

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

PRINTED: 08/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525625	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER LAKELAND HEALTH CARE CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1922 CTY RD NN ELKHORN, WI 53121		
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F 000	INITIAL COMMENTS Surveyor: 32769 This was a recertification survey conducted at Lakeland Health Care Center from 07/11/16 - 07/14/16. # Federal citations issued: 13 The most serious citations are F 241, F 314, F 315, F 441 and F 498 cited at a scope/severity level of E (potential for harm / pattern). Census: 120 Sample size: 24 Supplemental sample size: 5 Survey coordinator: #32769	F 000			
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing	F 156			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bernadette Jamiszewski

TITLE

Administrator

(X6) DATE

8/6/16

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 156	<p>Continued From page 1</p> <p>facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and</p>	F 156		

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F 156	<p>Continued From page 2</p> <p>advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 14108</p> <p>Based on staff interview and record review, the facility did not provide 1 (Resident 28) of 1 residents with the appropriate written notice of potential liability for payment for his non-covered stay when his Medicare Part A covered services were terminated by the facility for coverage reasons, and he remained at the facility after 6/9/16.</p> <p>Findings include:</p> <p>On 7/13/16, Surveyor 14108 reviewed the Medicare Part A notices provided by the facility.</p>	F 156		

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F 156	Continued From page 3 Resident 28's last day covered by Medicare Part A was 6/22/16. The facility provided Resident 28 with the Notice of Medicare Provider Non-Coverage (CMS (Centers for Medicare and Medicaid)-10123). The facility did not provide Resident 28 with written notice of potential financial liability for his non-covered stay, including the estimated cost per day. The CMS-10123 notice informs the resident that they have a right to request an immediate, independent review (appeal), while their services continue. CMS has directed skilled nursing facilities to use the ABN (Advanced Beneficiary Notice) CMS-10055 form or one of the five uniform denial letters posted on their website when Medicare Part A covered services are terminated for coverage reasons and the resident remains at the facility. When a resident's Medicare Part A covered services are terminated for coverage reasons by the facility, the resident has the right to ask the facility to submit the claim or bill Medicare if they disagree with the facility's decision. The resident must continue the covered services and be made aware of the potential estimated costs. During this time, the facility may not bill the resident for any Medicare Part A covered services. Once Medicare reaches a decision that denies payment, then the resident will be held financially liable for the identified services. On 7/13/16 at 4:15 p.m., Surveyor 14108 interviewed RN (Registered Nurse)-U regarding the Medicare notices provided to residents when they are terminated off Medicare Part A services	F 156		

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F 156	<p>Continued From page 4</p> <p>for coverage reasons. RN-U verified she did not add the daily rate to the CMS-10055 form for Resident 28, but should have. RN-U explained she was new to the position and had recently contacted the facility's consultant regarding the CMS-10055 and received a copy of the correct way to complete a CMS-10055 form approximately on 6/9/16. The copy included the daily rate of pay. During the interview, RN-U verified she missed adding the daily rate of pay on Resident 28's written CMS-10055 form.</p> <p>On 7/14/16 at 7:17 a.m., Surveyor 14108 interviewed NHA (Nursing Home Administrator)-A regarding Medicare A termination of services. NHA-A indicated RN-U hadn't provided Medicare Notices before and did not receive detailed training prior to being responsible to issue the Medicare Notices to residents and their legal representatives. NHA-A commented the facility has a consultant available and training was scheduled for RN-U on 8/2016.</p>	F 156		
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18815</p> <p>Based on observations, interviews and record review, the facility did not ensure 1 (Resident 27) of 22 sampled and supplemental sampled</p>	F 176		

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F 176	<p>Continued From page 5</p> <p>residents reviewed for self-administration of medications was assessed to be safe to self-administer medications.</p> <p>Resident 27 was observed with a plastic cup of cholestyramine (medicine used to lower cholesterol levels) mixed with water, unsupervised in the dining room. The facility had not determined if the resident was safe to self-administer medications prior Resident 27 self administering the cholestyramine.</p> <p>Findings include:</p> <p>According to the facility's "Self-Administration of Medications by Residents" policy and procedure with a revision date of October 2006, residents at the facility have the right to self-administer their medication per HFS (Health and Family Services) 132.60 and HFS 132.65 with a physician's order...An interdisciplinary team discussion relating to the appropriateness of self-administration of medications for that specific resident...The resident's cognitive, physical and visual as well as potential safety issues are evaluated prior to the interdisciplinary team documenting a decision. If the resident is deemed safe to self-administer medications, the information will be entered on a self-administration of medications care plan and obtain a physician's order that indicates the resident may self-administer medications.</p> <p>On 7/11/16 at 5:24 p.m., Surveyor 18815 observed RN (Registered Nurse)-Q leave cholestyramine mixed with water in a cup at the dining room table with Resident 27. (WebMD indicates not to sip the mixture or hold it in your mouth for a long time, as this can cause tooth</p>	F 176		

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F 176	<p>Continued From page 6</p> <p>problems such as discoloration, erosion of enamel, or decay.) The only staff present in the dining room at that time were CNAs (Certified Nursing Assistants).</p> <p>According to Resident 27's 30-day scheduled MDS (Minimum Data Set) assessment dated 6/20/16, Resident 27's cognition is severely impaired. Resident 27's medical record did not include documentation that the resident had been assessed to safely self-administer medications.</p> <p>On 7/11/16 at 6:03 p.m., Surveyor 18815 interviewed RN-Q, who verified the cholestyramine mixed with water in a cup was left for the resident to drink in the dining room without a nurse present. RN-Q stated "I don't have time to watch" the resident drink the cholestyramine. RN-Q then indicated it was "unknown" if the resident had been assessed to self-administer medications.</p> <p>On 7/12/16 at 7:31 a.m., Surveyor 18815 interviewed DON (Director of Nursing)-B regarding Resident 27 safely self administering the cholestyramine. DON-B verified Resident 27 did not have a self-administration assessment completed or care plan in place to self-administer medications.</p>	F 176			
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment</p>	F 225			

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F 225	<p>Continued From page 7</p> <p>of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36402</p> <p>Based on resident and staff interviews and record review, the facility did not ensure all alleged violations involving potential abuse were thoroughly investigated and reported to the State</p>	F 225		

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F 225	<p>Continued From page 8</p> <p>Survey and Certification Agency for 2 (Resident 2 and Resident 10) of 24 sampled residents reviewed.</p> <p>Resident 2 reported an allegation of caregiver misconduct to the facility staff. The facility did not conduct a thorough investigation and did not report the allegation of abuse to the State Survey and Certification Agency.</p> <p>Resident 29 was found with hands under Resident 10's shirt, fondling her breasts. Although the facility investigated this allegation of abuse, they did not complete a thorough investigation to include interviewing additional residents or staff and did not report the allegation to the State Survey and Certification Agency.</p> <p>Findings include:</p> <p>The facility's "Resident Abuse Prohibition" Policy last revised 01/2016 indicates: Purpose- ...will promptly investigate an allegation of abuse, neglect, including injuries of unknown source or misappropriation of resident property and will report investigative results to the appropriate agency in accordance with State and Federal laws and regulation.</p> <p>Policy and procedure-</p> <p>1. Any resident, family member, staff or concerned party who believes mistreatment, abuse, neglect, including injuries of unknown source or misappropriation of resident property has occurred shall report such actions immediately to a Unit Nurse Supervisor, Nurse Manager, Charge Nurse, Social Worker, or administration without fear of retribution.</p> <p>4. Allegations of abuse, neglect, including injuries of unknown source or misappropriation of</p>	F 225		

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F 225	<p>Continued From page 9</p> <p>resident property shall be reported immediately to the Nursing Home Administrator or designee. Immediately means as soon as possible, but not to exceed twelve hours after the discovery of the incident.</p> <p>7. Administration will determine the immediate action required to protect the resident pending investigation of the allegation.</p> <p>DQA (Division of Quality Assurance) Memo 10-008, dated 5/10/08, states: "Per CMS (Centers for Medicare & Medicaid Services) direction, all nursing homes must immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the facility administrator and to the DQA."</p> <p>Examples:</p> <p>1. On 7/11/16, Surveyor 36402 reviewed Resident 2's medical record. The resident's most recent MDS (Minimum Data Set) assessment dated 6/17/16, documented the resident's BIMS (Brief Interview of Mental Status) score of 15, indicating the resident is cognitively intact with no indicators of delirium present.</p> <p>On 7/12/16 at 7:56 a.m., during an interview with Surveyor 36402, Resident 2 commented approximately one month ago, a staff member was "rough." The resident further stated the incident had immediately been reported to the nurse working that shift and the resident has not seen the accused staff member since.</p> <p>On 7/12/16 at 11:05 a.m., Surveyor 36402 interviewed NHA (Nursing Home Administrator)-A</p>	F 225		

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F 225	<p>Continued From page 10</p> <p>regarding Resident 2's comments of a staff member being "rough." NHA-A stated, "If the resident reported something, it would have been investigated. I will check in the soft file and get it to you."</p> <p>On 7/12/16, NHA-A provided Surveyor 36402 with a typed document dated 6/21/16 and signed by NM (Nurse Manager)-G. The document regarding a complaint by Resident 2 indicates, "Within the first four days of admission, the night shift was very short with her..."</p> <p>On 7/13/16 at 9:06 a.m., Surveyor 36402 interviewed NM-G regarding Resident 2's allegation of caregiver misconduct. NM-G stated Resident 2 had complained during a care conference held on 6/21/16 and that was the first time she heard about Resident 2's concern regarding care received. NM-G commented "I think it was just a misunderstanding." NM-G indicated verbal interviews were conducted with CNAs, without documenting them. In addition, NM-G stated "I report everything that is reported to me to the administrator and DON (Director of Nursing). I reported this."</p> <p>On 7/13/16 at 7:30 a.m., Surveyor 36402 conducted a follow-up interview with Resident 2 regarding the resident's report of "rough" treatment by the night shift staff. Resident 2 stated the staff member involved was CNA (Certified Nursing Assistant)-P. Resident 2 stated "Usually they always use two people (when providing cares), but CNA-P did it alone and it was very rough. During cares, I was scared and then I felt angry because I didn't think I should be treated like that." Resident 2 stated the concerns were immediately reported to the nurse on duty</p>	F 225			

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F 225	<p>Continued From page 11</p> <p>and the nurse (later identified as RNUS (Registered Nurse Unit Supervisor)-F) came to the resident's room to discuss them. Resident 2 stated the nurse stated "I think you just misunderstood (CNA-P)." Resident 2 concluded the interview by stating, "To me, it was a really traumatic experience and I didn't feel I deserved that."</p> <p>On 7/13/16 at 9:27 a.m., Surveyor 36402 interviewed NHA-A regarding the alleged misconduct involving CNA-P with Resident 2. NHA-A stated "The complaint was from care conference notes, not a formal complaint." NHA-A commented because this was not a formal complaint, she was not notified of it. NHA-A further stated "This incident is concerning, I'm not sure why they didn't do a full investigation or report it." NHA-A verified that a thorough investigation had not been completed and the allegation had not been reported to the State Agency.</p> <p>On 7/13/16 at 10:15 a.m., Surveyor 36402 conducted a follow-up interview with NHA-A. During this interview, NHA-A indicated RNUS-F had more knowledge of the alleged incident involving Resident 2 and CNA-P. NHA-A provided the surveyor with copies of "Witness Statements" signed by CNA-P that was dated 6/12/16 and signed by RNUS-F that was dated 6/11/16. NHA-A stated RNUS-F started an investigation form and asked CNA-P to complete one. NHA-A commented "Normally we would start the full investigation on paper and the social worker would get involved. The social worker could have followed up a little more for this one."</p> <p>The witness statement signed by RNUS-F on</p>	F 225		

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F 225	<p>Continued From page 12</p> <p>6/11/16, documented RNUS-F answered Resident 2's call light. The resident was crying and asked to speak to the nurse. Resident 2 stated "The other lady was mean, she was so mad ... All the girls are so nice, but not her ... she was mad ... informed (Resident 2) that the nurse or opposite aide could help (Resident 2) instead."</p> <p>On 7/13/16 at 12:35 p.m., Surveyor 36402 interviewed RNUS-F regarding Resident 2's allegation of mistreatment by CNA-P. RNUS-F indicated the alleged incident occurred during the night shift on 6/11/16 into 6/12/16. RNUS-F stated during that shift, CNA-P reported her Resident 2 seemed upset. RNUS-F stated she went into Resident 2's room at that time to investigate the situation. RNUS-F stated Resident 2 commented "That other lady here wasn't very nice ... It seemed like Resident 2 thought the CNA didn't want to take care of her. RNUS-F indicated based on Resident 2's statements, CNA-P was not allowed to provide cares for Resident 2 the rest of that shift. RNUS-F stated she notified NM-G by phone during the night shift of Resident 2's allegation and it was decided CNA-P should not go back in Resident 2's room that night. RNUS-F indicated NM-G was notified right away, "Things like that have to be reported immediately." In addition, RNUS-F indicated the facility policy indicates the charge nurse on duty is to initiate an investigation immediately when something is reported, it should be reported to administration, and then they conduct a thorough investigation.</p> <p>Surveyor: 18815 2. On 7/14/16, Surveyor 18815 reviewed Resident 10's social service progress notes. The progress notes documented Resident 10's</p>	F 225			

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F 225	Continued From page 13 breasts had been fondled by Resident 29 the night of 11/10/15. Resident 29's care plan had been updated and interventions were put in place to avoid future contact between Resident 10 and Resident 29. Currently Resident 29 lives on B wing and Resident 10 lives on A wing. Resident 10's and Resident 29's medical records included Nursing notes that documented the incident Resident 10's breasts being fondled by Resident 29. No further incidents were noted in the medical records. The documentation did not include interviews of additional residents and staff or that the incident had been reported to the State Survey and Certification Agency. On 7/14/16 at 12:16 p.m., surveyor #18815 interviewed NHA-A regarding the alleged abuse incident. NHA-A indicated the former DON (Director of Nursing) did not report the allegation of abuse to her, regarding Resident 10 and Resident 29. NHA-A verified a thorough investigation should have been completed regarding the alleged incident of abuse and the incident should have been reported to the State Survey and Certification Agency.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 18815	F 241		

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F 241	<p>Continued From page 14</p> <p>Based on observation, staff and family interviews and record review, the facility did not promote care provided to residents in an environment to maintained dignity and respect for 4 (Resident 20, Resident 8, Resident 19, and Resident 13) of 28 sampled and supplemental sampled residents.</p> <p>Resident 20 and Resident 8 appeared with facial hair throughout the survey.</p> <p>The facility did not ensure Resident 19's personal privacy during cares, as the resident's genital area was unnecessarily exposed during a care observation.</p> <p>Resident 13 was left to wear a soiled incontinent brief that which showed evidence of moisture without being checked, changed or cleansed, until the colored lines on the exterior of the brief indicated a greater degree of wetness. Resident 13 was alert, but unable to make needs known or request assistance when wet, had odors or discomfort.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident 20's medical record included a quarterly MDS (Minimum Data Set) assessment dated 3/31/16, documenting the resident's cognition was severely impaired and the resident required extensive assistance from staff for personal hygiene. <p>On 7/11/16 at approximately 9:30 a.m., during the initial tour of the facility, Surveyor 18815 observed Resident 20 with long, thick chin hairs.</p> <p>On 7/12/16 at 11:00 a.m. and 7/13/16 at 9:27 a.m., Surveyor 18815 observed Resident 20 with</p>	F 241		

