STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145571	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH REHAB CENTER	**ONE PERRYMAN STREET LEBANON, IL 62254**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint #1445820 / IL 73959 - 157, F224, F241, 279, F314, 325 An extended survey was conducted.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		

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

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to timely notify the Physician of changes in condition of pressure ulcers and of a significant weight loss for 2 of 20 residents (R1, R4) reviewed for physician notification in the sample of 20. Findings include: 1. R4's Minimum Data Set (MDS) dated 12/16/2014 documents diagnoses, in part, of Atrial Fibrillation, Hypertension, Anxiety Disorder and Depression with an admission date of 9/5/2014. The facility face sheet, undated, also documents a diagnosis of unspecified calorie malnutrition. R4's weight record documents on 11/13/2014 R4 weighed 184.20 LBS. On 12/4/2014 R4 weighed 166.80 LBS, a 17.4 LB weight loss. On 12//31/2014 R4 weighed 150.8 LBS, an additional weight loss of 16 LBS. From 11/13/14 to 12/31/13 R4 had a total weight loss of 33.4 LBS, a significant weight loss of 18.1%. R4's record documents Z1, Physician was not notified of R4's 12/4/14 significant weight loss until 12/23/2014. The notification was done by fax and along with a request for Remeron. A "Change of Condition Report" dated 12/24/14, documenting New Orders - weekly weights times 4 / continue current diet and supplement, and was signed by Z10, Dietician.	F 157		

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F 157	Continued From page 2 On 1/14/2015, E2 Director of Nurses (DON), stated, "The Registered Dietician enters recommendations and requests to the Physician via the computer. The physician then agrees or disagrees through the computer". On 1/14/2015 at 1:36 PM, Z1, stated, "I was unaware of R4's weight loss until last week." Z1 also states, "I was unaware the Registered Dietician was requesting an appetite stimulant, because I was unaware the requests were being entered into a computer for me to check." When asked if Z1 could explain R4's weight loss he stated, "she had a very significant small bowel operation before entering the facility and I don't think she has ever recovered from the surgery. Z1 stated, "someone from the facility should have been calling me with this information". 2. R1's current face sheet documents diagnosis of Asthma, COPD, HTN, Cerebral Degeneration, TIA's, cough, history of falls, pressure ulcers unstageable, open wounds, and vitamin deficiency. R1's Physicians Order Sheet dated 5/21/14 documents: Admit to Hospice with Terminal Diagnosis of Alzheimer's. Z1, Medical Doctor attending and managing pain and symptoms. On 1/13/15 at 1:40 PM, E2, Director of Nursing stated that E3, Wound Nurse takes orders from the Hospice Nurse and inputs them into the computer. E2 stated she is unsure how the coordination of care with Hospice is done, since this was new to her. E2 also stated R1's orders come from Hospice. E2 further stated that she would expect staff to notify Z1 if R1 had no current physician on file or if residents don't have	F 157		

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F 157	Continued From page 3	F 157		

any preference.

The Facility Policy "Treatment Standing Orders" (undated) documents "Stage 2, 3, 4, UTD pressure with necrotic area.... Unless hospice then notify / receive new orders from hospice.

On 1/7/15 at 2:00 PM, Z2, Registered Nurse Case Manager/Hospice, stated she cared for R1 once a week for the past 6 months. Z2 stated that R1 developed a Stage 1- Stage 2 on coccyx and now has declined to --"what you see is what you get". Z2 stated that the facility was supposed to be getting orders for R1's pressure areas from Z1, Physician.
Z2 stated the Hospice Medical Director is not allowed to give orders at this facility due to the electronic computer system. Z2 further stated that Hospice nurses make recommendations or suggestions to the facility staff and the facility is supposed to get the order from Z1. R1 currently has a pressure area to right ear, a Stage 2-3 that had recently opened up on left outer ankle, and a Stage 4 coccyx wound that was infected.

On 1/7/15 at 2:30 PM, Z1, Medical Doctor, stated that he recalled R1 and that R1 is under the care of Hospice. Z1 stated he does not medically manage R1 and her care is done with Hospice. Z1 further stated he does not know anything about any of R1's pressure areas and is not involved in R1's care of pressure ulcers. Z1 stated the Facility contacted him once for a referral for wound management for R1 but was never notified by facility of R1's pressure ulcers.

The Facility policy "Managing Change of Condition" 10/2011, documents; If the change of condition does not appear life threatening, the

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F 157	Continued From page 4 following steps may be followed: 2. Notify physician and responsible party of assessment findings. If unable to communicate with the resident's attending or on-call physician, contact the facility Medical Director.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the Facility failed to identify a medical reason, assess risk versus benefits and least restrictive measures for the use of restraints for 2 of 4 residents (R14, R9) who utilize restraint devices in the sample of 20. Findings include: 1. R14 was originally admitted to the Facility on 10/24/14, with diagnoses, in part, of Congestive Heart Failure, Cirrhosis of the Liver and Brain Damage. R14 was observed sitting in a high back wheelchair, while not in bed, throughout all days of the survey. R14 was observed with an alarmed self-releasing lap belt across the waist while sitting in the wheelchair. R14's most recent Minimum Data Set (MDS), dated 12/22/14, documents that the Facility was unable to assess R14's cognitive ability; that R14 has short and long term memory problems; does	F 221		

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F 221	Continued From page 5 not ambulate; and requires extensive assistance for transfers, and activities of daily living. R14's plan of care, dated 12/12/14, documents a Problem of "At risk for falls and injuries related to: Psychotropic Medication (Meds), Cardiovascular Meds, Pain Meds, Cognitive Impairment, Poor safety awareness, unsteady gait and history of falls". Interventions for this Problem include: "self releasing seat belt". On 12/10/14, the "Verification of Incident Investigation/Administrative Summary", documents that R14 fell from his wheelchair at 1:30 AM. The form documents "Follow-Up Actions Taken: Placed alarmed safety self-release belt". R14's "Verification of Incident Investigation/Administrative Summary" forms, document that R14 experienced falls from his wheelchair, while wearing the alarmed self-releasing lap belt, on 12/13/14, 12/20/14, 12/26/14, 12/28/14, 12/30/14 and 1/5/15. There is not any type of assessments documenting the use of the alarmed self releasing lap belt present in R14's clinical record. R14's clinical record was reviewed with E4, Care Plan Nurse, on 1/8/15 at 11:15 AM. E4 confirmed that there is no assessment documenting the medical reasons, risks versus benefits or least restrictive measures attempted, for the use of R14's lap belt. On 1/8/15 at 11:53 AM, E21, Physical Therapy Assistant, stated "R14 has had multiple falls so, that's why it was decided that he needed the self-releasing lap belt. It is to keep him in the	F 221		

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F 221	Continued From page 6 chair". The Facility policy entitled "Operating Standard - Physical Restraints", documents "Any type of intervention that restricts freedom of movement must be in response to minimizing or eliminating the medical symptom contributing to the risk. It is important through the assessment and care planning process to identify and address any underlying problems causing the medical symptom". 2. R9's Physician Order dated 01/2015 documents, 'Check placement and functioning of self-releasing seat belt while up in wheelchair and diagnoses of Parkinson's Disease and Alzheimer's Disease '. The most recent MDS dated 10/30/14 documents R9 needs extensive assist of 2 staff for transfer and toilet use and has moderately impaired daily decision making skills. R9's Interdisciplinary Physical Restraint Assessment initiated on 1/15/14 and last updated on 10/30/14 documents, 'Identify the behavior interventions and reasons for moving to a restrictive device: Resident was having frequent falls. Type of Restraint used/considered: Self release, alarming seatbelt. Medical Reason for use of the restraint: Parkinson's Disease, Alzheimer's Disease. What is the Resident response to this restraint: Decreased episodes of falls. Resident is able to self release belt - verbally understands. Results of Restraint free time/behaviors exhibited: During toileting, restorative, etcetera. Decreased episodes of falls. Based on IDT (Interdisciplinary Team) assessment: Continue with self release seat belt to decrease risk of falls. 'The assessment does not identify risks or potential negative outcomes of using the seat belt.	F 221		

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F 221	Continued From page 7 R9's Care Plan for Use of Physical Restraints dated 1/15/14 and revised on 10/30/14 documents, 'Requires the use of Self Release Belt when in wheelchair Related to Poor Safety Awareness and Multiple Falls. Goals: Will achieve maximum physical mobility within limitation without evidence of injury. Will have no fall and injury daily. Interventions: Instruct resident and family of risk and benefits of intervention. Release every 2 hours for toilet use, circulation and exercises. IDT assessment and evaluation for restraint reduction quarterly. Try least restrictive devices. ' On 1/5/15 at 10:10 AM during initial tour, R9 propelled himself in his wheelchair in the hallway with a self release belt around his lap. On 1/5/15 at 12:05 PM, R9 ate lunch in the dining room with his seat belt on. On 1/5/15 at 12:37 PM, R9 sat in his wheelchair in his room with his seatbelt on. On 1/13/15 at 10:20 AM, E4, Care Plan Coordinator, stated the self release alarming seatbelt was put in place after R9's last fall on 1/9/14. E4 stated R9's restraint assessments are done quarterly and no attempts to reduce wear time or total restraint elimination have been done since 1/9/14. E4 stated potential risks for restraint use were not identified and she did not know why this had not been done. E4 stated the facility will reassess R9 for restraint elimination since R9 has not had any fall incidents in the past year.	F 221		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit	F 224		

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F 224	Continued From page 8 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility neglected to identify, accurately assess and monitor pressure ulcers, neglected to timely treat and seek new treatments when the pressure ulcer was declining, neglected to inform the physician and follow their policy and procedures for pressures ulcers for 3 of 7 residents (R1, R2, R8) reviewed for pressure ulcers in the sample of 20. This neglect resulted in R1 developing a Stage 4 pressure ulcer which became infected, a Stage 3 reoccurring Pressure Ulcer, and an unstageable pressure ulcer. R2 developed a facility acquired Stage 4 pressure ulcer that became infected. R8 developed two avoidable pressure ulcers. The failure resulted in an Immediate Jeopardy. While the Immediacy was removed on 1/8/15 the Facility remains out of compliance at Severity Level 2 as the facility continues to educate staff and evaluate the effectiveness of the facility policies and procedures and their system of assessing pressure ulcers and implementing timely intervention. Findings include: 1. R1's current face sheet documents diagnosis of asthma, COPD, HTN, Cerebral degeneration,	F 224		

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F 224	Continued From page 9 TIA, cough, history of falls, pressure ulcers unstageable, open wounds, and vitamin deficiency. R1's, 5/1/14 Physicians Order Sheet documents: Admit to Hospice with Terminal Diagnosis of Alzheimer's, Z1, Medical Attending / Medical Director (MA/MD) attending and managing pain and symptoms. The most recent Minimum Data Set (MDS) dated 11/21/14, documents R1's Brief Interview of Mental Status (BIMS) was left blank. The MDS documents R1 is totally dependent on two or more staff members for transferring, bed mobility, toileting, and is totally dependent on one staff for dressing, eating, personal hygiene and bathing. R1 is always incontinent of bowel and bladder. The MDS documents R1 has a Stage 1 or greater pressure area. Prevention measures for R1's pressure area were as follows: A. pressure reducing device for chair, B. pressure reducing device for bed, D. Nutrition or hydration intervention, E. Pressure Ulcer care, G. Application of nonsurgical dressings(with or without topical medications) and H. Applications of ointments and medications. The MDS did not identify as interventions: C. Turning and repositioning program, F. Surgical wound care, and Applications of dressing to feet. R1's review of R1's weekly " Skin Condition " reports beginning 5/22/14 through 7/11/14, document repeatedly that R1 had redness to her coccyx and was treated with Calazime per Standing Order of Z1. On 7/11/14, this treatment was discontinued, and a new Standing Order was started to begin treating R1's buttocks with "stock antifungal cream" three times per day.	F 224		

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F 224	Continued From page 10 On 8/8/2014, R1's, Skin Condition report documents "Duoderm applied to excoriated area on buttocks." On 8/15/14 through 8/29/14 the skin report continues to document R1 has an open area on Right ear, treatment continues to left buttock, Duoderm applied. R1's medical record and nursing notes for this time evidenced no documentation that Z1 MD, had been informed R1's buttocks continued to be excoriated and the facility staff were using Duoderm to treat it. On 9/5/14, R1's Skin Condition report documents "open area to right ear, sero-sanguineous. Left Buttock / Duoderm on wound noted, Right Buttock, 2 open areas, each measuring 1.0cm (centimeter) x .5cm and another 1.0cm x .5cm area." On 9/19/14, E3, Licensed Practical Nurse, Wound Nurse, (LPN) documented in R1's Nursing Notes: "N.O. (Nurse Order) from Hospice regarding incontinent associated lesion to buttock, for wound gel and to cover with optifoam. Change daily and PRN (as needed) as area has declined. On 10/4/14, R1's Nurses Note documents: "late entry: spoke with Hospice and family re: decline in residents wound to buttock. Asking for Santyl, as slough remains to wound bed. Hospice continues to want wound gel and Mepilex every 3 days to wound." On 9/17/14, R1's Nutrition Notes document: "wound report 9/4 excoriation butt .2 x.4, s/t (skin tear) right ear .6 x .8." Notes dated 10/17/14 document; R1's wound report 10/9 incontinent	F 224		

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F 224	Continued From page 11 lesion butt, 2.3 x 2.1x Necro and 4.2 x1. On 10/20/14, the Hospice record documents "R1 seen today face to face for hospice recertification. R1 with dementia, with continuing decline. R1 resides at LTC facility and is totally dependent on staff for all ADLS. R1 is incontinent of bowel and bladder. R1 sits in a broda chair or is bed bound. R1's husband is present during my visit today and states R1 continues to drinks 2 boost per day and eats 50-75% of her meals. R1 rarely verbalizes, only yes or no occasionally and nonsensically. R1 has recurrence of Stage 2 to her right upper helix. R1 leans on that ear chronically in her broda char. Repositioning techniques have been started." IDT/Services: "sitting in broda chair leaning to right. This puts pressure on right ear which is beginning to show reddened scabbed area again. Positioned with C- pillow to keep pressure off of ear. Also spoke with nurse asking to keep pressure off ear." On 11/4/14, R1's Nutrition Notes document; R1 skin 10/30 incontinent lesion butt 2.1 x 3.1 x necrosis; wound left ankle .5 x .5. Nurse says butt worse." On 11/13/14 Z3, Wound Manager/Nurse Practitioner, (WM/NP) documents: F/u (follow up) of this 72 year old female with a coccyx ulcer, currently treating with Santyl, Dakins', moistened gauze and dry dressing. Nursing requests that I examine her right ear, which was noted on 11/12/14 to have a pressure ulcer. Currently treating with TAO (triple antibiotic ointment). Nursing reports that the coccyx ulcer has increased necrosis and odor noted. Physical Exam: well nourished, groomed and normal body habitus; Wound #1 Pressure Ulcer/Coccyx,	F 224		

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F 224	Continued From page 12 Unstageable; Status: Not healed; Pre-Debridement length: 4.50cm Width: 5cm (increased size) Unable to determine pre-depth area: 22.5 cm 2. Description: Wound base color: yellow 40%, black 50%, Pink 10%: Necrotic tissue: Extensive; Procedures: Excisional debridement; Pre Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue, viable tissue obtained for tissue C&S (culture and sensitivity) today. Wound #2 Pressure Ulcer/Right Ear; Pressure ulcer/Stage III ; Acquired: 11/12/14; Pre-Debridement length: 2.00cm Width: 0.50cm Depth area: 0.30cm: Area: 1 cm 2, Volume: 0.3cm Description: Slough: minimal, Wound base color: yellow 30%, Pink 70%: Notes: Nursing to obtain pillow to help off-load pressure of ear." On 11/16/14, Z3, WM/NP, documents, "Nursing reports that this 72 year old female was noted on 9/29 to have a coccyx ulcer, which appears to be secondary pressure. Wound #1 Pressure Ulcer/Coccyx, Pressure ulcer/unstageable, Coccyx, acquired: 9/29/14; Acquired at outside facility: No (in facility); Pre-Debridement length: 4.50cm (cm), Width: 4.00 cm, Unable to determine pre-depth area: 16 cm 2. Description: Wound base color: yellow 100%, necrotic tissue: Extensive; Procedures: Excisional debridement; Pre-Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue. On 11/17/14, laboratory results for R1 document organisms of: 1) Proteus Mirabilis-moderate growth; 2) streptococcus agalactiae-Grp B-Heavy growth; 3) alpha hemolytic streptococci-	F 224		

