the facility smoking policy. Education was provided to the resident concerning the non-smoking campus. The resident voiced understanding. A review of the smoking risk assessment, dated 1/15/20 at 1:18 p.m., indicated the resident had a minimal problem with the ability to understand the facility safe smoking policy. She had a minimal problem for safely following the facility's Smoking Policy. Review of a Nurse's Note, dated 1/28/20 at 4:45 p.m., indicated a loud odor of cigarette smoke was noted in the hallway close to the resident's room. When the staff member entered the resident's room, the window was open and a cup of water contained two cigarette butts. During an interview, on 3/4/20 at 10:04 a.m., Licensed Practical Nurse (LPN) 33 indicated the Leave of Absence (LOA) log lacked dates and times when the resident left and returned to the facility on [DATE]. She indicated staff was unable to identify which residents were gone from the facility when the LOA logs were reviewed due to incomplete logs. During an interview, on 3/5/20 at 9:02 a.m., Resident 23 indicated she smoked. She indicated the facility allowed her to smoke in the designated smoking area located at the end of the sidewalk near the fence. The resident indicated she stored her cigarettes and lighter in her purse and with her at all times. During an interview, on 3/9/20 at 10:55 a.m., Certified Nurse's Aide (CNA) 37 indicated management mentioned concerns that residents did not smoke in the designated smoking area. She indicated the smoking residents were required to sign out LOA when they left the building and when they returned to the facility. 2. On 3/3/20 at 2:00 p.m., Resident 25 returned to the facility after smoking. She did not sign back into the LOA binder. Review of the LOA binder, indicated the resident failed to complete the LOA log on 3/3/20 at 2:00 p.m. On 3/4/20 at 9:46 a.m., Resident 25 was observed with a hooded sweatshirt on and let herself out the exit doors to smoke. She did not have a staff member with her when she smoked. On 3/4/20 at 9:54 a.m., Resident 25 returned to the facility from smoking. On 3/4/20 at 9:59 a.m., a review of the LOA binder indicated the log lacked documentation when the resident returned to the building from smoking. Resident 25's clinical record was reviewed on 3/3/20 at 3:45 p.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, [MEDICATION NAME] 10-325 mg every 12 hours as needed, Tylenol 650 mg every eight hours as needed, and [MEDICATION NAME] XR 150 mg daily, A current admission MDS assessment, dated1/30/20, indicated the residents cognitive status was not impaired. She required limited staff assistance with locomotion on and off the unit. The resident used a wheelchair for mobility. The MDS indicated the resident used tobacco products. Review of the resident's clinical record lacked a care plan for smoking. During a review of the clinical record, a smoking safety risk assessment dated [DATE] indicated the resident was not a current smoker and the remainder of the assessment was not completed. Review of a Social Service's Note, dated 1/26/20, indicated the resident used smoking products. During an interview, on 3/3/20 at 8:48 a.m., Resident 25 indicated she kept her lighter and cigarettes in her purse and stored in the drawer. She reported she is permitted to smoke independently out of the facility and away from the building along the fence. During an interview with the Housekeeping Director, she indicated the resident did not sign the LOA binder for 3/3/20 at 2:00 p.m. During a review of the binder, she indicated the resident signed in each time she left the facility but failed to sign out of the facility. During an interview, on 3/4/20 at 10:04 a.m., LPN 33 indicated the resident's LOA logs were not completed. She indicated staff did not know if residents were gone from the facility when they reviewed the logs. During an interview, on 3/5/20 at 4:26 p.m., the DON indicated residents were required to sign out and back in the LOA binder. 3. On 3/3/20 at 2:32 p.m., Resident 41 wheeled past the nurse's station wearing his coat. He did not sign the LOA log and continued out the exit doors. Staff were not with the resident when he exited the building. During an interview, on 3/3/20 at 2:48 p.m., the Housekeeping Director indicated the residents are supposed to sign the leave of absence log prior to an exit. She indicated the residents were permitted to smoke independently at the fence. During an interview, on 3/3/20 at 2:51 p.m., LPN 33 indicated the residents signed the POA log to ensure whether residents were in the building. During an interview, on 3/3/20 at 2:58, the Administrator indicated the residents signed out in the leave of absence log before they left the building. She indicated the residents were permitted to smoke in the designated area only. During an interview, on 3/3/30 at 3:33 p.m., the Housekeeping Director indicated the resident did not sign out in the LOA binder on 3/320 at 2:32 p.m. and had not signed out on the log since 2/24/20. Resident 41's clinical record was reviewed on 3/3/20 at 4:10 p.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, [MEDICATION NAME] (antipsychotic) 5 mg daily, [MEDICATION NAME] 15 mg daily, sodium chloride (supplement) 1 gram twice daily, Promod Liquid (supplement) 30 ml three times daily, [MEDICATION NAME] 20 mg (diuretic) twice daily, [MEDICATION NAME] acid (supplement) 500 mg daily, zinc sulfate (supplement) 225 mg once daily, and calcium alginate (wound) every shift. A quarterly MDS, dated [DATE], indicated the resident was not cognitively impaired. The resident required supervision for bed mobility and transfers. He is independent with locomotion on and off the unit. The resident was at risk for pressure ulcers and had stage 3 pressure ulcer present on admission. Skin interventions included nutrition to manage skin problems and an application of dressings to the feet. The MDS indicated Resident 41 used tobacco products. A current care plan for smoking, dated 1/16/20, indicated the resident smoked. Interventions included, but were not limited to, instruct resident about the facility policy on smoking: locations, times, safety