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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey for Subpart S: SMI	F 000		
F 314 SS=D	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 interview and record review the facility failed to promptly notify doctor, measure and assess weekly wound status and failed to obtain a physicians order for wound treatment for 1 of 2 residents (R6) reviewed for pressure ulcers in a sample of 10. This failure resulted in R6's pressure ulcer requiring surgical debridement. Findings Include: 1. R6's December 2015 Physician's Order Sheet (POS) documents diagnosis in part, diabetic foot ulcer, diabetic retinopathy, legally blind with a right above the knee amputation. R6's Braden Scale Assessment, dated 10/21/15, documents R6 is a high risk for developing	F 314		

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

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pressure sores. R6's Minimum Data Set (MDS), dated 6/19/15, documents R6 is cognitively intact, requiring limited assistance of 1 person physical assistance with bed mobility, transfers, ambulation and toileting.

R6's Care Plan, dated 5/20/15, documents R6 is at risk for skin breakdown related to requiring assistance with bed mobility, transfers, tilting and being non ambulatory with interventions of weekly treatment documentation to include measurements of each area of skin breakdowns' width, length, depth, type of tissue and exudate and any other notable changes or observations. R6's Care Plan, dated 7/25/15, documents open area to left heel unstageable. R6's Care Plan did not address R6's refusal of treatments or education of need to comply with treatments. R6's Care Plan did not document physician notification of R6's treatment refusals or a change for better compliance as a result of physician notification.

R6's December 2015 POS documents R6 was re-admitted to the facility on 7/23/2015 after having an above the knee amputation to the right leg. R6's Nurse's Note, dated 7/23/15 at 6:45 PM, documents in part, "(R6) arrived to the facility by ambulance." Nurses Note, dated 7/24/15 at 7:34 PM, documents in part, "(R6) refused to get out of bed today and refused re-admit weight. Unable to assess area of stump and buttocks due to pain and (R6) didn't want to turn states: 'to much pain'."

R6's Nurses Note, dated 7/25/15 at 5:00 PM, documents in part, "nurse able to complete skin assessment." No documentation in R6's Nursing Notes for left heel area noted. R6's Skin

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Assessment, dated 7/25/15, does not document any sore areas on R6's left heel.

R6's Nurses Note, dated 7/28/15 at 6:00 PM, documents, "(Z1, R6's wife) came to (E6, Licensed Practical Nurse, LPN) and stated that she removed (R6's) sock and noticed that the sock was wet and there was a brown drainage from (R6's) left foot. Upon inspection, dry flaking skin noted from left foot. 2 cm (centimeter) flap of skin noted on left side of left heel with small amount of brown drainage. 2 cm darkened area noted to bottom of left heel. No complaint of pain or discomfort. (R6) had decreased sensation to areas on heel. (R6) became tearful and stated, 'I can't go through another amputation.' (R6) assisted into bed via (mechanical) lift. Left heel cleansed with NS (normal saline). Santyl and nonstick dressing applied. Gauze wrapped around left lower extremity. (R6) has an appointment to see (Z2, R6's Vascular Surgeon) tomorrow at 11:30 AM. (Z3, Primary Physician) notified of changes to LLE (left lower extremity). NNO's (no new orders). (R6) currently resting in bed with (Z1) at bedside."

R6's Nurses Note, dated 7/29/15 at 8:40 AM, documents, "Call made to (Z2's) office to notify them of changes to (R6's) left foot. (R6) to attend an appointment today at 11:30 AM."

R6's Nurses Note, dated 7/29/15 at 10:00 AM, documents in part, "Inspected wound on (R6's) left foot. Flap of skin noted to be pulled further back on heel. Discoloration remains to bottom of heel. No complaint of pain or discomfort. (R6) stated that he can feel when heel is touched. Wound to left heel soft and cool to touch. No drainage noted at this time. Skin noted to be

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flaking off leg and foot. Santyl and non stick dressing applied to wound. Gauze wrapped around LLE. Heel protector boot in place to left foot."