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F 224	Continued From page 13 heavy growth in coccyx wound. On 11/20/14, Z3, WM/NP, documents "R1's tissue culture of her coccyx was + (positive) for Proteus Mirabilis and Streptococcus Agalactiae. Notes: Nursing to obtain pillow to help off-load pressure of ear." (2nd mention) The American Society for Microbiology, "Infection and Immunity" dated May 2004, documents: Proteus Mirabilis, is a common cause of urinary tract infections. Website: www.ncbi.nlm.nih.gov/. Mayo Foundation for Medical Education and Research, 1998-2015, documents: Group B Streptococcus is a common bacterium carried in the intestines or lower genital tract. Website: Mayoclinic.org/. R1's Nutritional Status/Quarterly Progress Record documented by E26, Food Service Manager, on 8/30/14 and 11/21/14 both indicate, "Plan/Follow-up: current pressure ulcer(s): No. On 11/24/14, Z3,WM/NP documents: F/u (follow up) of this 72 year old female with a coccyx ulcer, currently treating with Santyl, Bactroban, and Calcium Alginate and dry dressing. F/u of right ear ulcer, currently treating with Santyl. Nursing reports that she has a left lateral ankle ulcer that they would like me to evaluate, currently treating with skin prep, which was noted on 10/29/14. Physical Exam: well nourished, groomed and normal body habitus; Wound #1 Pressure Ulcer/Coccyx, unstageable; Acquired: 9/29/14; Pre-Debridement length: 5.00cm Width: 4.20cm Unable to determine pre-depth; Area: 21 cm 2. Undermining: 1 cm from 12 O'clock, Undermining: 2 cm from 3 O'clock; Wound base color: yellow 30%, Pink 70%: Wound #2	F 224		

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F 224	Continued From page 14 Pressure Ulcer/Right Ear; Wound type/grade: Pressure ulcer/Stage III; Body Part: Ear right; Acquired: 11/12/14; Acquired in facility ; Status: healed. Wound #3 Pressure ulcer/left ankle; Unstageable; Ankle left lateral; Acquired 10/29/14; Acquired in facility; Pre-Debridement length: 1.0cm Width: 1.0cm Unable to determine pre-depth Area: 1 cm 2. Description: Euchar: fully covered; Wound base color: black 100%; On 12/18/14, R1's Change of Condition-Skin Condition report documents "new onset, excoriation, open area and redness, side of/under left breast. Current size of wound: length=3.2 cm, width 1.3 cm, depth=n/a (not applicable). Progress Note update: staff notified this nurse of open area noted under R1's left breast. Upon assessment 3.2 x 1.3 cm excoriated area noted to left area under left breast with 1.6 x 0.4 cm reddened area next to open area." On 12/19/14, R1's, Non-Pressure Skin condition report documents: Site/locations: left side of chest, Condition is: scab, Length 1.2, Width 2.2 cm, Depth: Scab. On 12/26/14, R1's Measurements: Length: 1.4, Width, 1.6, Depth: Scab. On 12/19/14, R1's "Skin Integrity Care Plan: Non-Pressure Wound", documents: scab intact blister to left chest, left arm. Skin Prep TID (three times daily) to intact blisters and monitor scabbed area every shift for any changes until healed. On 12/19/14, Hospice documentation indicates: "R1 has a 4.8 x 3.6 cm - Stage 4 wound to sacrum, Stage 2 wounds to left ankle and under left breast, 3.2 x 1.3 cm, and Stage 1 wound to	F 224		

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F 224	Continued From page 15 right ear helix." On 12/30/14 at 12:35 PM, E3, Wound Nurse stated R1's redness to her coccyx started in 5/2014, as an "incontinent lesion" and has since declined to a Stage 4 pressure ulcer. E3 stated that Z3, WN/NP started seeing R1 in 11/2014, but only after a 3-4 week delay in treatment due to internal issues with Hospice. E3 stated R1's pressure areas were declining during this time. E3 stated she noted the area to be declining in 8/2014 or 9/2014, and knew the wound needed debridement. The Hospice provider was supposed to have a wound nurse come, but never did during that time. E3 stated she had never called R1's physician (Z1) to update him on R1's progression of pressure ulcer because she thought hospice took care of getting the physician's orders. On 12/30/14 at 2:30 PM, E2, DON stated that R1 had pressure area on her coccyx and her ear. E2 stated that E3 monitors the areas and she is not aware of any other pressure areas to R1. E2 stated there were issues with Hospice and E3 was reporting to Hospice that R1's pressure ulcer on her coccyx had gotten worse and was not healing. E2 stated she was not sure how long the pressure areas to coccyx and ear had been going on and she would have to look at the record. E2 stated, E3 fills out a monthly wound report that E2 reviews. E2 stated that the weekly skin assessments have not been done by facility staff, and E3's wound measurements were being copied from Z3's W/M, notes. Additionally, E2 stated, regarding residents at risk for skin breakdown; she would expect staff to turn and reposition R1 frequently, apply a low air loss mattress and be calling Z1, MA/MD. E2 further	F 224		

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stated that there is no documentation on turning and repositioning of residents, staff does not document on that.

On 1/7/15 at 9:07 AM, E2, DON, and E3 Wound Nurse, stated; when R1 was admitted to the facility on 4/17/14 she had a pressure reducing mattress, which is standard for all residents admitted to their facility. E2 stated on 8/2/14 through 9/19/14, R1 had excoriation to coccyx, developed an incontinence lesion and a Duoderm was applied. E3, stated during this time R1's pressure ulcer on her coccyx had started to decline and knew it needed debridement. On 9/29/14, Hospice wound nurse was supposed to come and evaluated R1 but never came. E2 stated they had no further orders from Hospice, and on 10/4/14, E3 was becoming impatient with hospice and requested orders for Santyl. Hospice did not want to do Santyl. E3 stated "No doctor was called /notified at that time". On 11/3/14 a low air loss mattress ordered from wound management. On 11/6/14 wound management started seeing R1 and noted R1 had unstageable pressure ulcer to coccyx and debrided it.

On 1/7/15 at 11:45 AM, E2 and E3 stated that R1's right ear pressure ulcer initially broke open 10/5/14 and then healed. They both stated that a neck pillow was provided by R1's husband upon admission and then it was lost for a week or two and Hospice provided another pillow. E2 and E3 stated that R1 was on a pressure reducing mattress since admission and R1, but did not have low air loss mattress implemented until wound management involved. E2 and E3 both stated they were unsure why it took so long to get R1 a low air loss mattress. Both stated that R1's

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wounds had been declining prior to wound management involvement on 11/6/14. E2 and E3 stated that R1 is turned and repositioned every 2 hours or more when needed and even turned and reposition every hour since 11/3/14. E2 stated "there is no documentation to provide to show that R1 has been turned and repositioned every hour or every 2 hours. E3 stated that R1 is currently turned and a pillow is placed behind R1's back to keep R1 on side. E3 stated that she doesn't think that the pillow is providing enough support to off load R1's pressure areas to coccyx, right ear and left ankle. E3 further stated that a wedge would be more appropriate for R1 to ensure proper off loading and is "something I need to get."

On 1/7/15 at 1:45 PM, E2, DON stated she cannot find any notes from Hospice for R1 and does not know where hospice keep their chart in the facility. On 1/8/15 at 8:45 AM, E2 produced R1's hospice record and stated she had called the Hospice Provider, and had her bring the records to the facility that morning for review.

On 1/7/15 at 2:00 PM, Z2, Registered Nurse/Hospice Case Manager stated she cared for R1 once a week for the past 6 months. Z2 stated that R1 developed a Stage 1 to Stage 2 on coccyx and now it has declined to --"what you see is what you get". Z2 stated "the facility was supposed to be getting orders for treatment of R1's pressure areas from Z1. Z2 stated the hospice medical director is not allowed to give orders at this facility due to his inability to access the electronic computer system. Z2 further stated that Hospice nurses make recommendations or suggestions to the facility staff and the facility is supposed to get the order from R1's attending

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physician. "

On 1/7/15, Z2, continued, stating "R1 had a pressure area to the right ear from a cervical collar that hit the tip of the ear and pressed against the right ear. The right ear was open, and would heal then reopen off and on. R1 favored laying her head to the right side against the wheelchair. R1's left outer ankle is a Stage 2 to Stage 3 that had recently opened up--around after 10/2014. Z2 stated that R1 would be sitting continuously in the recliner in her room and then in the wheelchair. Z2 stated Hospice did supply a neck pillow when R1's C-collar was lost, to help keep the ear pressure ulcer from opening up. Z2 stated that she would classify R1 as High Risk for pressure ulcers. Z2 also stated R1 has an infection in her coccyx wound. "

On 1/7/15 at 2:30 PM, Z1, Medical Doctor, stated that he recalled R1, R1 is under the care of Hospice and her care is with Hospice. Z1 further stated he does not know anything about any of R1's pressure areas and is not involved in R1's care of pressure ulcers. Z1 stated the Facility contacted him once for a referral for wound management for R1 but was never notified by facility of R1's pressure ulcers since that time.

On 1/8/15 at 10:45 AM, E2, DON, and E3 were asked if there were other pressure areas on R1. E2 stated she was not aware of any other areas. E3, Wound nurse stated at that time that there were no other areas on R1.

On 1/8/15 at 10:45 AM, E3, Wound nurse did a skin check on R1. R1 was lying in bed, alert and answering questions appropriately. R1's left breast/side was observed as E3 did a skin check.

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R1 had a quarter-sized reddened area to the underside of her left breast. E3 stated R1 is receiving no treatment or skin prep to the area at this time. E3 further stated that Hospice orders the treatments for R1's pressure areas.

On 1/8/15 at 11:50 AM, E3, Wound nurse stated she classified pressure areas as incontinence lesions, but was told by Z3, WM/ NP, that the areas should not be classified that way.

On 1/8/15 at 9:20 AM, Z3, WM/NP stated that she started seeing R1 on 11/6/14 and that R1 has really done well since starting with wound management. Z3 stated that R1 had a pressure ulcer to right ear that has closed and reopened at least twice since she started treated her. Z3 stated that R1's right ear recently reopened again and that R1 likes to lay on the right side. Z3 stated that R1 was provided with a neck pillow and is on low air loss mattress. Z3 stated the facility needed to figure out a way to keep R1 off her right side. Z3 further stated that gel pillows could help R1's right ear heal. Z3 stated that R1 has a Stage 4 pressure ulcer to her coccyx that the facility told her started 9/29/14. Z3 stated when she first started seeing R1 her pressure ulcer on her coccyx was unstageable. Z3 stated R1 needs a wound vac and would be healed by now but R1 is on hospice. Z3 stated R1 initially had necrosis to her coccyx but has improvement since R1 was debrided. Z3 stated that R1's pressure ulcer to her coccyx currently has undermining. Z3 further stated that R1 has " group B strep " in her coccyx wound and feces and urine could be the cause of R1's wound infections. Z3 stated that R1 has a left lateral ankle that is looking better but slow healing since starting with wound management, and at this time

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is unstageable. Z3 stated she gives E3, wound nurse recommendations for each resident's interventions to keep pressure areas from progressing. Z3 further stated that she does not think that placing a pillow under R1's back off-loads R1 enough to provide relief to the Stage 4 pressure area to coccyx. Z3 further stated a wedge would be more appropriate for R1 to offload pressure areas for R1's three pressure ulcers.

On 1/12/15, E3 stated R1's wound continued to decline and wound management requested for R1 to be laid down more frequently and that R1 should be turned every hour from side to side and only on her back only for meals. Both stated, on 11/3/14, the facility implemented turning every residents every 1 hour if they have active pressure ulcers. E3 stated that R1's right ear was sloughing on 11/13/14 and that R1 leans to right side and puts pressure on it.

On 1/12/15, E2, and E3, reviewed R1's Risk for Pressure Ulcers form dated 4/17/14, which documented R1 as " no risk " for pressure ulcers. The Pressure Ulcer form continued to document on 5/14/14, 8/30/14 and 11/21/14 that R1 was a "mild risk", even after though R1 had developed of a Stage 3 to right ear, an unstageable to left ankle and a Stage 4 to coccyx. E2 stated, "R1's assessments were not accurate and R1 was at a high risk for pressure ulcers". E3 agreed with the assessments being inaccurate.

On 1/13/15 at 1:40 PM, E2, Director of Nursing stated E3, Wound Nurse would take orders from the Hospice nurse and input them into the computer. E2 stated she is unsure how the

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Facility coordinates R1's care with Hospice since this was new to her. E2 further stated that she would expect nursing staff to notify Z1, Attending of R1 and Medical Director, if R1 had no current physician on file or if residents don't have any preference.
2. R2's Physician Order Sheet (POS) documented an admission date of 10/7/14, and a diagnoses that includes; Altered Mental Status, Hypertension, Cerebral Vascular Accident, Dementia, Hearing Loss. R2 had no pressure ulcers on admission to this facility.

On 11/17/14, E3, Licensed Practical Nurse, documented in the Nurses Notes "incontinence associated lesion on R2's right and left buttock with measurements of (0.6 x 0.6) on the right side and (0.8 X 0.9) on the left side " . The Facility Standing orders for Incontinence Associated Lesion dated 11/17/14 were started. The treatment is documented: cleanse area with normal saline, apply Duoderm every 3 days, and monitor dressing every shift and for signs and symptoms of infection.

On 11/17/14 a Skin Integrity Care Plan: Non-Pressure Wound, was implemented, for incontinence associated lesion to buttock with interventions for pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm care, maintain head of bed in lowest possible position, encourage resident to reposition as able.

R2's Minimum Data Set (MDS) dated 11/5/2014, documented R2's Brief Interview for Mental Status (BIMS) as a 2, moderately impaired. Under functional status, Activities of Daily Living,

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F 224	Continued From page 22 Bed Mobility documents R2 as a 3/2 (Extensive assist/One person physical assist). R2's MDS dated 12/5/14, under skin and ulcer treatments documents A. Pressure reducing device for chair. B. Pressure reducing device for bed. The MDS did not identify for skin ulcer interventions; C. Turning/repositioning program. On 11/18/14 at 11:50 AM, E3 Licensed Practical Nurse (LPN) Wound Nurse, documented on the Change of Condition report, "Area to right buttock has been compromised due to pressure and has developed into a pressure area. A low air loss mattress was implemented on 11/18/14. On 11/18/14, the Skin Integrity Care Plan Non-Pressure Wound, documented "Area was compromised by pressure and order changed to Santyl, Resident seen by Z3 Specialized Wound Management (SWM) Nurse Practitioner (NP). Z3, SWM/NP documented in her notes she saw R2 on 11/20/14, not on 11/18/14 as was documented on R2 ' s care plan. Z3 documented R2's pressure ulcer as unstageable, with measurements of 1.0 X 1.5. Z3 changed R2's treatment to clean wound with normal saline, apply Santyl to wound, cover with gauze and dry dressing. Change daily and as needed. On 11/24/14, Z3 saw R2 and documented pressure ulcer to coccyx unstageable with measurements of 1.5 X 1.5. Continue to cleanse pressure ulcer with normal saline, apply santyl to wound, cover with gauze and dry dressing. Change daily and as needed. The facility's pressure ulcer evaluation record dated 11/2014, documented wound	F 224		

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F 224	Continued From page 23 measurements to be 1.5 X 1.5, unable to determine stage. On 12/4/14, Z3 was at the facility, but R2 was unavailable. Nursing reported to Z3 that R2 was stable. Z3 documented will follow up next week. On 12/11/14, Z3 saw R2 and documented unstageable pressure ulcer to coccyx with measurements of 1.5 X 1.5. Z3 performed excisional debridement of necrotic tissue. Treatment of the pressure ulcer continues with clean with normal saline, apply Santyl to wound, cover with gauze and dry dressing. On 12/18/14, Z3 saw R2 and documented unstageable pressure ulcer with measurements of 1.1 X 1.0. Continue to cleanse pressure ulcer with normal saline, apply Santyl, cover with gauze and dry dressing. Change daily and as needed. The facility's pressure ulcer determination record dated 12/19/14, documented, unable to determine stage, with measurements of 1.1 X 1.0. See SWM notes. On 12/22/14, Z3 saw R2 and documented Stage IV pressure ulcer with measurements of 1.0 X 1.0 X 1.5, with undermining of 1 centimeter (cm) from 12 O'clock and 0.7 cm from 9 O'clock. Exposed structure: tendon. Z3 documented instructions for staff on importance of R2 being up for 2 hours max at a time to help with off-loading and promote in healing. The facility's pressure ulcer determination record dated 12/22/14 documented stage IV pressure ulcer with measurements of 1.0 X 1.0 X 1.5. See SWM notes.	F 224		

