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POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

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F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	Annual License and Certification Survey 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident was	F 164		

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

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F 164	Continued From page 1 covered during personal cares. This applies to 1 of 7 residents (R4) reviewed for privacy in the sample of 12. The findings include: R4's Minimum Data Set of October 9, 2015 shows R4 is cognitively impaired and requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting. On November 2, 2015 at 8:06PM, E4 and E8 (Certified Nurse Assistants-CNAs) transferred R4 from his wheelchair to his bed. R4 was incontinent of urine, and E4 and E8 removed R4's pants, and incontinence brief. E4 left R4's bedside to wash her hands in the bathroom, and E8 left the room to get linens. R4 was left uncovered, and exposed from the waist down until R4 brought his knees up to his chest, and pulled the gown down to cover himself. R4 yelled "cover me up" and "hurry and get me covered up". E4 and E8 walked back to the bedside and continued to provide personal care to R4. R4 was not covered until the personal care was completed. On November 4, 2015 at 12:30 PM, E2 (Director of Nursing- DON) said residents private areas should be covered when not receiving personal care. The facility "Resident's Rights for People In Long Term Care Facilities" brochure revised 2009 states "Your medical and personal care are private."	F 164		
F 248	483.15(f)(1) ACTIVITIES MEET	F 248		

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F 248 SS=D	Continued From page 2 INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide activities to meet resident ' s individual preferences and level of cognition. This applies to 1 resident (R14) in the supplemental sample reviewed for activities. The findings include: On November 2, 2015, R14 was in her room in her reclining geriatric chair positioned facing the television from 7:15 PM-9:00PM. The television did not have musical programming being shown. On November 3, 2015, R14 was in the dining room in her reclining geriatric chair for breakfast and lunch and in her reclining geriatric chair in her room positioned in front of the television between meals. The television did not have musical programming being shown. On November 3, 2015 at 10:05 AM, R14 was in her room alone facing the television. On November 3, 2015 at 10:20 AM, R14 was in her room in her chair and her spouse was at her side. On November 3, 2015 at 11:30 AM, R14 was pushed in her chair by her spouse to the dining room. R14 was in the dining room at 11:45 AM, 12:00 PM, 12:15 PM and 12:30 PM. On November 3, 2015, R14 was in her chair in her room facing the television at 12:45 PM, 1:15 PM and from 2:40 PM- 3:45 PM. On November 4,	F 248		

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F 248	Continued From page 3 2015, R14 was in her chair in the dining room at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM and 8:20 AM. At 8:25 AM, she was transferred to her room and positioned facing the television with a cartoon show on. On November 4, 2015 at 8:45 AM, R14 was being readied for a shower by E10 (Certified Nurse ' s Assistant-CNA) and Z3 (Hospice CNA). On November 4, 2015 at 9:30 AM, R14 was finished with the shower and was in her reclining geriatric chair positioned in front of the television. E10 and Z3 had minimal verbal interaction during the 45 minute showering process. There was no musical program being shown on R14 ' s television at this time. During observations November 2, 3 and 4, 2015, R14 was not observed being involved with any facility provided activities or engaged in any 1:1 stimulation with activity or other staff. R14 did not display any behaviors during the survey. On November 3, 2015 at 11:10 AM, Z4 (family member) stated he visits a couple times a week for an hour or two. Z4 stated R14 enjoyed art, coloring, traveling, time with family and being active in her church organization. On November 4, 2015 at 7:55 AM, E3 (Activity Director) stated individual activity needs are met by assessments on admission and then quarterly asking residents what their interests are. On November 4, 2015 at 1:00 PM, E3 stated if a resident is unable to communicate their needs or preferences in regards to activities, family is contacted to determine past interests and dislikes. E3 stated R14 enjoyed coloring when she first arrived at this facility and enjoys music. When E3 was told R14 was observed November 2, 3 and 4, 2015 positioned in front of the television alone in her room she replied she had not been down there to see that and television stations playing music are what they prefer to have on in her room.	F 248		