concerns, instruct about smoking risks and hazards and about smoking cessation aids that are available and notify the charge nurse immediately if it is suspected the resident has violated the facility smoking policy. A review of the resident's smoking safety risk assessment, dated 1/20/20, lacked a history of hazardous material (i.e., smoking in unauthorized areas or careless use of smoke materials, sustaining burns, fire starting). A current policy, titled Resident and Visitor Smoking Policy Notification, provided by the Administrator on 3/3/20 at 3:18 p.m., indicated the following: .There will be no smoking in any patient rooms. Residents: All residents shall smoke only in designated areas. Residents who pose a hazard with smoking materials will have supervised smoking times provided for and may be placed in a supervised program for safe smoking. Residents who may pose a hazard to themselves and others with smoking materials may have their cigarettes, lighters and matches removed from them and kept in a designated location for safety until such time as responsible smoking habits in compliance with facility safety rules are demonstrated by the resident 483.25(d)(2) |
| F 0756<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure pharmacist recommendations were forwarded to the prescribers for review for 2 of 5 residents reviewed for unnecessary medications (Resident 17, 19). Findings include: 1. Review of Resident 17's clinical record was completed on 3/3/20 at 3:06 p.m. [DIAGNOSES REDACTED]. The Pharmacist review recommendations indicated the following: a. The 1/18/19 review recommended a [MEDICAL CONDITION] level to be performed, due |

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| F 0756<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 3)<br>to the resident receiving [MEDICATION NAME] ([MEDICAL CONDITION] medication) and Llothyronine ([MEDICAL CONDITION] medication), and no labs on file since the previous October. The recommendation was not addressed until 2/27/20, and it was indicated she would be discharging from the facility, and could follow up with her outside medical provider. b. The 4/24/19 review recommended a [MEDICAL CONDITION] level to be performed, due to the resident receiving [MEDICATION NAME] and Llothyronine, and no labs on file since the previous October. The recommendation was not addressed until 5/17/19. The results of the [MEDICAL CONDITION] level lead to an increase in the [MEDICATION NAME] from 150 mcg daily to 200 mcg daily.<br>c. The 12/30/19 review indicated the resident had been on a sliding scale for insulin with glucose testing four times daily. Due to low blood glucose readings, and minimal coverage needed, it was recommended to not administer the insulin at bedtime due to risk for overnight and early morning low blood glucose readings. It was not addressed by the medical provider. d. The 2/19/20 review indicated it was a duplicate recommendation due to no response. The resident had been on a sliding scale for insulin with glucose testing four times daily. Due to low blood glucose readings, and minimal coverage needed, it was recommended to not administer the insulin at bedtime due to risk for overnight and early morning low blood glucose readings. It had not been addressed by the medical provider.<br><br>2. Resident 19's clinical record was reviewed on 3/4/20 at 9:29 a.m. [DIAGNOSES REDACTED]. Review of Pharmacist review recommendations indicated the following: a. The 12/20/19 review indicated the resident received [MEDICATION NAME] (treat heartburn) 20 mg every a.m. and [MEDICATION NAME] (treat heartburn) 150 mg every p.m. Recommendations were if PPI (Proton Pump Inhibitor) was required to consider decreasing Rantidine to 75 mg every p.m. or if a PPI was not required, consider discontinuing the [MEDICATION NAME] and changing the Rantidine to 75 mg twice daily. It had not been addressed by the medical provider. b. The 1/15/20 review indicated the resident had an order for [REDACTED]. This should then prompt nursing to ensure this maximum daily dose had not been exceeded prior to administration. It had not been addressed by the medical provider. 3. Resident 37's clinical record was reviewed on 3/6/20 at 9:21 a.m. [DIAGNOSES REDACTED]. Review of Pharmacist review recommendations indicated the following: a. The 12/30/19 review indicated the resident had orders for mens multivitamin, Reno Caps (vitamin) everyday, and [MEDICATION NAME] (multivitamin) twice daily, Hgb (hemoglobin) that month was 12.1 gm/dL, recommendation was to consider reducing burden if no longer warranted. It had not been addressed by the medical provider. b. The 10/8/19 review indicated [MEDICATION NAME] (antipsychotic) did not have an adequate [DIAGNOSES REDACTED]. It had not been addressed by the medical provider. A 1/15/20 review [MEDICATION NAME] (antidepressant) 20 mg every a.m. and [MEDICATION NAME][MEDICATION NAME](Orally Disintegrating Tablets) 5 mg at bedtime, had a [DIAGNOSES REDACTED]. It had not been addressed by the medical provider. During an interview, on 3/9/20 at 12:03 p.m., the interim DON indicated the January 2020 pharmacy recommendations had not been acted upon by the facility. She was not aware of which other months had been reviewed. Review of a current facility policy, titled Pharmacist Medication Regimen Review, dated 11/28/17 and provided by Nurse Consultant 12 on 3/10/20 at 4:03 p.m., indicated the following: .3. The Consultant Pharmacist will report any irregularities in writing to the attending physician, the Medical Director and the Director of Nursing for follow up .The Director of Nursing or designee will notify the attending physician of recommendations either in person, by telephone, fax or other secure system of notification within 3 business days of receiving report from the Consultant Pharmacist 3.1-25(i) |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>1. Based on observation and interview, the facility failed to properly label medications and correctly and securely store medications for 3 of 5 medication carts observed (D hall medication cart, D hall treatment cart and E hall treatment cart) Findings include: A. During an observation of D1 