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F 241	<p>Continued From page 15 long, thick chin hairs.</p> <p>On 7/13/16 at 6:41 p.m., Surveyor 18815 observed Resident 20 with long, thick chin hairs. At that time, Surveyor 18815 interviewed FM (family member)-II regarding the resident's chin hairs. FM-II verified Resident 20 had long, thick chin hairs and commented the chin hair would "bother" the resident if the resident knew how long the chin hairs were, because the resident was the "Mary Kay (representative) for 50 years."</p> <p>On 7/14/16 at 11:06 a.m., Surveyor 18815 observed Resident 20 with long, thick chin hairs while ambulating with CNA (Certified Nursing Assisitant)-KK. Surveyor 18815 interviewed CNA-KK at that time regarding the Resident 20's long, thick chin hairs. CNA-KK stated staff "do not offer to shave the long chin hairs" because Resident 20 "would grab and not let go." CNA-KK then ambulated Resident 20 to a private room and shaved Resident 20's chin hair. When completed, CNA-KK informed the surveyor Resident 20 was "very cooperative" with shaving.</p> <p>2. Resident 8's medical record included a quarterly MDS assessment dated 5/27/16, documenting the resident's cognition was severely impaired and the resident was dependent on staff for personal hygiene.</p> <p>On 7/11/16 at approximately 9:30 a.m., during the initial tour of the facility, Surveyor 18815 observed Resident 8 with long, thick chin hairs.</p> <p>On 7/12/16 at 11:02 a.m. and 7/13/16 at 9:15 a.m., Surveyor 18815 observed Resident 8 with long, thick chin hairs.</p>	F 241			

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F 241	<p>Continued From page 16</p> <p>On 7/14/16 at 11:10 a.m., Surveyor 18815 interviewed CNA-HH regarding the observation of Resident 8 with long, thick chin hairs and if resident 8 was offered to have the long, thick chin hairs shaved. CNA-HH verified the resident is asked and "sometimes can shave long chin hairs." CNA-HH stated the resident was not asked to shave this morning during cares. CNA-HH entered Resident 8's room and asked the resident if she would like the long, thick chin hairs shaved. The resident responded yes and CNA-HH shaved Resident 8's long, thick chin hairs without difficulty.</p> <p>3. Resident 19's medical record included a quarterly MDS assessment dated 6/16/16, documenting the resident's cognition was severely impaired and the resident required extensive assistance from staff for dressing and personal hygiene.</p> <p>On 7/13/16 at 1:49 p.m., Surveyor 18815 observed CNA-H and CNA Student-LL provide incontinence cares for Resident 19. At 2:08 p.m., CNA-H left Resident 19's room to get assistance with providing cares. Resident 19's genital area was left exposed to Surveyor 18815 and CNA Student LL for three minutes while CNA-H was out of the room. CNA-H and CNA-KK returned to the resident's room at 2:11 p.m., and changed the bed sheets, continuing to have Resident 19's genital area exposed. CNA-H and CNA-KK did not place a brief and/or clothing on Resident 8 until after the bed sheets were changed and incontinence cares were completed.</p> <p>On 7/13/16 at 2:25 p.m., Surveyor 18815 interviewed CNA-H regarding Resident 19's genital area exposed when she left the resident's</p>	F 241		

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F 241	<p>Continued From page 17</p> <p>room and while changing sheets. CNA-H verified the above observations and indicated the resident should not have been be left uncovered with genitals exposed.</p> <p>On 7/14/16 at approximately 1:00 p.m., Surveyor 18815 interviewed FM-JJ regarding Resident 19's genital area exposed during cares. FM-JJ indicated Resident 19 would have been bothered, as the resident was a private person and would not have wanted the genital area exposed during bed making.</p> <p>Surveyor: 32769</p> <p>4. 1. On 7/13/16 at 7:20 p.m., Surveyor 32769 observed CNA-EE check Resident 13 for incontinence. The resident was wearing an incontinent brief with a moisture indicator, which will turn blue to indicate moisture within it. CNA-EE confirmed the indicator had less than 10% blue coloring and stated usually the brief would not be changed until it was "more wet" and nearly 100% blue. CNA-EE verified the darkened area indicated moisture collection inside the brief. The indicator visible from the exterior of the incontinent brief was observed to be greater than 10 inches in diameter. CNA-EE then removed the brief and an odor of urine was detected and the presence of moisture was verified on an area of the brief that had been in contact with the resident's skin.</p> <p>On 7/13/16 at 7:55 p.m., Surveyor 32769 interviewed CNA-FF regarding Resident 13. CNA-FF indicated Resident 13 had been sitting in the wheelchair from 5:00 p.m. until 7:20 p.m., and prior to 5:00 p.m., had been napping. CNA-FF verified the resident's brief had not been changed when transferred to the wheelchair, as the lines</p>	F 241		

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F 241	Continued From page 18 on the resident's brief were yellow, not blue. On 7/14/16 at 9:55 a.m., Surveyor 32769 interviewed DON (Director of Nursing)-B regarding Resident 13. DON-B confirmed staff should be changing incontinent briefs when they are soiled and not wait for them to be "more wet," or when the moisture indicator line turns 100% blue. On 7/14/16, at 11:50 a.m., Surveyor 32769 interviewed FM-NN regarding Resident 13. FM-NN indicated Resident 13 was always concerned with being clean and tidy in appearance. FM-NN stated Resident 13 "wouldn't want to wear soiled clothes."	F 241		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 285		

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F 285	<p>Continued From page 19</p> <p>services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36402</p> <p>Based on record review and staff interviews, the facility did not ensure that the PASRR (Preadmission Screening and Resident Review) level II screen had been completed for 1 (Resident 1) of 24 sampled residents reviewed.</p> <p>Resident 1's medical record did not include a PASRR level II screen, based on the requirements of the Level I screen that had been completed.</p>	F 285		

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F 285	<p>Continued From page 20</p> <p>Findings include:</p> <p>The facility's PASRR Screen Policy last revised 01/2016, indicates if a resident is admitted for short term rehabilitation but stays long term (in the facility for more than 30 days), a PASRR screen is required to be completed. The Admissions Coordinator/designee ensures the PASRR form is completed and submits the form to BCS (Behavioral Consulting Services) to review if the resident requires specialized services.</p> <p>On 7/11/16, Surveyor 36402 reviewed Resident 1's medical record and it indicated Resident 1 was admitted to the facility 7/3/14 with diagnoses to include Major Depressive Disorder. The record included a Level I PASRR which was completed by the facility on 7/2/14. The form had the box checked that indicated Resident 1 was suspected of having a serious mental illness. In Section A, the boxes were checked indicating Resident 1 had a current diagnosis of a major mental disorder and was receiving psychotropic medications to treat the symptoms or behaviors of a major mental disorder. No exemptions were indicated on the Level 1 PASRR. Section D of the form instructed the facility staff to refer the resident for a level II screen, to determine whether or not the resident needs nursing home placement and if the resident requires specialized services.</p> <p>Progress notes indicate Resident 1 expressed suicidal thoughts to facility staff within the first week of the resident's original admission, requiring "suicide precautions" to be initiated.</p> <p>Resident 1's medical record did not include</p>	F 285		

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F 285	Continued From page 21 documentation that the required Level II PASRR screen had been completed. On 7/12/16 at 2:50 p.m., Surveyor 36402 interviewed NHA (Nursing Home Administrator)-A and SW (Social Worker)-D regarding Resident 1's PASRR screen. NHA-A and SW-D verified a Level II PASRR had not been completed at the time of admission. SW-D indicated she submitted a Level II PASRR to BCS for Resident 1 on 7/12/16, after the form was requested by the survey team. NHA-A verified Resident 1 had diagnoses that included Major Depression at the time of admission, and a Level II PASRR should have been submitted to BCS at that time, Resident 1's admission to the facility.	F 285			
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 14108 Based on observation, staff interviews and record review, the facility did not ensure that 7 (Residents 15, Resident 16, Resident 5, Resident 13, Resident 25, Resident 14, Resident 8, 9, 19,	F 314			

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F 314	<p>Continued From page 22 and 25) of 23 sampled and supplement sampled residents reviewed for pressure injuries and pressure injury risk received necessary services to prevent pressure injuries from developing.</p> <p>Resident 15 has a healing unstageable pressure injury to the left heel and is at high risk for for the development of pressure injuries. Staff did not place the Prevalon boot on Resident 15's left foot to provide pressure relief when seated in the Broda chair. In addition, Resident 15's left heel pressure injury was in direct contact with the metal bar of the foot rest of the Broda chair and CNA-K did not apply barrier cream following an incontinence episode per a physician's order to prevent skin breakdown.</p> <p>Resident 16 has a healing unstageable pressure ulcer to the right heel and is at high risk for the development of pressure injuries. Resident 16 was observed with heels in full contact with her mattress.</p> <p>Resident 5 has a stage 2 pressure ulcer on right upper buttocks and is at risk for developing pressure injuries. Resident 5 was observed more than 2 1/2 hours and 5 hours sitting in a Broda chair without being repositioned.</p> <p>Resident 13 was at risk for pressure injuries and had a chronic vascular wound. Multiple observations were made of the resident's heels in direct contact with the mattress and with lift sling and grippy socks causing redness and indentations to the resident's skin.</p> <p>Resident 25 was at risk for pressure injuries. Multiple observations were made of the resident's heels in contact with a pillow and not free-floated.</p>	F 314		

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F 314	<p>Continued From page 23</p> <p>Resident 14's skin was fragile where a heel wound had recently healed. Staff did not provide Prevalon boots and a heel lift cushion to the resident when in bed and could not provide evidence that the resident refused the pressure relieving devices.</p> <p>Resident 8 was at high risk for developing pressure injury. Observations were made of Resident 8's heels not free floating and the resident having a full body mesh sling under the resident while up in a chair.</p> <p>Resident 9's plan of care indicated the resident was at risk for skin breakdown/impaired skin integrity related to surgery and limited mobility. The resident was observed with the Prevalon boot on the left foot with heel not in cut out of boot and placed directly on the heel riser rather than free floating. Additionally, the right heel was placed directly on the heel riser rather than free floating.</p> <p>Resident 19's current plan of care indicated the resident had impaired skin integrity related to history of blister to right heel. The resident was observed sitting in the wheelchair on a mesh sling which was placed over the pressure redistribution cushion that caused red marks on the back of the left and right legs near the thigh area that were the size of the binding on the mesh sling and the resident had a large red mark the size of the binding on the left buttock, and had a red mark the size of the binding on the right buttock.</p> <p>Findings include:</p> <p>The Quick Reference Guide entitled "Pressure</p>	F 314		

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F 314	<p>Continued From page 24</p> <p>Ulcer Prevention", published by the National Pressure Ulcer Advisory Panel in 2009 ... Reposition the individual in such a way that pressure is relieved or redistributed. High pressures over bony prominence's, for a short period of time, and low pressures over boney prominence's, for along period of time, are equally damaging. In order to lessen the individual's risk of pressure ulcer development, it is important to reduce the time and the amount of pressure he/she is exposed to. The second edition published by NPUAP in 2014, entitled "Prevention and Treatment of Pressure Ulcers: Quick Reference Guide":</p> <p>~ indicated the reduction of pressure and shear at the heel is an important point of interest in clinical practice. The posterior prominence of the heel sustains intense pressure, even when a pressure redistribution surface is used. Ensure that the heels are free of the surface of the bed. Ideally, heels should be free of all pressure, a state sometimes called 'floating heels.' Use heel suspension devices that elevate and offload the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon. Heel suspension devices are preferable for long term use, or for individuals who are not likely to keep their legs on the pillows.</p> <p>A NPUAP (National Pressure Ulcer Advisory Panel) White Paper (March 2015) entitled "Do Lift Slings Significantly Change the Efficacy of Therapeutic Support Surfaces?" examined the risks and benefits of leaving a sling under a resident/patient. When lift slings are used in combination with therapeutic support surfaces, critical thinking needs to increase. The fabric or composition of the device is important, as some</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>may have less impact than others on the therapeutic functions of the support surface. The assessment of the patient should be reviewed against the physical features of the sling to be utilized. "Healthcare clinicians for each individual patient must critically review the impact, both the risk and the benefit, of leaving a sling beneath a patient." The NPUAP White Paper concluded, "The decision regarding placement/removal of Safe Patient Handling and Mobility (SPHM) equipment between uses must balance the putative risk (decreased efficacy of a therapeutic support surface) and potential benefit (easier repositioning increasing frequency and/or efficacy) on pressure ulcer prevention. Without evidence regarding the effect of slings upon support surface performance, the clinical recommendation is based on expert opinion to be found within the Guidelines combined with clinical assessment and an individualized plan of care by the team of health care professionals at the bedside."</p> <p>1. Surveyor 14108 reviewed Resident 15's medical record and noted the resident was currently receiving Hospice services. Resident 15 has multiple diagnoses according to the "Diagnoses List" that included Alzheimer's Disease, dementia, Pressure Injury to Left heel, Overactive bladder and history of a left knee replacement.</p> <p>Resident 15's CAA (Care Area Assessment) for pressure injuries completed with a Significant Change of Condition MDS (Minimum Data Set) assessment dated 3/24/16, documented Resident 15 had a stage 4 pressure injury to left heel measuring 3.4 cm (centimeters) by 5 CM. The pressure injury had necrotic tissue,</p>	F 314		

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F 314	<p>Continued From page 26</p> <p>serosanguineous drainage, foul odor and the wound was not healing as expected related to terminal diagnosis. In addition, Resident 15 had persistently wet skin and/or maceration related to incontinence, poor appetite, was bedfast or chairfast most of the time and required staff to move sufficiently to relieve pressure over any one site.</p> <p>Resident 15's most recent quarterly MDS assessment dated 6/16/16, documented the resident's short and long term memory were impaired and ability for decision making was severely impaired. Resident 15 required extensive assistance of two staff member for bed mobility and toileting, and extensive assistance of one staff member for transfers and personal hygiene. Resident 15 is nonambulatory and frequently incontinent of bladder. Resident 15 had one unstageable pressure injury and one stage 2 pressure injury.</p> <p>Resident 15's nurses' notes include the following documentation: ~ 1/31/16- left heel had loosened skin with flap exposing red/pink tissue. Drainage on linens. Prevalon Boots and Air mattress ordered. 2+ edema on top of left foot. ~ 2/1/16- heels are to be elevated off bed. ~ 2/4/16- left heel wound tissue was pink with a dark purple center and was larger in size. ~ 2/8/16- a firm dark necrotic area remains and loose flap adjacent...has yellowish tissue to his left mid buttock. ~ 2/10/16- a stage 2 pressure injury with an unstageable center. DTI (deep tissue injury) in evolution. ~ 2/18/16- left buttock was healed skin discoloration remains.</p>	F 314		