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F 248	Continued From page 4 R 14 ' s August 20, 2015 Activity Assessment shows it is very important for her to listen to music she likes. R14 ' s activity care plan shows staff will assist to attend activities of previous interest and will assist to activities that allow opportunity for tactile, visual and auditory stimulation. R14 ' s individual activity documentation shows R14 watched television in her room and talked with staff (made eye contact) every day in the month of October (Z3 stated R14 has not spoke in over a year). R14 ' s August 20, 2015 Activity Progress Note by E3 shows R14 being nonverbal cannot physically participate or follow directions. The facility ' s October 2015 calendar shows music activities were offered five days (on the 4th, 12th, 14th, 19th and 26th) and R14 observed the music activity only three days. The October 2015 activity daily participation record shows R14 was invited to activities 61 times. R14 ' s activity daily participation record shows participation in sensory activities and bird watching on only two occasions in October. The activity documentation also shows R14 slept during 1:1 activities every day in the month of October. R14 ' s August 20, 2015 Minimum Data Set (MDS) shows R14 is unable to express ideas and wants and rarely/never understands others. This MDS shows R14 ' s cognitive skills for daily decision making is severely impaired (could not make a decision or communicate a decision about attending an activity if invited). R14 ' s August 20, 2015 MDS shows R14 is totally dependent on staff to move, feed, dress, toilet, bath and transport her anywhere (could not attend an activity under her own power if invited). The September 23, 2015 ADL (activity of daily living) care plan shows R14 is dependent on staff to propel her wheelchair.	F 248		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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:
Based on observation, interview, and record review the facility failed to ensure a resident received the necessary care and services to prevent a delay in treatment for a resident with right-sided weakness, and bruising and swelling to the right arm. The facility failed to ensure a resident with wounds received physician prescribed nutritional supplements, and failed to have a plan to reduce moisture and promote wound healing for a resident with moisture associated wounds.

This applies to 2 of 9 residents (R4, R1) reviewed for necessary care and services in the sample of 12.

The findings include:

1. R4's Physician Order Sheet dated October 1, 2015 shows diagnoses to include: Dementia with impaired safety awareness, delirium, fracture of right metacarpal, Parkinson',s and dementia with poor trunk control and poor safety awareness.

R4's Minimum Data Set (MDS) of March 19, 2015 shows R4 is independent with bed mobility,

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F 309	Continued From page 6 transfers, ambulation, and walking. R4's MDS of October 9, 2015 shows R4 is cognitively impaired and requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting. On November 3, 2015 at 8:05 AM, R4 was sitting in a low wheelchair with a plastic lap trap, using his feet to propel himself in the hallway. R4's right arm was tucked towards his body, resting on the lap tray. R4's nurse notes dated July 22, 2015 at 10:00AM shows "resident presents with right sided weakness, right arm appears limp, right hand swollen, unable to make a fist, unable to grab onto walker. Complain of pain when touched, bruises noted to fingers. will not stand to transfer. Dr notified. will await response." R4's nurse note dated July 22, 2015 at 2:00 PM shows "CNA [Certified Nurse Assistant] reported resident observed on floor, calling for help. upon entering room, resident sitting on bottom, feet facing his bed...complain of pain to right hand remains, swelling still present. paged [medical doctor on call] as primary is on vacation..." R4's nurse note dated July 22, 2015 at 7:20 PM shows "Received call from [MD on call]...would like resident transferred to ER for eval if ok with family...Received approval for eval at 3:50 PM. MD paged at 3:52 PM and again at 4:20 PM. Received orders at 4:20 PM to send resident to ER for eval...ambulance arrived at 4:26 PM [over 6 hours after R4 presented with right side weakness, limp arm, swollen hand, and bruising]....resident complains of pain to Right	F 309		

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arm. Swelling continued to Right hand. Resident unable to move right arm at that time..."

R4's hospital Emergency Room documentation dated July 22, 2015 at 8:21 PM shows "Diagnostic Impression: Renal insufficiency, Dementia, Right Empress - Possible CVA [Cerebral Vascular Accident- stroke], and closed fracture of metacarpal bone."

On November 3, 2015 at 12:45 PM, E14 (Licensed Practical Nurse- LPN) said she was working as R4's nurse on July 22, 2015. E14 said at approximately 10:00 AM, R4 had an "overall change in condition" from the previous day and he presented with a "definite change in condition". E14 said R4's right side weakness, swollen arm, and bruising to the right hand were abnormal for R4. E14 said she called R4's doctor but did not know that he was on vacation and did not get a return phone call. E14 said she usually would follow up with the doctor within a couple hours, depending on the severity, if the doctor did not respond to her phone call. E14 said she called the office again later in the shift after R4 fell, (over 4 hours after he presented with a change in condition) and was told that R4's doctor was on vacation, and at that time she called the on-call physician who was covering for him.