medication cart on 3/03/20 at 9:45 a.m., accompanied by LPN 71, the following was observed: a. [MEDICATION NAME] 0.2-0.5% opthamalic solution (treat glacoma)with no open date, it was delivered to the facility on [DATE]. b. [MEDICATION NAME] (insulin)with no open date, delivered to the facility on [DATE]. c. [MEDICATION NAME] (insulin) with no open date, delivered to the facility on [DATE]. B. An observation of D Hall treatment cart on 3/03/20 at 9:54 a.m. accompanied by LPN 71, included, but was not limited to the following: a. In a three sectioned drawer, one section contained a partially used and undated package of Preparation H ([MEDICATION NAME] discomfort), an unopened salonpas [MEDICATION NAME] plus (pain relief) with no resident identifier on it, a partially used bottle of ammonium [MEDICATION NAME] lotion (dry skin), and a partially used bottle of biofreeze (pain reliever). b. In a second section of three sectioned drawer contained a partially used tube of [MEDICATION NAME] nitrazate cream(antrifungal) and a tube of biofreeze. c. In the third section of the three sectioned in a drawer contained a partially used tube of [MEDICATION NAME] cream (corticosteroid), a partially used tube of Gold Bond lotion and a partially used tube of triple antibiotic ointment. d. In the fifth drawer was a partially used tube of dermaclens (wound cleansing) with no resident identifiers on it. C. On 3/03/20 at 7:52 a.m., the door was open to the ADON's office, the treatment cart was unlocked and unattended inside the office. On top of the treatment cart was skin protectants, antifungals and wound cleansers. Inside the cart contained, but was not limited to, an open and partially used tube of [MEDICATION NAME] cream with no resident identifiers on it. [MEDICATION NAME] cream tub for a discharged resident, various needles and syringes. On 3/3/20 at 8:02 a.m., a nurse was unable to be located on the unit. The Interim Administrator 2 was near the main dining room and she indicated the cart should not be unlocked with items accessible and she locked the cart. . On 3/03/20 at 8:08 a.m. a review of the electronic medical record indicated the discharged resident, discharged on [DATE]. A current policy, titled Medicaton Storage, provided by the Regional Nurse Consultant, on 3/10/20 at 3:04 p.m., indicated the following: Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles .3. General Storage Procedures: .3.1 Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals. 3.2 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors .5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 3.1-25(j) 3.1-25(k) 3.1-25(m) |
| F 0773<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to ensure the medical provider was notified of critical laboratory results for 2 of 2 residents reviewed for abnormal laboratory values (Residents 17 and 95). Findings include: 1. Resident 17's clinical record was reviewed on 3/3/20 at 3:06 p.m. [DIAGNOSES REDACTED]. She had an unstageable pressure ulcer to her left posterior lower leg. Review of a 3/9/20 progress note indicated at 12:21 p.m., the resident complained of severe pain to her left lower extremity. The Nurse Practitioner (NP) ordered, but was not limited to, a STAT complete blood count (CBC). The results for the CBC were resulted electronically to the facility on [DATE] at 3:43 p.m., with a critical hemoglobin of 7.9 grams (g) per deciliter (dL) (normal results were 13.0-18.0 mg/dL). The clinical record lacked notification of the resident's medical provider of the critical results. During an interview, on 3/10/20 at 10:32 a.m., the interim DON indicated the NP had just been notified of the lab results. 2. Review of Resident 95's closed clinical record was completed on 3/5/20 at 7:26 a.m. [DIAGNOSES REDACTED]. Review of a 3/4/20 CBC indicated they were resulted to the facility on [DATE] at 2:59 p.m., with a critical hemoglobin of 8.3 g/dL. The clinical record lacked notification of the resident's medical provider of the critical results. During an interview, on 3/5/20 at 9:29 a.m., the NP indicated she had not been notified of the resident's hemoglobin. She had reviewed it when she arrived at the facility for rounds, during her record review. During an interview, on 3/5/20 at 9:38 a.m., LPN 15 indicated the computer program dashboard showed lab results to be reviewed, or they could be viewed in the resident's record. During an interview, on 3/5/20 at 11:21 a.m., the interim DON indicated lab results were faxed to the facility as well. She would expect the NP to be notified immediately of |

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| F 0773<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 4)<br>critical lab results. Review of a current facility policy, titled Physician Notification of Laboratory/Radiology/Diagnostic Results, dated 3/14/18 and provided by the interim DON on 3/9/20 at 9:08 a.m., indicated the following: .Purpose: To assure physician ordered diagnostic test(s) are performed, and to assure test results are reported to the physician so that prompt, appropriate action may be taken if indicated for the resident's care .A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the physician or other practitioner who ordered them .Guidelines for Reporting Abnormal Results: All Critical laboratory values .Unless other parameters are ordered by physician: .Hemoglobin < 9 if not pre-existing and without treatment 3.1-49(f)(2) |
