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F 431	Continued From page 20 different occasions. 6. On 5/15/13 at 3:40pm the label on R27's multi dose vial of Novolin Insulin was dated as opened on 4/14/13 and was to be discarded on 5/14/13. The Medication Record dated May 2013 states R27 received the outdated Novolin Insulin on 3 different occasions. The record states that R27 receives Lantus Insulin daily. The multi use vial of Lantus Insulin was not dated when it was opened. E10, Licensed Practical Nurse, stated on 5/15/13 at 3:40pm that R26 and R27's multi use insulin vials were outdated and should be discarded. E10 stated the multi use vials were currently being used for R26 and R27.	F 431		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	F9999		

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F9999	Continued From page 21 and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	F9999		

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F9999	Continued From page 22 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to implement a pressure relieving mattress for R18, resulting in the development of an avoidable Stage 3 pressure ulcer to the right lateral ankle and a Stage 2 pressure ulcer to the right buttock. The facility failed to reapply a dressing in a timely manner to R3's coccyx pressure ulcer. The facility failed to assess and document weekly pressure ulcer measurements for R21. R18, R3 and R21 are three of six residents reviewed with pressure ulcers in the sample of 15. Findings include: 1. The Physician's Order Sheet(POS) dated 5/2013 states that R18 has diagnoses of Parkinson's and Atrial Fibrillation. The Minimum Data Set(MDS) dated 12/24/13 stated that R18 is	F9999		

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at risk for pressure ulcers, but does not have any pressure ulcers. The MDS dated 3/26/13 stated R18 has one Stage 2 and one Stage 3 pressure ulcer. The assessment states R18 requires extensive assist with bed mobility and transfers. The Care Plan dated 3/6/13 identifies an intervention dated 10/4/12 for a "pressure reducing mattress."

The Progress Note dated 1/22/13 documents, "[R18] has unstageable pressure ulcer to right lateral ankle measuring 0.6cm[centimeter] by 0.7cm..." The note dated 1/29/13 states, "Stage 3 pressure ulcer right lateral malleolus now 1.4cm by 1.3cm with presence of 90% slough....." The note dated 3/19/13 states, "[R18] has open area to [right] buttocks measuring 2.5cm by 1.5cm by 0.1cm, [right] ankle measuring 0.4cm by 0.5cm....." The note dated 4/9/13 states, "right ischium 0.4cm by 0.5cm by 0.1cm, right ankle has no open area...."

The Wound Evaluation Sheet dated 4/16/13 states R18 has a pressure ulcer(reopened) on the "Malleolus Lateral/Ankle Right, Stage III" measuring 1.0cm by 1.0cm by 0.2cm with granulation and slough 15%....Erythema/redness-Blanchable..." The Wound Evaluation Sheet states R18 has a pressure ulcer on the buttock, "Stage II" measuring 0.5cm by 0.5cm by 0.1cm with "light exudate....non blanchable erythema.....epithelial wound bed..."

The Progress Note dated 5/7/13 states, ""right lateral ankle is 1.0cm by 1.0cm by 0.1cm.....Buttocks is 0.4cm by 0.7cm by 0.1cm....." The weekly Pressure Ulcer Log dated

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F9999	Continued From page 24 5/7/13 identifies R18's right lateral ankle ulcer as Stage 3 and the right buttock ulcer as a Stage 2. On 5/15/13 at 9:50am an oversize bed frame with a regular mattress was in R18's room. At 10:55am E6, Certified Nurse Aide(CNA) transferred R18 to the bed. At 1:30pm R18 was lying in bed in her room. The mattress on the bed was not pressure relieving. E3, Housekeeping Supervisor, stated on 5/15/13 at 12:25pm that R18's bed and mattress were rented for her, but E3 did not know whether the mattress was pressure relieving or not. E3 stated she thought R18 had the mattress and bed for awhile but did not know the date when it was ordered. At 12:50pm E3 confirmed the bed and mattress which was rented for R18 was not a low air loss mattress. E3 stated she checked with the company the bed/mattress was rented from, and was told the mattress was a regular one, not pressure relieving or reducing. The undated invoice from the equipment company documents a bariatric bed with regular mattress was delivered to the facility on 6/20/12. E3, Housekeeping Supervisor, confirmed on 5/16/13 at 2:30pm that the invoice provided was for R18's bed/mattress which was delivered on 6/20/12. On 5/15/13 at 10:55pm E4, LPN(Licensed Practical Nurse) did the treatment to R18's pressure ulcer on the right buttock/ischium. At 1:35pm E4 measured R18's right lateral malleolus/ankle pressure sore. The ulcer measured 1.0cm by 1.0cm, the wound bed was covered with yellow slough with erythema/redness in the peri wound. E4 then did	F9999		

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F9999	Continued From page 25 the treatment to the ankle. E4 stated on 5/15/13 at 1:45pm that R18 always lays on her right side when in bed, which puts pressure on her right lateral/outer ankle area. E4 stated staff will turn R18 to the left, but she will turn herself back to the right, which puts pressure on the right outer ankle. E4 stated, "I know a lot of it is because she[R18] won't stay off of it[right side]." E4 stated R18 has a history of a pressure ulcer on the right lateral ankle, which will close and reopen. 2. The Weekly Pressure Ulcer Assessment dated 4/30/13 states that R3 has a Stage 3 pressure ulcer on the coccyx measuring 1.5cm by 0.6cm by 0.2cm with a small amount of exudate and slough. The Progress Note dated 5/7/13 states, "coccyx is 2.0cm by 0.9cm, slough 100%....." The Physician's Order dated 5/8/13 states to "Check dressing to coccyx, if soiled or removed, cleanse with normal saline, apply santyl to wound bed, calcium alginate, cut to fit wound bed, cover with bordered foam twice a day." On 5/13/13 at 11:40am, 12:30pm and 1:00pm R3 was sitting in the wheeled recliner chair. At 1:30pm E7 and E6, CNAs transferred R3 from the chair to the bed. E4 cleaned R3's perineal/rectal area following a bowel incontinence. The dressing to R3's coccyx was not in place when R3's disposable brief was removed. The wound bed of the ulcer contained slough. E5, LPN, cleaned the ulcer, applied Santyl, calcium alginate and a bordered foam dressing to the ulcer.	F9999		