On November 4, 2015 at 12:30 PM, E2 (Director of Nursing - DON) said if a resident has a change in condition, the nurse would want an immediate response from the physician. E2 said if the nurse does not get in contact with the medical doctor, and needs a physician, they should call the facility medical director. E2 said there was too long of a delay from the time R4 presented with symptoms and the time the physician was updated. E2 said

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F 309	Continued From page 8 the nurse could have sent R4 to the hospital and then obtained an order later, and that she felt the doctor would have given orders based on his condition change to transfer to the hospital immediately. On November 4, 2015 at 11:15 AM, E16 (LPN) said the nurse should use nursing judgement to determine if a resident should be sent to the hospital before obtaining a physician order. E16 said she would consider right sided weakness a significant change and would get a hold of the doctor immediately, or send to the Emergency Room for evaluation. On November 5, 2015 at 9:35 AM, E1 (Administrator) said based off R4's change in condition and symptoms, the nurse should have used nursing judgement and sent R4 to the hospital and notified the physician later. The undated facility policy "Notification for Change in Resident Condition or Status" states the facility and/or facility staff shall promptly notify appropriate individuals (...physician...). of changes in the resident's medical/mental condition and/or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: b. a discovery of injuries of unknown source; d. a significant change in the resident's physical/emotional/mental condition; g. a need to transfer the resident to a hospital/treatment center; The nurse supervisor/chare nurse will notify the ... Physician... of the aforementioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries	F 309		

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of an unknown source;
b. There is a significant change in the resident's physical, mental or psychological status.

2. R1's Physican Order Sheet (POS) dated November 1, 2015 shows diagnoses to include Anemia, Depression, and Asthma.

R1's Minimum Data Set (MDS) of October 21, 2015 shows R1 is cognitively intact and requires extensive assistance of 2 staff with bed mobility, transfers, dressing, and toileting. The MDS shows R1 is frequently incontinent of urine, and occasionally incontient of stool. The MDS shows R1 is at risk for pressure ulcers but has no pressure ulcers or moisture associated skin damage.

R1's skin assessments dated May 7, 2015, August 6, 2015, and October 4, 2015 shows she is high risk for skin breakdown, her skin is very moist, she is chairfast, has very limited mobility, and has a potential problem with friction and shear.

On November 2, 2015 at 8:40 PM, R1 was sitting in a wheelchair in her room. R1 said she had been up in her chair all day. R1 said she had waited over 30 minutes with her call light on to go to the bathroom, and she was last taken to the bathroom around 4:30 PM. E4 and E8 used a mechanical stand lift to stand R1 and assist her to a bedside commode. R1's wheelchair pad was saturated with urine, and her bottom was dark red. After toileting, E4 and E8 raised R1 with the mechanical stand lift. R1 had a gauze dressing to her right posterior thigh that was attached with tape on one side and falling off the skin on the

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other side. R1's left posterior thigh had scattered, circular, open areas. R1's inner thighs were reddened and R1 said "that's where my diapers rub". E4 said she notified "them" last night (November 1, 2015) about the open areas to R1's left posterior thigh. E4 said she thinks R1's wheelchair is too small and that is what is making R1's bottom sore, and that it isn't long enough and her thighs are rubbing on the edge of it.

R1's Nurse Notes dated October 31, 2015 shows the doctor saw R1, and the three open areas/blister to her right posterior thigh. Feels they are from moisture and sitting with little change in position.

R1's weekly wound tracking record shows an excoriated area was identified on October 21, 2015 to the right abdominal fold, and on October 22, 2015 a open area to R1's right posterior thigh. The weekly wound documentation for R1 shows on October 31, 2015 3 additional open areas were identified to R1's posterior thigh. The wound assessments do not identify the type of wound, description of wound bed, or depth of the wound.

R1 did not have an assessment completed of the wounds to her Left posterior thigh until November 4, 2015, 3 days after the CNA said she reported them to the nurse.

The only intervention on R1's Activities of Daily Living care plan dated September 21, 2013 for toileting is to "assist with toileting right before meals".
R1's "at risk for skin breakdown" care plan from September 21, 2013 shows R1 is at risk for breakdown related to incontinence of bowel and

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bladder. This care plan shows Toilet/change brief when wet, and upon rising, at hs (bedtime) and after meals.