| F 0835<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Administer the facility in a manner that enables it to use its resources effectively and efficiently.**<br><br>Based on record review and interview, the facility failed to ensure consistent management was in place to provide continuity of care, prevent system breakdown, and prevent repeat deficiencies. Findings include: Review of the Employee Records listing indicated the following dates of employment with the facility: The Administrator's start date was 2/3/20. The DON's start date was 2/24/20. The Social Service Director's start date was 12/20/19. The MDS Coordinator's start date was 1/29/20. The Dietary Manager's start date was 2/13/20. The Maintenance Director's start date was 1/15/20. During an interview, on 3/4/20 at 7:41 a.m., the interim DON indicated she had started the prior week, and had planned on staying for a five week tenure. During an interview, on 3/5/20 at 3:05 p.m., the interim Administrator indicated she had completed her five week contract, and was leaving the next day. During an interview, on 3/09/20 at 12:03 p.m., the interim DON indicated a Nurse Consultant had been assigned to the facility until a replacement consultant was hired, due to the previous consultant leaving the position. During an interview, on 3/6/20 at 11:13 a.m., the interim Medical Records Clerk indicated she had been helping the facility out the past two days, until a medical records clerk could be hired. During an interview, on 3/9/20 at 1:49 p.m., the Regional Vice President of Operations indicated he had been assigned to the facility the previous week, and would be the acting Administrator until the interim Administrator began the following week. Review of a Facility Visits for Support document, provided by the Regional Vice President of Operations on 3/9/20 at 3:01 p.m., indicated the Administrator Consultant had last been at the facility on 2/18/20. The Nurse Consultant had last been at the facility on 2/5/20. There had been no other consultant visits until the start of the annual survey on 3/2/20. Review of a list of Administrators and DONs, provided by the Regional Vice President of Operations on 3/10/20 at 11:10 a.m., indicated there had been seven Administrators, not including the Regional Vice President of Operations, since October 2019. There had been four DONs since October 2019. During an interview, on 3/10/20 at 3:31 p.m., the Regional Vice President of Operations indicated a new interim Administrator would be starting the following week, with a 30 day contract, which was to be extended at 30 day increments until recruitment could be completed for an Administrator. The facility had been trying to overlap the schedules to ensure communication and training to assist with continuity. The facility had repeat deficiencies in the care areas of pressure ulcer care, medical records, and reporting of abnormal laboratory values. The facility had wide-spread deficiencies regarding the infection control program. Cross Reference F867. 3.1-13(q) |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br><br>Based on observation, interview, and record review, the facility failed to ensure resident medical records were stored in an organized manner and entered into the electronic health record to ensure accessibility for review, during random observations of the facility medical record storage area. Findings include: During a random observation, on 3/5/20 at 3:00 p.m., the facility medical records room contained, but was not limited to, the following: Three crates, with file folders labeled alphabetically, were on a table. Random observations of the papers contained in the crates indicated they were medical records dated April 2019, June 2019, and August 2019. There were stacks of papers on file cabinets, which contained, but were not limited to, laboratory results, consultation records, and PASRR records, dated from 2019 and 2020. During an interview, on 3/5/20 at 3:07 p.m., the Regional Consultant indicated the facility medical records room contained records from up to 10-11 months prior, which had not yet been scanned into the clinical records. During an interview, on 3/6/20 at 11:13 a.m., the Medical Records Consultant indicated she had begun working on scanning in the records two days prior. The records dated back to around April 2019, but the facility seemed to have been scanning in new admission paperwork as residents were admitted . The records were both closed records and open charts. The black cabinets contained records already scanned into the clinical records. Observation of the records, during the time of the interview, indicated the records contained, but were not limited to, therapy certifications and recertifications, office visits and consultations, PASRR Level 1 and 2 assessments, laboratory results, radiology reports, hospice records, and controlled substance records. The records were not sorted by resident identifiers. Review of a current facility policy, titled Medical Records - Scanning, dated 11/1/14 and provided by the interim DON on 3/9/20 at 9:14 a.m., indicated the following: .Clinical Records, whether paper-based, computer based, or scanned into electronic systems are maintained in accordance with the State and Federal Regulations and Professional Practice Standards .Clinical Records shall be readily accessible and systematically organized to facilitate retrieving and compiling information .Originals will be destroyed after the EHR Coordinator has validated the document .Originals will be destroyed per facility policy 3.1- 50(a)(1) 3.1- 50(a)(2) 3.1- 50(a)(3) 3.1- 50(a)(4) |
| F 0867<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**<br><br>Based on observation, record review, and interview, the facility failed to ensure issues were identified in which quality assessment and assurance activities were necessary as evidenced by the severity and deficiencies cited and to ensure quality assurance procedures were followed and plans of action implemented to prevent deficiencies from re-occurring. This affected 4 of 5 residents reviewed for pressure ulcers, 2 of 2 residents reviewed for abnormal laboratory values, and had the potential to affect 42 of 42 residents for infection control and environment. Findings include: Review of a current facility policy, titled Quality Assurance Committee, dated 5/23/18 and provided in the facility Survey Readiness Binder on 3/2/20, indicated the following: .Purpose: To ensure the organization has an organized quality assessment and improvement process program that includes performance measurement, performance assessment, and performance improvement .6. Quality of care will be monitored and evaluated in areas of resident care and services, including but not limited to: .Quality Measures over 75th percentile, Pressure Ulcers, Infection Control/Antibiotic Stewardship, Abuse/Resident Rights, Grievances, Environment/Life Safety .The