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F 224	Continued From page 24 On 12/25/14 at 3:30 PM, E30, LPN documented on Nurses Notes that Z4, Power of Attorney (POA), notified E30, that R2 had an odor coming from R2's coccyx wound. Z4 told E30 "I know the wound is getting worse and there is an odor to it. I know the odor is not coming from bowel movement (BM)." E30, notified Z6, Nurse Practitioner of Z4's concerns of the odor coming from R2's wound and new orders were received for one time dose of Rocephin 1 gram intramuscular (IM) now. Culture coccyx wound. Complete Blood Count (CBC) in AM. Laboratory results from wound culture obtained 12/25/14, documented; Positive for Escherichia, many white blood cells, gram negative rods, many gram positive cocci, many gram positive rods. On 12/29/14, Z3 saw R2 and documented stage IV pressure ulcer with measurements of 3.00 X 5.00 X 1.50. Undermining: 9 cm from 3 O'clock. Undermining: 1 cm from 9 O'clock. Undermining 2.5 cm from 12 O'clock. Undermining:1 cm from 3 O'clock. Exposed structure: Bone, Tendon. Treatment changed to cleanse pressure ulcer with normal saline, apply Santyl, Dakins' 0.125% moisten gauze packing, cover with gauze dry dressing. Change daily and as needed. Z3-instructed staff on importance of R2 being side to side turn only to help with off-loading and promote in healing. R2 is currently on bed rest. Foley catheter was placed for wound healing. On 12/30/14 at 12:30 PM, E2 Director of Nurses (DON), was asked if the facility has any documentation of when staff turn and reposition residents. E2 said "No".	F 224		

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F 224	Continued From page 25 The facility's pressure ulcer evaluation record dated 12/30/14 documented Stage IV with measurements of 3 X 5, see SWM notes. The facility's Resident Treatment Administration Record (TAR) for December 2014, documents the nurses initials in a box each day the dressing change was done. No Nurses Notes were available to describe the wounds characteristics or odors. On 12/25/14, the TAR initials that E23 LPN did the wound treatment and dressing change. No documentation or description of the wound size, odor or condition was available. On 1/5/15 at 12:25 PM, E3 LPN Wound Nurse was asked where she documents the size, depth, tissue, drainage of a wound after doing treatment. E3 said," whoever does the dressing change signs it off on the TAR, there is no documentation of the wounds except when SWM comes." When E3 was asked if the measurements on the facility's pressure ulcer evaluation record were her measurements and assessment of R2's wounds, E3 said "No, they are SWMs measurements and assessments". E3 said the pressure ulcer evaluation record dated 12/30/14 were SWMs measurements for 12/29/14. They were not E3's measurements for 12/30/14 as documented. The Facility's Policy "Skin Integrity Standard" dated March 2005 and updated June 2010, documented, Procedure: - Documentation of the turning and repositioning at least every two (2) hours while in bed or in a chair. Dependent residents sitting or in bed may need a position change for 'tissue offloading' every hour. Weekly "head to toe" assessment of	F 224		

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F 224	Continued From page 26 all residents by Licensed nurse with narrative documentation of findings. - Weekly narrative documentation must include: description of skin tissue, color, turgor, rashes, bruising, skin tears, edema, incision lines and any other skin related issues. - If skin integrity issues are identified post-admission to the facility the following documentation is required: #2. Notation on the 24 hour report indicating the skin condition. #5. Incident report completed for in house acquired Stage III and/or IV. Use in tracking/trending and QA&A program. - Director of Nurses DON/Designee completes weekly random skin assessments. On 1/7/15, at 11:45 AM, E2, DON, stated she had not been doing the weekly random skin assessments as directed by facility policy. 3. R8's was admitted to the Facility on 12/5/14 after discharge from a local hospital. Discharge documents indicate R8 had a Stage 1 pressure ulcer to the left heel and a blister on the right heel, no measurements were given by local hospital. The Facility Nurses Notes dated 12/5/2014 at 10:00 pm document in part; "Pink area noted to coccyx." There is no documentation R8 ' s heels were observed or if measurements were taken of R8's heel ulcers upon readmission. On 12/9/2014 the "Pressure Ulcer Evaluation Record" of the right heel documents a Deep Tissue Injury area width a length of 2.6 centimeters with a width a 2.8 centimeters. These measurements were taken 4 days after	F 224		

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F 224	Continued From page 27 readmission. R8's Minimum Data Set (MDS) dated 12/17/14 documents R8 has a Brief Interview of Mental Status (BIMS) of 15 which indicates no mental impairment. This same MDS document diagnoses, in part, of Congestive Heart Failure, Congenital Musculoskeletal deformities, and Cellulitis. On 1/13/15 at 1:00 PM, R8, stated he had gotten the pressure areas to his heels before admission, while in the hospital. On 12/19/2014 the "Pressure Ulcer Evaluation Record" of the right heel documents a deep pressure area width a length of 2.6 centimeters with a width a 2.8 centimeters. On 1/13/2015 at 10:30 AM, E2 Director of Nurses, stated, She is unsure why a full skin assessment was not completed on R8 upon readmission. E2 further stated, a full skin assessment should be completed upon all resident admissions and readmissions. On 1/13/2015 at 10:35 AM, E3 Wound Nurse, stated "yes 10 days had passed without measurements of R8's heel wounds during the period of 12/9/2014 and 12/19/2014". E3 stated, "I assess every week as long as the assessment happens sometime in the following week , it's ok". On 1/1/15 R8's left heel, previously a blister, now measures 1.7cm x 2.1cm x 0.2cm. The Immediate Jeopardy situation was identified to have begun on 11/17/14, when the Facility neglected to notify Z1 of a change of condition to R1's skin, neglected to accurately identify,	F 224		

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F 224	Continued From page 28 assess, seek timely treatment and the pressure ulcer worsened and became infected.The facility failed to accurately identify new pressure ulcers for R2, and R8 and failed to properly assess and initiate timely and preventative treatment to avoid worsening and infection of R2's pressure ulcers. E1 and E2 were notified of the Immediate Jeopardy on 1/8/15 at 12:50 PM. Beginning 1/8/15, in interviews, observation and record review the Facility took the following actions to remove the Immediacy: 1. 1/8/15 - The Facility reviewed R1 and R2 head to toe, to ensure there were no other new or declining pressure ulcers. All treatment orders were reviewed to ensure they were clinically appropriate for each resident ' s status. 2. 1/8/15 - The facility reviewed all current residents with known pressure ulcers to ensure accurate assessment, monitoring / measuring, and treatment of ulcers were being carried out per facility policy. 3. 1/8/15 - The Facility initiated head to toe skin checks on all residents to identify any new pressure ulcers and ensure they had clinically appropriate orders for their skin conditions. 4. 1/8/15 - The Facility began contacting each resident's physician, with pressure ulcers, to review and update treatment orders. 5. 1/8/15 - All Facility RN ' s, LPN ' s, and C.N.A ' s began re-education on the Facility's policy for appropriate assessment, reporting, monitoring, treatment, and physician notification, when there	F 224		

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F 224	Continued From page 29 is a change in status of a resident ' s skin condition, or change in condition of a pressure ulcer. 6. 1/8/15 - The Facility began measures to ensure staff follow it's policy of weekly measurements of pressure ulcers, and of informing the physician when thereis no improvement in the wound progress within 2 weeks. Wound care and status will be monitored weekly by E2, DON.	F 224		
F 241 SS=D	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: Based on observation, interview and record review , the Facility failed to interact with the resident in a dignified manner for 1 of 17 residents (R4) reviewed for dignity in the sample of 20. Findings include: 1. R4's Minimum Data Set (MDS) dated 12/16/2014 documents diagnoses, in part, of Atrial Fibrillation, Hypertension, Anxiety Disorder and Depression. This same MDS documents R4 has a Brief Interview of Mental Status (BIMS) of 6 with 15 being the highest cognition score. R4's Care Plan dated 12/16/2014 documents extensive maximum assist of two staff members	F 241		

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F 241	Continued From page 30 for transfers. On 1/8/2015 at 10:27 AM, E5 Certified Nurses Aide (CNA) was asked by, E29 Registered Nurse (RN), to assist R4 from the wheelchair to bed. E5 walked into the room, turned the bedding down, unclipped R4's personal alarm and call light from R4's shirt. E5 proceeded to walk to R4's right side and grab R4 under the arm and state "Come on" while attempting to stand R4 up, then stated "turn your foot." R4 was having a difficult time standing and turning to the bed. E5 sat R4 on a small section of the edge of the bed. R4 flopped backwards and her legs were off the bed with her back in the middle of the bed almost parallel to the bed. E5 picked up R4's legs and put them on the bed. E6 CNA entered the room to help position R4 correctly in bed, E6 explained to R4 what she was doing to R4 and once positioning was complete E6 left the room. During the positioning, E5 was rolling R4 over without explaining what was going to happen, or give adequate time for R4 to respond to the physical cues E5 was was giving. E5 would push or pull R4 in the direction E5 wanted R4's body to go. Once R4 was positioned in bed and covered up, R4 was requesting a special pillow, E5 was ignoring R4's request. R4 continued to ask over and over until E5 finally asked R4, what she wanted, and then stated "it must be in the laundry." E5 then left the room. R4 had on a light peach t-shirt which was visibly wet from water R4 had spilled down the front of her t-shirt during lunch. On 1/8/2015 at 10:40 AM, E5 was questioned about why she did not interact with R4. E5 stated, "I don't feel good." When questioned why E5 layed R4 down in a visibly wet t-shirt, E5 stated, "I	F 241		

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F 241	Continued From page 31 didn't notice that it was wet." On 1/8/2015 at 11:40 AM, E2 Director of Nurses (DON), stated she expects her staff to treat the residents with respect, dignity, say hello and explain all procedures to the residents. E2 states, "the behavior that E5 displayed is unacceptable." E2 stated that R4 has had a very flat affect since being admitted. On 1/5/2015 at 11:15 AM, E29 stated that R4 has a very flat affect, is unmotivated to do anything or eat. The facility "Inservice Dignity and Privacy ,undated, documents, in part, "Include him in conversation. Speak to him as an adult, even if you're not sure how much he understands".	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to provide psychiatric services in a timely manner for 1 of 20 residents (R4) reviewed for social services in the sample of 20. Findings include: R4's Minimum Data Set (MDS) dated 12/16/2014	F 250		

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documents diagnoses, in part, of Atrial Fibrillation, Hypertension, Anxiety Disorder and Depression with an admission date of 9/5/2014. This same MDS documents R4 has a Brief Interview of Mental Status (BIMS) of 6 which indicates severe mental impairment.

The facility Care Plan dated 9/5/2014 documents, in part, "Resident has a diagnosis of Depression Potential for a decline in mood. Resident currently does not display any signs of depression. Intervention : Psychiatric services as need."

The facility's document "INITIAL/ADMISSION IDT WALKING ROUND" ,9/5/2014, documents under Social Services "IDT Plan to address Identified Needs: anxious and nervous - agrees to psychiatrist consult".

Physician Order dated 12/30/2014 documents, Psych (psychiatric) Consult with, Z7 (Psychiatrist) which is scheduled for 01/16/2015 at 1:00 PM

The facility policy "Mental Health Services" dated December 2011, documents, in part, "The facility will help residents maintain or improve their psychosocial conditions and will provide or arrange counseling, psychotherapy, or other mental health services when indicated.
1. The facility will maintain a listing of available community resources for mental health services which include: A. Psychiatric consults B. Psychological services C. Group and individual counseling D. Temporary acute psychiatric placement.
2. If assessment indicates a need for mental health services, a physician order is obtained and a consult is requested in a timely manner.

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F 250	Continued From page 33 On 1/13/2015 at 9:18 AM, E31 Social Service Director, when asked why a psychiatric consult was not made for R4 when recommend 4 months ago on 09/5/2014. E31 stated, " I simply forgot about it." On 1/8/2015 at 11:40 AM, E2 Director of Nurses (DON), stated that R4 has had a very flat affect since being admitted and no motivation to get out of bed. On 1/5/2015 at 11:15 AM, E29 stated that R4 has a very flat affect, is unmotivated to do anything or eat. On 1/14/2015 at 1:36 PM, Z1 Physician, stated he was not made aware of R4 requesting to see a psychiatrist on 09/5/2014. Z1 states that if he had known he would have ordered a psychiatric consult. Z1 also states he was not aware of R4's poor appetite and her no motivation to get out of bed until last week.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

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F 279	Continued From page 34 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to develop comprehensive plans of care to address individual care needs for 3 of 20 (R1, R2, R4) resident's in the sample of 20. Findings include: 1. R1's current face sheet documents diagnosis of asthma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, pressure ulcers unstageable, open wounds, and vitamin deficiency. R1's 5/1/14 Physicians Order Sheet documents: Admit to Hospice with Terminal Diagnosis of Alzheimer's, Z1, Medical Doctor (MD) attending and managing pain and symptoms. The most recent Minimum Data Set (MDS) dated 11/21/14 R1 is totally dependent on two or more staff members for transferring, bed mobility, toileting, and is totally dependent on one staff for dressing, eating, personal hygiene and bathing. R1 is always incontinent of bowel and bladder. The MDS documents Determination of Pressure Ulcer risk: resident has a Stage 1 or greater pressure area. "Skin and Ulcer Treatments"	F 279		

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identified for R1's pressure area were as follows: A. pressure reducing device for chair, B. pressure reducing device for bed, D. Nutrition or hydration intervention, E. Pressure Ulcer care, G. Application of nonsurgical dressings(with or without topical medications) and H. Applications of ointments and medications. The MDS did not identify as interventions: C. Turning and repositioning program, F. Surgical wound care, and Applications of dressing to feet.

On 4/23/14, 5/30/14, 8/30/14, and 1121/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able. There are no therapeutic devices listed for pressure ulcer prevention, and repositioning of R1 is not adequately addressed in this care plan, as the MDS documents she would need assistance of 2 staff.

R1's review of R1's weekly "Skin Condition" reports beginning 5/22/14 through 7/11/14, document repeatedly that R1 had redness to her coccyx and was treated with Calazime per Standing Order of Z1. On 7/11/14, this treatment, and a new Standing Order was started to begin treating R1's buttocks with "stock antifungal cream" three times per day. There is no update or individualized care plan documented for R1's

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F 279	Continued From page 36 coccyx during this time frame. On 8/8/2014, R1's, Skin Condition report documents "Duoderm applied to excoriated area on buttocks." On 8/15/14 through 8/29/14 the skin report continues to document R1 has an open area on Right ear, treatment continues to left buttock, Duoderm applied. There is no update or individualized care plan documented for R1, for this time frame. On 9/5/14, R1's Skin Condition report documents "open area to right ear, sero-sanguineous. Left Buttock / Duoderm on wound noted, Right Buttock, 2 open areas, each measuring 1.0cm (centimeter) x .5cm and another 1.0cm x .5cm area." There is no individualized or updated care plan documented for this event. On 9/19/14, E3, Licensed Practical Nurse, Wound Nurse, (LPN) documented in R1's Nursing Notes: "N.O. (Nurse Order) from Hospice regarding incontinent associated lesion to buttock, for wound gel and to cover with optifoam. Change daily and PRN (as needed) as area has declined. There is no individualized or updated care plan documented for this event. On 10/20/14, Z2 Hospice Nurse documented; "R1 seen today face to face for hospice recertification. R1 with dementia, with continuing decline.... R1 has recurrence of Stage 2 to her right upper helix. R1 leans on that ear chronically in her broda char. Repositioning techniques have been started." IDT/Services: "sitting in broda chair leaning to right. This puts pressure on right ear which is beginning to show reddened scabbed area again. Positioned with C- pillow to keep pressure off of	F 279		

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ear. Also spoke with nurse asking to keep pressure off ear." There is no individualized or updated care plan documented for this event at this time.

On 11/13/14 Z3, Wound Manager/Nurse Practitioner, (WM/NP) documents: F/u (follow up) of this 72 year old female.... Nursing requests that I examine her right ear, which was noted on 11/12/14 to have a pressure ulcer. Currently treating with TAO (triple antibiotic ointment). Wound #2 Pressure Ulcer/Right Ear; Pressure ulcer/Stage III ; Acquired: 11/12/14; Pre-Debridement length: 2.00cm Width: 0.50cm Depth area: 0.30cm: Area: 1 cm 2, Volume: 0.3cm Description: Slough: minimal, Wound base color: yellow 30%, Pink 70%: Notes: Nursing to obtain pillow to help off-load pressure of ear." On 11/2014, Z3, WM/NP also asked that the facility acquire a pillow for R1 to keep pressure off of her ear. On 12/11/14 a care plan for R1's ear was written, but failed to adequately address repositioning, and pressure relief for R1's ear, these sections of the care plan were left blank. The concerns identified by Z2, to keep pressure off of the ear and requests to provide a pillow for position, were not included in the care plan.