R1's Dietary Notes dated October 31, 2015 shows "dietary consult for skin issues, add to medications multivitamin, Arginaid 1 packet daily til healed".
R1's Dietary Services Communication form dated October 22, 2015 shows a recommendation for MVI, and Arginaid (protein supplement) 1 packet/day until healed, that was signed by R1's nurse practitioner on October 28, 2015. Review of R1's Medication Administration Record, and physician orders on November 4, 2015 shows R1 was not getting the daily Arginaid, or the daily multivitamin. On November 3, 2015 at 11:15 AM, E16 (LPN) said Arginaid and a multi-vitamin would be provided by nursing, written on the MAR, and given to the resident during med pass. E16 said the dietician will write a recommendation, give it to nursing, and nursing contacts the medical provider to get the order for the recommendation. On November 5, 2015 at 9:35 AM, E1 (Administrator) said the order was obtained from the physician to start the dietary recommendation for Arginaid, and the Multi-vitamin for R1. E1 said when the order was given to nursing, instead of processing the order, they returned it to dietary, so the order did not get initiated when it was signed on October 28, 2015.

On November 3, 2015 at 9:30 AM, R1 said she lets the CNAs know when she has to go to the bathroom. R1 said she was "wet" last night because she had to wait for help, and she's incontinent almost every night because after supper they are putting residents to bed, and she has to wait for help. R1 said "I don't like to be wet

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at all". On November 5, 2015 at 8:30 AM, R1 said the CNAs only take her to the bathroom when she asks, they do not stop in and offer to take her. R1 said she waits longer at night for help because they do not have enough staff. R1 said the CNAs only move her when she is going to the bathroom.

On November 4, 2015 at 1:10 PM, Z1 (Nurse Practitioner) said R1's wounds are secondary to incontinence, and increased fluid. Z1 said R1 needs to get off her bottom, and needs to be repositioned so the wounds can heal. Z1 said both Arginaid, and a Multivitamin would be appropriate for R1 due to her wounds.

On November 2, 2015 at 9:50 AM, E14 (LPN) said they try to take R1 to bathroom before she is incontinent but that does not always happen. E14 said R1 was seen by her Physican this past weekend (Saturday, October 31, 2015) and the physician said R1 has moisture related open areas on her bottom.

On November 3, 2015 at 3:10 PM, E2 (DON) said R1 has ongoing issue with incontinence, and R1's wounds are related to her incontinence and moisture. E2 said R1 is not on a formal toileting schedule and she will notify staff when she needs to go to the bathroom. E2 said if R1 does not want to lay down during the day the staff could go in and stand her or reposition her to relieve pressure to her bottom.

On November 4, 2015 at 1:10PM, E15 (Restorative Nurse) said bowel and bladder incontinence causes skin to become more fragile and makes it easier for skin to breakdown and shear.

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POLO REHABILITATION & HCC	703 EAST BUFFALO POLO, IL 61064

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F 309	Continued From page 13 On November 5, 2015 at 8:30 AM, E10 (CNA) said R1 is not on a toileting schedule, and they (CNAs) wait for her to let them know when she wants to go to the bathroom. E10 said R1 does not have any interventions to promote healing to her bottom that are in place for the CNAs. The facility January 1, 2002 policy "Skin Condition Monitoring" shows: Policy: to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. Upon notification of skin lesion, wound, stasis ulcer, or other skin abnormality, the charge nurse will assess and document the findings. The charge nurse will...notify the physician and obtain treatment order if needed. Any skin abnormality will have specific treatment order for frequency and not as needed. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: Size, Shape, Depth, Color, Presence of granulation tissue or necrotic tissue Prevention techniques	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312		