Quality Assurance Committee shall review any survey deficiencies and ongoing audits related to these findings to monitor for any trends as indicated Review of a Quality Assurance Performance Improvement Meeting Minutes Template, included with the Quality Assurance Committee policy, indicated copies of reports and action plans were to be reviewed and attached to the minutes for, but not limited to, evaluation of pharmacy services, laboratory services, pressure injuries, infection control, grievances, abuse reporting, employee turnover, and computer based training and education. The facility's Quality Assurance Committee did not identify, develop, and implement appropriate measures to prevent deficiencies as follows: 1. Pressure Ulcers: During an interview, on 3/4/20 at 10:10 a.m., the interim DON indicated the Wound Nurse managed the facility's wounds. During an interview, on 3/10/20 at 9:40 a.m., the interim DON indicated she had been under the impression the facility Wound Nurse was certified and had been responsible for the wound and skin program. During an interview, on 3/10/20 at 3:31 p.m., the Regional Vice President of Operations/Acting Administrator indicated the QAPI team had been monitoring in-house skin issues, but no trends had been identified. There was no evidence the facility had identified, developed, or implemented an action plan to ensure the facility skin management and assessment program was being monitored for residents with pressure ulcers. The facility had previously been cited for pressure ulcer management on November 1, 2019, during a complaint investigation. Cross reference F686. 2. Infection Control: During a review of the facility infection control program, on 3/4/20 at 10:49 a.m., with the interim DON |

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| F 0867<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 5)<br>indicated she had taken over the infection control program the week before, when she had started at the facility. She was not able to speak to how the monitoring had been completed prior to her arrival at the facility. During an interview, on 3/10/20 at 3:31 p.m., the Regional Vice President of Operations/Acting Administrator indicated the QAPI team had been monitoring infection control concerns related to handwashing, but no trends had been identified. Cross Reference F880. 3. Environment: During review of the QAPI committee activities, there was no evidence provided of resident common areas in need of repairs being addressed by the committee. There was no evidence of discussion of lack of preventative maintenance being performed. Cross Reference F921. 4. Notification of abnormal laboratory results: The facility had previously been cited for notification of abnormal laboratory results on 8/16/19, during a complaint investigation. Cross Reference F773. 5. Medication storage: The facility had previously been cited for secure medication storage on 5/16/19 and 8/16/19 during a complaint investigation. Cross Reference F761. 6. Access to medical records: Cross Reference F842. The facility had previously been cited for medical records on 12/12/19 during a complaint investigation. During a review of the facility QAPI program, with the Regional Vice President of Operations/Acting Administrator on 3/10/20 at 3:31 p.m., he indicated the facility meeting minutes indicated the following topics had been reviewed, but were not limited to: late or missing medication administrations, staffing, infection control regarding hand washing, appropriate clothing, preparing meals, falsification of documentation, and in-house skin issues, but hadn't identified any trends. 3.1-52(b)(2) |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>A. Based on observation, interview, and record review, the facility failed to ensure transmission based precautions were followed and maintained during random observations of care for 1 of 1 residents requiring contact precautions (Resident 19) and failed to keep urinary catheter bag and tubing of the floor and out of the trash can 1 of 1 residents reviewed for urinary catheters (Resident 15). B. Based on observation, interview, and record review, the facility failed to maintain an infection control and surveillance program and failed to for 3 of 10 months reviewed (June, August, and November 2019) and failed to perform a risk assessment of the facility's water system to reduce the risk of Legionella infection and other water-borne illnesses. Findings include: A.1. Resident 19's clinical record was reviewed on 3/4/20 at 7:49 a.m. [DIAGNOSES REDACTED]. Current orders included, but were not limited to, contact isolation and [MEDICATION NAME] (antibiotic) 125 mg orally every other day for 60 days. A 2/18/20, admission, Minimum Data Set (MDS) assessment indicated she was cognitively intact,required extensive assistance with transfers, limited assistance with walking, extensive assistance with toileting, and limited assistance with hygiene. She was continent of urine and occasionally incontinent of bowel. The following concerns were noted throughout the survey: a. During an interview with Resident 19, who was on transmission-based precautions, on 3/2/20 at 12:59 p.m., the following was observed: the resident's bathroom contained, but was not limited to, two barrels in her shower- one contained trash and the other linens and clothing. There was a small trash can next to the toilet. There was no soap dispenser at the sink; the wall next to the sink had an area with adhesive tabs and a tear in the wall, as if a dispenser had been there and removed. The resident indicated there had not been a soap dispenser in the bathroom since her admission a few weeks prior, but her son had brought her some soap for personal use from home. There was some body wash in a dispenser in the shower, adjacent to the barrels, if needed for handwashing. The next available sink was at the D Hall nurses station. The soap dispenser at the nurses station sink was broken and not dispensing soap. During an interview, on 3/2/20 at 1:13 p.m., LPN 17 indicated she had no idea why there wasn't a soap dispenser at Resident 19's sink, but she usually washed her hands out at the nurses