On 11/13/14 Z3, Wound Manager/Nurse Practitioner, (WM/NP) documents; Nursing reports that this 72 year old female was noted on 9/29 to have a coccyx ulcer, which appears to be secondary pressure. Nursing reports that the coccyx ulcer has increased necrosis and odor noted. Wound #1 Pressure Ulcer/Coccyx, Unstageable; Status: Not healed; Pre-Debridement length: 4.50cm Width: 5cm (increased size) Unable to determine pre-depth

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F 279	Continued From page 38 area: 22.5cm x 2cm. Description: Wound base color: yellow 40%, black 50%, Pink 10%: Necrotic tissue: Extensive; Procedures: Excisional debridement; Pre Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue, viable tissue obtained for tissue C&S (culture and sensitivity) today. On 11/17/14, laboratory results for R1 document organisms of: 1) Proteus Mirabilis-moderate growth; 2) streptococcus agalactiae-Grp B-Heavy growth; 3) alpha hemolytic streptococci-heavy growth in coccyx wound. On 11/20/14, Z3, WM/NP, documents "R1's tissue culture of her coccyx was + (positive) for Proteus Mirabilis and Streptococcus Agalactiae. A care plan "Actual Pressure Ulcer," dated 11/6/14 documents; Site - Coccyx, requires assist with turning and repositioning / one assist. Interventions listed (in part) Monitor pain, check dressing placement, Monitor for signs and symptoms of infection daily, Assess weekly by licensed nurse, Notify MD every 2 weeks..., Provide off loading of ulcer site, Monitor incontinence, Encourage resident to reposition as able / reposition every 2 hours and PRN. This care plan is not individualized to address Z3 WM/NP's ongoing visits or treatments, and does not identify the Stage 4 status of R1's coccyx wound. From 11/6/14 through 1/12/15 the care plan has not been updated for the infection to the wound, for increased need of repositioning, or any other interventions, although R1 continues to be seen by Z3. On 11/24/14, Z3,WM/NP documents: F/u (follow	F 279		

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F 279	Continued From page 39 up) of this 72 year old female..... Wound #3 Pressure ulcer/left ankle; Unstageable; Ankle left lateral; Acquired 10/29/14; Acquired in facility; Pre-Debridement length: 1.0cm Width: 1.0cm Unable to determine pre-depth Area: 1 cm 2. Description: Euchar: fully covered; Wound base color: black 100%. On 10/29/14, R1's Skin Integrity Care Plan - Non-Pressure Wound documents; Left Ankle, Scab, Will show signs of improvement x 90 days, Pressure Reducing Mattress to bed... encourage to reposition as able. Monitor Scab to Left ankle each shift. On 12/4/14, the Care Plan was updated and documents; Area has been compromised by pressure. Treatment changed / Cleanse with normal saline, apply Santyl, 4 x 4, secure with tape. This care plan for R1 has not been individualized and does not reflect the MDS assessment regarding R1's abilities or need of staff assistance. No further information regarding the worsening of this ankle wound, or treatments needed, or interventions recommended by Z3 Wound Manager/ Nurse Practitioner were documented on this care plan. The care plan has not been updated for therapeutic pressure relief and continues to recommend repositioning every 2 hours. On 12/30/14 at 9:45 AM, E3, Wound Nurse stated that R1 is being treated by Z3, WM/NP for the Stage 3 pressure ulcer to her right ear, the unstageable wound to R1's left outer ankle and the Stage 4 wound to her coccyx. On 1/12/15, E2, and E3, reviewed R1's Risk for Pressure Ulcers form dated 4/17/14, which documented R1 as "no risk" for pressure ulcers. The Pressure Ulcer form continued to document	F 279		

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F 279	Continued From page 40 on 5/14/14, 8/30/14 and 11/21/14 that R 1 was a "mild risk" , even after though R1 had developed of a Stage 2 to right ear, an unstageable to left ankle and a Stage 4 to coccyx. E2 stated, "R1's assessments were not accurate and R1 was at a high risk for pressure ulcers " . E3 agreed with the assessments being inaccurate. In a previous interview on 12/30/14 at 1:00 PM, E4, Care Plan Nurse stated she is not sure if R1's care plan is individualized for interventions for R1's three pressure areas. E4 stated she will have to ask E3, Wound Nurse. In a previous interview on 12/30/14 at 1:10 PM E3, stated that R1's Care Plan does not individualize interventions to keep R1's three pressure areas from declining. E3 further stated that no individualized care plan interventions were put into place to keep R1's pressure areas from declining until 11/6/14 when Z3 WM/NP began visiting R1. 2. The Facility's Policy "Skin Integrity Standard" dated March 2005 and updated June 2010, documented, Procedure: - Documentation of the turning and repositioning at least every two (2) hours while in bed or in a chair. Dependent residents sitting or in bed may need a position change for 'tissue off loading' every hour. Weekly "head to toe" assessment of all residents by Licensed nurse with narrative documentation of findings. - Weekly narrative documentation must include: description of skin tissue, color, turgor, rashes, bruising, skin tears, edema, incision lines and any other skin related issues. - If skin integrity issues are identified post-admission to the facility the following documentation is required:	F 279		

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F 279	Continued From page 41 #2. Notation on the 24 hour report indicating the skin condition. #5. Incident report completed for in house acquired Stage III and/or IV. Use in tracking/trending and QA&A program. - Director of Nurses DON/Designee completes weekly random skin assessments. R2 was admitted to this facility on 10/7/14. R2's Physician Order Sheet (POS) documented R2's diagnoses to include Altered Mental Status, Hypertension, Cerebral Vascular Accident, Dementia, Hearing Loss. R2 had no pressure ulcers on admission to this facility. On 10/13/14 a Skin Integrity Care Plan: Prevention, was implemented, under Problem: documented, Requires assist with turning and repositioning with one assist. Under interventions: Encourage to reposition as able. The plan fails to document how often R2 is to be Repositioned. The Skin Integrity Care Plan Non-Pressure Wound, updated on 11/18/14, documented "Area to buttock was compromised by pressure and order changed to Santyl, Resident seen by Z3 Specialized Wound Management (SWM) Nurse Practitioner (NP). Z3 documented in her wound care notes, her first initial visit with R2 on 11/20/14, not on 11/18/14 as was documented on R2's care plan. Z3 documented R2's pressure ulcer as unstageable, with measurements of 1.0 X 1.5. Z3 changed R2's treatment to clean wound with normal saline, apply santyl to wound, cover with gauze and dry dressing. Change daily and as needed. R2's Minimum Data Set (MDS) dated 11/5/2014,	F 279		

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documented R2's Brief Interview for Mental Status (BIMS) as a 2, moderately impaired. Under functional status, Activities of Daily Living, Bed Mobility (how a resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture documents R2 as a 3/2 (Extensive assist/One person physical assist). R2's MDS dated 12/5/14, under skin and ulcer treatments documents A. Pressure reducing device for chair. B. Pressure reducing device for bed. C. Turning/repositioning program, is not marked for pressure ulcers.

On 11/17/14 a Skin Integrity Care Plan: "Non-Pressure Wound", was implemented for R2's "Incontinence Associated Lesion" to buttock with interventions for pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm care, maintain head of bed in lowest possible position, encourage resident to reposition as able.

Only the (above) Skin Integrity Care Plan for Prevention and a Skin Integrity Care Plan for "Non-Pressure Wounds", was initiated for R2's skin. On 12/29/14, Z3 WM/NP, documented R2's coccyx wound to have increased in size to that of 3.00 cm (centimeters) by 5.00 x 1.50 cm depth, with undermining. R2's care plans continued to document this Pressure Ulcer as an Incontinence Lesion / Non-Pressure Wound, and do not identify the worsening of this ulcer. Since the above care plans were initiated on 11/17/14 no additional necessary preventative interventions that may be needed to alleviate continued worsening of this wound.
3. R4's Minimum Data Set (MDS) dated 12/16/2014 documents diagnoses, in part, of

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Atrial Fibrillation, Hypertension, Anxiety Disorder and Depression with an admission date of 9/5/2014. This same MDS documents R4 has a Brief Interview of Mental Status (BIMS) of 6 which indicates severe mental impairment. The facility face sheet, undated, also documents a diagnosis of unspecified calorie malnutrition.

The facility Care Plan dated 9/5/2014 documents, in part, "Resident has a diagnosis of Depression Potential for a decline in mood. Resident currently does not display any signs of depression. Interventions, in part, : Psychiatric services as need."

The facility's document "INITIAL/ADMISSION IDT (interdisciplinary department team) WALKING ROUND", 9/5/2014, documents under Social Services "IDT Plan to address Identified Needs: anxious and nervous - agrees to psychiatrist consult".

Physician Order dated 12/30/2014 documents, Psych (psychiatric) Consult with, Z7 (Psychiatrist) which is scheduled for 01/16/2015 at 1:00 PM.

On 1/13/2015 at 9:30 AM, E4 Social Service Director, stated, "I am the one that does the Social Service Care Plans". When asked if E4 thought R4's Care Plan for Depression was accurate, E4, stated, "no because she is displaying signs and symptoms of depression now".

The facility Care Plan dated 9/11/2014 documents, in part, "Altered Nutrition and hydration related to protein calorie malnutrition. Goals: Will have no signs and symptoms of altered hydration times 3 months, Will consume

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F 279	Continued From page 44 as much oral intake as desired/ tolerated times 3 months". This Care Plan documents no interventions for staff to follow to ensure R4 receives the nurtrtion needed to prevent weight loss. On 1/13/15, no documentation was eveidenced that the Care Plan had been updated to address R4's ongoing weight loss. On 1/13/2015 at 9:18 AM, E4 Care Plan Coordinator, stated, "Usually I gather my information from the change of condition report then add that issue to the Care Plan unfortunately R4's Care Plan did not get updated".	F 279		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the Facility failed to timely resolve issues with the the Hospice provider and ensure coordination and implementation of services for 1 of 2 residents (R1) reviewed who received Hospice Services in the sample of 20. This failure resulted R1 having a coccyx Stage 1 pressure ulcer worsen into a Stage 4, in R1 developing a reoccurring Stage 3 pressure ulcer to right ear and R1 developing an unstageable pressure ulcer to the left ankle.	F 309		

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F 309	Continued From page 45 Findings include: 2. R1's current face sheet documents diagnosis of ashtma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, presuure ulcers unstageable, open wounds, vitamin deficiency. R1's Physicians Order Sheet documents: Admit to Hospice with Terminal Diagnosis of Alzherimers, Z1, Medical Doctor attending and managing pain and symptoms. On 5/21/14, R1's Nurses Notes document the following orders; Admit to local hospice provider. Terminal diagnoses of Alzheimer's. Z1, Attending Physician of R1 (not hospice physician) to be managing pain and symptoms. Do Not Resussitate. Activity as tolerated. Diet as tolerated. Oxygen at 2 - 4 liters/as needed/for shortness of breath. Continue current medication. The Hospice Care Plan dated 5/30/14, documented the following; Hospice to provide medication as appropriate, pain medication as needed, services based on identifying needs 24/7, provide supplies, and provide visits and assess pain every visit. Notify Hospice and MD of any changes as indicated. (Facility) nursing staff to communicate with and assist haopice. Decline in condition to be expected Related/To terminal Diagnoses and Hospice Care. The Facility Social Service Care Plan dated 6/2/14, documents R1 is now receiving Hospice services for End Stage Dementia, and will be receiving with a goal to keep R1 comfortable and pain free. R1's weekly Skin Condition reports from May 2014 through July 2014 document R1 had	F 309		

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ongoing reddness to coccyx and was treated with antifungal cream (Calazime). No physician update or order for antifungal cream was found in R1's clinical record, and no care plan for this event is documented. There are no updates to either the Facility or Hospice Care plans identifying treatments or interventions during this time.

R1's Nursing Notes dated 9/19/14 document: "N.O. (Nurse Order) from hospice regarding incontinet associated lesion to buttock for wound gell cover with optifoam. Change daily and PRN (as needed) as area has declined. " R1's Nursing Notes dated 10/4/14 document: "late entry: spoke with hospice and family re: decline in residents wound to buttock. Asking for santyl as slough reamins to wound bed. Hospice continues to want wound gel and mepilex every 3 days to wound."

On 1/7/15 at 9:07AM, E2, Director of Nursing, and E3, Licensed Practical Nurse / Treatment Nurse, stated that R1 was admitted to the facility on 4/17/14. E2 stated that R1 had a pressure reducing mattress, which is standard for all residents admitted to their facility. E2 stated on 8/2/14, R1 had excoriation to coccyx and a duoderm was applied. On 9/19/14, R1 continued to have excoriation and incontinent lesion. E3 stated that R1's pressure ulcer on her coccyx had started to decline and she knew it needed debridement. On 9/29/14, Hospice wound nurse was supposed to come and evaluated R1 but never came. E2 stated they had no further orders from Hospice.

E3, continued, on 10/4/14, E3 was becoming impatient with hospice and requested orders for

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Santyl from hospice. Hospice did not want to do Santyl. No doctor was notified for the decline in R1's pressure ulcer. On 11/6/14 wound management started seeing R1 and noted R1 had an unstageable pressure ulcer to coccyx and debrided it. Additionally, Z3 ordered a low air loss mattress for R1.

On 11/12/14, E3 stated R1's wound continued to decline and wound management requested for R1 to be layed down more frequently and should be turned every hour from side to side and back only for meals. Both stated on 11/3/14, the facility implemented turning every 1 hour and staff should turn residents every 2 hours and if have active pressure ulcer then turn every hour. E3 stated that R1's right ear was sloughing 11/13 and that R1 leans to right side.

On 4/23/14, 5/30/14, 8/30/14, and 11/21/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able. There are no therapeutic devices listed for pressure ulcer prevention. Repositioning of R1 is not adequately addressed in this care plan, as the MDS documents she would need assistance of 2 staff. The care plan documents that R1 is expected to decline and is receiving Hospice care. The care plan fails to document R1's

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F 309	Continued From page 48 pressure ulcers, or interventions to improve R1's wound status, or document treatment interventions prescribed by Hospice. On 11/20/14 Z3, Wound Mangament notes document "R1's tissue culture of her coccyx was + (positivie) for Proteus mirabillis and steptoccus Agalactiae. Notes: Nursing to obtain pillow to help off-load pressure of ear." Hospice documentation dated 12/19/14 indicates: "R1 has a 4.8 x 3.6 cm, Stage 4 wound to sacrum, a Stage 2 wounds to left ankle and under left breast, 3.2 x 1.3 cm, and Stage 1 wound to right ear helix." No Hospice care plans were provided for R1's pressure ulcers. On 12/30/14 at 12:35 PM, E3, Wound Nurse stated R1's redness to her coccyx started in 5/2014, as an " incontinent lesion " and has since declined to a Stage 4 pressure ulcer. E3 stated that Z3, WN/NP started seeing R1 in 11/2014, but only after a 3-4 week delay in treatment due to internal issues with Hospice. E3 stated R1's pressure areas were declining during this time. E3 stated she noted the area to be declining in 8/2014 or 9/2014, and knew the wound needed debridement. The Hospice provider was supposed to have a wound nurse come, but never did during that time. E3 stated she had never called R1's physician (Z1) to update him on R1's progression of pressure ulcer because she thought hospice took care of getting the physician's orders. On 1/7/15 at 11:45 AM, E2 and E3 both stated that Hospice was following R1 and the facility was getting orders from Hospice for R1's pressure areas.	F 309		

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On 1/7/15 at 1:45 PM, E2, DON stated she cannot find any notes from Hospice for R1 and does not know where hospice keep their chart in the facility. On 1/8/15 at 8:45 AM, E2 produced R1's hospice record and stated she had called the Hospice Provider, and had her bring the records to the facility that morning for review.

On 1/7/15 at 2:00 PM, Z2, Registered Nurse, RN/Hospice Case Manager stated she has cared for R1 once a week for the past 6 months. Z2 stated that R1 developed a Stage 1 to Stage 2 on coccyx and now it has declined to --"what you see is what you get". Z2 stated "the facility was supposed to be getting orders for treatment of R1's pressure areas from Z1, Physician of R1, (not Hospice Physician). Z2 stated the hospice medical director is not allowed to give orders at this facility due to his inability to access the electronic computer system. Z2 further stated that Hospice nurses make recommendations or suggestions to the facility staff and the facility is supposed to get the order from R1's attending physician (Z1)."