R6's Nurses Note, dated 7/29/15 at 2:20 PM, documents in part, "(R6) returned from appointment with (Z2) back to facility at this time. N.O. (new orders) received. Dressing changes to left heel qd (everyday), 4 x 4's Kerlex roll, ace wrap, air boot."

R6's Nurses Note, dated 8/2/15 at 2:20 AM, documents, "Left heel noted to have red fleshy wound with dry skin and some dark discoloration noted, heel protector on as ordered."

R6's Nurses Note, dated 8/3/15 at 2:50 AM, documents in part, "dressing changed to left heel, scant amount of bloody drainage noted on previous dressing, wound bed pink, red, and dark discoloration with excessive dry skin, left heel kept in boot."

R6's Nurses Note, dated 8/3/15 at 2:55 PM, documents in part, "treatment to left heel measurement of 4 cm x 2 cm to wound bed (inner) with tissue black in color and outer pink in color."

R6's Nurses Note, dated 8/8/15 at 1:30 PM, documents in part, "dressing changed to left heel per MD (Physician) orders. Open area to left heel noted to be yellow and pink in color. Skin soft and mushy. Necrotic tissue noted around area."

R6's Nurses Note, dated 8/12/15 at 3:00 PM, documents in part, "dressing to left heel dry and intact. Dressing changed per MD orders. Open

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area to left heel noted to be pink and yellow with necrotic tissue surrounding it. Area 10 inches x 5 inches."

R6's Nurses Note, dated 9/14/15 at 10:45 AM, documents, "dressing to left heel changed per MD orders. Black and foul smelling tissue noted to cover wound to left heel. Slim drainage noted. (R6) complained of tenderness to wound. Dry skin noted to surround wound. Area cleansed and new dressing applied per MD orders."

R6's Nurses Note, dated 9/22/15, not timed, documents in part, "dressing to heel changed. Foul odor noted with small amount of yellow-green drainage noted on old dressing. Area cleansed with normal saline along with blackened tissues. Dressing changed as ordered."

R6's Nurses Note, dated 9/25/15 at 11:45 AM, documents in part, "(R6) left facility at 10:40 AM. Was headed to have left heel surgically debrided."

The facility's Weekly Other Skin Condition Report, dated 7/31/15 and 8/7/15, both document a facility acquired open area to R6's left heel measuring 2 cm x 2 cm.

The facility's Skin Logs, dated 8/14/15, 8/21/15, 8/28/15, 9/4/15, 9/11/15, and 9/18/15, do not document measurements or wound appearance of R6's wound to his left heel. The facility's Skin Log, dated 9/25/15, documents, "(R6) out to hospital for debridement today to left heel."

The facility's Pressure Ulcer Log, dated 10/2/15 documents R6's pressure ulcer to the left heel as

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F 314	Continued From page 5 15 x 8.5 x undetermined and does not document the stage. On 12/16/16 at 11:10 AM, E6 stated that she and E1, Administrator, looked at R6's wound on 7/28/15. E6 stated that she measured it at that time,cleaned it up,applied Sanytl and a non stick dressing. E6 stated that she was unsure where the Santyl came from, but said "we just had some in our cart." R6's POS, dated 7/2015, did not document an order for Santyl. R6's Treatment Record, dated 8/2015, documents dressing change to left heel twice a day with Santyl, 4 x 4's, Kerlix and ace wrap. The record documents 4 treatments were not done and 18 treatments were refused by R6. On 12/16/15 at 12:00 PM, E1 stated that R6's left heel pressure ulcer was caused by shearing from his bed with movement and also by using his left heel to propel his (R6) wheelchair. E1 further stated she would expect the nursing staff to document wound measurements weekly and confirmed that R6 did not have a physician order for Santyl to be applied to left heel pressure ulcer on 7/28/15 and 7/29/15. E1 also stated that there was no further documentation on R6's wound measurement from 8/14/15-10/2/15. When asked for R6's shower sheets for July 2015, E1 stated that the facility does not keep shower sheets past 90 days, they destroy them. On 12/17/15 at 2:30 PM, Z2 was interviewed via telephone and stated the facility did not contact him about R6's left heel pressure ulcer getting worse. Z2 stated he wasn't aware R6 was	F 314		

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refusing treatment or not getting treatments as ordered. Z2 futher stated that R6 was a high risk for pressure ulcer and the facility should have known to keep an eye on his heel.