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F 314	<p>Continued From page 27</p> <p>~ 4/3/16- 4 - 3.4 cm (centimeter) blister to fleshy part of middle right buttock.</p> <p>~ 4/7/16- has a new wound to his right buttock. It appears to be a shearing wound. Barrier cream until healed.</p> <p>~ 6/16/16- right buttock is discolored.</p> <p>~ 7/9/16- a small area to his bottom that was healing. Barrier cream to decrease skin breakdown.</p> <p>Resident 15's physician's order dated 2/24/16, included to apply barrier and Sencicare cream to skin discoloration.</p> <p>Resident 15's physician's order dated 7/5/16, documented a change to Resident 15's dressing to left heel:</p> <p>~ wound cleanser to the resident's left heel wound;</p> <p>~ apply hydrogel with Vaseline gauze;</p> <p>~ three pieces of regular gauze and cover with foam.</p> <p>~ Heel protector;</p> <p>~ Change every other day.</p> <p>Resident 15's care plan for skin dated 2/28/16, related to limited mobility, cognitive impairment, dehydration, poor tissue perfusions, poor nutritional status manifested by pressure ulcer to left heel included interventions:</p> <p>~ complete daily skin assessments,</p> <p>~ administer medications/treatments as ordered and evaluate for effectiveness,</p> <p>~ reduce pressure and friction,</p> <p>~ elevate heels in bed,</p> <p>~ use pressure reducing devices: boots,</p> <p>~ use skin protective devices,</p> <p>~ monitor turning/reposition program,</p> <p>~ apply dressings (with or without topical</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>medications), ~ administer supplements between meals, ~ reposition every 2 hours and as needed, and ~ apply barrier cream with incontinence episodes and as needed.</p> <p>Resident 15's skin care plan added on 6/28/16: ~ use pillows for support, ~ do not position resident directly on pressure ulcer or areas of redness, ~ heel protectors.</p> <p>Resident 15's current CNA Care Card located in the resident's room dated 7/13/16, directs staff to use pillows for support, keep heels elevated in bed, do not position resident directly on pressure ulcer or areas of redness, use heel protectors and pressure relief devices. The Care Card indicates Resident 15 uses a Rest Q Mattress. An observation of Resident 15 was made that the resident currently uses an alternating air mattress. Resident 15's CNA Care Card had not been updated when given the air mattress. The CNA Care Card directs staff to assist the resident to reposition and indicates resident requires extensive to total assistance with personal hygiene.</p> <p>On 7/13/16 at 2:08 p.m., Surveyor 14108 observed Resident 15's FM (family member) sitting with Resident 15 while resident was lying on backside in bed. Surveyor 14108 interviewed FM-MM and together observed Resident 15's feet. Resident 15 wore a Prevalon Boot on the left foot only. The Prevalon Boot provides pressure relief to the heel. Resident 15's right leg was bent, causing the right outer ankle and heel to be in direct contact with the air mattress. There was a pillow under Resident 15's knees and upper</p>	F 314		

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F 314	<p>Continued From page 29</p> <p>calves, the pillow was too high up to elevate the resident's heels off of the mattress. When Surveyor 14108 asked FM-MM when staff laid Resident 15 down, FM-MM indicated staff laid him down after lunch around 1:00 p.m., and stated Resident 15 does not eat well.</p> <p>On 7/13/16 at 3:05 p.m. and 3:21 p.m., Surveyor 14108 observed Resident 15's right foot in the same position noted at 2:08 p.m.</p> <p>On 7/13/16 at 3:40 p.m., Surveyor 14108 observed CNA-L stop and talk to Resident 15. CNA-L informed Resident 15 supper would be in about an hour and asked if he would like to get up. Resident 15 told CNA-L "no." CNA-L did not reposition Resident 15 at that time.</p> <p>On 7/13/16 at 3:43 p.m., Surveyor 14108 observed Resident 15's right foot in the same position as noted at 2:08 p.m.</p> <p>On 7/13/16 at 6:03 p.m., Surveyor 14108 observed Resident 15's right foot in a similar position as at 3:43 p.m. Resident 15 told Surveyor 14108 that (resident) was hungry and wanted to get up to eat something.</p> <p>On 7/13/16 at 6:06 p.m., Surveyor 14108 interviewed CNA-BB and she indicated Resident 15 declined to get up earlier for supper.</p> <p>On 7/13/16 at 6:07 p.m., Surveyor interviewed CNA-L and she verified Resident 15 did not want to get up for supper, but added that she provided cares, "right before 5:00 p.m." Surveyor 14108 shared Resident 15 indicated wanted to get up to eat.</p>	F 314		

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F 314	<p>Continued From page 30</p> <p>On 7/13/16 at 6:11 p.m., CNA-L asked Resident 15 if the resident wanted to get up and eat something and Resident 15 said, "yes." CNA-L removed Resident 15's Prevalon Boot, stating Resident 15 wears a shoe on right foot only. CNA-L and CNA-BB assisted Resident 15 to get up using the sit-to-stand lift at 6:14 p.m. When CNA-BB asked if they should toilet Resident 15, CNA-L answered "no." and explained she had changed the resident at 5:00 p.m. Staff did not check Resident 15 at that time to see if the was wet. Surveyor 14108 observed a thick washable incontinence pad on Resident 15's air mattress that the resident had been lying on. CNA-BB and CNA-L transferred Resident 15 into a Broda chair and placed Resident 15's shoe onto the right foot. Resident #15 wore a sock on the left foot. CNA-L rested both of Resident 15's feet onto the foot rest of the Broda chair and CNA-L took Resident 15 out of the room, Surveyor 14108 asked CNA-L if the resident had the Prevalon Boot on the left foot. CNA-L answered, "no, (resident)'s wearing a grippy sock." Surveyor 14108 reviewed Resident 15's CNA Care Plan and at 6:24 p.m., CNA-L looked at Resident 15's CNA Care Plan and said that the boot was only worn in he was in bed. CNA-L then took Resident 15 into the dining area and heated up a plate of food. During this time Resident 15's left heel in the location of the healing unstageable pressure injury, was directly on the front metal bar of the foot rest and his right shoe was resting against the back of the left heel.</p> <p>On 7/13/16 at 6:34 p.m. Surveyor 14108 interviewed the wound nurse RN-T. RN-T reviewed Resident 15's care plan and verified that the resident should wear the Prevalon Boot on the left foot at all times and when Resident 15 is in bed he should be wearing Prevalon Boots on</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>both feet. Surveyor 14108 and RN-T observed Resident 15 at 6:38 p.m., seated in the Broda chair without the Prevalon Boot on the left foot and the left heel resting on the front metal bar of the footrest and the right shoe directly behind the left foot against the back of the heel. RN-T verified that this placed Resident 15 at risk for the healing unstagable pressure injury not to heal and/or worsen. RN-T immediately had staff put Resident 15's Prevalon Boot on the left foot.</p> <p>On 7/13/16 at approximately 6:43 p.m. Surveyor 14108 interviewed RN-T regarding Resident 15's CNA Care Plan. RN-T verified the care plan did not clearly direct staff to apply Resident 15's Prevalon Boot to the left foot at all times.</p> <p>On 7/13/16 at 7:03 p.m. RN-T revised Resident 15's CNA Care Plan so it directed staff to apply Resident 15's Prevalon Boot to the left foot when in the chair and should wear Prevalon Boots on both feet when in bed.</p> <p>On 7/14/16 at 7:48 a.m. Surveyor 14108 observed Resident 15 lying in bed with his right heel in full contact with his air mattress. The pillow under the knees and calves was positioned too high up underneath Resident 15's legs to elevate the right heel off of the mattress. Resident 15 was wearing a Prevalon boot on the left calf and foot only.</p> <p>On 7/14/16 at 7:52 a.m. Surveyor 14108 interviewed CNA-K who was assigned to Resident 15. CNA-K verified that she had not provided any cares on Resident 15 since she started at 6:30 a.m. and Resident 15 is fourth on her list to provide cares. CNA-K explained that third shift is finished at 7:30 a.m. When asked if</p>	F 314		

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F 314	<p>Continued From page 32</p> <p>she knew when cares were last done on Resident 15, CNA-K indicated, third shift performed cares at 6:30 a.m. Resident 15 was lying in bed without a Prevalon Boot on right foot for 1 1/2 hours without providing pressure relief to the right heel.</p> <p>On 7/14/16 8:14 a.m. Surveyor 14108 was positioned to protect Resident 15's privacy while allowing Surveyor 14108 to observe CNA-K. Resident 15 had been incontinent of a large to moderate amount of urine in his brief per interview with CNA-K at 8:05 a.m., and Resident 15 had a bowel movement in the toilet. CNA-K provided frontal and backside pericare appropriately, without applying barrier cream per Resident 15's physician's order.</p> <p>On 7/14/16 at 8:18 a.m., Surveyor 14108 interviewed CNA-K regarding the Barrier cream, and she verified that she forgot to apply it and should have. CNA-K then applied the barrier cream as ordered.</p> <p>2. Surveyor 14108 reviewed Resident 16's medical record and it included a "Diagnoses List" indicating Cerebral infarction secondary to unspecified occlusion or stenosis, right sided hemiplegia and a pressure injury to right heel.</p> <p>Resident 16's Initial MDS assessment dated 5/16/16, documents Resident 16 had short term memory problems and moderate impairment with daily decisions. Resident 16 required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Resident 16 was nonambulatory and frequently incontinent of both bowel and bladder. Resident 16 has range of motion limitation for both upper and lower extremities to one side. Resident 16 was</p>	F 314		

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F 314	<p>Continued From page 33</p> <p>assessed to be at risk for the development of pressure injuries, but did not have any at the time of the assessment.</p> <p>A physician's order dated 5/31/16, documents staff are to apply heel protectors at all times.</p> <p>A physician order dated 6/8/16, documents staff are to apply skin prep to both heels three times a day related to a diagnosis of a blister to Resident 16's right heel and to prevent pressure injuries to her left heel.</p> <p>Resident 16's current CNA Care Card dated 7/14/16, documents Resident 16 requires extensive assistance for bed mobility. Staff are to reposition Resident 16 every two hours while in bed. Staff are to place a pillow under Resident 16's right calf and right arm in bed. Heel protectors at all times.</p> <p>On 7/14/16 at 10:50 a.m., Surveyor 14108 and RN-K observed Resident 16's heels directly on her mattress. There was a pillow positioned under Resident 16's calves, but it had flattened so that Resident 16's heels were not elevated off of the bed. RN-K verified that they know they had a problem with pillows flattening out and not keeping residents' heels elevated off their mattresses. RN-K indicated it was very important for staff to monitor Resident 16 because has very little movement on right side related to the stroke and heels should be free floating. RN-K indicated the facility has ordered some heel risers to elevate residents' heels off of their mattress because of the increase in problems with residents' heels.</p> <p>Surveyor: 32768</p>	F 314		

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F 314	<p>Continued From page 34</p> <p>3. According to Resident 5's MDS assessment dated 6/20/16, the resident requires extensive assist with bed mobility, ambulation, hygiene, and transfers.</p> <p>Resident 5 has a current stage 2 pressure injury on the right upper buttocks that was discovered on 5/11/15 and measures 0.7 cm by 0.4 cm., and has had a history of recurrent pressure injuries on the buttocks. Resident 5's pressure injury on the right upper buttocks noted on 3/8/15, healed on 5/4/15.</p> <p>According to the resident's care plan dated 3/16/15, Resident 5 should be repositioned every 2 hours and PRN (as needed).</p> <p>On 7/12/16 at 7:45 a.m., surveyor 32768 observed Resident 5 sitting in a broda chair in the dining area waiting for breakfast. Resident 5 was observed again in the broda chair at 8:10 a.m., eating breakfast with assistance from staff and at 9:30 a.m. and 10:10 a.m., sitting in the broda chair in the dining area in the same position. At 10:25 a.m., Resident 5 was taken to their room to be changed.</p> <p>On 7/13/16 7:50 a.m., surveyor 32768 observed Resident 5 sitting in a broda chair in dining area waiting for breakfast. Resident was observed again from 9:30 a.m. until 11:08 a.m., sitting in a broda chair in dining room area. At that time, Resident 5 was taken outside in the broda chair by Activity staff, without being repositioned or checked for incontinence prior.</p> <p>On 7/13/16 at 12:50 p.m., surveyor 32768 interviewed CNA-O, who indicated Resident 5 had not been repositioned in the chair or had any</p>	F 314		

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F 314	<p>Continued From page 35</p> <p>cares done since night shift had gotten the resident up around 6:30 a.m. CNA-O stated "I took (resident) to room after activities brought back from outside, so I would say around 11:30 a.m. or so...Yes this is the only time this shift I did cares with (resident). Night shift gets the resident up in chair probably around 6:30 a.m. and they bring (resident) into the dayroom, so (resident) has been there the whole time before breakfast and until activities got (resident) around 11:00 a.m. No I didn't reposition (resident) in chair, only when I lifted (resident) out of chair around 11:30 a.m., to do cares."</p> <p>On 7/13/16 at 1:10 p.m., surveyor 32768 interviewed Nurse Manager-G. Nurse Manager-G indicated the expectation is to have CNAs reposition Resident 5 while in the broda chair, and is part of resident's care plan to reposition in chair. Nurse Manager-G indicated the CNA's know to reposition Resident 5 in chair.</p> <p>Surveyor: 32769</p> <p>4. On 7/11/16, Surveyor 32769 reviewed Resident 13's medical record. The MDS assessment dated 7/11/16, indicated some of the resident's multiple diagnoses included Dementia, Arthritis, Edema an Chronic Venous Insufficiency. Resident 13 was dependent upon staff for extensive assistance with mobility, utilized a wheelchair and was receiving Hospice care.</p> <p>According to the facility's 7/12/16 CNA Care Card, Resident 13 was not ambulatory and required a mechanical lift for transfers.</p> <p>According to Resident 13's 7/9/16 Braden assessment, the resident was at risk for skin breakdown and could not always communicate</p>	F 314		

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F 314	<p>Continued From page 36 pain or a need to reposition.</p> <p>On 7/11/16, at 3:20 p.m., Surveyor 32769 observed Resident 13 lying on bed, with blankets pulled firmly over toes and folded blanket resting against the soles of resident's feet, pulling the bedding tighter against the resident's toes. CNA-GG lifted the bedding and verified the resident's heels were in direct contact with the mattress, before elevating them with a pillow under the lower legs.</p> <p>On 7/13/16, from 7:05 p.m. to 7:20 p.m., Surveyor 32769 observed Resident 13 seated in a wheelchair, over a cushion, with a mesh sling between the resident and the cushion. CNA-EE verified the resident had been seated in the chair since 5:00 p.m., for dinner. After transferring the Resident 13 from the chair to bed, CNA- removed the sling, which left wrinkled indentations in the reddened skin of the buttocks and hips, which were consistent with the sling straps. CNA-EE confirmed the skin redness and indentations were from the sling and continued with the resident's care. Upon removal of the resident's "grippy socks," Surveyor 32769 observed numerous small indentations in the reddened skin of the resident's toes. CNA- verified "that's from the pattern on the grippy socks." CNA-EE continued to prepare the resident for bed, placing a pillow under the resident's lower legs, then pulling the bedding up, which caused it to tighten over the resident's toes.</p> <p>On 7/13/16 at 7:50 p.m., when the above cares were complete, the bedding was lifted and CNA-EE verified the resident's heels were directly on the mattress and that the tight blanket was putting pressure on the resident's toes. CNA-EE</p>	F 314		