On 1/7/14 at 2:30 PM, Z1, Medical Doctor, stated that he recalled R1 and that R1 is under the care of Hospice. Z1 stated he does not medically manage R1 and her care is done with Hospice. Z1 further stated he does not know anything about any of R1's pressure areas and is not involved in R1's care of pressure ulcers. Z1 stated the Facility contacted him once for a referral for wound management for R1 but was never notified by facility of R1's pressure ulcers.

On 1/8/15 at 9:20 AM, Z3, Nurse Practicioner stated that she started seeing R1 on 11/6/14 and

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that R1 has really done well since starting with wound management. Z3 stated that R1 had a pressure ulcer to right ear that has closed and reopened at least twice since she started treated her. Z3 stated that R1's right ear recently reopened again and that R1 likes to lay on the right side. Z3 stated that R1 was provided with a neck pillow and is on low air loss mattress. Z3 stated the facility needed to figure out a way to keep R1 off her right side. Z3 further stated that gel pillows could help R1's right ear to heal. Z3 stated that R1 has a stage 4 pressure ulcer to her coccyx that the facility told her started 9/29/14. Z3 stated when she first started seeing R1 her pressure ulcer on her coccyx was unstageable. Z3 stated R1 needs a wound vac and would be healed by now, but R1 is on Hospice.

On 1/13/15 at 1:40 PM, E2, Director of Nursing stated that E3, Wound Nurse, would take orders from Z2, Hospice Nurse and input them into the computer. E2 stated she is unsure how the coordination of care with Hospice is supposed to happen as this was new to her. E2 stated that Hospice was writing orders for R1's pressure ulcers.

A review of R1's care plans from 10/29/14 through 12/11/14 found documentation that the facility had begun to individualize it's care plans for R1's three pressure ulcers, but all three updates failed to address ongoing problems for R1 with positioning and pressure relief. None of the updates included information that Hospice was involved in R1's care.

The Initial Care Plan of 5/30/14 remained unchanged, although it was documented as updated on 8/30/14 and 11/21/14.

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F 309	Continued From page 51 A review of the Facility's "Service Agreement By and Between" signed by the Hospice Provider 8/31/99, and signed by the Facility 9/7/99, documents: 2:13 "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals established by the Interdisciplinary Group, which includes (a) an assessment of each Hospice Patient's needs, (b) an identification of the Hospice Services, Including management of discomfort and symptom relief, needed to meet such Hospice Patients needs and ...., (c) details concerning the scope and frequency of such Hospice Services, and (d) details concerning the Nursing Facility Services to be provided to the Hospice Patient.... 3.2 Design and Maintenance of Care Plan, (a) Nursing Facility Residents: In accordance with the Federal and State laws and regulations, Hospice shall coordinate with Nursing Facility to develop a Plan of Care for each new Residential Hospice Patient. Hospice shall Furnish Nursing Facility with a copy of the Plan of Care. (c)Modifications ..... the Interdisciplinary Group will review and modify, if necessary, the Plan of Care. The Hospice will consult and coordinate with Nursing Facility... with respect to any modification of the Plan of Care, and will provide the Nursing Facility with any modification of the Plan of Care. In a previous interview on 12/30/14 at 1:00 PM, E4, Care Plan Nurse, stated she is not sure if Hospice had done a care plan, the she had not been involved in coordinating care with hospice. On 1/13/15 at 1:40 PM, When E2, DON was	F 309		

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F 309	Continued From page 52 asked if the facility had any proceedures for coordinating care with the Hospice Provider, no additional information was given by E2. B. Based on observation, interview and record review, the Facility failed to provide adequate pain management services to address pain for 1 of 9 residents (R13) reviewed for pain management in the sample of 20. Findings include: 1. R13's Electronic Physician Order Sheet (POS) dated 01/2015 documents diagnoses of Chronic Pain Syndrome, Lumbago, Osteoarthrosis, Status Post Surgery Congenital Fusion of the Spine. R13's POS documents Oxycodone ER 20 mg tablet every 12 hours, Oxycodone 10 mg by oral route every 4 hours as needed, Lidoderm 700 mg/patch adhesive to each knee daily. R13's most recent Minimum Data Set (MDS) dated 12/12/14 documents a BIMS (Brief Interview of Mental Status) score of 15 (no cognitive impairment). R13's Pain Assessment dated 10/29/14 documents, "...chronic and constant severe pain of both lower legs, an 8 on a scale of 1 (no pain) to 10 (worst pain). Pain Management includes Lidoderm 700 mg/Patch, Oxycodone ER 20 mg twice a day and Oxycodone 10 mg every 4 hours as needed. Pain Management Evaluation: Continue with current interventions as pain appears adequately managed. Interdisciplinary Team update on 12/12/14 documents pain management remains the same. " R13's Comprehensive Care Plan: Pain Management dated 10/29/14 and reviewed	F 309		

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F 309	Continued From page 53 12/12/14 documents, "Consult with MD when pain regimen changes are indicated: inadequate pain relief. Non pharmacological approaches: frequent position changes, exercise/physical activity, resting periods during activities of daily living. R13's POS with order date 10/22/14 documents, "Refer (R13) to Pain Management per (Z5, Nurse Practitioner). R13's POS with order date 11/12/14 documents, "Consult with pain management due to chronic leg pain. " On 1/5/15 at 10:08 AM, R13 was in bed and rubbing her right leg. R13 stated she was in pain, a '4' on her right leg and she just had her scheduled pain medication two hours earlier and it only worked for a short time. R13 stated she gets pain medication twice a day and she can ask in between as needed but the medication only helps temporarily. R13 stated she has told staff her pain medication is not working and has not worked for a long time. R13 stated she cannot do her restorative exercises on her right leg because of the pain. R13 stated even if she asks for pain medication every 4 hours it will just work for an hour or so and the pain is back. R13 stated she has not been to any pain management consult since she was readmitted in October 2014 after a back surgery related to her spinal fusion. On 1/8/15 at 9:02 AM, R13 was in bed, grimacing, and stated her pain was an '8' on her right leg and a '6' on her left leg and she just took a pain pill an hour ago. R13 stated it seems like she is having pain all the time. On 1/12/15 at 10:05 AM, E19, Certified Nursing	F 309		

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F 309	Continued From page 54 Aide, CNA, provided range of motion exercises to R13. R13 refused to do the right leg because it was painful. R13 stated it was a "6" on the right leg. A review of R13's clinical record indicated no documentation that pain management consultation was done as ordered on 10/22/14 and again on 11/12/14. On 1/8/15 at 9:25 AM, E23, Licensed Practical Nurse, stated she cannot recall R13 having a pain management consult since R13's return to the facility sometime in October 2014. On 1/13/15 at 1:10 PM, E2, Director of Nursing stated she had called Z5 and asked where to go for R3's pain management consult. E2 stated Z5 never got back to them to provide information on pain management consultants. E2 added the facility does not have any pain consultants that they can send their residents to. The Facility Operating Standard Pain Management Process dated 6/2009, documents, "The objective of the pain management process is to identify resident need and determine potential referrals/interventions to affect positive functional change through pain reduction, modification of the perception of pain, and enhancement of the quality of life...Guidelines, (in part): Review of continued effectiveness and appropriateness of Pain Management Plan of Care during routine IDT (Interdisciplinary Team) walking rounds. "	F 309		
F 312 SS=G	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 55 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide complete incontinent care for 3 of 6 residents (R1, R5 and R14) observed for incontinent care in the sample of 20. Findings include: 1. R5's most recent MDS dated 11/28/14 documents R5 is totally dependent on staff for all activities of daily living and incontinent of bowel and bladder. On 1/5/15 at 1:33 PM, E12 and E13, CNAs, provided perineal care to R5. R5's adult disposable briefs was slightly saturated with urine. E12 and E13 washed their hands and prepared a basin of soapy water using liquid soap from the wall soap dispenser and a second basin of water for rinsing. Using a soapy washcloth, E12 wiped R5's groin area and across the vaginal area with back to front strokes. E12 failed to spread the labial folds. E12 dried the area but did not rinse the soap off of R5. E13 turned R5 to her left side. E12 cleansed the buttocks and rectal area with a soapy washcloth and dried the area. E12 failed to rinse the soap off of R5. 2. R14's most recent MDS dated 12/6/14 documents R14 needs extensive assist with	F 312		

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F 312	Continued From page 56 transfers, dressing and toileting and is incontinent of bowel and bladder. On 1/8/15 at 3:30 PM, R14 was incontinent of bowel and bladder. E15, CNA, washed her hands and prepared washcloths wet with water and regular soap. E15 wiped the inner thighs and the shaft of the penis and rinsed the area. E16 failed to retract the foreskin. E15 failed to dry the wet area before turning R14 to his left side. E15 used a wet soapy towel to cleanse the buttocks and rectal area. E14 failed to dry the wet areas before applying protective barrier to R14's buttocks. On 1/13/15 at 9:39 AM, E27, Director of Staff Development, stated she expects staff to wash, rinse and dry and to thoroughly wash the the vaginal area in females and retract the foreskin in males during perineal care. E7 stated it is important to wash in a front to back direction to prevent infection. The Facility Policy on Incontinent Care dated 8/2014 documents, "Purpose: To keep skin dry, free of irritation and odor. To prevent skin breakdown. To prevent infection. Procedure: 5. Wash all soiled skin areas including skin folds, washing from front to back, rinse and dry." The policy does not show specific procedure for cleaning male and female genitalia. R1's December 2014 face sheet documents diagnosis of ashtma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, presuure ulcers unstageable, open wounds, vitamin deficiency. R1's Minimum Data Set dated 11/21/14	F 312		

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documents R1's Brief Interview of Mental Status (BIMS) was left blank. The MDS further documents that R1 is totally dependent on two or more staff members for transferring, bed mobility, toilieting and totally dependent on one staff member for dressing, eating, personal hygiene and bathing and that R1 is always incontinent of bowel and bladder.

On 12/30/14 at 9:00AM, E6, Certified Nurse Assistant (CNA) and E7, CNA provided incontinent care to R1, who had visible brown feces on her peri-anal area that saturated the coccyx wound dressing. E6 wiped R1's peri-anal area with a wet washcloth to remove brown feces. E6 then transferred the soiled washcloth to her (E6) opposite hand to dispose in trash bag. E6 placed both soiled gloved hands in the clean wash basin with clean washclothes to retrieve new washcloth. E6 wiped R1's peri-anal area again with brown feces on washcloth and E6 stated R1 was "still pooping." At no time did E6 rinse or dry R1's peri-anal area. E6 left visible brown feces around R1's wound to her coccyx and R1's wound dressing was visibly soiled with brown feces. E6 covered R1 back up and stated she was done with care.

On 12/30/14 at 9:45 AM, E3, Wound Nurse and E5, CNA changed R1's dressing to R1's coccyx. R1's dressing to her coccyx had visible brown feces saturating the dressing covering her coccyx pressure ulcer and also feces around the peri-anal area. E3 removed R1's dressing that was saturated with bowel and cleansed the peri-anal area around R1's Stage 4 pressure ulcer with gauze soaked in normal saline. E3 stated she was finished cleaning R1 coccyx and that she cleansed the wound and peri-anal area

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F 312	Continued From page 58 surrounding the wound with normal saline. E3 further stated she would normally used soap and water to clean visible feces from peri-anal area not normal saline.	F 312		
F 314 SS=J	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: Based on observation, interview and record review the facility failed to accurately assess and identify residents at risk, implement interventions to prevent the development of pressure ulcers, failed to promptly notify the physician, provide timely appropriate treatments, infection management, and interventions to prevent the worsening progression of pressure ulcers for 4 of 7 residents (R1, R2, R8, R14) reviewed for pressure ulcers in the sample of 20. This failure resulted in R1 developing a facility acquired Stage 4 pressure ulcer to the coccyx which became infected, develop a reoccurring Stage 3 pressure ulcer to right ear and develop an unstageable pressure ulcer to the left ankle. R4 developed a facility acquired Stage 4 pressure ulcer to the coccyx with undermining which also became infected.	F 314		

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F 314	Continued From page 59 The failure resulted in an Immediate Jeopardy. While the Immediacy was removed on 1/8/15 the Facility remains out of compliance at Severity Level 2 as the Facility continues to educate staff and evaluate and monitor the effectiveness of the Facility policies, procedures and it ' s system of assessing pressure ulcers and implementing timely interventions. Findings include: 1. R1's current face sheet documents diagnosis of asthma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, pressure ulcers unstageable, open wounds, and vitamin deficiency. R1's 5/1/14 Physicians Order Sheet documents: Admit to Hospice with Terminal Diagnosis of Alzheimer's, Z1, Medical Doctor (MD) attending and managing pain and symptoms. The most recent Minimum Data Set (MDS) dated 11/21/14, documents R1's Brief Interview of Mental Status (BIMS) was left blank. The MDS documents R1 is totally dependent on two or more staff members for transferring, bed mobility, toileting, and is totally dependent on one staff for dressing, eating, personal hygiene and bathing. R1 is always incontinent of bowel and bladder. The 11/21/14, MDS, documents R1 has no limitations in range of motion. The MDS documents no weight loss or gain of 5% or more in last 6 months. The MDS documents Determination of Pressure Ulcer risk: resident has a Stage 1 or greater pressure area. "Skin and Ulcer Treatments" identified for R1's pressure	F 314		

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area were as follows: A. pressure reducing device for chair, B. pressure reducing device for bed, D. Nutrition or hydration intervention, E. Pressure Ulcer care, G. Application of nonsurgical dressings(with or without topical medications) and H. Applications of ointments and medications. The MDS did not identify as interventions: C. Turning and repositioning program, F. Surgical wound care, and Applications of dressing to feet.

R1's, hospital laboratory results done just prior to admission, dated 4/14/14 document; R1's protein 6.7 g/dl (grams per deciliter) with a normal range of 6.3-8.7 g/dl, and an albumin 3.5 g/dl with a normal range of 3.5-5.2 g/dl.

R1's review of R1's weekly " Skin Condition " reports beginning 5/22/14 through 7/11/14, document repeatedly that R1 had redness to her coccyx and was treated with Calazime per Standing Order of Z1. On 7/11/14, this treatment, and a new Standing Order was started to begin treating R1's buttocks with "stock antifungal cream" three times per day.

On 5/16/14, Z10, Dietician, documented in R1's Nutritional Progress Notes: " R1 labs from 4/23 WNL (Within Normal limits), weight 124. Skin 4/27 excoriation butt and peri area. Notes dated 6/17/14 document; weight 115, R1's labs 5/6 TP/Alb (total protein/albumin) WNL. Notes dated 8/15/14 document: weight 110, skin 8/2 excoriated butt, 8/1 s/t (skin tear) to right ear 1.2 x 6, 8/12 s/t right ear 1x8; excoriation butt .2 x.4. "

On 8/8/2014, R1's, Skin Condition report documents "Duoderm applied to excoriated area on buttocks." On 8/15/14 through 8/29/14 the skin report continues to document R1 has an

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open area on Right ear, treatment continues to left buttock, Duoderm applied. R1's medical record and nursing notes for this time evidenced no documentation that Z1 MD, had been informed R1's buttocks continued to be excoriated and the facility staff were using Duoderm to treat it.

On 9/5/14, R1's Skin Condition report documents "open area to right ear, sero-sanguineous. Left Buttock / Duoderm on wound noted, Right Buttock, 2 open areas, each measuring 1.0cm (centimeter) x .5cm and another 1.0cm x .5cm area."

On 9/19/14, E3, Licensed Practical Nurse, Wound Nurse, (LPN) documented in R1's Nursing Notes: "N.O. (Nurse Order) from Hospice regarding incontinent associated lesion to buttock, for wound gel and to cover with optifoam. Change daily and PRN (as needed) as area has declined.
On 10/4/14, R1's Nurses Note documents: "late entry: spoke with Hospice and family re: decline in residents wound to buttock. Asking for Santyl, as slough remains to wound bed. Hospice continues to want wound gel and Mepilex every 3 days to wound."

On 9/17/14, R1's Nutrition Notes document: " wound report 9/4 excoriation butt .2 x.4, s/t right ear .6 x .8. Notes dated 10/17/14 document; R1's wound report 10/9 incontinent lesion butt, 2.3 x 2.1x Necro and 4.2 x1.