The facility's Wound Care Policy, dated 7/28/15, documents, "Purpose: To identify factors that places the resident at risk for the development of pressure ulcers and to implement appropriate interventions to prevent the development of clinically avoidable wounds. To promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown." "Procedure: Risk Identification and Assessment: 3. Upon identification of the development of a wound, the wound assessment will be documented on the Initial Wound Assessment Form. 5. Residents should be examined thoroughly at least weekly by a licensed nurse to identify existing pressure ulcers. a.) Findings from the weekly skin assessment should be documented by the licensed nurse on a Body Audit Assessment Form. 6. Nurse Aides should complete a Comprehensive CNA (Certified Nurses Aide) Shower Review on all residents when they are bathed or showered and given to the charge nurse. a.) Additionally, CNA's should observe skin integrity during the daily provision of routine cares and report any impairments to the charge nurse for appropriate follow-up. b.) After review by the Charge Nurse, the Comprehensive CNA Shower Review should be given to the Wound Nurse, or designee, for appropriate follow-up. c.) The Comprehensive CNA Shower Review should be reviewed by the DON routinely. 7. Any skin impairments, including pressure ulcers, non-pressure ulcer wounds, surgical wounds, skin tears, abrasions, etc., should be

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F 314	Continued From page 7 assessed and documented weekly by the Wound Nurse, or designee, on the Wound Evaluation Flow Sheet or the PCC Weekly Wound Assessment. a.) Documentation should cover all pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor or tunneling, or undermining."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the Facility failed to provide complete indwelling urinary catheter care for 1 of 1 resident (R4) reviewed for indwelling urinary catheters in the sample of 10. Findings: R4's current face sheet documents R4 was admitted on 12/11/15. R4's Resident Data Collection, dated 12/11/2015, documents, in part, R4 was admitted with an indwelling urinary	F 315		

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F 315	Continued From page 8 catheter. On 12/15/2015 at 11:30 PM, E4, Certified Nurse's Aide (CNA), performed indwelling urinary catheter care on R4. E4 failed to retract R4's foreskin to cleanse the entire penile shaft. On 12/15/2015 at 11:40 PM, E4, stated, "I forgot to pull foreskin back, usually I do." On 12/17/2015 at 9:00 AM, E2, Director of Nurses (DON), stated, "I expect staff to pull the foreskin back during indwelling urinary catheter care." The facility policy and procedure "Catheter Care," dated 8/1/15, documents, in part, "For the male resident, retract the foreskin of the uncircumcised penis to expose the urethral meatus and catheter insertion site."	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322		

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F 322	Continued From page 9 skills. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the Facility failed to check the gastrostomy tube for residual stomach content before administering medication and flush the gastrostomy tube before and after medication administration according to physicians orders for 1 of 1 resident (R2) reviewed for a gastrostomy tube in the sample of 10. Findings include: On 12/14/2015 at 12:25 PM, E6, Licensed Practical Nurse (LPN), checked placement on R2's gastrostomy tube per auscultation, attached a 60 milliliters (ml) syringe, poured 10 ml of liquid Tylenol into the gastrostomy tube, then poured 300 ml of water into the gastrostomy tube. On 12/17/2015 at 9:00 AM, E2, Director of Nurses (DON), stated, "The nurse should have checked for residual stomach content before administering medication and flushed with 30 cc (cubic centimeters) of water before and after the medication was given." R2's December 2015 Physician Order Sheet (POS) documents, "1. Flush with 30 cubic centimeter (cc) of water before and after medication pass. 2. Flush with 300 cc after each feeding and twice during the day."	F 322		