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F 312	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents dependent on staff for assistance received oral hygiene at bedtime and assistance with toileting. This applies to 5 of 8 residents (R1, R3, R4, R9, R11) reviewed for assistance with activities of daily living and 5 residents in the supplemental sample. The findings include: 1. On November 2, 2015 at 7:30 PM, R11 was transported to his room via wheelchair to go to bed by E7 (Certifed Nursing Assistants - CNA). R11 was transferred to his bed; his sweat pants were wet between his legs and across his buttocks. The cloth seat of his wheelchair was wet. The incontinence brief was removed and was saturated with liquid and a strong smell of urine was noted. Skin creases and an oozing open area on R11's buttocks were noted under the soiled brief. E7 stated R11 is not on a toileting schedule because he uses his call light and lets us know when he needs to be changed. E7 stated R11 has been in his wheelchair since her shift started at 2 PM, and was not aware if he was toileted on her shift. R11 did not receive any oral care during his evening bedtime cares. The Minimum Data Set for R11 dated August 26, 2016 shows R11 is dependent on assistance of 2 staff for hygiene and toileting, and is frequently incontinent of urine and bowel. The care plan shows R11 has had a cerebral vascular accident,	F 312		

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and will point or gesture to make his needs known. Interventions include to anticipate his needs and resident will be come very restless and antsy when he needs to use the restroom.

On November 2, 2015 at 7:55 AM, E12 (Registered Nurse - RN) stated, "R11 has expressive aphasia from a stroke. R11 points to communicate, but it's helpful to be familiar with his care needs. He wears brief during the day, but uses a urinal at night".

On November 11, 2015 at 2:00 PM, E2 (Director of Nurses - DON) stated, "The CNA staff should provide oral care at bedtime to include removing dentures, brushing, and soaking them, and offering mouth wash. Residents should be assisted to brush their own teeth if they have them".

2. On November 2, 2015 at 8:10 PM, R13 was seated in a recling geriatric chair in front of a public restroom in the hallway with a safety alarm attached to his shirt. R13 attempted to stand, setting off the alarm. Without inquiry, staff sat R13 back into the chair and reattached the alarm. At 8:25 PM, R13 again stood up from the chair and set off the alarm. R13 took a few steps reaching toward the bathroom door handle; lost his balance and fell to the floor. When the staff questioned R13, he responded he needs to go to the bathroom. R13 was taken to the toilet in his room, his incontinece brief was soiled with bowel movement and urine. R13 expelled a large bowel movement while seated on the toilet. R13 was transferred out of the bathroom, no oral care was provided at the sink. R13 fell to sleep after positioned in bed.
E5 (CNA) stated R13 was in bed when their shift

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F 312	Continued From page 16 started at 2 PM, and got up between 3 - 3:30 PM for the evening meal. E5 was not aware if R13 had been assisted to the toilet after dinner. On November 3, 2015 at 12:40 PM, E16 (Licensed Practical Nurse - LPN) stated, "I am not certain of R13's toileting pattern. I do know he becomes fidgety and if you ask him, he will let you know he needs to go to the bathroom." E16 stated "Perhaps R13 was fidgety last night because he had to go to the bathroom." 3. On November 2, 2015 at 7:40 PM, E4 and E8 (CNAs-Certified Nurse Assistants) transferred R3 from his wheelchair to his bed. E4 and E8 provided bedtime personal care to R3 . E4 and E8 did not provide oral care to R3 or brush R3's teeth. 4. On November 2, 2015 at 7:00 PM, E4 and E8 (CNAs) transferred R18 from her wheelchair to her bed. E4 and E8 provided bedtime care to R18 but did not provide oral care to R18 or brush R18 teeth. 5. On November 2, 2015 at 8:06 PM, E4 and E8 transferred R4 from his wheelchair to his bed. E4 and E8 provided bedtime care to R4 but did not provide oral care or brush R4's teeth. 6. On November 2, 2015 at 8:40 Pm, E4 and E8 provided bedtime personal care to R1. E4 and E8 did not provide oral care to R1, or offer for R1 to brush her teeth. 7. On November 2, 2015, R9 was sitting in his chair in his room at 7:25 PM and from 7:55 PM-9 PM. On November 3, 2015, R9 was sitting in his chair at 7:25 AM, 7:30 AM, 8:15 AM, 8:45 AM, 8:55 AM, 9:00 AM, 9:05 AM, 9:55 AM, 10:05 AM,	F 312		