On 10/20/14, Z2, Hospice Nurse documents "R1 seen today face to face for hospice recertification. R1 with dementia, with continuing decline. R1 resides at LTC facility and is totally dependent on

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staff for all ADLS. R1 is incontinent of bowel and bladder. R1 sits in a broda chair or is bed bound. R1's husband is present during my visit today and states R1 continues to drinks 2 boost per day and eats 50-75% of her meals. R1 rarely verbalizes, only yes or no occasionally and nonsensically. R1 has recurrence of Stage 2 to her right upper helix. R1 leans on that ear chronically in her broda char. Repositioning techniques have been started." IDT/Services: "sitting in broda chair leaning to right. This puts pressure on right ear which is beginning to show reddened scabbed area again. Positioned with C- pillow to keep pressure off of ear. Also spoke with nurse asking to keep pressure off ear."

On 11/4/14, R1's Nutrition Notes document; R1 skin 10/30 incontinent lesion butt 2.1 x 3.1 x necrosis; wound left ankle .5 x .5. Nurse says butt worse."

On 11/13/14 Z3, Wound Manager/Nurse Practitioner, (WM/NP) documents: F/u (follow up) of this 72 year old female with a coccyx ulcer, currently treating with Santyl, Dakins', moistened gauze and dry dressing. Nursing requests that I examine her right ear, which was noted on 11/12/14 to have a pressure ulcer. Currently treating with TAO (triple antibiotic ointment). Nursing reports that the coccyx ulcer has increased necrosis and odor noted. Physical Exam: well nourished, groomed and normal body habitus; Wound #1 Pressure Ulcer/Coccyx, Unstageable; Status: Not healed; Pre-Debridement length: 4.50cm Width: 5cm (increased size) Unable to determine pre-depth area: 22.5 cm 2. Description: Wound base color: yellow 40%, black 50%, Pink 10%: Necrotic tissue: Extensive; Procedures: Excisional

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debridement; Pre Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue, viable tissue obtained for tissue C&S (culture and sensitivity) today. Wound #2 Pressure Ulcer/Right Ear; Pressure ulcer/Stage III ; Acquired: 11/12/14; Pre-Debridement length: 2.00cm Width: 0.50cm Depth area: 0.30cm: Area: 1 cm 2, Volume: 0.3cm Description: Slough: minimal, Wound base color: yellow 30%, Pink 70%: Notes: Nursing to obtain pillow to help off-load pressure of ear."

On 11/16/14, Z3, WM/NP, documents, "Nursing reports that this 72 year old female was noted on 9/29 to have a coccyx ulcer, which appears to be secondary pressure. Wound #1 Pressure Ulcer/Coccyx, Pressure ulcer/unstageable, Coccyx, acquired: 9/29/14; Acquired at outside facility: No (in facility); Pre-Debridement length: 4.50cm (cm), Width: 4.00 cm, Unable to determine pre-depth area: 16 cm 2. Description: Wound base color: yellow 100%, necrotic tissue: Extensive; Procedures: Excisional debridement; Pre-Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue.

On 11/17/14, laboratory results for R1 document organisms of: 1) Proteus Mirabilis-moderate growth; 2) streptococcus agalactiae-Grp B-Heavy growth; 3) alpha hemolytic streptococci-heavy growth in coccyx wound.

On 11/20/14, Z3, WM/NP, documents "R1's tissue culture of her coccyx was + (positive) for Proteus Mirabilis and Streptococcus Agalactiae. Notes: Nursing to obtain pillow to help off-load

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F 314	Continued From page 64 pressure of ear." (2nd mention) The American Society for Microbiology, "Infection and Immunity" dated May 2004, documents: Proteus Mirabilis, is a common cause of urinary tract infections. Website: www.ncbi.nlm.nih.gov/. Mayo Foundation for Medical Education and Research, 1998-2015, documents: Group B Streptococcus is a common bacterium carried in the intestines or lower genital tract. Website: Mayoclinic.org/. R1's Nutritional Status/Quarterly Progress Record documented by E26, Food Service Manager, on 8/30/14 and 11/21/14 both indicate, "Plan/Follow-up: current pressure ulcer(s): No. On 11/24/14, Z3,WM/NP documents: F/u (follow up) of this 72 year old female with a coccyx ulcer, currently treating with Santyl, Bactroban, and Calcium Alginate and dry dressing. F/u of right ear ulcer, currently treating with Santyl. Nursing reports that she has a left lateral ankle ulcer that they would like me to evaluate, currently treating with skin prep, which was noted on 10/29/14. Physical Exam: well nourished, groomed and normal body habitus; Wound #1 Pressure Ulcer/Coccyx, unstageable; Acquired: 9/29/14; Pre-Debridement length: 5.00cm Width: 4.20cm Unable to determine pre-depth; Area: 21 cm 2. Undermining: 1 cm from 12 O'clock, Undermining: 2 cm from 3 O'clock; Wound base color: yellow 30%, Pink 70%: Wound #2 Pressure Ulcer/Right Ear; Wound type/grade: Pressure ulcer/Stage III; Body Part: Ear right; Acquired: 11/12/14; Acquired in facility ; Status: healed. Wound #3 Pressure ulcer/left ankle; Unstageable; Ankle left lateral; Acquired 10/29/14; Acquired in facility; Pre-Debridement	F 314		

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F 314	Continued From page 65 length: 1.0cm Width: 1.0cm Unable to determine pre-depth Area: 1 cm 2. Description: Euchar: fully covered; Wound base color: black 100%; On 12/18/14, R1's Change of Condition-Skin Condition report documents "new onset, excoriation, open area and redness, side of/under left breast. Current size of wound: length=3.2 cm, width 1.3 cm, depth=n/a (not applicable). Progress Note update: staff notified this nurse of open area noted under R1's left breast. Upon assessment 3.2 x 1.3 cm excoriated area noted to left area under left breast with 1.6 x 0.4 cm reddened area next to open area." On 12/19/14, R1's Change of Condition-Skin Condition documents "new onset, blister/scab, left side of chest and left arm. Current size of wound: length=0.3 x 0.3 blister, width= blank, depth=1.2 x 2.2 scab. Skin prep to blister TID (three times a day) and monitor scabbed area every shift for any changes until healed. Progress note update: R1 noted to have a scabbed area to left chest by breast that measured 1.2 x 2.2 cm. R1 also was noted to have a blister intact to left arm that matched area to chest that measured 0.3 x 0.3 cm. Wrote orders from hospice for skin prep to intact blister TID to arm and monitor area to chest every shift till healed. On 12/19/14, R1's, Non-Pressure Skin condition report documents: Site/locations: left side of chest, Condition is: scab, Length 1.2, Width 2.2 cm, Depth: Scab. On 12/26/14, R1's Measurements: Length: 1.4, Width, 1.6, Depth: Scab.	F 314		

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On 12/19/14, R1's "Skin Integrity Care Plan: Non-Pressure Wound", documents: scab intact blister to left chest, left arm. Skin Prep TID (three times daily) to intact blisters and monitor scabbed area every shift for any changes until healed.

On 12/19/14, Hospice documentation indicates: "R1 has a 4.8 x 3.6 cm - Stage 4 wound to sacrum, Stage 2 wounds to left ankle and under left breast, 3.2 x 1.3 cm, and Stage 1 wound to right ear helix."

On 12/30/14 at 9:45 AM, E3, Wound Nurse stated that R1 is being treated by Z3, WM/NP for the Stage 3 pressure ulcer to her right ear, the unstageable wound to R1's left outer ankle and the Stage 4 wound to her coccyx.

On 12/30/14 at 9:45 AM, E3, Wound Nurse and E5, Certified Nurses Aide, CNA, changed R1's dressing to R1's coccyx. R1's dressing to her coccyx had visible brown feces saturating the dressing covering her coccyx pressure ulcer. E3 removed R1's dressing that was saturated with bowel and cleansed the area around R1's stage 4 pressure ulcer with gauze soaked in normal saline. E3 stated she was finished changing R1's dressing to her coccyx and that she cleansed the wound and area surrounding the wound with normal saline. E3, stated she normally uses soap and water to clean visible feces from wound area not normal saline. E3 did not say why she failed to use soap for this cleaning.

On 12/30/14 at 12:35 PM, E3, Wound Nurse stated R1's redness to her coccyx started in 5/2014, as an " incontinent lesion " and has since declined to a Stage 4 pressure ulcer. E3 stated that Z3, WN/NP started seeing R1 in

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11/2014, but only after a 3-4 week delay in treatment due to internal issues with Hospice. E3 stated R1's pressure areas were declining during this time. E 3 stated she noted the area to be declining in 8/2014 or 9/2014, and knew the wound needed debridement. The Hospice provider was supposed to have a wound nurse come, but never did during that time. E3 stated she had never called R1's physician (Z1) to update him on R1's progression of pressure ulcer because she thought hospice took care of getting the physician ' s orders.

On 12/30/14 at 1:00 PM, E4, Care Plan Nurse stated she is not sure if R1's care plan is individualized for interventions for R1's three pressure areas. E4 stated she will have to ask E3, Wound Nurse.

On 4/23/14, 5/30/14, 8/30/14, and 1121/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able.

On 12/30/14 at 1:10 PM E3, stated that R1's Care Plan does not individualize interventions to keep R1's three pressure areas from declining. E3 further stated that no interventions were written for R1's pressure areas to keep them from declining until 11/6/14 when Z3 WM/NP began

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F 314	Continued From page 68 visiting R1. On 12/30/14 at 2:30 PM, E2, DON stated that R1 had pressure area on her coccyx and her ear. E2 stated that E3 monitors the areas and she is not aware of any other pressure areas to R1. E2 stated there were issues with Hospice and E3 was reporting to Hospice that R1's pressure ulcer on her coccyx had gotten worse and was not healing. E2 stated she was not sure how long the pressure areas to coccyx and ear had been going on and she would have to look at the record. E2 stated, E3 fills out a monthly wound report that E2 reviews. E2, stated she would expect staff to turn and reposition R1 frequently, apply a low air loss mattress and be calling Z1, MA/MD, E2 further stated that there is no documentation on turning and repositioning of residents, staff does not document on that. On 1/7/15 at 9:07 AM, E2, DON, and E3 Wound Nurse, stated; when R1 was admitted to the facility on 4/17/14 she had a pressure reducing mattress, which is standard for all residents admitted to their facility. E2 stated on 8/2/14 through 9/19/14, R1 had excoriation to coccyx, developed an incontinence lesion and a Duoderm was applied. E3, stated during this time R1's pressure ulcer on her coccyx had started to decline and knew it needed debridement. On 9/29/14, Hospice wound nurse was supposed to come and evaluated R1 but never came. E2 stated they had no further orders from Hospice, and on 10/4/14, E3 was becoming impatient with hospice and requested orders for Santyl. Hospice did not want to do Santyl. E3 stated "No doctor was called /notified at that time". On 11/3/14 a low air loss mattress ordered from wound management. On 11/6/14 wound	F 314		

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management started seeing R1 and noted R1 had unstageable pressure ulcer to coccyx and debrided it.

On 1/7/15 at 11:45 AM, E2 and E3 stated that R1's right ear pressure ulcer initially broke open 10/5/14 and then healed. The both stated that a neck pillow was provided by R1's husband upon admission and then it was lost for a week or two and Hospice provided another pillow. E2 and E3 stated that R1 was on a pressure reducing mattress since admission and R1, but did not have low air loss mattress implemented until wound management involved. E2 and E3 both stated they were unsure why it took so long to get R1 a low air loss mattress. Both stated that R1's wounds had been declining prior to wound management involvement on 11/6/14. E2 and E3 stated that R1 is turned and repositioned every 2 hours or more when needed and even turned and reposition every hour since 11/3/14. E2 stated "there is no documentation to provide to show that R1 has been turned and repositioned every hour or every 2 hours. E3 stated that R1 is currently turned and a pillow is placed behind R1's back to keep R1 on side. E3 stated that she doesn't think that the pillow is providing enough support to off load R1's pressure areas to coccyx, right ear and left ankle. E3 further stated that a wedge would be more appropriate for R1 to ensure proper off loading and is "something I need to get."

On 1/7/15 at 1:45 PM, E2, DON stated she cannot find any notes from Hospice for R1 and does not know where hospice keep their chart in the facility. On 1/8/15 at 8:45 AM, E2 produced R1's hospice record and stated she had called the Hospice Provider, and had her bring the

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F 314	Continued From page 70 records to the facility that morning for review. On 1/7/15 at 2:00 PM, Z2, Registered Nurse/Hospice Case Manager, stated she cared for R1 once a week for the past 6 months. Z2 stated that R1 developed a Stage 1- Stage 2 on coccyx and now it has declined to --"what you see is what you get". Z2 stated " the facility was supposed to be getting orders for treatment of R1's pressure areas from Z1. Z2 stated the hospice medical director is not allowed to give orders at this facility due to his inability to access the electronic computer system. Z2 further stated that Hospice nurses make recommendations or suggestions to the facility staff and the facility is supposed to get the order from R1's attending physician. " On 1/7/15, Z2, continued, stating "R1 had a pressure area to the right ear from a cervical collar that hit the tip of the ear and pressed against the right ear. The right ear was open, and would heal then reopen off and on. R1 favored laying her head to the right side against the wheelchair. R1's left outer ankle is a Stage 2 to Stage 3 that had recently opened up--around after 10/2014. Z2 stated that R1 would be sitting continuously in the recliner in her room and then in the wheelchair. Z2 stated Hospice did supply a neck pillow when R1's C-collar was lost, to help keep the ear pressure ulcer from opening up. Z2 stated that she would classify R1 as High Risk for pressure ulcers. Z2 also stated R1 has an infection in her coccyx wound. " On 1/7/14 at 2:30 PM, Z1, Medical Doctor, stated that he recalled R1, R1 is under the care of Hospice and her care is with Hospice. Z1 further stated he does not know anything about any of	F 314		

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R1's pressure areas and is not involved in R1's care of pressure ulcers. Z1 stated the Facility contacted him once for a referral for wound management for R,1 but was never notified by facility of R1's pressure ulcers since that time.

On 1/8/15 at 10:45 AM, E2, DON, and E3 were asked if there were other pressure areas on R1. E2 stated she was not aware of any other areas. E3, Wound nurse stated at that time that there were no other areas on R1.

On 1/8/15 at 10:45 AM, E3, Wound nurse did a skin check on R1. R1 was lying in bed, alert and answering questions appropriately. R1's left breast/side was observed as E3 did a skin check. R1 had a quarter-sized reddened area to the underside of her left breast. E3 stated R1 is receiving no treatment or skin prep to the area at this time. E3 further stated that Hospice orders the treatments for R1's pressure areas.

On 1/8/15 at 11:50 AM, E3, Wound nurse stated she classified pressure areas as incontinence lesions, but was told by Z3, WM/ NP, that the areas should not be classified that way.

On 1/13/15 at 1:40 PM, E2, Director of Nursing stated E3, Wound Nurse would take orders from the Hospice nurse and input them into the computer. E2 stated she is unsure how the Facility coordinates R1's care with Hospice since this was new to her. E2 further stated that she would expect nursing staff to notify Z1, MA/MD, if R1 had no current physician on file or if residents don't have any preference.

On 1/8/15 at 9:20 AM, Z3, WM/NP stated that she started seeing R1 on 11/6/14 and that R1 has

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really done well since starting with wound management. Z3 stated that R1 had a pressure ulcer to right ear that has closed and reopened at least twice since she started treated her. Z3 stated that R1's right ear recently reopened again and that R1 likes to lay on the right side. Z3 stated that R1 was provided with a neck pillow and is on low air loss mattress. Z3 stated the facility needed to figure out a way to keep R1 off her right side. Z3 further stated that gel pillows could help R1's right ear heal. Z3 stated that R1 has a Stage 4 pressure ulcer to her coccyx that the facility told her started 9/29/14. Z3 stated when she first started seeing R1 her pressure ulcer on her coccyx was unstageable. Z3 stated R1 needs a wound vac and would be healed by now but R1 is on hospice. Z3 stated R1 initially had necrosis to her coccyx but has improvement since R1 was debrided. Z3 stated that R1's pressure ulcer to her coccyx currently has undermining. Z3 further stated that R1 has " group B strep " in her coccyx wound and feces and urine could be the cause of R1's wound infections. Z3 stated that R1 has a left lateral ankle that is looking better but slow healing since starting with wound management, and at this time is unstageable. Z3 stated she gives E3, wound nurse recommendations for each resident ' s interventions to keep pressure areas from progressing. Z3 further stated that she does not think that placing a pillow under R1's back off-loads R1 enough to provide relief to the Stage 4 pressure area to coccyx. Z3 further stated a wedge would be more appropriate for R1 to offload pressure areas for R1's three pressure ulcers.