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F 314	<p>Continued From page 37</p> <p>placed an additional pillow to elevate the resident's heels from the mattress and loosened the blanket from the toes.</p> <p>On 7/14/16, at 10:00 a.m., DON (Director of Nursing)-B verified to Surveyor 32769, that heels should be free floated (lifted off the mattress) on heel lift devices, not pillows. DON-B confirmed a sling should not be under Resident 13 in a chair and if socks or other items are causing pressure or leaving marks, they should not be used.</p> <p>On 7/14/16, at 12:30 p.m., Surveyor 32769 interviewed NM (Nurse Manager)-T who confirmed the resident used multiple blankets and stated "I'm going to order a foot cradle to keep the blankets off of (Resident 13's) toes."</p> <p>5. On 7/14/16, Resident 25's medical record was reviewed by Surveyor 32769. The resident's CNA Care Card indicated the resident was non-ambulatory and dependent upon staff for mobility</p> <p>On 7/12/16, at 7:55 a.m., Surveyor 32769 observed Resident 25 seated on a padded broda chair, with heels directly on a pillow, atop an extended footrest. Similar observations were made that same day at 8:00 a.m., 8:39 a.m. to 9:11 a.m., 9:35 a.m., 10:04 a.m., 10:12 a.m. and 10:50 a.m..</p> <p>On 7/13/16, at 8:30 and 9:10 a.m., Surveyor 32769 observed Resident 25 positioned on a broda chair with heels directly on the pillow over the extended footrest.</p> <p>On 7/14/16, at 7:40 a.m., Surveyor 32769 observed Resident 25 as above, with heels</p>	F 314		

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F 314	<p>Continued From page 38</p> <p>directly on the pillow over the broda chair footrest.</p> <p>On 7/14/16, at 10:00 a.m., Surveyor 32769 interviewed DON-B who confirmed the resident should not have heels placed on pillows.</p> <p>6. On 7/11/16, Surveyor 32769 reviewed Resident 14's medical record, which indicated the resident had multiple diagnoses, including Dementia, a pressure injury to the right heel and was receiving Hospice care. The resident's 5/24/16 MDS assessment indicated the resident's cognition was moderately impaired and the resident depended upon staff for extensive assistance with mobility.</p> <p>The 7/12/16 CNA Care Card indicated the resident had "Impaired skin integrity," a "High risk for heel ulcer," and instructed: "Heel lift cushion under resident's calves in bed and recliner. Blue Prevalon boots to both feet when in bed." The document also directed staff to "Report changes to nurse."</p> <p>On 7/13/16, at 8:03 p.m., Surveyor 32769 observed Resident 14 lying in bed, with two Prevalon boots and heel lift cushion resting on chairs. CNA-L lifted the resident's covers as Surveyor 32769 observed, and CNA-L confirmed, both heels were in contact with the mattress. CNA-L reported placing the boots on Resident 14 earlier.</p> <p>On 7/13/16 at 8:15 p.m., Surveyor 32769 interviewed CNA-BB, who confirmed the resident's Care Card required the use of the heel lift cushion and two Prevalon boots, when in bed. CNA-BB verified putting Resident 14 to bed without these interventions stating, "(Resident 14)</p>	F 314		

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F 314	<p>Continued From page 39</p> <p>refused the Prevalon boots and pillows.</p> <p>On 7/14/16 at 2:00 p.m., NM (Nurse Manager)-T confirmed Resident 14 had a healed wound to the right heel, which remained fragile and required pressure redistribution interventions.</p> <p>On 7/14/16 at 4:00 p.m., NM-T verified the facility had no documentation to support the claim that the resident refused the pressure reducing interventions (Prevalon boots and heel lift cushion.)</p> <p>Surveyor: 18815</p> <p>7. Resident 8's face sheet, dated 10/1/13, indicated the resident was admitted to the facility with diagnoses to include multiple sclerosis and left hemiparesis.</p> <p>Resident 8's MDS quarterly assessment dated 5/27/16, documented the resident was assessed to score 3 of 15 on the cognitive screen (the higher the score, the more cognizant), was totally dependent on staff for bed mobility, transfers, and did not ambulate. Resident 8 had range of motion deficits in bilateral upper and lower extremities, and was at risk for the development of pressure injury. The resident had a pressure reducing device for bed and chair.</p> <p>Resident 8's Braden Scale, dated 5/23/16, indicated the resident scored a 10. A score of 10-12 indicated a resident would be at very high risk for developing pressure injury. According to the Braden, Resident 8 is completely immobile, is chairfast, nutrition is probably inadequate, and can't always communicate the need to reposition.</p> <p>Resident 8's current plan of care dated 6/22/16,</p>	F 314	

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F 314	<p>Continued From page 40</p> <p>indicated the resident had a potential for impaired skin. The care plan approaches included to note changes in level of risk for skin breakdown and to reposition every two hours.</p> <p>Resident 8's current CAA not dated, indicated the resident is at risk for the development of pressure injury. Will develop care plan.</p> <p>On 7/11/16 from 3:52 p.m. to 6:08 p.m., Surveyor 18815 observed Resident 8 sitting in the Maxi-Plus chair with both heels placed directly on a pillow and with a full-body mesh sling under the resident that is placed over the pressure redistribution cushion.</p> <p>On 7/12/16 from 7:53 a.m. to 10:59 a.m., Surveyor 18815 observed Resident 8 sitting in the Maxi-Plus chair with both heels placed directly on a pillow and with a full-body mesh sling under the resident that is placed over the pressure redistribution cushion.</p> <p>On 7/12/16 at 11:02 a.m., Surveyor 18815 observed CNA-I and CNA-QQ transfer Resident 8 to bed from the Maxi-Plus chair. The resident had red marks that were blanchable on both buttocks which were consistent with the size of the binding on the full-body mesh sling. CNA-I and CNA-QQ verified the red marks were the size of the binding on the sling. After cares were completed, CNA-I placed a soft boot on the left foot and placed the right heel directly on the mattress. CNA-I verified the resident uses a pillow in the Maxi-Plus chair for comfort for legs with heels placed directly on the pillow. CNA-I also verified the resident does not require the heels to be free floating while in bed. At 11:30 a.m., the resident remained in bed with the left</p>	F 314		

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F 314	<p>Continued From page 41</p> <p>heel in the soft boot and the right heel placed directly on the mattress until 3:05 p.m.</p> <p>On 7/12/16 from 3:50 p.m. until 5:13 p.m., Surveyor 18815 observed Resident 8 sitting in the Maxi-Plus chair with the left foot in the Flex boot and the right heel placed directly on a pillow and with a full-body mesh sling under the resident that is placed over the pressure redistribution cushion.</p> <p>On 7/13/16 from 9:15 a.m. to 10:24 a.m., Surveyor 18815 observed Resident 8 sitting in the Maxi-Plus chair with both heels placed directly on a pillow and with a full-body mesh sling under the resident that is placed over the pressure redistribution cushion.</p> <p>On 7/13/16 from 10:30 a.m. to 2:30 p.m., Surveyor 18815 observed Resident 8 in bed with both heels placed directly on the mattress.</p> <p>On 7/13/16 from 5:50 p.m. to 7:15 p.m., Surveyor 18815 observed Resident 8 sitting in the Maxi-Plus chair with both heels placed directly on a pillow and with a full-body mesh sling under the resident that is placed over the pressure redistribution cushion. At 7:15 p.m., CNA-RR and CNA-R transferred Resident 8 from the Maxi-Plus chair to bed. The right leg/buttock area has pink lines that appear to be from the binding on the mesh sling. At 7:23 p.m., CNA-RR verified the lines on the resident's right leg/buttock area look like "binding marks." At 7:57 p.m., the resident's heels were placed directly on a pillow under the resident's legs by CNA-RR.</p> <p>On 7/14/16 at 11:00 a.m., Surveyor 18815 observed Resident 8 sitting in the Maxi-Plus chair with the right heel placed directly on the metal of</p>	F 314			

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F 314	<p>Continued From page 42</p> <p>the chair and the left heel placed directly on a pillow. The resident was sitting on a full-body mesh sling that was placed over the pressure redistribution cushion.</p> <p>8. Resident 9's face sheet, dated 7/2/16, indicated the resident was admitted to the facility with diagnoses to include advanced dementia, dehydration and a left hip fracture.</p> <p>Resident 9 did not have an MDS completed due to date of admission. Resident 9's Braden Scale, dated 7/2/16, indicated the resident scored a 16. A score of 15-18 indicated a resident would be at mild risk for developing pressure injury. According to the Braden, Resident 9's mobility is very limited, walks occasionally, and is in bed/chair most of time.</p> <p>Resident 9's current plan of care dated 7/3/16, indicated the resident was at risk for skin breakdown/impaired skin integrity related to surgery and limited mobility. The care plan approaches included to use pillows for support. On 7/7/16, an approach was added to use a heel riser while in bed, Prevalon boot to left heel when up in chair, and foot cradle to help keep blankets off feet after the resident developed a DTI (deep tissue injury) to the left heel.</p> <p>Resident 9's current CAA not dated, indicated the resident has impaired cognitive function and is at risk for recurrent pressure injury. Will develop care plan.</p> <p>The physician discharge summary from the hospital dated 7/2/16, indicated Resident 9 had no rashes, jaundice or other lesions appreciated other than the surgical wound on the left hip.</p>	F 314		

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F 314	<p>Continued From page 43</p> <p>The progress notes dated 7/2/16 at 10:31 p.m., indicated Resident 9 did not have a pressure injury noted at time of admission.</p> <p>The progress notes dated 7/2/16 at 11:21 p.m., indicated skin issues were noted. Surgical wounds to left hip area and light purple discoloration to bilateral shins and tops of feet.</p> <p>On 7/7/16, the Weekly Wound Observation Report indicated Resident 9 had developed a pressure injury to the left heel (middle) not blister area. The area measured 0.3 cm (centimeters) by 0.6 cm and was purple. It was also documented on 7/7/16 the resident had a purple blister noted to the left outer heel that was new and measured 2.7 cm by 1.8 cm. On 7/12/16, the Weekly Wound Observation Report indicated the two areas above became one purple blister on the resident's left heel measuring 4.0 cm by 7.0 cm and had deteriorated despite interventions put in place.</p> <p>On 7/11/16 at 4:43 p.m., Surveyor 18815 interviewed DON-B regarding the development of the DTI on Resident 9's left heel. DON-B felt the purple area "was missed on the original assessment and not noticed until 7/7/16. No proof (the resident) had it on admit."</p> <p>On 7/12/16 at 2:23 p.m., Surveyor 18815 observed CNA-J and CNA-QQ transfer Resident 9 from the wheelchair to the bed for cares. The Prevalon boot was placed on the resident's left foot, but the heel was not positioned in the cut out of the boot. At 2:39 p.m., RN-SS came in the room to change the dressing on the left heel. It was noted there was a large blood blister</p>	F 314	

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F 314	<p>Continued From page 44</p> <p>covering the left heel. RN-SS stated the heel is "still soft. Have a feeling it's going to open real soon. One little area, real soft. Should have been free floating heels when (the resident) first came in. Weren't" free floating heels on admit.</p> <p>On 7/12/16 at 2:54 p.m., Surveyor 18815 interviewed CNA-J regarding the placement of the Prevalon boot on Resident 9's left foot. CNA-J verified the boot slips forward and the heel is not positioned in the boot when the resident is in the wheelchair and when lifting the resident in the lift. The resident "got the boot about a week ago because (the resident) got the sore, (DTI on left heel) doesn't fit right."</p> <p>On 7/12/16 at 4:01 p.m., Surveyor 18815 interviewed RN-T regarding Resident 9. RN-T verified the Prevalon boot, heel riser and skin prep were "put in place on 7/7/16 after the DTI was discovered" on the resident. RN-T also verified the resident's left heel was not purple right away on admit, but felt the DTI had started on admission. Surveyor 18815 advised RN-T the Prevalon boot was slipping, was not a proper fit with heel in cut out or staff were in need of education on how to position the boot. RN-T indicated the boot would be looked at.</p> <p>On 7/13/16 at 7:33 p.m., Surveyor 18815 observed Resident 9 laying in bed with the Prevalon boot on the left foot with heel not in cut out of boot and placed directly on the heel riser rather than free floating. Additionally, the right heel was placed directly on the heel riser rather than free floating.</p> <p>On 7/13/16 at 7:42 p.m., Surveyor 18815 interviewed CNA-TT regarding Resident 9.</p>	F 314	

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F 314	<p>Continued From page 45</p> <p>CNA-TT stated the resident was "laid down at 6:50 p.m." in bed. CNA-TT verified the left heel was not positioned in the cut out of the Prevalon boot. CNA-TT also verified heels should be positioned on the pillow and demonstrated positioning of the heels on the heel riser. The resident remained in the same position in bed with both heels placed directly on the heel riser at 7:53 p.m.</p> <p>On 7/13/16 at 7:58 p.m., Surveyor 18815 interviewed LPN (Licensed Practical Nurse)-UU regarding the placement of Resident 9's heels in bed. LPN-UU verified the resident's heels should be free floating and the Prevalon boot should not be worn in bed, only when up in wheelchair per care plan. LPN-UU removed the boot and free floated the resident's heels.</p> <p>On 7/14/16 at 11:14 a.m., Surveyor 18815 observed Resident 9 in bed with the left heel placed directly on the heel riser. CNA-QQ verified the resident was still in bed from the night before and the heel should be free floating rather than placed directly on the heel riser. CNA-QQ free floated the resident's left heel.</p> <p>On 7/14/16 at 11:25 a.m., Surveyor 18815 interviewed RN-T regarding Resident 9. RN-T verified Resident 9 needs heels free floated while in bed. RN-T also verified Resident 8's heels should be free floating when in bed. The facility is "ordering more heel risers." Additionally, RN-T verified lift "slings are a no no to be left under residents. Risk of pressure ulcer" development when a sling is left under a resident.</p> <p>On 7/14/16 at 11:30 a.m., Surveyor 18815 interviewed RN-F who is wound care certified</p>	F 314		

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F 314	<p>Continued From page 46</p> <p>regarding Resident 9. RN-F verified the facility follows the NPUAP 2014 guidelines related to the development and treatment of pressure injury. RN-F also verified residents "should not sit on slings over pressure redistribution cushions unless contraindicated." After wound care was completed at 11:51 a.m., RN-F indicated if the heels "are not offloaded, pressure injury could start within 20 minutes. If heels are not offloaded, will continue to deteriorate. A pressure injury will not develop five days after surgery. Developed here. Needed to offload heels when admitted."</p> <p>On 7/14/16 at 1:25 p.m., Surveyor 18815 interviewed DON-B regarding resident 9. DON-B verified Resident 9's cognition is severely impaired, the resident is at risk for the development of pressure injury, uses a pressure related device in bed and chair, and has a DTI to the left heel. DON-B stated (RN-VV) "documented the feet were looked at on admission, but the purple area was not documented." RN-VV verbally advised DON-B via telephone after Surveyor 18815 asked about the development of the DTI that the area was noted on admit, but was not documented. DON-B stated RN-VV "should document (in the medical record) after assessing heels."</p> <p>9. Resident 19's face sheet, dated 1/27/15, indicated the resident was admitted to the facility with diagnoses to include dementia and chronic kidney disease.</p> <p>Resident 19's MDS quarterly assessment dated 6/16/16 documented the resident was assessed to score 3 of 15 on the cognitive screen (the higher the score, the more cognizant), required extensive assistance from staff for bed mobility,</p>	F 314		