station after leaving the resident's room. The soap dispenser at the nurses station had stopped working that morning, due to a new soap refill not being compatible with the dispenser. During an interview, on 3/2/20 at 1:20 p.m., CNA 35 indicated the repair of soap dispensers was not the responsibility of the CNAs. She washed her hands in the resident's sink, and was not aware there was not a soap dispenser in he room. During an interview, on 3/2/20 at 1:21 p.m., CNA 21 indicated the resident needed help or guidance with toileting. Her normal procedure for entering isolation rooms was to put all the personal protective equipment (PPE) on before going in, and to take it off before leaving the room. She would wash her hands in the bathroom sink, had just used the last of her soap that morning, and had forgotten to have it refilled. She did not have a response for why there was not a soap dispenser in the room. During an interview, on 3/2/20 at 1:27 p.m., Administrator 2 indicated there should have been a soap dispenser in the resident's room. b. During a random observation, on 3/4/20 at 8:03 a.m., LPN 23 entered Resident 19's room to administer medications, after donning PPE. She removed the PPE in the resident's bathroom, walked to the door, touched the door handle, and then returned to the bathroom. She washed her hands for approximately seven seconds, went back to the door, and opened it the rest of the way with her hand on the door handle. She went to the medication cart and used the computer. On 3/4/20 at 8:13 a.m., LPN 23 removed a meal tray from Resident 19's room, and entered the hallway. She handed the tray off to CNA 35, who placed it on a cart at the nurses station. LPN 23 went to the medication cart and began prepping medications. Neither the CNA, nor the LPN, performed hand hygiene after carrying the tray. On 3/4/20 at 8:34 a.m., LPN 23 was washing her hands at the nurses station sink for 10 seconds, with minimal friction. During an interview, on 3/4/20 at 8:36 a.m., LPN 23 indicated handwashing was to be performed for maybe 15 seconds, and was to be done before and after leaving a resident room, and when hands were soiled. c. During a random observation, on 3/4/20 at 10:26 a.m., Housekeeper 7, left Resident 19's room wearing a gown and gloves. Carrying two bags of trash, she opened the lid on the trash receptacle on the housekeeping cart, and placed the bags in the receptacle. She re-entered the room, and placed a new trash bag into a trash can next to the resident's bed and in the bathroom. She returned to the housekeeping cart and removed a spray bottle of quaternary disinfectant cleaner and re-entered the resident's room. She wiped down the surfaces in the room, and entered the bathroom. The Maintenance Director approached the cart, lifted the trash lid, and disposed of some trash. He then entered an adjacent room. After leaving the bathroom, the housekeeper returned to the cart and placed the cleaning rag in a bag tied to the cart, with other soiled cleaning rags. She returned to the bathroom, carrying a cleaning swab, and then replaced the swab in a bag tied to the cart after leaving the bathroom. She removed her gloves and disposed of them in the cart trash receptacle, removed keys from her pocket and unlocked the cart. She returned to the resident's bathroom with the keys in her hand, returned to the cart carrying the bottle of spray cleaner, and replaced it in the cart. She donned a new pair of gloves, and removed a mop (with a removable cleaning pad on it), and filled it with quaternary floor cleaner. She entered the resident's bathroom, returned to the cart, and placed the pad in the bag with the rags on the cart. She removed her gloves and disposed of them in the cart trash receptacle, placed the mop back on the cart, and then took a vacuum cleaner in the room and vacuumed the floors. She returned to the cart with the vacuum cleaner, removed her gloves and gown, and placed them in the cart trash receptacle. She did not perform hand hygiene throughout the observation. During an interview, at the time of the observation, Housekeeper 7 indicated she had just started a few weeks prior. She had not received training specific to cleaning rooms for residents on transmission-based precautions. She had been trained to use a gown and gloves when entering the room, and masks were only as needed. She used the same kind of cleaner for Resident 19's room as the other rooms for basic daily cleaning. Review of a current facility policy, titled [MEDICAL CONDITION] - ([MEDICAL CONDITION]), dated 6/27/19 and provided by Nurse Consultant 9 on 3/2/20 at 2:01 p.m., indicated the following: .8. Hand washing with soap and water is needed after removal of gloves or gown prior to exiting room. Alcohol based hand rub is not effective against [MEDICAL CONDITION] spores and should not be used .Housekeeping Guidelines: .13. Disposable cloths should be used to dust and clean surfaces Review of a current facility policy, titled Hand Hygiene/Handwashing, dated 1/10/18 and provided by Nurse Consultant 9 on 3/2/20 at 2:01 p.m., indicated the following: .After known or suspected exposure to [MEDICAL CONDITION] if you facility is experiencing an outbreak or higher endemic rates .Examples of When to Perform Hand Hygiene .After glove removal .Procedure for Washing Hands with Soap and Water .Vigorously rub hands together to create friction for at least 15-20 seconds Review of a current facility policy, titled Isolation Room Cleaning - Housekeeping, dated 1/19/18 and provided by the DON on 3/4/20 at 3:22 p.m., indicated the following: .NOTE: Use germicidal solution containing 1 ml or 5-6% sodium hypochlorite solution (household bleach) and 9 ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite Review of a current facility policy, titled Infection Precaution Guidelines, dated 1/10/18 and provided by the DON on 3/4/20 at 3:22 p.m., indicated the following: .Handwashing is the single most important precaution to prevent the transmission of infection from one person to another .All personal protective equipment (disposable isolation gowns, mask, gloves, etc.) should be used once and discarded in wither the trash or used linen receptacle before you leave the room A.2. During an interview, on 3/3/20 at 8:28 a.m., Resident 15's catheter bag was in the trashcan next to her low bed, with trash inside the container. She indicated she could transfer with some supervision, but staff managed the catheter. On 3/4/20 at 8:42 a.m., she was sitting up in bed, with her catheter tubing on the floor and her drainage bag in a trash can at bedside. The trash can contained |