On 1/12/15, E3 stated R1's wound continued to decline and wound management requested for

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F 314	Continued From page 73 R1 to be laid down more frequently and that R1 should be turned every hour from side to side and only on her back only for meals. Both stated, on 11/3/14, the facility implemented turning every residents every 1 hour if they have active pressure ulcers. E3 stated that R1's right ear was sloughing on 11/13/14 and that R1 leans to right side and puts pressure on it. On 1/12/15, E2, and E3, reviewed R1's Risk for Pressure Ulcers form dated 4/17/14, which documented R1 as "no risk" for pressure ulcers. The Pressure Ulcer form continued to document on 5/14/14, 8/30/14 and 11/21/14 that R 1 was a "mild risk" , even after though R1 had developed of a Stage 3 to right ear, an unstageable to left ankle and a Stage 4 to coccyx. E2 stated, "R1's assessments were not accurate and R1 was at a high risk for pressure ulcers". E3 agreed with the assessments being inaccurate. On 4/23/14, 5/30/14, 8/30/14, and 1121/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able. There are no therapeutic devices listed for pressure ulcer prevention, and repositioning of R1 is not adequately addressed in this care plan, as the MDS documents she would need assistance of 2 staff.	F 314		

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2. R2's Physician Order Sheet (POS) documented an admission date of 10/7/14, and a diagnoses that includes; Altered Mental Status, Hypertension, Cerebral Vascular Accident, Dementia, Hearing Loss. R2 had no pressure ulcers on admission to this facility.

In the nurses notes dated 11/17/14, E3, Licensed Practical Nurse, documented an "incontinence associated lesion on R2's right and left buttock with measurements of (0.6 x 0.6) on the right side and (0.8 X 0.9) on the left side " . The Facility Standing orders for Incontinence Associated Lesion dated 11/17/14 were started. The treatment is documented: cleanse area with normal saline, apply Duoderm every 3 days, and monitor dressing every shift and for signs and symptoms of infection.

On 11/17/14 a Skin Integrity Care Plan: Non-Pressure Wound, was implemented, for incontinence associated lesion to buttock with interventions for pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm care, maintain head of bed in lowest possible position, encourage resident to reposition as able.

R2's Minimum Data Set (MDS) dated 11/5/2014, documented R2's Brief Interview for Mental Status (BIMS) as a 2, moderately impaired. Under functional status, Activities of Daily Living, Bed Mobility documents R2 as a 3/2 (Extensive assist/One person physical assist). R2's MDS dated 12/5/14, under skin and ulcer treatments documents A. Pressure reducing device for chair. B. Pressure reducing device for bed. The MDS

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did not identify for skin ulcer interventions; C. Turning/repositioning program.

On 11/18/14 at 11:50 AM, E3 Licensed Practical Nurse (LPN) Wound Nurse, documented on the Change of Condition report, "Area to right buttock has been compromised due to pressure and has developed into a pressure area. A low air loss mattress was implemented on 11/18/14.

On 11/18/14, the Skin Integrity Care Plan Non-Pressure Wound, documented "Area was compromised by pressure and order changed to Santyl, Resident seen by Z3 Specialized Wound Management (SWM) Nurse Practitioner (NP).

Z3, SWM/NP documented in her notes she saw R2 on 11/20/14, not on 11/18/14 as was documented on R2 ' s care plan. Z3 documented R2's pressure ulcer as unstageable, with measurements of 1.0 X 1.5. Z3 changed R2's treatment to clean wound with normal saline, apply Santyl to wound, cover with gauze and dry dressing. Change daily and as needed.

On 11/24/14, Z3 saw R2 and documented pressure ulcer to coccyx unstageable with measurements of 1.5 X 1.5. Continue to cleanse pressure ulcer with normal saline, apply santyl to wound, cover with gauze and dry dressing. Change daily and as needed.

The facility's pressure ulcer evaluation record dated 11/2014, documented wound measurements to be 1.5 X 1.5, unable to determine stage.

On 12/4/14, Z3 was at the facility, but R2 was unavailable. Nursing reported to Z3 that R2 was

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stable. Z3 documented will follow up next week.

On 12/11/14, Z3 saw R2 and documented unstageable pressure ulcer to coccyx with measurements of 1.5 X 1.5. Z3 performed excisional debridement of necrotic tissue. Treatment of the pressure ulcer continues with clean with normal saline, apply Santyl to wound, cover with gauze and dry dressing.

On 12/18/14, Z3 saw R2 and documented unstageable pressure ulcer with measurements of 1.1 X 1.0. Continue to cleanse pressure ulcer with normal saline, apply Santyl, cover with gauze and dry dressing. Change daily and as needed.

The facility's pressure ulcer determination record dated 12/19/14, documented, unable to determine stage, with measurements of 1.1 X 1.0. See SWM notes.

On 12/22/14, Z3 saw R2 and documented Stage IV pressure ulcer with measurements of 1.0 X 1.0 X 1.5, with undermining of 1 centimeter (cm) from 12 O'clock and 0.7 cm from 9 O'clock. Exposed structure: tendon. Z3 documented instructions for staff on importance of R2 being up for 2 hours max at a time to help with off-loading and promote in healing.

The facility's pressure ulcer determination record dated 12/22/14 documented stage IV pressure ulcer with measurements of 1.0 X 1.0 X 1.5. See SWM notes.

On 12/25/14 at 3:30 PM, E30, Licensed Practical Nurse, LPN, documented on Nurses Notes that Z4, Power of Attorney (POA), notified E30, that R2 had an odor coming from R2's coccyx wound.

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Z4 told E30 "I know the wound is getting worse and there is an odor to it. I know the odor is not coming from bowel movement (BM)." E30 notified Z6, Nurse Practitioner of Z4's concerns of the odor coming from R2's wound and new orders were received for one time dose of Rocephin 1 gram intramuscular (IM) now. Culture coccyx wound. Complete Blood Count (CBC) in AM.

Laboratory results from wound culture obtained 12/25/14, documented; Positive for Escherichia, many white blood cells, gram negative rods, many gram positive cocci, many gram positive rods.

In reviewing Nurses Notes and TAR for 12/25/14, no documentation was found by E23, Licensed Practical Nurse, LPN, who did R2's dressing change on 12/25/14. No documented Change of Condition report or mention of the odor to R2's pressure ulcer was written in the nursing notes, even though orders for treatment of R2's infected pressure ulcer was sought for that same day.

In a later interview on 1/13/15 at 9:15 AM, E23 was asked if she recalled an odor to R2's pressure ulcer on 12/25/14 when changing R2's dressing. E23 said "No, I don ' t remember smelling a foul odor". E23 was asked what she would do if there was a change in a wound. E23 said "If there was a change in a wound she would chart it in the Nurses Notes and do a change of condition report".

On 12/29/14, Z3 saw R2 and documented stage IV pressure ulcer with measurements of 3.00 X 5.00 X 1.50. Undermining: 9 cm from 3 O'clock. Undermining: 1 cm from 9 O'clock. Undermining 2.5 cm from 12 O'clock. Undermining:1 cm from

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F 314	Continued From page 78 3 O'clock. Exposed structure: Bone, Tendon. Treatment changed to cleanse pressure ulcer with normal saline, apply Santyl, Dakins' 0.125% moisten gauze packing, cover with gauze dry dressing. Change daily and as needed. Z3-instructed staff on importance of R2 being side to side turn only to help with off-loading and promote in healing. R2 is currently on bed rest. Foley catheter was placed for wound healing. On 12/30/14 at 12:30 PM, E2 Director of Nurses (DON), was asked if the facility has any documentation of when staff turn and reposition residents. E2 said "No". The facility's pressure ulcer evaluation record dated 12/30/14 documented Stage IV with measurements of 3 X 5, see SWM notes. The facility's Resident Treatment Administration Record (TAR) for December 2014, documents the nurses initials in a box each day the dressing change was done. No Nurses Notes were available to describe the wounds characteristics or odors. On 12/25/14, the TAR initials that E23 LPN did the wound treatment and dressing change. No documentation or description of the wound size, odor or condition was available. On 1/5/15 at 12:25 PM, E3 LPN Wound Nurse was asked where she documents the size, depth, tissue, drainage of a wound after doing treatment. E3 said," whoever does the dressing change signs it off on the TAR, there is no documentation of the wounds except when SWM comes." When E3 was asked if the measurements on the facility's pressure ulcer evaluation record were her measurements and assessment of R2's wounds, E3 said "No, they are SWMs	F 314		

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measurements and assessments". E3 said the pressure ulcer evaluation record dated 12/30/14 were SWMs measurements for 12/29/14. They were not E3's measurements for 12/30/14 as documented.

On 1/8/15 at 9:45 AM, Z3 SWM Nurse Practitioner was asked about the significant change in R2's pressure sore, Z3 said, a couple weeks ago she thought R2's wound was looking better, Z3 said she was concerned about an area to the wound which was necrotic, and was concerned maybe she had been sitting or lying on the wound for too long. Z3 said 2 hours was too long for R2 to be up at all. Z3 was asked if, in her opinion, the staff had not been turning and repositioning R2 as had been ordered. Z3 said "I cannot tell you what happened from one week to the next, but R2's wound had changed so quickly, it had been measured as 1 X 1 and now she is measured at 3 X 5. It looked like a completely different wound. It could have been from not being turned as often as she needed to be."

The TAR for December 2014 documented per E23's initials, that E23 did the wound treatment and dressing changes for R2 on 12/6/14, 12/7/14, 12/9/14, 12/10/14, 12/16/14, 12/20/14, 12/21/14, 12/23/14 and 12/25/14.

The Facility's Policy "Skin Integrity Standard" dated March 2005 and updated June 2010, documented, Procedure:
- Documentation of the turning and repositioning at least every two (2) hours while in bed or in a chair. Dependent residents sitting or in bed may need a position change for 'tissue offloading' every hour. Weekly "head to toe" assessment of all residents by Licensed nurse with narrative

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F 314	Continued From page 80 documentation of findings. - Weekly narrative documentation must include: description of skin tissue, color, turgor, rashes, bruising, skin tears, edema, incision lines and any other skin related issues. - If skin integrity issues are identified post-admission to the facility the following documentation is required: #2. Notation on the 24 hour report indicating the skin condition. #5. Incident report completed for in house acquired Stage III and/or IV. Use in tracking/trending and QA&A program. - Director of Nurses DON/Designee completes weekly random skin assessments. On 1/7/15, at 11:45 AM, E2, DON, stated she had not been doing the weekly random skin assessments as directed by facility policy. 3. R8's was admitted to the Facility on 12/5/14 after discharge from a local hospital. Discharge documents indicate R8 had a Stage 1 pressure ulcer to the left heel and a blister on the right heel, no measurements were given by local hospital. The Facility Nurses Notes dated 12/5/2014 at 10:00 pm document in part; "Pink area noted to coccyx." There is no documentation R8 ' s heels were observed or if measurements were taken of R8's heel ulcers upon readmission. On 12/9/2014 the "Pressure Ulcer Evaluation Record" of the right heel documents a Deep Tissue Injury with a length of 2.6 centimeters with a width a 2.8 centimeters which were taken 4 days after readmission.	F 314		

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F 314	Continued From page 81 On 12/19/2014 the "Pressure Ulcer Evaluation Record" of the right heel documents a deep pressure area width a length of 2.6 centimeters with a width a 2.8 centimeters. R8's Minimum Data Set (MDS) dated 12/17/14 documents R8 has a Brief Interview of Mental Status (BIMS) of 15 which indicates no mental impairment. This same MDS documents diagnoses, in part, of Congestive Heart Failure, Congenital Musculoskeletal deformities. On 1/13/15 at 1:00 PM, R8, stated he had gotten the pressure areas to his heels before admission, while in the hospital. On 1/13/2015 at 10:30 AM, E2 Director of Nurses, stated, She is unsure why a full skin assessment was not completed upon readmission. E2 further stated, a full skin assessment should be completed upon resident admission and readmission. On 1/13/2014 at 10:35 AM, E3 Wound Nurse, stated "yes 10 days had passed without measurements of R8's heel wounds during the period of 12/9/2014 and 12/19/2014". E3 stated, "I assess every week as long as the assessment happens sometime in the following week , it's ok". On 1/1/15 R8's left heel, previously a blister, now measures 1.7cm x 2.1cm x 0.2cm. 4. R14 was originally admitted to the Facility on 10/24/14, with diagnoses, in part, of Congestive Heart Failure, Cirrhosis of the Liver and Brain Damage. R14 was observed sitting in a high back wheelchair, while not in bed, throughout all days of the survey. R14 was observed with an alarmed self-releasing lap belt across the waist while sitting in the wheelchair.	F 314		

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F 314	Continued From page 82 R14's most recent Minimum Data Set (MDS), dated 12/22/14, documents that the Facility was unable to assess R14's cognitive ability; that R14 has short and long term memory problems; does not ambulate; and requires extensive assistance for transfers, and activities of daily living. R14's "Pressure Ulcer Risk Assessment", dated 11/29/14, documents that R14 was at moderate risk for the development of a pressure ulcer. R14's nurses notes, dated 12/2/14, documents "10:12 AM, resident noted to have skin breakdown to buttock. Area was cleansed with normal saline and protective bandage applied per standing orders. Resident also noted to be incontinent of both stool and urine". There is no documentation regarding R14's open area on the "Pressure Ulcer Log" from 12/2/14 through 1/8/15. R14's "Change of Condition SBar-Skin Condition" form dated 12/2/14, documents "skin breakdown from incontinence on R14's coccyx. Current size of wound: Length=2.2 centimeters (cm), Width=1.6 cm, Depth=0.2 cm". The form documents that R14's physician was notified of the open area and gave an order to "cleanse with normal saline. Apply protective bandage every 3 days and as needed until healed". R14's "Non-Pressure Skin Condition Report", with an original date of 12/30/14, documents "incontinence associated lesion - 1.2 length, 0.6 width, 0.2 depth". The back of the form is dated 1/8/15 and documents "area is healed at this time - per wound nurse's assessment".	F 314		

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F 314	Continued From page 83 On 1/8/15 at 11:50 AM, E3, Treatment Nurse, was asked why the open area on R14's was not tracked on the "Pressure Ulcer Log". E3 stated that she had incorrectly classified R14's pressure sore as an "incontinent lesion". E3 said that the wound nurse consultant informed E3 that R14 did have a pressure sore. R14's "Skin Integrity Care Plan: Prevention", dated 11/29/14, documents "Problem: potential for impaired skin integrity. Goal: No pressure ulcers will develop in the next 90 days". The "Interventions" for this "Problem" include "reposition every hour while in the wheelchair". On 1/8/15, R14 was kept under direct visual observation while he was sitting in his wheelchair, from 10:40 AM until 1:05 PM. R14 was not repositioned during that time period. The Immediate Jeopardy situation was identified to have begun on 11/17/14, when the facility failed to accurately identify, assess, and seek appropriate treatment and interventions for R1's pressure ulcer which developed into an infected Stage 4 Pressure Ulcer and did not heal. The facility failed to accurately identify new pressure ulcers for R2, and R8 and failed to properly assess and initiate timely and preventative treatment to avoid worsening and infection of R2's pressure ulcers. E1 and E2 were notified of the Immediate Jeopardy on 1/8/15 at 12:50 PM. Beginning 1/8/15, in interviews, observation and record review the Facility took the following actions to remove the Immediacy:	F 314		

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F 314	Continued From page 84 1. 1/8/15 - The Facility reviewed R1 and R2 head to toe, to ensure there were no other new or declining pressure ulcers. All treatment orders were reviewed to ensure they were clinically appropriate for each resident ' s status. 2. 1/8/15 - The facility reviewed all current residents with known pressure ulcers to ensure accurate assessment, monitoring / measuring, and treatment of ulcers were being carried out per facility policy. 3. 1/8/15 - The Facility initiated head to toe skin checks on all residents to identify any new pressure ulcers and ensure they had clinically appropriate orders for their skin conditions. 4. 1/8/15 - The Facility began to contact each resident ' s physician with pressure ulcers to review and update treatment orders. 5. 1/8/15 - all Facility RN ' s, LPN ' s, and C.N.A ' s began receive re-education on the Facility ' s policy for appropriate assessment, reporting, monitoring, treatment, and physician notification, when there is a change in status of a resident ' s skin condition, or change in condition of a pressure ulcer. 6. 1/8/15 - The Facility began measures to ensure staff follow it ' s policy of weekly measurements of pressure ulcers, and of informing the physician when there is no improvement in the wound progress within 2 weeks. Wound care and status will be monitored weekly by E2, DON.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 85 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: Based on observation, interview and record review the facility failed to provide complete incontinent care to prevent urinary tract infections for 1 of 2 residents (R13) reviewed for urinary tract infections in the sample of 20. Findings include: 1. R13's most recent Minimum Data Set (MDS) dated 12/12/14 documents R13 has active diagnosis of Neurogenic Bladder, has a suprapubic catheter and needs extensive assist with dressing, toileting and bathing. R13's MDS also documents R13 is frequently incontinent of bowel. A Urine Culture Report dated 12/23/14 documents Results: Escherichia coli 50,000-100,000 colonies per milliliter and Presumptive Proteus mirabilis 10,000-50,000 colonies per milliliter. The Physician Order Sheet dated 12/23/14 documents Macrobid 100 milligrams (bid) twice a day x 10 days. On 1/12/15 at 9:19 AM, R13 was incontinent of bowel. E19 and E20, Certified Nursing Aides,	F 315		

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F 315	Continued From page 86 CNAs, washed hands and gloved. E19 brought a soapy towel, a wet towel for rinsing and a third towel for drying. E19 washed R13's inner thighs , groin area and across the vaginal area then rinsed and dried the areas. E19 failed to thoroughly clean the vaginal area and spread the labia. E20 turned R13 to her right side. R13 had a small bowel movement. E19 washed, rinsed and dried the buttocks and rectal area using the same 3 towels designated for washing, rinsing, drying and changing the area of the towel after each wipe. E19 failed to change her soiled gloves prior to rinsing, and drying R13's buttocks and rectal area. On 1/12/15 at 10:25 AM, R13 stated she doesn't really get properly cleaned in her private parts everyday and her catheter has been leaking to her urethra for a couple of days. R13 stated she only gets really clean down there during her showers twice a week. R13 stated she just had a bladder infection last month and these things are all connected together. On 1/13/15 at 9:35 AM, E27, Registered Nurse/Director of Staff Development, stated staff are supposed to change gloves from dirty to clean and to thoroughly wash the vaginal area to prevent infection.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the Facility failed to assess for contributing factors and implement progressive interventions for 1 of 5 residents (R14) in the sample of 20 with a history of falls; and failed to provide safe transfers for 3 of 8 (R4, R5 and R9) resident's dependent on staff for transfers, in the sample of 20.