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E7 and E6, CNAs stated on 5/13/13 at 1:55pm that the dressing on R3's coccyx ulcer pulled off when they turned R3 prior to getting her up for lunch. E7 and E6 stated they got R3 up in the chair for lunch at around 11:15am. E7 and E6 stated they told E5, LPN, that R3's dressing had come off. At this same time, when asked why she did not replace R3's dressing when it was reported, E5 stated that R3 was up in the chair for lunch when she found out the dressing was off, so she waited until 1:35pm when R3 was put back to bed to reapply the dressing.

3. R21's Admission Progress Note dated 3/13/13 documented no pressure ulcer on admission. R21's initial MDS dated 3/22/13 identified R21 as cognitively intact, requiring extensive assistance of one staff for bed mobility and transfers. R21 was assessed on 3/22/13 at risk of developing a pressure ulcer but having no pressure ulcers.

Progress Notes dated 4/22/13 document that R21 had developed an open area to the left buttock. The note documented the area measured 1.0cm x 0.5 cm. The note documents R21 refused to off load the area. The Progress Notes dated 4/23/13 documents the ulcer measured 1.0 cm x 1.0 cm x 0.1 cm. The area was cleansed with Normal Saline and Duoderm was applied per the 4/23/13 Physician Order.

Progress Note dated 4/30/13 documents "resident developed small ulcers to buttocks. 3 small stage II ulcers measuring 1.0 cm x .5 cm x 0.1 cm. Duoderm applied to area. Encourage off loading with no effect."

Progress note dated 5/06/13 and the facility

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Pressure Ulcer report documented on 5/06/13 R21 developed stage I pressure ulcers to the right and left elbows.

The Pressure Ulcer report dated 5/13/13 did not include any current measurements for the left coccyx pressure ulcer last measured 4/30/13, nor the status of the stage 1 ulcers of the elbows that developed on 5/06/13. There was no evidence of weekly documentation for 5/07/13, or 5/14/13 to monitor the size and condition of the ulcers in the electronic record.

The Director of Nurse's E2 stated on 5/14/13 at 12:45 pm that the facility Wound Nurse, E19 documents pressure sore measurements weekly on Tuesdays. E19 was currently on vacation. E2 was to do the weekly pressure ulcer measurement and documentation for R21 on Tuesday (5/14/13) but stated she got busy and did not do it. E2 could not find any documentation in the electronic record nor any hard copy documentation for the previous weekly pressure ulcer documentation that was due on 5/07/13. On 5/16/13 at 9:00 am E2 assessed R21's pressure ulcer to the left coccyx ulcer as a stage 2, measuring 0.6 cm x 0.3 cm x 0.1 cm.

The facility "Skin Condition and Pressure Ulcer Assessment Policy dated 2008 states, #14. An individual Skin Integrity Observation will be initiated when a pressure and or other ulcer...are identified by licensed nurse. This form is a permanent clinical record. Until the wound heals, the Skin Integrity Observation may be maintained with the residents Treatment Administration Record... #15 Pressure Ulcer and other ulcers..will be measured at least weekly and

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F9999	Continued From page 28 recorded in centimeters on the Skin Integrity Report....the report will include type of ulcer, Size (length x width x depth), Stage (I-IV and Unstageable), Odor, Drainage amount,...description of wound bed and date and signature of individual performing assessment. #20 For each wound location , previous skin measurements will be reviewed weekly for wound progress and healing.. #24 Weekly the Treatment Nurse or designee will complete the Pressure Ulcer and Skin Report. " (B) 300.1230 k)1) Staffing Effective September 12, 2012 a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. These requirements were not met as evidenced by the following: Based on record review and interview the facility failed to have 10% of nursing and personal care time provided by a Registered Nurse for 3 of 14 days reviewed. This has the potential to affect all 60 residents residing in the facility. Findings include: The undated spread sheet provided by E1, Administrator on 5-14-13 at 10:30 A.M. documents the period of time reviewed for staffing was from April 22, 2013 - May 5, 2013. E2, Director of Nurses stated on 5-15-13 at 3:25 P.M., the facility had 20 skilled residents and 40	F9999		

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intermediate residents for that time period, which equals 160 hours of minimum direct care staff. The total hours of direct care calculated (160 hours) times 10% equals the number of Registered Nurse (RN) time(16 hours). The Minimum RN hours per 24 hour period are calculated to be 16 hours.

The staffing spread sheet documents the following hours per 24 hour period for RNs:

5-22-13 - 12 RN hours
5-23-13 - 12 RN hours
5-26-13 - 12 RN hours

The schedule dated April 22 - May 5 2013 confirms the hours worked by RN's on the preceding dates.

On 5-16-13 at 11:30 A.M. E2, Director of Nurses, stated the RN hours listed on the schedule sheet for each day are accurate.

According to the facility's Centers for Medicare and Medicaid Services CMS-672 (Resident Census and Conditions of Residents), 60 residents reside at the facility.

(No Violation, Comments Accepted)