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| | 155799 | A. BUILDING _____ B. WING _____ | 03/10/2020 |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 6)<br>trash in it. On 3/4/20 at 11:31 a.m., she was in the main dining room for lunch. Her catheter bag was hanging under her wheelchair, and into the spokes of the left wheel. On 3/9/20 at 11:08 a.m., she was seated in her wheelchair in the main dining room for lunch. Her catheter tubing was laying on the floor, with her right foot over top of it. 3/9/20 1:48 p.m. in activity room, catheter tubing on floor, resident propelling self into room, pulling self through doorway with hands.<br>Resident 15's clinical record was reviewed on 3/4/20 at 1:55 p.m. [DIAGNOSES REDACTED]. Current orders included, but were not limited to: change suprapubic catheter every 3 weeks, 20 French, 10 milliliter balloon to gravity drainage. She had a current, 5/3/19, care plan problem of history of urinary tract infection. Interventions included, but were not limited to, monitor use of catheter. She had a current, 5/3/19, care plan problem of a suprapubic catheter. Interventions included, but were not limited to, position catheter bag and tubing below the level of the bladder and away from the entrance room door.<br>During an interview, on 3/9/20 at 11:10 a.m., LPN 28 indicated the catheter tubing probably should not be on the floor, but the resident preferred the tubing down her pant leg. Review of a current facility policy, titled Urinary Catheter Care, dated 2/14/19 and provided by the Regional Vice President of Operations/Acting Administrator indicated the following: .7. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly . B.1. During a review of the facility infection control program, on 3/4/20 at 10:49 a.m., with the interim DON indicated she had taken over the infection control program the week before, when she had started at the facility. She was not able to speak to how the monitoring had been completed prior to her arrival at the facility. Review of the facility tracking binder contained, but was not limited to, the following: a. June 2019 Monthly Infection Log indicated eight infections, from 6/1/19 through 6/7/19. The Infection Control Monthly Trend Summary indicated there had been 15 facility acquired infections and eight community acquired infections. Weekly reports were ran for, but not limited to, anti-infectives, eye drops, and ear drops. There were no trends or action plans indicated. b. There was no surveillance competed for August 2019. c. November 2019 Monthly Infection Log indicated 12 logged infections, of which 11 were skin infections. A report was ran on 12/5/19 for November 2019, for current residents only, who had been prescribed anti-infectives. The Infection Control Monthly Trend Summary was not completed, nor were trends or action plans identified. d. Review of a 12/4/19 fax sent to Indiana State Department of Health, observed during a review of facility reportable incidents, indicated there had been an outbreak of nausea, vomiting, and diarrhea among 17 residents and three staff members, from 11/23/19 through 11/24/19, with the exception of one staff member, whose symptoms began on 11/18/19. The gastrointestinal outbreak was not contained or identified in the facility infection control surveillance program. Review of a current facility policy, titled Infection Prevention and Control Program, dated 11/28/17 and provided by the interim DON on 3/4/20 at 3:22 p.m., indicated the following: .3. The designated Infection Control employee and Quality Assurance Committee is responsible for monitoring the effectiveness of the program and continually improving outcomes .6. The program provides for the recording of each suspected infection and surveillance activities as they relate to individual resident infections. A log is maintained of suspected and actual infections on a day-to-day basis .20. Trends related to infections and/or use of antibiotics, new measures implemented, and outcomes will be communicated to the appropriate facility staff. Review of a current facility policy, titled Infection Surveillance, Tracking, and QA Reporting, dated 2/14/18 and provided by the DON on 3/4/20 at 3:22 p.m., indicated the following: .Infection Tracking includes, but is not limited to: Completing Infection Tracking Log for all residents with an infection and/or treated with antibiotics. Review documentation of clinical signs and symptoms .Monitor for trends by unit/location, clusters of same infection types/organisms, outbreaks, employee illnesses. Track resident and staff outbreaks and complete outbreak line-listing report/investigation. 2. During an interview, on 3/9/20 at 11:43 a.m., the Maintenance Director indicated he did not have an assessment of the building's water management program, as he had not been there long enough to initiate one. Review of a current facility policy, titled Water Management Program for Prevention of Legionella Growth, dated 7/9/19 and provided by the Maintenance Director on 3/9/20 at 11:43 a.m., indicated the following: .Legionella can become a health problem in building water systems .Common issues that contribute to water stagnation include renovations that lead to 'dead legs' and reduced building occupancy .Preventative maintenance will be performed as applicable: Hot water temperatures will be obtained at the domestic hot water boiler and at the mixing valve at least 5 times per week. Eye wash stations will be inspected and flushed weekly. Ice machines will be inspected and cleaned internally at least monthly and as needed for leakages or contamination . 3.1-18(a) 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C) 3.1-18(b)(3) |