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F 312	Continued From page 17 10:20 AM, 10:30 AM, 10:45 AM, 11:30 AM-11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM, 1:15 PM and from 2:40 PM-3:45 PM. On November 4, 2015, R9 was in his chair at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM and 8:20 AM. On November 3, 2015 at 3:30 PM, E10 (Certified Nurse ' s Aide-CNA) stated that she was assigned to R9 ' s hall on this date and he was out of bed when she began her shift at 6:00 AM and she did not remove him from his chair for repositioning or toileting until 1:40 PM. E10 stated R9 ' s incontinent brief was wet when he was toileted at 1:40 PM and it takes two people to transfer/toilet this resident. On November 4, 2015 at 7:40 AM, E2 (Director of Nursing-DON) stated residents who are unable to communicate toileting needs should be toileted or incontinence care provided with am and pm care, after every meal, as needed and should be checked on hourly rounds to see if incontinence care is needed. E2 stated if this toileting/incontinence care is not done skin breakdown, resident dignity and overall care becomes a concern. The October 12, 2015 Minimum Data Set for R9 shows he is always incontinent of bowel and bladder and requires extensive assistance of two people to transfer ,toileting, hygiene, bathing and mobility. This MDS shows R9 is rarely/never understood and rarely/never understands others, is aphasic (cannot speak) and has non-Alzheimer ' s dementia. R9 ' s October 7, 2015 care plan shows R9 should be out of his chair at least two times per shift, assisted to reposition at least every two hours and toileting/change brief when wet and after meals. The October 7, 2015 skin integrity care plan shows R9 should be toileted/change brief when wet and upon rising, at hs and after meals. The October 12, 2015 facility bowel and bladder assessment shows R9 is not	F 312		

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able to communicate needs to void/defecate, is unable to use a call light, is unaware of the need to void and is always incontinent. This document also shows R9 requires extensive assistance to transfer to toilet and is totally dependent to transfer to a toilet.
8. On November 2, 2015, R14 was in her room in her chair at 7:15 PM, 7:28 PM and 7:55PM-9:00 PM. On November 3, 2015, R14 was in her chair at 7:30 AM, 8:30 AM, 8:45 AM, 9:00 AM, 9:05 AM, 9:55 AM,10:05 AM, 10:20 AM,11:30 AM-11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM,1:15 PM, and 2:40 PM-3:45 PM. On November 4, 2015, R14 was in her chair at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM, 8:20 AM, 8:25 AM. On November 4, 2015, continuous observation (with exception of approximately10 minutes) of transfer/showering was done from 8:35 AM-9:30 AM. R14 ' s buttocks were very reddened when observed during care at 8:45 AM on this date.
On November 4, 2015 at 11:35 AM, E10 (Certified Nursing Assistant-CNA) stated R14 was not toileted or laid down during her shift on November 3, 2015. E10 stated she is assigned to R14 ' s wing and R14 requires two people to toilet/transfer and patient care suffers when staff is not available to help her.
The facility August 20, 2015 bowel and bladder assessment shows R14 is totally dependent for mobility/transfer, toileting, always incontinent and experiences dribbling of urine. This assessment also shows the need to check/change every two hours, that R14 is severely cognitively impaired and wears incontinence briefs when out of bed.
The August 20, 2015 Braden assessment for pressure ulcer risk shows R14 has a score of 12 which indicates a high risk. The August 20, 2015 Minimum Data Set (MDS) for R14 shows total

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dependence for hygiene/bathing, mobility and toileting. This MDS also shows R14 rarely/never makes herself understood and is rarely/never able to understand others and is always incontinent of bowel and bladder. The September 15, 2014 admission history and physical shows R14 has a history of Alzheimer ' s dementia and catatonia (not responsive). The September 23, 2014 skin risk care plan (most recently updated September 15, 2015) for R14 shows to toilet/change brief when wet and upon rising, at bed time and after meals and to reposition at least every two hours and offer assistance out of wheelchair into bed or recliner after meals. The September 23, 2015 ADL (activity of daily living) care plan shows R14 is dependent on staff to propel her wheelchair and for hygiene and pericare, needs extensive assistance of 2 staff for transfers into chair, bed and toilet and repositioning and to offer toileting in the morning, before and after meals and at bed time.
9. On November 2, 2015 at 7:50 PM, E7 and E11 (Certified Nursing Assistants- CNAs) were providing evening care for R19 prior to laying R19 down for bed. No oral care was provided or offered to R19. R19 is dependant on staff for personal hygiene.