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F 314	<p>Continued From page 47</p> <p>transfers, and did not ambulate. Resident 8 was at risk for the development of pressure injury. The resident had a pressure reducing device for bed and chair.</p> <p>Resident 19's Braden Scale, dated 5/6/16, indicated the resident scored a 17. A score of 15-18 indicated a resident would be at mild risk for skin breakdown. According to the Braden, Resident 19's mobility is very limited and is chairfast.</p> <p>Resident 19's current plan of care dated 1/19/15, indicated the resident had impaired skin integrity related to history of blister to right heel. The care plan approaches with a date of 6/23/16, indicated heels were to be elevated in bed with Prevalon boots and to use a pressure reduction cushion in chair.</p> <p>Resident 19's current CAA not dated, indicated the resident is at risk for the development of pressure injury. Will develop care plan.</p> <p>On 7/13/16 from 9:15 a.m. to 1:48 p.m., Surveyor 18815 observed Resident 19 sitting in the wheelchair on a mesh sling which was placed over the pressure redistribution cushion. At 1:49 p.m., CNA-H attached the resident to a full mechanical lift to transfer to bed from the wheelchair. At 1:54 p.m., CNA-H verified to Surveyor 18815 that the resident had red marks on the back of the left and right legs near the thigh area that were the size of the binding on the mesh sling and the resident had a large red mark the size of the binding on the left buttock, and had a red mark the size of the binding on the right buttock. All areas of redness were blanchable. CNA-H verified the resident had not been</p>	F 314		

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F 314	Continued From page 48 repositioned today while sitting in the wheelchair and stated "sometimes (the resident) needs repositioning if leans, did not need repositioning today." After cares were completed, CNA-H placed a pillow under the resident's legs and placed both heels directly on the pillow. CNA-H verified the resident's heels were placed directly on the pillow rather than free floating. On 7/13/16 from 5:50 p.m. to 6:43 p.m., Surveyor 18815 observed Resident 19 sitting in the wheelchair on a mesh sling which was placed over the pressure redistribution cushion. On 7/14/16 at 11:02 a.m., Surveyor 18815 observed Resident 19 sitting in the wheelchair on a mesh sling which was placed over the pressure redistribution cushion.	F 314	
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 36402 Based on observation, staff interviews and record review, the facility did not ensure that 3 (Resident	F 315	

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F 315	<p>Continued From page 49</p> <p>17, Resident 18 and Resident 19) of 8 residents reviewed for Foley catheter management and 3 (Resident 8, Resident 9 and Resident 13) of 10 residents observed receiving perineal cares, received appropriate treatment and services to prevent UTI (Urinary Tract Infection). Resident 17's urinary drainage bag was observed in full contact with the floor. Resident 18's urinary drainage bag was observed in full contact with the floor. Resident 19's catheter urinary drainage bag was observed above the level of the resident's bladder during transfer.</p> <p>Resident 8 and Resident 9 were not provided complete perineal cleansing following an episode of urinary/stool incontinence.</p> <p>Resident 13 was given incomplete perineal care.</p> <p>Findings include:</p> <p>The facility's Foley Catheter Care policy last revised 05/2016 indicates, "Attach drainage bag to chair/wheelchair when up. When in bed, attach to side of bed."</p> <p>HICPAC (Healthcare Infection Control Practices Advisory Committee) 2009 Guideline For Prevention Of Catheter Associated UTIs instructs staff not to rest the urinary drainage bag on the floor.</p> <p>The Facility's policy entitled "Catheter Care Teaching Sheet," undated, indicated staff are to keep the catheter urinary drainage bag below the level of the bladder.</p> <p>The Facility's policy entitled "Peri Care Policy"</p>	F 315	

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F 315	<p>Continued From page 50</p> <p>with a revision date of 11/2015, indicated the purpose of providing perineal care regularly and properly will reduce the risk of urinary tract infection which can lead to bladder and kidney infection. When performing perineal cares on a female, staff should separate labia and wash urethral area first wiping downward from front to back. Continue to wash the perineum moving outward to and including thighs, alternating from side to side, and using downward strokes. Using another cleansing cloth, wash the rectal area thoroughly, washing from the base of the labia and extending over the buttocks. Rinse and dry in the same manner.</p> <p>1. On 7/13/16, Surveyor 36402 reviewed Resident 18's medical record that contained diagnoses to include Urinary Retention and Neuromuscular Bladder dysfunction, resulting in the resident's long term use of an indwelling Foley catheter.</p> <p>On 7/14/16 at 7:22 a.m., Surveyor 36402 observed Resident 18 lying in bed. The resident's urinary drainage bag was lying directly on the floor with the front of the bag face down on the floor. No protective fabric covering was located on the urinary drainage bag and urine was visible in the drainage tube during the observation.</p> <p>On 7/14/16 at 7:35 a.m., Surveyor 36402 observed CNA (Certified Nursing Assistant)-E transfer Resident 18 from bed to the resident's wheelchair with the urinary drainage bag in full contact with the floor. CNA-E verified the drainage bag was lying directly on the floor and stated, "Yea, it's not supposed to be." Upon transferring Resident 18 to the wheelchair, CNA-E clipped the urinary drainage bag to the right side of Resident 18's wheelchair, causing</p>	F 315	

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F 315	<p>Continued From page 51</p> <p>the bottom of the urinary drainage bag to be in direct contact with the right wheel of the wheelchair, while the CNA took Resident 18's feet off of the lift used to assist in the transfer. CNA-E then clipped the urinary drainage bag to the frame of the wheelchair beneath Resident 18's buttocks.</p> <p>On 7/14/16 at 7:45 a.m., Surveyor 36402 interviewed CNA-E regarding the observation of cares with Resident 18. CNA-E verified placing the urinary drainage bag on the right frame of the wheelchair while removing the resident's legs from the lift, causing the bottom of the drainage bag to be in direct contact with the right wheel of the wheelchair. CNA-E stated, "I didn't want it to get tangled while moving (Resident 18's) legs. I clipped it to the bottom of the wheelchair right after."</p> <p>On 7/14/16 at 9:58 a.m., Surveyor 36402 interviewed DON (Director of Nursing)-B regarding observations of Resident 18's urinary drainage bag in direct contact with the floor. DON-B stated, "The drainage bag should be hooked to the bed. Standards of practice indicate the drainage bag should never be on the floor."</p> <p>2. On 7/13/16, Surveyor 36402 reviewed Resident 17's medical record. The resident's most recent MDS (Minimum Data Set) assessment dated 4/27/16, documented the resident has an indwelling urinary catheter.</p> <p>On 7/13/16 from 4:03 p.m. until 5:37 p.m., Surveyor 36402 was in continuous observation of Resident 17. The resident was seated in a recliner chair in the resident's room with the urinary drainage bag clipped to a garbage can on the Resident's right side. The urinary drainage bag hung against the exterior surface of the garbage can. No protective covering was on the urinary drainage bag, and the bottom of the bag</p>	F 315	

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F 315	<p>Continued From page 52</p> <p>was in direct contact with the floor. On 7/14/16 at 9:58 a.m., Surveyor 36402 interviewed DON-B regarding observations of Resident 17's urinary drainage bag in direct contact with the floor. DON-B reported standards of practice indicate a urinary drainage bag should never be on the floor. Surveyor: 18815</p> <p>3. Resident 19's quarterly MDS (Minimum Data Set) assessment dated 6/16/16, documented the resident's cognition was severely impaired. Additionally, the MDS documented the resident had an indwelling catheter.</p> <p>On 7/13/16 at 1:49 p.m., Surveyor 18815 observed CNA-H and CNA Student-LL transfer Resident 19 from the wheelchair to the bed using a full mechanical lift. CNA-H attached the resident's catheter urinary drainage bag to the lift near the resident's chest area and raised the lift to transfer the resident to bed. The catheter urinary drainage bag was observed above the level of the resident's bladder during transfer.</p> <p>On 7/13/16 at 2:25 p.m., Surveyor 18815 interviewed CNA-H regarding the above observations. CNA-H verified the observations as written and stated catheter "should not be above bladder because it won't flow."</p> <p>4. Resident 8's quarterly MDS (Minimum Data Set) assessment dated 5/27/16, documented the resident's cognition was severely impaired. The MDS documented the resident was always incontinent of bladder and bowel, and was totally dependent on staff for personal hygiene.</p> <p>On 7/12/16 at 11:02 a.m., Surveyor 18815 observed CNA-I and CNA-PP transfer Resident 8</p>	F 315		

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F 315	<p>Continued From page 53</p> <p>from the Maxi-Plus chair to the bed using a full mechanical lift. CNA-I verified the resident was incontinent of urine. While wearing gloves, CNA-I cleansed the resident's anal/buttocks area and the back of the urethral area with a disposable wipe. CNA-I and CNA-PP then placed a clean incontinence brief on the resident and assisted the resident to take a nap. The CNAs did not cleanse the resident's groin/frontal area, even though the resident's incontinence brief had been soiled with urine.</p> <p>On 7/12/16 at 11:20 a.m., Surveyor 18815 interviewed CNA-I regarding the above observation of incontinence care for Resident 8. CNA-I verified the above observation and stated "no groin/frontal cares (provided) even though (the resident) was incontinent of urine."</p> <p>5. Resident 9 was admitted to the facility on 7/2/16 and did not have a completed MDS.</p> <p>On 7/12/16 at 2:23 p.m., Surveyor 18815 observed CNA-J and CNA-QQ transfer resident 9 from the chair to the bed with a sit to stand lift. CNA-J and CNA-QQ verified the resident was incontinent of a large amount of urine and stool. CNA-J cleansed the resident's anal/buttocks area and the back of the urethral area with a disposable wipe. CNA-J and CNA-QQ then placed a clean incontinence brief on the resident, pulled up the resident's pants and assisted the resident to take a nap, without cleansing the resident's groin/frontal area even though the resident's incontinence brief had been wet with a large amount of urine and stool.</p> <p>On 7/12/16 at 2:54 p.m., Surveyor 18815 interviewed CNA-J regarding the above</p>	F 315		

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F 315	<p>Continued From page 54</p> <p>observations of incontinence care. CNA-J verified the above observations as written regarding Resident 9 and stated "should have cleansed the groin/frontal area and more of the urethral area. Only did back part of urethral area from front to back."</p> <p>Surveyor: 32769 6. On 7/11/16, Surveyor 32769 reviewed Resident 13's medical record. The 7/11/16 MDS (Minimum Data Set) assessment documented the resident had multiple diagnoses, including urinary frequency, was frequently incontinent and dependent upon staff for extensive assistance with toileting and hygiene.</p> <p>According to the facility's 7/12/16 CNA Care Card, Resident 13 utilized an incontinent pad and required staff assistance for bowel and bladder care.</p> <p>On 7/11/16 at 8:00 a.m., Surveyor 32769 observed CNA-OO provide incontinent cares for Resident 13. CNA-OO rolled the resident onto their left side. From behind, CNA-OO removed the resident's incontinent brief and confirmed it was wet. Then with gloved hands from behind the resident, CNA-OO lifted the resident's right leg with own left hand, and while reaching between legs wiped once, front-to-back, over the urethral and anal area. A small smear of stool was noted on the wet cloth. CNA-OO folded the cloth, wiped front-to-back again, over the same areas, then dried the resident by wiping once with a towel. The resident's groin folds were not opened or cleansed.</p> <p>On 7/11/16, at 9:32 a.m., CNA-OO verified to</p>	F 315	
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F 315 F 329 SS=D	Continued From page 55 Surveyor 32769 that the resident's groin folds were not cleansed in the above observation. 483.25(j) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 14108 Based on record review and staff interviews, the facility did not ensure 1 (Resident 15) of 24 sampled residents drug regimen was free from	F 315 F 329		

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F 329	<p>Continued From page 56 unnecessary drugs.</p> <p>Resident 15's last Seroquel (an antipsychotic medication) GDR (gradual dose reduction) was 4/24/15, over a year since the last GDR. Resident 15's medical record did not include current Pharmacy recommendations for a GDR, nor a risk benefit statement indicating the benefits out weigh the risks.</p> <p>Findings include:</p> <p>According to the SOM (State Operations Manual) under considerations Specific to Antipsychotic medications. The regulation addressing the use of antipsychotic medications identifies the process of tapering as a GDR and requires a GDR, unless contraindicated.</p> <p>Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility is to attempt a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated. After the first year, a GDR is to be attempted annually, unless clinically contraindicated.</p> <p>Surveyor 14108 reviewed Resident 15's medical record and it included a "Diagnoses List" that included Alzheimer's, dementia, and anxiety.</p> <p>A physician's order dated 4/25/15, documented Resident 15 is taking Seroquel 50 mg (milligrams) at 1630 (4:30 p.m.).</p> <p>A physician's order dated 5/3/15, included Seroquel 25 mg at 0830 (8:30 a.m.).</p>	F 329		

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F 329	<p>Continued From page 57</p> <p>A nurse's note dated 3/28/15, documented Resident 15's Seroquel was reduced from 100 mg to 50 mg at 1630.</p> <p>A nurse's note dated 4/24/15, documented to try reducing a.m. dose of Seroquel to 25 mg from 50 mg.</p> <p>On 7/13/16, at the daily exit meeting with facility staff Surveyor 14108 requested Resident 15's last GDR and/or risk benefit statement regarding Resident 15's Seroquel.</p> <p>On 7/14/16 at 10:10 a.m., Surveyor 14108 interviewed SW (Social Worker)-D regarding Resident 15's last Seroquel GDR, dated 4/2015. SW-D indicated when Resident #15 went on Hospice, they spoke with Resident 15's family and they did not want any changes with the psychotropic medications. SW-D indicated she did not know if Resident 15's physician wrote a risk benefit statement not to reduce Resident 15's Seroquel.</p> <p>On 7/14/16 at 12:15 p.m., Surveyor 14108 interviewed RN (Registered Nurse)-AA, who provided a copy of "Lakeland Health Care Center Recommendation from the Behavioral Health Team" completed by RN-AA, dated 7/14/16. RN-AA indicated on the form, Resident 15 was admitted to Hospice on 3/13/16 and the family does not want changes to the Seroquel dose. Please provide a risk benefit statement regarding Seroquel for Resident 15. The Hospice physician responded on 7/14/16, documenting "Patient has been on Seroquel for a long time, any changes should be attempted by his psychiatrist." RN-AA verified the documentation obtained was not a</p>	F 329		

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F 329	Continued From page 58 risk benefit statement to continue Resident 15's Seroquel at the current dose. On 7/14/16 at 12:39 p.m., Surveyor 14108 interviewed SW-D, who verified the facility had not attempted a GDR on Resident 15's Seroquel since 4/24/15, or had received a Pharmacy recommendation to attempt a GDR on Resident 15's Seroquel and did not obtain a risk benefit statement from Resident 15's physician, indicating the risks outweighed the benefits of reducing Resident 15's Seroquel. SW-D indicated Resident 15's physician would be contacted regarding a GDR for Resident 15's Seroquel or a risk benefit statement.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 18815 Based on record review, observation and staff interviews, the facility did not ensure residents were free of a medication error rate of 5 percent or greater for 1 (Resident 27) of 7 sampled and supplemental sampled residents observed during medication administration. Three of thirty opportunities observed during medication administration resulted in a medication error rate of 10 percent.	F 332		