| F 0881<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Implement a program that monitors antibiotic use.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to ensure a resident did not receive an antibiotic without indication (Resident 14). Findings include: Resident 14's clinical record was reviewed on 3/4/20 at 12:05 p.m. [DIAGNOSES REDACTED]. Medications included, but were not limited to, Bactrim (antibiotic) DS (double strength) 800-160 mg (milligram) for bacterial infection related to urinary tract infection, site not specified for seven days with a start date of 2/28/20. Physician orders [REDACTED]. Collect UA C & S (Culture and Sensivity) 2/22/20 due to altered mental. Collect UA C & S 2/4/20 per hospice due to concentrated urine, altered mental. A quarterly MDS (Minimum Data Set) dated 12/31/19, indicated she was moderately cognitively impaired. She required extensive assistance with toileting. She was always incontinent of bladder. She had a focus care plan, revised on 11/13/19, for risk for bladder incontinence. Interventions included, but were not limited to, clean peri-area with each incontinence episode, monitor/document for signs and symptoms of UTI (Urinary Tract Infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. Nurses notes indicated the following: a. On 2/4/20 at 12:13 p.m. the Hospice RN was in to see the resident. There was a new order to collect UA C&S due to concentrated urine and due to guest having more confusion. Hospice NP (Nurse Practitioner) was to fax script to pharmacy. b. On 2/6/20 at 6:02 a.m. since the change in condition, the symptoms have remained the same. No behaviors noted. UA shows no growth at two days. c. On 2/8/20 at 9:20 a.m. the lab results were faxed to the NP. There were no new orders at this time. d. On 2/22/20 at 10:14 a.m. the resident had been yelling out, hallucinating and seemed very drowsy. Hospice was notified and they were to collect a UA C&S. e. On 2/23/20 at 3:55 p.m. multiple attempts were made over the weekend to obtain a urine sample via straight cath. Each were unsuccessful. NP aware. f. On 2/28/20 at 3:52 p.m. a new order was received for Bactrim DS for seven days. One by mouth every 12 hours. [DIAGNOSES REDACTED]. Residents were not supposed to be on an ATB until UA had been completed and sent for culture then they would treat. They would refer to the McGeer's criteria. She indicated she educated the Nurse Practitioner on Monday 2/24/20 about needing to meet the criteria for antibiotics. On 3/04/20 at 3:44 p.m. the Interim DON indicated the labs that she was able to find was labs from the beginning of February and the antibiotic the resident was receiving did not meet criteria. |
| F 0921<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to maintain the resident common areas to ensure the the carpeting, doors, and walls were in good condition and the facility failed to maintain water temperatures at a safe and comfortable temperature for 2 of 2 nursing units (D and E Halls). Findings include: 1. During an initial tour of the facility, on 3/2/20 at 9:20 a.m., a softball-sized hole was observed in the ceiling of a small alcove on E Hall, near room [ROOM NUMBER]. The wall near the E hall nurses station had a large, linear scratch, with the paint removed to the area. The carpet throughout the D Hall had ripples and bubbles in it, where it had raised from the floor, with large, dark stains present near the nurses station, and leading to area near the dining room. A large scratch ran the width of the lower part of the D Hall Housekeeping closet door. Large scratches were observed along the width of the Spa entry door. The healthcare dining room had various scratched areas to the walls. During an interview, on 3/4/20 at 1:39 p.m., Residents 1 and 18 indicated the carpet on D Hall had been in poor repair for awhile, and they had seen a lot of people get tripped up on them. They indicated to look down the hallway and see all of the bumps in the carpet. During an interview, on 3/10/20 at 1:08 p.m., the Maintenance Director indicated he had begun cataloging needed repairs for the resident rooms, but had not yet begun the common areas. 2a. During an interview, on 3/3/20 at 8:25 a.m., Resident 15 indicated her hot water took awhile to get hot, but then became scalding hot. The water temperature measured 138 degrees Fahrenheit (F). b. An observation of the hot water in room E 102, on 3/3/20 at 8:35 a.m., indicated the water was slow to heat, then measured 139 |

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| F 0921<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 7)<br>degrees F. The water was too hot to hold a hand under. c. During an observation of the hot water in room E102, on 3/3/20 at 8:51 a.m., the Maintenance Director indicated he measured the water temperature at 130 degrees F. He indicated he had not received any complaints about the water temperature since he had started at the facility. He had not yet begun monitoring the water temperatures routinely. d. During an observation of the hot water in room E126, on 3/3/20 at 8:54 a.m., the Maintenance Director indicated the temperature varied from 122- 124 degrees F, although the water was too hot to hold a hand under. e. During an observation of the hot water in room D101, on 3/3/20 at 8:58 a.m., the Maintenance Director indicated the temperature varied from 122- 124 degrees F, although the water was too hot to hold a hand under. f. During an observation of the hot water in room D123, on 3/3/20 at 9:02 a.m., the Maintenance Director indicated the temperature was 122 degrees F, although the water was too hot to hold a hand under. During an interview, on 3/3/20 at 9:12 a.m., CNA 21 indicated the water got really hot every now and then. During an interview, on 3/3/20 at 9:13 a.m., CNA 5 indicated she was not aware of any residents having been injured from the hot water. The water got really hot. During an interview, on 3/3/20 at 9:40 a.m., the Maintenance Director indicated he could not locate any logs since November 2019 for water temperature checks. Review of the Maintenance Log indicated water temperatures should be between 105-120 degrees F, and checked daily. 3.1-19(f)(5) 3.1-19(r)(1) 3.1-19(r)(2) |