10. On November 2, 2015 at 8:05 PM, E7 and E11 (CNAs) were providing evening care for R15 prior to laying R15 down for bed. No oral care was provided or offered to R15. R15's Minimum Data Set dated September 3, 2015 shows R15 is dependant on staff for personal hygiene.
11. On November 2, 2015, R9 was sitting in his chair in his room at 7:25 PM and from &:55 PM-9 PM. On November 3, 2015, R9 was sitting in his chair at 7:25 AM, 7:30 AM, 8:15 AM, 8:45 AM, 8:55 AM, 9:00 AM, 9:05 AM, 9:55 AM, 10:05 AM,

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F 312	Continued From page 20 10:20 AM, 10:30 AM, 10:45 AM, 11:30 AM-11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM, 1:15 PM and from 2:40 PM-3:45 PM. On November 4, 2015, R9 was in his chair at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM and 8:20 AM. On November 3, 2015 at 3:30 PM, E10 (Certified Nurse ' s Aide-CNA) stated that she was assigned to R9 ' s hall on this date and he was out of bed when she began her shift at 6:00 AM and she did not remove him from his chair for repositioning or toileting until 1:40 PM. E10 stated R9 ' s incontinent brief was wet when he was toileted at 1:40 PM and it takes two people to transfer/toilet this resident. On November 4, 2015 at 7:40 AM, E2 (Director of Nursing-DON) stated residents who are unable to communicate toileting needs should be toileted or incontinence care provided with am and hs care, after every meal, as needed and should be checked on hourly rounds to see if incontinence care is needed. E2 stated if this toileting/incontinence care is not done skin breakdown, resident dignity and overall care becomes a concern. The October 12, 2015 Minimum Data Set for R9 shows he is always incontinent of bowel and bladder and requires extensive assistance of two people to transfer ,toileting, hygiene, bathing and mobility. This MDS shows R9 is rarely/never understood and rarely/never understands others, is aphasic (cannot speak) and has non-Alzheimer ' s dementia. R9 ' s October 7, 2015 care plan shows R9 should be out of his chair at least two times per shift, assisted to reposition at least every two hours and toileting/change brief when wet and after meals. The October 7, 2015 skin integrity care plan shows R9 should be toileted/change brief when wet and upon rising, at hs and after meals. The October 12, 2015 facility	F 312		

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bowel and bladder assessment shows R9 is not able to communicate needs to void/defecate, is unable to use a call light, is unaware of the need to void and is always incontinent. This document also shows R9 requires extensive assistance to transfer to toilet and is totally dependent to transfer to a toilet.
12. On November 2, 2015, R14 was in her room in her chair at 7:15 PM, 7:28 PM and 7:55PM-9:00 PM. On November 3, 2015, R14 was in her chair at 7:30 AM, 8:30 AM, 8:45 AM, 9:00 AM, 9:05 AM, 9:55 AM,10:05 AM, 10:20 AM,11:30 AM-11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM,1:15 PM, and 2:40 PM-3:45 PM. On November 4, 2015, R14 was in her chair at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM, 8:20 AM, 8:25 AM. On November 4, 2015, continuous observation (with exception of approximately10 minutes) of transfer/showering was done from 8:35 AM-9:30 AM. R14 ' s buttocks were very reddened when observed during care at 8:45 AM on this date.
On November 4, 2015 at 11:35 AM, E10 (Certified Nursing Assistant-CNA) stated R14 was not toileted or laid down during her shift on November 3, 2015. E10 stated she is assigned to R14 ' s wing and R14 requires two people to toilet/transfer and patient care suffers when staff is not available to help her.
The facility August 20, 2015 bowel and bladder assessment shows R14 is totally dependent for mobility/transfer, toileting, always incontinent and experiences dribbling of urine. This assessment also shows the need to check/change every two hours, that R14 is severely cognitively impaired and wears incontinence briefs when out of bed.
The August 20, 2015 Braden assessment for pressure ulcer risk shows R14 has a score of 12 which indicates a high risk. The August 20, 2015

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F 312	Continued From page 22 Minimum Data Set (MDS) for R14 shows total dependence for hygiene/bathing, mobility and toileting. This MDS also shows R14 rarely/never makes herself understood and is rarely/never able to understand others and is always incontinent of bowel and bladder. The September 15, 2014 admission history and physical shows R14 has a history of Alzheimer ' s dementia and catatonia (not responsive). The September 23, 2014 skin risk care plan (most recently updated September 15, 2015) for R14 shows to toilet/change brief when wet and upon rising, at hs and after meal and to reposition at least every two hours and offer assistance out of wheelchair into bed or recliner after meals. The September 23, 2015 ADL (activity of daily living) care plan shows R14 is dependent on staff to propel her wheelchair and for hygiene and pericare, needs extensive assistance X2 staff for transfers into chair, bed and toilet and repositioning and to offer toileting in the morning, before and after meals and at hs.	F 312		
F 314 SS=G	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:	F 314		