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F 332	<p>Continued From page 59</p> <p>Resident 27 was not administered metformin (an antidiabetic drug) and primidone (an anticonvulsant used for tremors in this resident) as directed by the physician. Additionally, Resident 27 was administered cholestyramine (antilipemic) that was left at the dining room table for the resident to drink later. RN (Registered Nurse)-Q did not observe the complete medication administration process.</p> <p>Findings include:</p> <p>1. On 7/11/16 at 5:06 p.m., Surveyor 18815 observed RN-Q check Resident 27's blood sugar and had continuous observations of RN-Q and/or Resident 27 until 6:05 p.m., with the following noted:</p> <p>~ 5:24 p.m.- RN-Q took Resident 27's cholestyramine mixed with water to the dining room table where Resident 27 was eating dinner. RN-Q placed the cholestyramine mixed with water on the dining table with the resident, while eating. RN-Q left the dining room. There were residents and CNAs (Certified Nursing Assistants) in the dining room.</p> <p>~ 5:38 p.m.- RN-Q returned to the dining room to remove Resident 27 out of the dining room to give an insulin injection.</p> <p>~ 5:41 p.m.- RN-Q returned Resident 27 to the dining room. RN-Q did not encourage the resident to drink the cholestyramine mixed with water and again left Resident 27 at the dining room table with the cholestyramine to drink later. Surveyor 18815 then asked RN-Q if the resident would be administered any additional medications. RN-Q verified the cholestyramine</p>	F 332		

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F 332	<p>Continued From page 60</p> <p>mixed with water and insulin were the "only meds given for now" at dinner time.</p> <p>At that time, Surveyor 18815 and RN-Q reviewed the electronic medication administration record for Resident 27. Surveyor 18815 interviewed RN-Q regarding additional medications that were to be administered at dinner time. RN-Q stated "not at this time."</p> <p>Surveyor 18815 observed Resident 27 in the dining room until the resident was done eating and CNA-R removed the glass of cholestyramine mixed with water from the dining room table and poured the full glass of cholestyramine mixed with water in the sink.</p> <p>~ 5:54 p.m.- CNA-R verified to Surveyor 18815 that the entire glass of medication mixed with water was poured in the sink.</p> <p>~ 6:03 p.m.- Surveyor 18815 interviewed RN-Q regarding the cholestyramine mixed with water that she left with Resident 27 in the dining room. RN-Q stated cholestyramine is an "antidiarrheal like supplement" for Resident 27 and the resident "is supervised" in the dining room by the CNAs. RN-Q stated the CNAs "tell me how much" the resident drinks. "I don't have time to watch" the resident drink the cholestyramine. RN-Q then indicated it was "unknown" if the resident had been assessed to self-administer medications.</p> <p>Resident 27's current physician's orders for the month of July 2016 with a print date of 7/12/16, indicated Resident 27 is to receive one cholestyramine powder packet three times daily in the morning, at midday (noon time) and after noon (dinner time). The physician's orders</p>	F 332		

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F 332	Continued From page 61 indicated the resident was to be administered one 50 mg (milligram) tablet and one 250 mg tablet of primidone three times daily in the morning, after noon (dinner time) and at bedtime. Additionally, the physician's orders indicated the resident was to be administered a 500 mg tablet of metformin twice daily in the morning and after noon (dinner time) with meals. On 7/13/16 at 4:21 p.m., Surveyor 18815 interviewed DON (Director of Nursing)-B regarding Resident 27. DON-B verified the resident had not been assessed to self-administer medications prior to staff leaving the cholestyramine mixture at the dining room table for the resident. Additionally, DON-B verified the primidone and metformin were documented on the medication administration record as administered on 7/11/16 at 5:11 p.m. by RN-Q.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356		

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F 356	<p>Continued From page 62</p> <p>of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 14108</p> <p>Based on observation, staff interview and review, the facility did not ensure the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift was posted for two of the four survey days.</p> <p>Findings include:</p> <p>According to the DQA (Division of Quality Assurance) Memo 12-020 dated 12/6/12, Federally Certified Nursing Homes required information needed to be on the posted nurse staffing information included: actual hours worked per shift for the categories of licensed RNs (Registered Nurses), LPNs (Licensed Practical Nurses, and unlicensed, CNAs (Certified Nursing Assistants).</p> <p>Surveyor 14108 observed the facility's daily nursing staffing posting on 7/13/16 and 7/14/16 in</p>	F 356		

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F 356	<p>Continued From page 63</p> <p>the front entrance right of the receptionist desk. The facility did not post the actual hours worked by the RNs and LPNs.</p> <p>On 7/14/16 at 9:26 a.m., Surveyor 14108 interviewed SC (Staffing Coordinator)-CC regarding the facility's daily Licensed Staff Postings for 7/13/16 and 7/14/16, which indicated there were 10.5 RNs on the day shift for 7/13/16 and 2.5 LPNs on the second shift for 7/14/16. Surveyor 14108 reviewed the DQA Memo with SC-CC regarding the correct way to post the staff hours. SC-CC verified the actual hours for the half shift was not posted correctly.</p> <p>On 7/14/16 at 12:54 p.m., Surveyor 14108 interviewed SM (Staff Manager)-DD, who indicated the format of the daily nurse staffing postings now match the example in the DQA Memo.</p>	F 356		
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of</p>	F 425		

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F 425	<p>Continued From page 64</p> <p>a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18815</p> <p>Based on record review, observation and staff interviews, the facility did not provide pharmaceutical services, including procedures that assured the accurate dispensing of all medications to meet the needs of 1 (Resident 26) of 1 resident observed receiving inhaled steroid medication.</p> <p>Staff did not provide Resident 26 with a cup or place to spit water out after rinsing their mouth with water, after receiving an Advair inhaler, a steroid medication.</p> <p>Findings include:</p> <p>The manufacturer's instructions for Advair inhaler indicated the mouth should be rinsed with water without swallowing after using the Advair inhaler, to help reduce the chance of developing a fungal infection (thrush) of the mouth or throat.</p> <p>On 7/11/16 at 4:09 p.m., during medication pass observations, Surveyor 18815 observed LPN (Licensed Practical Nurse)-S administer an inhalation of the Advair inhaler to Resident 26. After the inhalation, LPN-S gave the resident a drink of water from a plastic cup, advised the resident to rinse mouth with the water and spit the</p>	F 425		

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F 425	Continued From page 65 water out after rinsing. Resident 26 followed the instructions of rinsing their mouth, but was unable to spit the water out as the resident was not given a cup or place to spit the water out. Resident 26 swallowed the water, because there was no place for the resident to spit after rinsing their mouth with water. On 7/11/16 at 4:13 p.m., Surveyor 18815 interviewed LPN-S regarding the observation of Resident 26 and the Advair. LPN-S verified the observation and stated the resident "held it, but didn't have another cup to spit in, so (the resident) swallowed" the water. Didn't think of cup with water to give to the resident to spit in. The resident shouldn't have swallowed the water."	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		

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F 441	<p>Continued From page 66</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36402</p> <p>Based on observation, record review and staff interviews, the facility did not maintain an infection control program designed to help prevent the development and transmission of disease and infection as observed during the provision of cares for 7 (Resident 1, Resident 5, Resident 11, Resident 8, Resident 9, Resident 10 and Resident 19) of 18 sampled and supplemental sampled residents observed receiving cares.</p> <p>~ Following Foley catheter and perineal care, CNA (Certified Nursing Assistant)-C did not remove soiled gloves and cleanse hands before touching Resident 1's personal and shared items.</p> <p>~ During incontinence cares, CNA-M did not</p>	F 441		
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F 441	<p>Continued From page 67</p> <p>wash or sanitize hands between glove changes and after providing care to Resident 5's buttocks area.</p> <p>~ During incontinence cares, CNA-N did not change gloves or cleanse hands, after providing perineal care and before touching Resident 11's personal and shared items.</p> <p>~ During Resident 11's dressing changes, LPN (Licensed Practical Nurse)-S used a personal scissors and marker taken from LPN-S's shirt pocket to cut and label the resident's clean dressings, without sanitizing before use, between dressings, or prior to returning the equipment to own shirt pocket. Additionally, LPN-S contaminated the clean work field area by placing soiled items in direct contact with clean items and did not utilize strategies to reduce the transmission of microorganisms from one wound to another.</p> <p>~ During incontinence cares, CNA-I did not change gloves or cleanse hands after providing perineal cares and prior to touching Resident 8's personal items.</p> <p>~ During incontinence cares, CNA-J did not change gloves or cleanse hands after providing perineal cares and prior to touching Resident 9's personal and shared items.</p> <p>~ During perineal cares, CNA-H did not change gloves or cleanse hands after providing cares and prior to touching Resident 10's personal and shared items.</p> <p>~ During incontinence cares, CNA-H did not change gloves or cleanse hands after providing</p>	F 441		

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F 441	<p>Continued From page 68</p> <p>cares and prior to touching Resident 19's personal items.</p> <p>Findings include:</p> <p>The facility's 'Handwashing' Policy last revised 02/2016 states:</p> <ol style="list-style-type: none"> 1. When hands are visibly soiled or contaminated, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water 2. If hands are not visibly soiled an alcohol-based hand rub for routinely decontaminating hands may be used. 3. Decontaminate hands before and after assisting a resident with personal cares. 9. Decontaminate hands after contact with inanimate objects (including medical equipment, soiled linens, bedpan, urinals etc.) in the immediate vicinity of the resident. 10. Decontaminate hands immediately after removing gloves and prior to putting on another glove(s) between each single task. <p>PROCEDURE:</p> <ol style="list-style-type: none"> 2. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to the hands and rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use fresh towel to turn off the faucet.. <p>Review of the Morbidity and Mortality Weekly Report, dated 10/25/02 and published by the Centers for Disease Control and Prevention, entitled "Guideline for Hand Hygiene in Health Care Settings" indicates recommendations to wash hands after removing gloves and to decontaminate hands after contact with body</p>	F 441		

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F 441	<p>Continued From page 69</p> <p>fluids or excretions and when moving from a contaminated body site to a clean body site during patient care.</p> <p>1. On 7/12/16 at 7:25 a.m., Surveyor 36402 observed CNA-C perform morning cares for Resident 1 while the resident lay in bed. Upon entering the resident's room, CNA-C applied gloves without first performing hand hygiene. The following observations were made while CNA-C performed cares with Resident 1:</p> <ul style="list-style-type: none"> ~ obtained a urinal from the resident's bathroom and drained the urinary drainage bag. ~ poured the urine from the urinal into the toilet, rinsed the urinal with water from the sink, poured the contaminated water into the toilet, flushed the toilet, and then placed the urinal in a storage container under the sink in Resident 1's bathroom. ~ while wearing the same soiled gloves, continued performing cares for Resident 1- washing the resident's underarms, applying deodorant, assisting the resident in putting a t-shirt on, turning the sink on in the bathroom, and obtaining an additional wash cloth from the bathroom. CNA-C then used the washcloth to wash Resident 1's frontal perineal area as well as rectal area. ~ while wearing the same soiled gloves, obtained barrier cream and applied to the resident's rectal area. ~ removed the resident's brief and applied a clean brief. ~ inserted the resident's urinary drainage bag through the left pant leg and proceeded to put the pants on the resident and shirt. ~ while wearing the same soiled gloves, adjusted the pillow beneath the resident's head, pulled the resident's shirt down, adjusted the resident's 	F 441		

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F 441	<p>Continued From page 70</p> <p>pants, and tied them.</p> <p>~ while wearing the same soiled gloves, repositioned the resident on the left side and placed a pillow to assist the resident to maintain that position, as well as an additional pillow between Resident 1's legs.</p> <p>~ while wearing the same soiled gloves, removed the dirty linen and brief from the foot of the resident's bed, placed the soiled linen on the edge of the sink in Resident 1's bathroom and placed the brief in the garbage can.</p> <p>~ while wearing the same soiled gloves, tied the garbage bag and placed the bag on top of the dirty linen on the sink. Applied a new liner to the garbage can and returned to the resident's room from the resident's bathroom.</p> <p>~ while wearing the same soiled gloves, pulled the sheet and blanket over Resident 1 and lowered the bed. Entered the resident's bathroom, removed gloves, and performed hand hygiene in the sink for 5 seconds.</p> <p>~ CNA-C then applied gloves and removed the dirty linen and garbage bag from resident 1's bathroom and carried the items to the soiled utility room on the unit. CNA-C performed hand hygiene in the utility room after depositing the items and removing gloves.</p> <p>On 7/12/16 at 7:52 a.m., following the completion of the above observation, Surveyor 36402 interviewed CNA-C. CNA-C verified no hand hygiene was completed between cares with Resident 1. In addition, CNA-C verified only washing hands in the sink for 5 seconds following the provision of cares to Resident 1.</p> <p>On 7/14/16 at 9:55 a.m., Surveyor 36402 interviewed DON (Director of Nursing)-B regarding the observation of cares to Resident 1 by CNA-C. DON-B verified the facility's expectation is for hand hygiene to be completed</p>	F 441		

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F 441	<p>Continued From page 71</p> <p>"After touching each potentially contaminating surface." DON-B further stated the facility's expectation is for, "Handwashing after peri-care as well as catheter care or emptying."</p> <p>Surveyor: 32768</p> <p>2. On 7/12/16 at 10:25 a.m., surveyor 32768 observed incontinence cares with Resident 5. CNA-M applied gloves without washing or sanitizing hands. CNA-M assisted the resident from broda chair to bed with lift. CNA-M at this time pulled the resident's pants down to knees then removed the soiled brief. CNA-M wiped the resident's groin area with a clean wipe front to back. CNA-M then repositioned the resident onto their right side while wearing the same soiled gloves. CNA-M wiped the resident's buttocks area front to back with a clean wipe. While wearing the same soiled gloves, CNA-M applied barrier cream on the gloves and applied to the resident's buttocks area. CNA-M removed gloves and without washing or sanitizing hands, applied a clean brief on Resident 5. CNA-M then pulled up the resident's pants, touched multiple objects and surfaces in the resident's room including the resident's sling and broda chair before washing hands at the sink.</p> <p>On 7/12/16 at 10:40 a.m., surveyor 32768 interviewed CNA-M. CNA-M verified not washing or sanitizing hands before applying gloves to provide incontinence cares with Resident 5. In addition, CNA-M verified wearing soiled gloves to provide incontinence cares, applying cream to buttocks and additional tasks observed.</p> <p>Surveyor: 32769</p> <p>3. According to the facility's policy "Wound</p>	F 441		