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F 322	Continued From page 10 R2's December 2015 Medication Administration Record documents the two 300 cc flushes during the day are scheduled at 12:00 PM and 5:00 PM. The facility's policy and procedure "Tube Feedings: Flushing Feeding Tube", dated 8/1/2015, documents, in part, "Flush with the prescribed amount, of room temperature or warm water after checking residual stomach content. Flush enteral feeding tubes with prescribed amount, of room temperature or warm water before and after administration of medications."	F 322		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

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F 441	Continued From page 11 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately cleanse a multiple-use blood glucose monitoring device after resident use and failed to follow glove changing standards of practice for 3 of 9 residents (R5, R6, R4) reviewed for infection control practices in the sample of 10 and 1 resident (R17) in the supplemental sample. Findings include: 1. On 12/14/15 at 11:58 PM, E5, Licensed Practical Nurse (LPN), performed blood glucose fingerstick monitoring on R6. E5 cleansed the blood glucose monitoring device with a germicidal wipe for 5 seconds prior to using it on R6 and cleansed the blood glucose monitoring device with 1 germicidal wipe for 2 seconds and put it on top of the medication cart. 2. On 12/14/15 at 12:19 PM, E5 performed blood glucose monitoring on R17. After the procedure,	F 441		

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E5 cleansed the blood glucose monitoring device with one germicidal wipe for 2 seconds and put it in top drawer of the medication cart.

3. On 12/14/15 at 12:36 PM, E5 performed blood glucose monitoring on R5. After the procedure, E5 cleansed the machine with one germicidal wipe for 2 seconds and put it on top of the medication cart.

On 12/16/15 at 9:35 AM , E2, Director of Nursing (DON) stated she expects the nurses to follow the manufacturer's directions to provide adequate sanitizing of the glucometer.

The Facility Policy on Cleaning and Disinfection of a Glucometer, dated 8/1/15, documents, "To provide guidelines to adequately clean and disinfect glucometers used by multiple residents, in accordance with manufacturer recommendations. Ensure the meter remains wet for (3) minutes and allow to air dry for an additional minute before using on the next resident."

The Germicidal Wipes Label Instructions, undated, documents, "Directions for Use: Deodorizing and Disinfecting: To disinfect nonfood contact surfaces only: Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure continuous 3 minute contact time. Let air dry."

4. On 12/15/2015, at 11:30 PM, E4, Certified Nurses Aide (CNA), performed indwelling urinary catheter care on R4. During this care, E4 wore one pair of gloves to perform the care. Each time E4 needed another washcloth, she would take

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(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 441	Continued From page 13 the multi-use periwash wash bottle and spray the periwash onto the washcloth with her dirty gloves. E4 did this multiple times during the care. When care was completed, E4 removed her dirty gloves and sanitized her hands and placed the periwash bottle into her scrub pants pocket. On 12/15/2015 at 11:40 PM, E4, stated, "I didn't even think about touching the periwash bottle with my dirty gloves or cross contamination. I carry this same bottle all day long and use it on different residents." On 12/17/2015 at 9:00 AM, E2 stated, "Staff should not touch the periwash bottle with dirty gloves. It is a not good infection control practice." The facility policy and procedure "Standard Precautions", dated 8/1/15, documents, in part, "Gloves will be changed between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Gloves will be removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident."	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review the Facility failed to provide 80 square feet of floor	F 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145785	A. BUILDING _____ B. WING _____	12/17/2015

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F 458	Continued From page 14 space per resident bed for 2 residents (R1, R2) reviewed for physical environment in the sample of 10 and 6 residents (R11, R12, R13, R14, R15, R16) in the supplemental sample Findings Include: 1. The Facility has six two bed resident rooms. According to historical data, these rooms provide only 77.5 square feet per resident bed. These six rooms are certified for Medicare and Medicaid. R1, R2, R11, R12, R13, R14, R15 and R16 reside in Rooms 107, 109, 110, 112, 115 and 117. All of these rooms are on the 100 hallway.	F 458		