Findings include:

1. R14 was originally admitted to the Facility on 10/24/14, with diagnoses, in part, of Congestive Heart Failure, Cirrhosis of the Liver and Brain Damage. R14 was observed sitting in a high back wheelchair, while not in bed, throughout all days of the survey. R14 was observed with an alarmed self-releasing lap belt across the waist while sitting in the wheelchair.

R14's most recent Minimum Data Set (MDS), dated 12/22/14, documents that the Facility was unable to assess R14's cognitive ability; that R14 has short and long term memory problems; does not ambulate; requires extensive assistance for transfers, and activities of daily living: and is not steady and only able to stabilize with staff assistance for moving from a seated to standing position, and surface-to-surface transfers.

R14's plan of care, dated 12/12/14, documents a Problem of "At risk for falls and injuries related to: Psychotropic Medication (Meds), Cardiovascular Meds, Pain Meds, Cognitive Impairment, Poor safety awareness, unsteady gait and history of

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falls". Interventions for this Problem include: "self releasing seat belt". There is no documentation present in R14's clinical record assessing for the use of the alarmed self releasing seat belt. E4, Care Plan Nurse, confirmed that the Facility did not have an assessment for the use of R14's alarmed self-releasing lap belt.

R14's current Physician's Order Sheet (POS), dated 1/1-31/15, documents the following medications with subsequent adverse reactions:
Amiodarone hydrochloride, 200 milligrams (mg) orally, daily. Adverse Reaction: Cardiovascular (CV) - hypotension.
Carvedilol, 3.125 mg, orally, twice daily. Adverse Reactions: CV - hypotension, orthostatic hypotension.
Furosemide, 20 mg, orally, twice daily. Adverse Reactions: CV - orthostatic hypotension. Central Nervous System (CNS) - vertigo, dizziness.
Pantoprazole sodium, 40 mg, orally, daily. Adverse Reactions: CNS - dizziness.
Seroquel, 50 mg, orally, twice daily. Adverse Reactions: CNS - dizziness. CV - orthostatic hypotension.

R14's "Verification of Incident Investigation/Administrative Summary" forms, document that R14 experienced falls from his wheelchair on 10/27/14, 12/5/14, 12/9/14, 12/10/14, 12/13/14, 12/20/14, 12/26/14, 12/28/14, 12/30/14 and 1/5/15. R14 fell from his wheelchair while wearing the alarmed self-releasing lap belt, on 12/13/14, 12/20/14, 12/26/14, 12/28/14, 12/30/14 and 1/5/15.

The "Verification of Incident Investigation/Administrative Summary", for R14's falls document the following:

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F 323	Continued From page 89 10/27/14 - 4:45 PM. "Found on floor sitting on buttocks with head resting on recliner in his room. Resident confused and anxious. Resident removed safety alarm and slid to floor from the wheelchair. Description of injury: Right wrist forearm scratch. Follow-Up Action Taken: Sensor alarm to replace tab alarm in wheelchair". 12/5/14 - 4:10 PM. "Staff heard safety alarm. Found resident on floor in hallway next to wheelchair. Description of injury: none. Follow-Up Action Taken: Frequent safety checks". 12/9/14 - 9:00 AM. "Resident in the hallway sitting in wheelchair. Certified Nurses Aide (CNA) witnessed resident fall over the side of the wheelchair. Resident confused - unable to determine what he was trying to do. Follow-Up Actions Taken: Physical Therapy notified to evaluate for wheelchair positioning". 12/10/14 - 1:30 AM. "Resident sitting up in wheelchair in hallway. Staff responded to safety alarm. Found resident on floor, unable to determine why resident fell. Follow-Up Actions Taken: Placed alarmed safety self-release belt". 12/10/14 - 3:20 PM. "Staff found resident on floor in front of wheelchair. Seat belt alarm still intact. Appears resident slid under belt. Resident unable to explain what happened due to confusion. Description of injury: complaint of general pain. Follow-Up Actions Taken: Pain meds administered. Non-slip matting placed under and on top of wheelchair cushion prevent sliding". 12/13/14 - 8:45 PM. "Resident outside in hallway after breakfast by the vending machines. Safety release belt did not activate. Resident continues to remove alarm. Resident appears to have slipped from wheelchair. Description of injury: swelling to right eye. Follow-Up Actions Taken: Keep resident in common area for added supervision while not in bed as much as resident	F 323		

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F 323	Continued From page 90 will tolerate". 12/20/14 - 5:45 AM. "Staff alerted to resident's alarm sounding in common area. Found resident sitting on buttocks without injury. Staff members were getting other resident's up for breakfast. Follow-Up Actions Taken: keep resident in hallway common area where staff is present, for supervision, as much as resident will tolerate". 12/26/14 - 3:15 PM. "Found resident lying on floor on right side. Wheelchair tipped over on right side in hallway. Nurse able to assist resident back to wheelchair without difficulty. Description of injuries: complaint of generalized pain to right upper extremities. Follow-Up Actions Taken: Wheelchair inspected. Anti-slippers for wheelchair to help reduce wheelchair tipping". 12/28/14 - 11:00 AM. "Found on floor in bedroom beside wheelchair. Complaining of pain to lower back and coccyx. Also swelling noted to right eye. His is very hard to redirect. Resident is non-compliant with safety alarm. Follow-Up Action Taken: Staff supervision as much as possible. Provide one-on-one activities as much as resident will tolerate". 12/30/14 - 1:15 AM. "Staff responded to safety alarm but could not reach him before resident had fallen to floor on his right side. Small laceration to bridge of nose and right upper eyelid. Resident continues to be non-compliant with safety devices and self propels around facility and hallway from staff. Resident tends to get upset and anxious with direct supervision and wheels chair away. Follow-Up Actions Taken: Staff supervision as much as he will tolerate. Power of attorney looking for facility with a closed unit to help contain resident and keep him from wandering as much as in this open Facility". 1/5/15 - 8:00 PM. "Visitor reported to nurse that resident was on the floor. Resident propels up	F 323		

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F 323	Continued From page 91 and down hallway. When last seen by staff shortly before found on the floor. Resident has restless behaviors and had a history of agitation and propelling self up and down the hall. Resident is difficult to redirect. Description of Injuries: none. Follow-Up Actions Taken: Therapy supplied new high back wheelchair with more efficient roll back anti-tippers. Resident appears more stable with positioning in new wheelchair". The investigations do not identify potential contributing factors - such as orthostatic hypotension, medication side effects, when R14 was last seen prior to the fall or when R14 was last toileted prior to the fall. The Facility did not implement progressive interventions based on the potential contributing factors, nor did they monitor the effectiveness of the interventions and modify them as necessary in accordance with current standards of practice. E2, Director of Nursing (DON), confirmed in an interview on 1/13/15 at 3:00 PM, that the Facility failed to identify potential contributing factors to R14's falls, such as side effects of medication, or when R14 was last seen or toileted. E2 confirmed that there are no baseline orthostatic hypotension readings documented in R14's clinical record. 2. R5's MDS dated 11/28/14 documents total dependence on 2 staff for transfers and toilet use with impairment on both sides of the upper and lower extremities. R5's Skin Integrity Care Plan with review date 9/2/14 documents, 'Problem: Potential for Impaired Skin Integrity Related to: Requires assist with turning and repositioning of two assist. Interventions: Mechanical lift for all transfers.	F 323		

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On 1/5/15 at 1:00 PM, E13, Certified Nursing Aide, CNA, transferred R5 from her wheelchair to the bed while E12, CNA, stood on the opposite side of the bed straightening the pad and bed linens. E13 did all lifting preparations, stirred the lift and lowered R5 onto the bed then E12 assisted E13 with positioning R9 properly in bed and unhooking the sling from the lift.

On 1/13/15 at 9:31 AM, E27, Registered Nurse/ Director of Staff Development, stated the second staff should be positioned close to the resident while assisting the staff who is operating the mechanical lift to ensure a safe transfer of the resident. Both are expected to work together, make sure the straps are attached securely and guide the resident for proper positioning in bed.

The Facility Education Lesson Plan entitled (Mechanical Lift) Transfers, undated, documents, 'Participant will be able to: Properly transfer resident from one surface to another with assistance from another nursing staff personnel.'

3. R9's MDS dated 10/3014 documents extensive assist of 2 staff during transfers and limited range of motion on both lower extremities.

R9's Activities of Daily Living Care Plan updated 10/30/14 documents two person extensive assist with transfers.

On 1/5/15 at 12:39 PM, E11, CNA, transferred R9 from the wheelchair to the bed with extensive assist using a gaitbelt applied loosely around R9's waist. E11 pulled on the gaitbelt which slid up to his chest level as she stood on R9's side. As E11 pulled the belt up from behind, it reached up to

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R9's upper back when E11 assisted R9 to stand up from the wheelchair.

In an interview on 1/5/15 at 12:44 PM, E11 stated as far as she knows R9 only requires 1 assist and that is what she had been doing.

In an interview on 1/13/15 at 9:31 AM, E27, Director of Staff Development, stated staff are expected to follow the care plan for R9's transfer needs for safety.

The Facility Procedure: Use of Transfer Belts, undated, documents, 'Use the transfer belt in the following manner: 2. Apply the transfer belt snugly around the resident's waist."

4. R4's Minimum Data Set (MDS) dated 12/16/2014 documents diagnoses, in part, of Atrial Fibrillation, Hypertension, Anxiety Disorder and Depression. This same MDS documents R4 has a Brief Interview of Mental Status (BIMS) of 6 which indicates severe cognitive impairment and R4 needs limited assistance of 1 with transfer. R4's Care Plan dated 12/16/2014 documents extensive maximum assist of two staff members for transfers.

On 1/8/2015 at 10:27 AM, E5 Certified Nurses Aide (CNA) was asked by, E29 Registered Nurse (RN), to assist R4 from the wheelchair to bed. E5 walked into the room, turned the bedding down, unclipped R4's personal alarm and call light from R4's shirt. No gait belt was placed on R4 for safety with the transfer. E5 proceeded to walk to R4's right side and grab R4 under the arm and state "Come on" while attempting to stand R4 up, then stated "turn your foot." R4 was having a difficult time standing and turning to the bed. E5

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F 323	Continued From page 94 sat R4 on a small section of the edge of the bed. R4 flopped backwards and her legs were off the bed with her back in the middle of the bed almost parallel to the bed. E5 picked up R4's legs and put them on the bed. E6 CNA entered the room to finish help position R4 in bed. On 1/13/2015 at 1:01 PM, E27 Director of Staff Development, stated that staff should go by the Care Plan when there are difference between the MDS and the Care Plan. E27 also states, "staff should always use a gait belt when transferring a resident". The facility's policy and procedures for transfers, undated, documents, "The resident should wear a transfer belt whenever he or she is being transferred."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, The facility failed to assess, monitor and implement	F 325		

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progressive interventions for weight loss for 1 of 20 residents (R4) reviewed for weight loss.

Findings include:

R4's Minimum Data Set (MDS) dated 12/16/2014 documents diagnoses, in part, of Atrial Fibrillation, Hypertension, Anxiety Disorder and Depression with an admission date of 9/5/2014. This same MDS documents R4 has a Brief Interview of Mental Status (BIMS) of 6 which indicates severe mental impairment.

Review of R4's weight record reveals on 9/5/2014 the date of admission, R4 weighed 182.4 pounds (LBS). On 11/13/2014 R4 weighed 184.20 LBS. On 12/4/2014 R4 weighed 166.80 LBS which is a 17.4 LB weight loss. On 12//31/2014 R4 weighed 150.8 LBS which is a loss of 16 LBS. From 11/13/14 to 12/31/13 R4 had a total weight loss of 33.4 LBS, a significant weight loss of 18.1% in the last past 6 weeks.

On 1/5/2014 at 11:15 AM, E29 stated that R4 has a very flat affect, is unmotivated to do anything or eat.

On 1/7/2014 at 11:52 AM, R4 states she is not hungry or thirsty and that nothing sounds good to her to eat.

On 1/8/2015 at 11:40 AM, E2 Director of Nurses (DON), stated that R4 has had a very flat affect since being admitted and has no motivation to get out of bed.

On 11/17/2014 (untimed), Z10 Registered Dietician, documents ,in part, "ST (speech therapy) says at lunch, res (resident only ate a

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F 325	Continued From page 96 bite, says not hungry, refused breakfast. Has a very flat affect will coordinate with staff for a Ear Nose and Throat consult to rule out if feeling is medical problem or psychological. Recommend ask MD (Medical Doctor) if appetite stimulate is desired. Nurse says res (resident) wants to stay in bed, comes back from appointments and wants to go to bed, doesn't want to be up for more that an hour, will get up for bathroom, needs motivation to get out of bed." On 11/24/2014 Z10 documents ,in part, "Resident on mechanical soft diet, supercereal at breakfast, and house supplement three times a day." On 12/5/2014 Z10, documents appetite poor, oral intake encouraged snack occasionally in room. Noted Remeron not ordered to date". On 1/6/2014 Z1 documents, in part, "Diet regular mechanical soft, supercereal at breakfast, House Supplement three times a day, appetite poor, oral intake encouraged, MD notified of weight loss request for appetite stimulant. Seen on 12/11/2014 for esophago-gastroduodenoscopy (EGD) and biopsies taken. Appetite stimulant not ordered to date. Noted weight loss continues nurse says resident not eating. Recommend current diet continue supplement Boost three times a day provided by family, ask MD if appetite stimulant desired." R4's most recent care plan dated 9/11/14 failed to show any recent update to address R4's ongoing weight loss. On 1/14/2015 at 9:00 AM, E2 Director of Nurses, stated, "The Registered Dietician enters her recommendation into the computer, then the Z1, acknowledges the recommendation through the computer."	F 325		

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	145571	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH REHAB CENTER	ONE PERRYMAN STREET LEBANON, IL 62254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 97 On 1/14/2015 at 1:36 PM, Z1 Physician, stated he was not notified by the Facility of R4's poor appetite and her no motivation to get out of bed until last week. Z1 also states that he was unaware of the Registered Dietician recommendations that were being made because he did not realize the recommendations were being entered in the computer for him to acknowledge. Z1 stated he just found that out last week. Z1 stated R4 has recently had small bowel surgery, and this may be impacting her weight loss, and he should have been notified about the weight loss via phone.	F 325		