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F 441	<p>Continued From page 72</p> <p>Prevention and Treatment Program," last revised 5/2016: 12. Clean Aseptic technique shall be used with all wound care following standard precautions unless otherwise specified by provider order. A resident with multiple wound sites should treat each wound as individual wound. Equipment should be disinfected and hand hygiene performed between each site to prevent contamination. Aseptic techniques should be utilized between each wound treatment.</p> <p>According to the Journal of Wound, Ostomy & Continence Nursing: March/April 2012 - Volume 39 - Issue 2S - p S30-S34: "Clean technique means free of dirt, marks, or stains. Clean technique involves: ~ strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. ~ meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves and sterile instruments, and preventing direct contamination of materials and supplies ~ is considered most appropriate for long-term care ...for patients receiving routine dressings for chronic wounds ... "aseptic technique is the purposeful prevention of the transfer of organisms from one person to another by keeping the microbe count to an irreducible minimum." On 7/11/16, Surveyor 32769 reviewed Resident 11's medical record. The resident's MDS (Minimum Data Set) assessment dated 4/14/16, documented diagnoses included dementia and a stage 3 pressure injury. Resident 11 was receiving Hospice care and relied on staff for extensive assistance with personal cares and</p>	F 441		

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F 441	<p>Continued From page 73</p> <p>hygiene.</p> <p>The resident's skin integrity plan of care, last revised 7/6/16, indicated Resident 11 had four open wounds to the coccyx, buttocks and posterior knee.</p> <p>On 7/12/16, at 11:40 a.m., Surveyor 32769 observed LPN (Licensed Practical Nurse)-S provide wound treatments and dressing changes to four wounds on Resident 11. LPN-S entered the resident's room with an open laptop computer and placed it on a table near the resident's bed. LPN-S washed hands, applied gloves and gathered supplies, placing them atop the keyboard of the open laptop. LPN-S removed a scissor and marker from their shirt pocket and without sanitizing them, added them to supplies on the laptop, then placed a clean field (disposable pad) on the resident's bed near the left knee. Observation of LPN-S are as follows:</p> <ul style="list-style-type: none"> ~ removed a wound dressing from open wound #1 (the resident's left knee), which had notable drainage, and placed it on a corner of the clean field. ~ wearing same soiled gloves, sprayed the wound with simple saline, patted it with gauze and touched multiple supplies resting upon the computer. ~ wearing same soiled gloves, opened a dressing package and removed the calcium alginate dressing inside, cut it with the soiled scissor, placing the scissor back on the clean supplies. ~ wearing same soiled gloves, placed the dressing into the open knee wound, with a cotton tipped applicator, then opened a new dressing and marked initials and date on the exterior with marker from shirt pocket, before returning it to the clean supplies. Placed the dressing over the 	F 441		

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F 441	Continued From page 74 wound, removed gloves and sanitized hands. ~ moved the remaining supplies from the laptop to the right side of the resident's bed and applied clean gloves. ~ 11:45 a.m., after opening a new clean field and placing it near the resident, who was lying on left side, transferred the supplies from the resident's bottom sheet to the right side of clean field. Removed a soiled dressing from open wound #2 (Resident 11's right upper buttock) and placed it on a left corner of the clean field. ~ wearing the same soiled gloves, cleansed the wound, cut a dressing with the soiled scissors, used the same marker to initial and date the clean dressing, applied skin prep to the periwound and covered the wound with Adaptic before applying the clean Mepilex dressing. Discarded soiled gloves, sanitized hands and applied clean gloves. ~ Removed a soiled dressing from nickel-sized open wound #3 (Resident 11's coccyx) and placed it onto a left corner of the clean field. ~ wearing the same soiled gloves, cleansed the wound with simple saline, three times and patted it dry with gauze. Wiped a pad pre-moistened with skin prep around the wound, packed a strip of calcium alginate into the wound with a cotton tipped applicator, cutting off the excess with the soiled scissor used earlier. ~ wearing the same soiled gloves, opened a dressing package, dated the outside of the dressing with the soiled marker and applied the dressing over wound #3. Picked up a soiled dressing, from atop the soiled portion of the clean field, and pulled soiled gloves off of hands and over the dressing, placing gloves and dressing back on the field, before sanitizing hands. ~With clean gloves, removed a dressing from wound #4 (Resident 11's right hip area) and	F 441		

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F 441	<p>Continued From page 75</p> <p>placed it on the left (soiled) side of the field. ~ wearing the same soiled gloves, cleansed the area with simple saline and patted it dry with gauze. Applied a new Mepilex dressing to the wound, after dating and initialing with the same marker used above. Rolled up the soiled dressings, remaining clean supplies, scissors and marker in the clean, field and carried it into the bathroom. ~ After removing gloves and sanitizing hands, LPN-S and CNA-N pulled up the resident's pants, positioned with pillows and covered the resident with bedding. ~ LPN-S returned to the bathroom, applied gloves, unrolled the now fully contaminated clean field and discarded the soiled items. Clean items (gloves, single dose saline, hand gel and cover roll) which had come into contact with soiled items, were returned to the bathroom's (clean) cabinet and the black-handled scissor and marker were placed back into LPN-S' shirt pocket without sanitizing them.</p> <p>On 7/12/16, at 11:58 a.m., Surveyor 32769 interviewed LPN-S who confirmed the above observations, indicating gloves should have been changed and hands sanitized between tasks, clean and soiled items should not have been placed in contact with one another and the scissors and marker should have been sanitized before use, between wounds and before returning to LPN-S' pocket.</p> <p>On 7/14/16, at 8:00 a.m., Surveyor 3769 interviewed IP (Infection Preventionist)-WW who confirmed that the preference is for each resident to have a dedicated scissor for dressing changes and verified staff should sanitize scissors before and after use on each wound.</p>	F 441		

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F 441	<p>Continued From page 76</p> <p>4. On 7/12/16, at 11:15 a.m., Surveyor 32769 observed CNA-N perform incontinent cares for Resident 11. After washing hands and applying clean gloves, CNA-N removed the resident's soiled brief. With the same soiled gloves, CNA-N cleansed the resident's perineal area from behind the resident by reaching between the legs and wiping front-to-back three times with a cloth, folding the cloth each time. Then, with the same soiled gloves, CNA-N dried the resident's perineal area with a towel, wiping front-to-back and folding it each time. With the same soiled gloves, CNA-N touched the resident's closet door, bathroom door and multiple items inside while retrieving a clean brief and barrier cream. Wearing the same soiled gloves, applied barrier cream on Resident 11's buttocks and perineal area. Then, without removing the gloves, CNA-A placed a clean brief under the resident, touching the inside of the brief that rested against the resident's perineal area. CNA-N then removed the soiled gloves and sanitized hands.</p> <p>On 7/12/16 a.m., Surveyor 32769 interviewed CNA-N who verified the above observations and confirmed gloves should have been removed and hands sanitized after each task.</p> <p>On 7/14/16, at 8:00 a.m., Surveyor 3769 interviewed IP (Infection Preventionist)-WW who confirmed staff should change gloves and sanitize hands between dirty and clean tasks.</p> <p>Surveyor: 18815</p> <p>5. On 7/12/16 at 11:02 a.m., Surveyor 18815 observed CNA-I and CNA-PP apply gloves to assist Resident 8 with incontinence cares. With gloved hands, CNA-I cleansed the resident's</p>	F 441		

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F 441	<p>Continued From page 77</p> <p>anal, buttocks and urethral areas with disposable wipes. Without removing gloves, CNA-I assisted CNA-PP to roll the resident to place a clean incontinence brief under the resident. After the clean brief was placed under Resident 8, CNA-I picked up the tube of barrier cream and placed the cream on the resident's anal/buttocks areas. CNA-I assisted CNA-PP with rolling the resident in bed to adjust the clean incontinence brief and pull the resident's pants up. CNA-I then removed gloves and without washing/sanitizing hands, CNA-I assisted CNA-PP with removing the resident's shirt and placing a clean shirt on the resident. CNA-I then picked up the packet of disposable wipes and tube of barrier cream, and placed both items on the back of the toilet. CNA-I then washed hands.</p> <p>On 7/12/16 at 11:20 a.m., Surveyor 18815 interviewed CNA-I who verified the above observations as written and stated "lost track of glove changes."</p> <p>6. On 7/12/16 at 2:23 p.m., Surveyor 18815 observed CNA-J and CNA-QQ apply gloves to assist Resident 9 with incontinence cares. With gloved hands, CNA-J cleansed the resident's anal and buttocks areas with disposable wipes. Without removing gloves, CNA-J picked up the tube of barrier cream and placed the cream on the resident's anal/buttocks areas. CNA-J then removed gloves and without washing/sanitizing hands, CNA-J assisted CNA-QQ with attaching Resident 9's clean brief, pulling up pants, raising the bed, removing the sling from the lift, repositioning the pillow under the resident's head, removing shoes, and placing a pillow under the resident's legs. CNA-J applied gloves to tie the bag of trash. CNA-J then removed gloves and</p>	F 441		

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F 441	<p>Continued From page 78</p> <p>washed hands.</p> <p>On 7/12/16 at 2:54 p.m., Surveyor 18815 interviewed CNA-J who verified the above observations as written.</p> <p>7. On 7/13/16 at 10:13 a.m., Surveyor 18815 observed CNA-H apply gloves to assist Resident 10 with toileting. With gloved hands, CNA-H wiped the resident's urethral area with toilet tissue. Without removing gloves, CNA-H placed a clean brief on the resident and pulled up the resident's pants. CNA-H then removed gloves and without washing/sanitizing hands, CNA-H pulled the lift out of the bathroom, placed the resident in the wheelchair, pulled shirt down, removed the sling from the lift, moved the lift, and adjusted the resident's sweater. CNA-H then washed hands.</p> <p>On 7/13/16 at 10:25 a.m., Surveyor 18815 interviewed CNA-H who verified the above observations as written and stated "usually leave gloves on."</p> <p>8. On 7/13/16 at 1:49 p.m., Surveyor 18815 observed CNA-H apply gloves to assist Resident 19 with incontinence cares. With gloved hands, CNA-H wiped stool from the resident's anal area. CNA-H removed gloves and without washing/sanitizing hands, CNA-H placed barrier cream on Resident 19's buttocks area. CNA-H then removed gloves and without washing/sanitizing hands, CNA-H rolled the resident in bed, pulled the resident's shirt down, and placed clean bedding on the bed. CNA-H then washed hands.</p> <p>On 7/13/16 at 2:25 p.m., Surveyor 18815</p>	F 441		

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F 441	Continued From page 79 interviewed CNA-H who verified the above observations as written.	F 441	
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 36402 Based on observation and staff interviews, the facility did not ensure 7 (CNAs (Certified Nursing Assistants)-C, CNA-M, CNA-I, CNA-J, CNA-H, CNA-EE, CNA-OO) of 12 aides observed were able to demonstrate competency in skills and techniques necessary to care for 7 (Resident 1, Resident 5, Resident 8, Resident 9, Resident 10, Resident 19 and Resident 13) of 18 sampled residents observed receiving cares. CNA-C did not demonstrate proficiency in infection control related to glove usage and hand hygiene during the provision of cares to Resident 1. CNA-M did not demonstrate proper infection control procedures during incontinence cares of Resident 5 related to hand hygiene and peri care. CNA-I did not demonstrate proficiency regarding infection control related to hand hygiene and complete perineal cares while assisting Resident 8.	F 498	

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F 498	<p>Continued From page 80</p> <p>CNA-J did not demonstrate proficiency regarding infection control related to hand hygiene and complete perineal cares while assisting Resident 9.</p> <p>CNA-H did not demonstrate proficiency regarding infection control related to hand hygiene while assisting Resident 10.</p> <p>CNA-H did not demonstrate proficiency regarding infection control related to hand hygiene or when Resident 19's urinary catheter drainage bag was placed above the resident's bladder during transfer.</p> <p>CNA-EE did not demonstrate proficiency when intentionally leaving Resident 13 in a soiled incontinent brief, which showed evidence of moisture.</p> <p>CNA-OO did not demonstrate proficiency when performing incomplete perineal cleansing on Resident 13.</p> <p>Findings include:</p> <p>1. On 7/12/16 at 7:25 a.m., Surveyor 36402 observed CNA-C perform morning cares for Resident 1 while the resident lay in bed. Upon entering the resident's room, CNA-C applied gloves without first performing hand hygiene. While performing cares, CNA-C obtained a urinal from the resident's bathroom and drained the Resident 1's urinary drainage bag. CNA-C then poured the urine from the urinal into the toilet, rinsed the urinal in the sink, poured the contaminated water into the toilet, flushed the toilet, and then placed the urinal in a storage</p>	F 498		

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F 498	Continued From page 81 container under the sink in Resident 1's bathroom. CNA-C then continued performing cares for Resident 1 without performing any hand hygiene, including: washing the resident's underarms, applying deodorant, assisting the resident in putting a t-shirt on, turning the sink on in the bathroom, and obtaining an additional wash cloth from the bathroom. CNA-C then used the washcloth to wash Resident 1's frontal perineal area as well as rectal area. Without performing hand hygiene, CNA-C then obtained barrier cream and applied to the resident's rectal area. CNA-C then removed Resident 1's brief and applied a clean brief. CNA-C then inserted the resident's urinary drainage bag through the left pant leg and proceeded to put the pants on the resident. After completing dressing the resident, CNA-C adjusted the pillow beneath Resident 1's head, pulled the resident's shirt down, adjusted the resident's pants, and tied them. CNA-C then turned the resident to the left side and placed a pillow to assist the resident in maintaining that position, as well as an additional pillow between Resident 1's legs. CNA-C then removed the dirty linen and brief from the foot of the resident's bed, placed the soiled linen on the edge of the sink in Resident 1's bathroom and placed the brief in the garbage can. CNA-C then tied the garbage bag and placed the bag on top of the dirty linen on the sink. CNA-C then applied a new liner to the garbage can. CNA-C then returned to the resident's room from the resident's bathroom and pulled the sheet and blanket over Resident 1 and lowered the bed. CNA-C then entered the resident's bathroom, removed gloves, and performed hand hygiene in the sink for 5 seconds. CNA-C then applied gloves and removed the dirty linen and garbage bag from resident 1's bathroom and carried the items to the	F 498		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525625	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2016	
NAME OF PROVIDER OR SUPPLIER LAKELAND HEALTH CARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1922 CTY RD NN ELKHORN, WI 53121		
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F 498	<p>Continued From page 82</p> <p>soiled utility room on the unit. CNA-C performed hand hygiene in the utility room after depositing the items and removing gloves.</p> <p>On 7/12/16 at 7:52 a.m., following completion of the above observation, Surveyor 36402 interviewed CNA-C. CNA-C verified no hand hygiene was completed between cares with Resident 1. In addition, CNA-C verified hand washing in the sink for 5 seconds following the provision of cares to Resident 1.</p> <p>On 7/14/16 at 9:55 a.m., Surveyor 36402 interviewed DON (Director of Nursing)-B regarding the observation of cares to Resident 1 by CNA-C. DON-B verified the facility's expectation is for hand hygiene to be completed, "After touching each potentially contaminating surface." DON-B further stated the facility's expectation is for, "Handwashing after peri-care as well as catheter care or emptying."</p> <p>Surveyor: 32768</p> <p>2. On 7/12/16 at 10:25 a.m., surveyor 32768 observed incontinence cares with Resident 5. CNA-M applied gloves without washing or sanitizing hands, assisted resident from broda chair to bed with lift. CNA-M pulled the resident's pants down to knees then removed soiled brief from resident. CNA-M wiped the resident's groin area with clean wipe front to back and repositioned the resident to right side while wearing the same soiled gloves. CNA-M then wiped buttocks area front to back with a clean wipe and put barrier cream on the same gloved hand and applied the cream to the resident's buttocks area. CNA-M then removed gloves and without washing or sanitizing hands, applied a clean brief on the resident, then pulled up the resident's pants, touched multiple objects and surfaces in the resident's room, including the resident's sling and broda chair before washing</p>	F 498		

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F 498	<p>Continued From page 83 hands at sink.</p> <p>Surveyor: 18815 3. On 7/12/16 at 11:02 a.m., Surveyor 18815 observed CNA-I and CNA-PP apply gloves to assist Resident 8 with incontinence cares. CNA-I verified the resident was incontinent of urine. While wearing gloves, CNA-I cleansed the resident's anal/buttocks area and the back of the urethral area with a disposable wipe. Without removing gloves, CNA-I assisted CNA-PP to roll the resident to place a clean incontinence brief under the resident. After the clean brief was placed under Resident 8, CNA-I picked up the tube of barrier cream and placed the cream on the resident's anal/buttocks areas. CNA-I assisted CNA-PP with rolling the resident in bed to adjust the clean incontinence brief and pull the resident's pants up. Resident 8's groin/frontal area had not been cleansed even though the resident's incontinence brief had been wet with urine. CNA-I then removed gloves and without washing/sanitizing hands, CNA-I assisted CNA-PP with removing the resident's shirt and placing a clean shirt on the resident. CNA-I then picked up the packet of disposable wipes and tube of barrier cream, and placed both items on the back of the toilet. CNA-I then washed hands.</p> <p>On 7/12/16 at 11:20 a.m., Surveyor 18815 interviewed CNA-I regarding the above observations of incontinence care and hand hygiene. CNA-I verified the above observations regarding Resident 8 and stated "no groin/frontal cares (provided) even though (the resident) was incontinent of urine."</p> <p>4. On 7/12/16 at 2:23 p.m., Surveyor 18815</p>	F 498		

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F 498	<p>Continued From page 84</p> <p>observed CNA-J and CNA-QQ transfer resident 9 from the chair to the bed with a sit to stand lift. CNA-J and CNA-QQ verified the resident was incontinent of a large amount of urine and stool. With gloved hands, CNA-J cleansed the resident's anal/buttocks area and the back of the urethral area with a disposable wipe. Without removing gloves, CNA-J picked up the tube of barrier cream and placed the cream on the resident's anal/buttocks areas. CNA-J then removed gloves and without washing/sanitizing hands, CNA-J assisted CNA-QQ with attaching Resident 9's clean brief, pulling up pants, raising the bed, removing the sling from the lift, repositioning the pillow under the resident's head, removing shoes, and placing a pillow under the resident's legs. CNA-J then removed gloves and washed hands.</p> <p>Resident 9's groin/frontal area had not been cleansed even though the resident's incontinence brief had been wet with a large amount of urine and stool.</p> <p>On 7/12/16 at 2:54 p.m., Surveyor 18815 interviewed CNA-J regarding the above observations of incontinence care and hand hygiene. CNA-J verified the above observations as written regarding Resident 9 and stated "should have cleansed the groin/frontal area and more of the urethral area. Only did back part of urethral area from front to back."</p> <p>5. On 7/13/16 at 10:13 a.m., Surveyor 18815 observed CNA-H apply gloves to assist Resident 10 with toileting. With gloved hands, CNA-H wiped the resident's urethral area with toilet tissue. Without removing gloves, CNA-H placed a clean brief on the resident and pulled up the resident's pants. CNA-H then removed gloves</p>	F 498		

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F 498	<p>Continued From page 85</p> <p>and without washing/sanitizing hands, CNA-H pulled the lift out of the bathroom, placed the resident in the wheelchair, pulled shirt down, removed the sling from the lift, moved the lift, and adjusted the resident's sweater. CNA-H then washed hands.</p> <p>On 7/13/16 at 10:25 a.m., Surveyor 18815 interviewed CNA-H who verified the above observations as written and stated "usually leave gloves on."</p> <p>6. On 7/13/16 at 1:49 p.m., Surveyor 18815 observed CNA-H apply gloves to assist Resident 19 with incontinence cares. CNA-H attached the resident's catheter urinary drainage bag to the lift near the resident's chest area and raised the lift to transfer the resident to bed. The catheter urinary drainage bag was above the level of the bladder during transfer. With gloved hands, CNA-H wiped stool from the resident's anal area. CNA-H removed gloves and without washing/sanitizing hands, CNA-H placed barrier cream on Resident 19's buttocks area. CNA-H then removed gloves and without washing/sanitizing hands, CNA-H rolled the resident in bed, pulled the resident's shirt down, and placed clean bedding on the bed. CNA-H then washed hands.</p> <p>On 7/13/16 at 2:25 p.m., Surveyor 18815 interviewed CNA-H regarding the above observations. CNA-H verified the observations as written and stated catheter "should not be above bladder because it won't flow."</p> <p>Surveyor: 32769</p> <p>8. On 7/11/16 at 8:00 a.m., Surveyor 32769 observed CNA-OO provide incontinent cares for</p>	F 498		

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F 498	<p>Continued From page 86</p> <p>Resident 13. CNA-OO rolled the resident to the left side. From behind, CNA-OO removed the resident's incontinent brief and confirmed it was wet. Then with gloved hands from behind the resident, CNA-OO lifted the resident's right leg with own left hand, and while reaching between legs wiped once, front-to-back, over the urethral and anal area. A small smear of stool was noted on the wet cloth. CNA-OO folded the cloth, wiped front-to-back again, over the same areas, then dried the resident by wiping once with a towel. The resident's groin folds were not opened or cleansed.</p> <p>On 7/11/16, at 9:32 a.m., CNA-OO verified to Surveyor 32769 that the resident's groin folds were not cleansed in the above observation.</p>	F 498		

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ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
F 156	<p>The MDS Coordinator has received training regarding the proper use of Medicare Non-Coverage (denial) forms. A policy and procedure has been Developed and states the Medicare billers will review a copy of the form to ensure the resident is informed of their rights as well as any potential expense that they may incur as a result of the termination of Medicare Part A services. The Medicare billers will submit a quarterly analysis of their review of all Medicare notices to the Quality Assurance Committee. This committee will provide guidance on the continuation or modification of auditing.</p>	8/5/2016
F176	<p>Our "<i>Self-Administration of Medication by Residents</i>" policy and procedure was reviewed with Registered Nurse Q on an individual basis. This nurse was counseled regarding the importance of following all LHCC policies and procedures. She was counseled regarding the importance of following nursing standards of care and best practices. A nurse manager will audit a minimum of one time a week for 6 weeks of Nurse Q med passes. If no deficiencies after 6 weeks The nurse manager or her designee will monitor 1 of this nurse's medication passes each calendar quarter for the next year.</p> <p>The "<i>Self-Administration of Medication by Residents</i>" policy was reviewed with all nurses at the August mandatory monthly meetings. There will be four additional medication audits on (different nurses) per month. These audits can default to the current number of audits.</p> <p>Results of routine audits of medication passes and of medication carts are submitted to the Quality Assurance Committee on a quarterly basis. This committee provides guidance on the continuation or modification of auditing.</p>	8/14/2016

The individual signing the first page of the SOD (CMS-2567) is indicating their approval of the plan of

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correction being submitted on this form.

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F 225	Nurse Manager G received education from Director of Nursing and Nursing Home Administrator regarding the importance of addressing all concerns voiced at care planning meetings. Full investigations must be completed,	
	Each incident is reviewed at morning meeting. Specific training has been given to all charge nurses and House supervision on the meaning of immediately. Incidents that are reportable will be sent to the state within the established time frames.	7/14/2016
	All staff received re-education regarding the <i>Resident Abuse Prohibition</i> policy. The importance of reporting ALL allegations and the importance of reporting "immediately" was stressed.	8/4/2016
	Nurse Managers were coached as to the importance of following up with any concerns listed on the 24 hour board. Also, the importance of auditing documentation in order to look for potential problems or concerns. Director of Nursing audits the 24 hour report looking at potential problems within the population.	8/4/2016
F 241	The policies were reviewed concerning Dignity, cares, perineal care and catheter care. The employees named in the Statement of Deficiency were counseled regarding the need to treat residents in a respectful manner. They were re-educated regarding the importance of treating the residents with dignity,	
	All staff members attended an in-service regarding treating residents with respect and dignity. All staff members were trained in care with dignity prior to 8/20	8/20/16
	The Behavior Management Team will audit the memory care unit when	

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	<p>they do their weekly rounds. They will work to ensure our residents are treated with respect. They focus on their appearance. The team will analyze their findings and present a report to the Quality Assurance Committee. This committee provides guidance on the continuation or modification of auditing. The nurse managers, charge nurses and DON will make rounds at least daily ensuring that the residents are cared for with dignity (Clean, dry, turned and modesty intact.)</p>	8/4/2016
F 285	<p>The PASRR Screens policy and procedure has been updated to reflect the need to scan all Level 1 screens into the electronic charting system. The Level 1 screens will be reviewed quarterly and updated PRN by the unit Social worker, or designee. If a Level II is needed, it will be scanned in the Computer. Having all the PASRRs in one spot provide all the needed information and will ensure required Level IIs are not missed. The nurses and social workers will work to ensure this process is complete.</p>	8/3/2016

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F314	<p>It seems evident that we teach our employees to follow the plan of care and the CNA care card. We do not do an effective job of teaching them "why" we do things. In this case, staff needs to be better educated Regarding the prevention of pressure ulcers.</p>	
	<p>All nursing staff attended training on slings. The policy reviewed with single use slings. We will be obtaining physician orders when leaving the sling in place is a greater risk than potential harm in removing the sling.</p>	8/20/16
	<p>All staff attended an initial in-service regarding following the plan of care and CNA care cards. This educational session included information regarding the importance of properly elevating heels. It included info RE: the use of Prevalon boots and the importance of repositioning.</p>	8/3/2016
	<p>We will use our "toilet talk" program to offer a short series of information regarding pressure ulcer prevention over the next several weeks. We began with the first mini-lesson on August 5, 2016</p>	8/14/2016
	<p>During the month of August all nursing department staff will receive pressure ulcer training.</p>	8/20/16
	<p>Nurse managers and members of behavior management team will do weekly audits throughout the building to determine if care plans/ CNA care cards for Residents with pressure ulcers are being followed. Audit findings will be summarized and submitted to the Quality Assurance committee on a quarterly basis. This committee provides guidance on the continuation or modification of auditing.</p>	8/14/2016

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	The weekly wound care rounds will include an analysis of why or why not pressure ulcers are improving. Interviews with staff members are an important piece of doing a root cause analysis.	8/14/2016
	All employees named in the SOD have been counselled regarding the importance of following the care card. If they are confused about what they should do they are encouraged to meet with their nurse, their manager or the Director of Nursing.	8/14/2106
	Information published by the National Pressure Ulcer Advisory Panel has been shared with LHCC nurses. We will continue to share various articles and hold open discussion meetings at our monthly nurse meetings.	8/14/2016
F315	Nursing and CNA staff attended an in-service regarding catheters and UTIs. All survey deficiencies were discussed with staff, along with a review of our polices and procedures regarding catheters and peri care.	
	Employees named in the SOD received individual counseling regarding what was observed. They are encouraged to meet with the nurse and/or Manager whenever they are confused or have concerns. UIT prevention was discussed.	
	All nursing staff will view catheter care in-service through our on-line Relias training sessions before the end of August.	
	Nurses, Nurse managers, supervisors, and DON will do daily audits. The Behavior Management Team will do weekly audits to ensure catheter bags are not lying on the floor. They will observe to ensure protective coverings are in place	8/14/2016
	Staff has been educated regarding the importance of not having the catheter urinary drainage bag above the level of the resident's bladder during a transfer.	8/4/2016

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F 329	<p>Our Behavior Management Specialist will review ALL of the pharmacy recommendations to attempt a GDR. This will be done for all residents on antipsychotic medications – even if the resident is on hospice. She will contact the physician regarding a risk/benefit statement.</p>	
	<p>The charts of all residents on antipsychotic medications will be reviewed on a weekly basis by the nurses caring for the residents and quarterly by the Behavior Management Specialist so that we ensure we have attempted a GDR in two separate calendar quarters during the first year a resident is admitted on separate calendar quarters during the first year a resident is admitted on an antipsychotic medication or after we have initiated an antipsychotic medication, after the first year we will ensure we have attempted a GDR annually,</p>	7/25/2016
F332	<p>We have met with the nurse involved in this deficiency. We discussed the need to follow basic nursing standards of care. She must follow all of our policies and procedures. She has been advised to meet with her manager or the Director of Nursing if she needs help in organizing her time.</p> <p>Nurse manager and DON will be auditing on a weekly basis for 6 weeks if no discrepancies we will change audit to monthly x6 months, they will be reported to the Quality Assurance Committee and they will decide when specific auditing of this nurse can cease.</p>	
	<p>All Nursing staff was educated in regards to policies on medication self-administration, clean technique, administrating inhaled substances and infection control policies.</p>	7/31/16
	<p>Nurse Managers and the Director of Nursing will randomly audit medication passes each month. They will report their findings to the Quality Assurance Committee on a quarterly basis.</p>	8/4/2016
F356	<p>The Daily Nursing Staffing posting has been revised to reflect actual hours worked. The charge nurses have been trained in completing these new tasks.</p>	7/14/2016

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F 425	<p>We reviewed the deficiency with the nurse who did not provide a cup to the resident to use to spit out the water used to rinse his mouth after using an Advair inhaler. This nurse was reminded how important accurate dispensing is. The Nurse managers, charge nurse and DON are monitoring the medication passes. Weekly x 6 weeks if no patterns seen than once a month x 6 months and reported back in Quality Assurance.</p>	7/22/2016
	<p>We discussed the importance of accurate dispensing with all nurses during a mandatory in-service following the State survey.</p>	8/4/2016
F 441	<p>All involved employees have been counseled regarding the importance following all policies and procedures. Infection control practices that help prevent the development and spread of disease and infection must be followed. All employees have been taught on proper use of gloves and hand washing, Nursing staff has been taught about clean technique concerning items they store in their pockets. The Nurse Manager, Charge nurse and Don will be auditing monthly to ensure this does not reoccur.</p>	
F 441 continued	<p>Wall dispensers for hand sanitizers have been installed near the residents' beds in each room so that hand sanitization can occur easily during cares. All staff attended a hand washing in-service. Staff was required to participate in a proper hand washing demonstration.</p>	8/14/2016
	<p>All certified nursing attendants attended a skills fair and Power Point demonstration on proper perineal care.</p>	
	<p>Nurses are now required to randomly audit personal cares of a CNA one time each month. They must submit the audit report to the nurse manager who will analyze the data and provide a report to the Quality Assurance Committee on a quarterly basis. This committee will provide guidance on the continuation or modification of auditing.</p>	8/14/2016
F 498	<p>We will verify the certified nursing attendants skills sets by holding a hand hygiene, glove usage, perineal care, catheter care including positioning, lift usage now and with a skills fair one time each year.</p>	
	<p>We will verify the attendants skills sets by randomly auditing personal cares each month. Nurses, managers and the Director of Nursing will</p>	

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be involved in this effort.	
Specific perineal care, hand hygiene, glove usage, catheter care including placement training have been added to the training modules for new certified nursing attendants.	8/14/16