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F 314	Continued From page 23 Based on observation, interview, and record review the facility failed to modify care interventions when they became aware a resident was self adjusting the tension on a fracture brace to his right hand. The facility failed to identify risk factors related to the use of a fracture brace. The facility failed to complete a wound assessment, failed to initiate a treatment plan and failed to notify the physician and family when a resident's skin breakdown was identified The facility failed to implement pressure relieving interventions (monitoinrg and repositioning) to prevent the development of a pressure ulcers This failure resulted in diminished circulation to R4's right fifth digit and the tip becoming necrotic. This applies to 4 of 9 residents (R3, R4, R9, R11) reviewed for pressure ulcers in the sample of 12. The findings include: 1. R4's hospital Emergency Room documentation dated July 22, 2015 at 8:21 PM shows "closed fracture of metacarpal bone." R4's nurse note dated July 22, 2015 shows "arrived back at facility per our van, right forearm and hand has soft cast immobilizer in place..." Z2's (Orthopedic Surgeon) office note dated July 27, 2015 shows R4's soft brace was replaced with a Exo fracture brace (hard brace immobilizing smallest finger and extending over R4's forearm). R4's skin integrity care plan date July 27, 2015 shows R4 is at risk for skin breakdown related to decline in mobility, and has splint to right hand/wrist. The skin integrity care plan shows	F 314		

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"check for skin irritation from brace and CMS [circulation, motor function, sensation] to fingers on right hand."

R4's nurse note dated August 11, 2015 at 3:30 PM, shows "CNA [Certified Nurse Assistant] reported that when helping him [R4] to bed for a nap that he had [his] brace tight and that pinky finger on right hand, tip of it was black, upon my assessment he had brace tight and twisted with little finger bent inside of hand with straps of brace twisted." The incorrect placement of the brace lead to the development of a neurotic pressure area on R4's pinky finger.

Z2's office noted dated August 12, 2015 shows R4 "is definitely going to need some sort of revision amputation to his left small fingertip, but I would watch this for another couple of weeks just to let it fully demarcate...would like to see him in about 2 weeks so we can reevaluate the small finger and decide the level of amputation."

Z2's noted dated September 24, 2015 shows treatment option for R4's finger includes "an amputation most likely at the middle phalanx level versus continued observation expectant treatment..." and with expectant treatment "there is a possibility that the finger may just wither away and fall off, and if it leaves an exposed bony area, might need amputation at that time..."

R4's Physician Order Sheet dated October 1, 2015 shows diagnoses to include: Dementia with impaired safety awareness, delirium, fracture of right metacarpal, and Parkinson's and dementia with poor trunk control and poor safety awareness.

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R4's MDS of October 9, 2015 shows R4 is cognitively impaired and requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting. R4's skin risk assessment dated August 6, 2015, and October 9, 2015 shows R4 is high risk for skin breakdown, and has a potential problem with fiction and shear..

R4's Weekly Wound Tracking dated October 18, 2015 shows a necrotic right pinky measuring 2.5 cm x 1.5 cm. No weekly assessments of R4's pinky have been completed since October 18, 2015 (over 2 weeks ago).

On November 3, 2015 at 10:00 AM, R4 had his fingers curled towards his palm and resting on the lap tray.

On November 3, 2015 at At 1:00 PM, R1 was in his wheelchair, and E2 (DON) helped R4 open his right hand. The tip of R4's right small finger was completely black all the way around the finger, with a small flap of dried black tissue present. R4 pulled his hand away from E2 and said "no" when she attempted to touch it.

On November 3, 2015 at 11:15 AM, E16 (LPN) when they found the brace too tight on R4, his hand was inside his brace with his pinky laying flat, squeezed against the inside of his hand (palm). E16 said the tip of R4's finger was black and necrotic. R4's brace was as tight as it could go. E16 continued to say R4 would "play" with the brace and say "I just want it off". R4 was caught turning the dial before they found the injury, and she was unsure how long it had been since the brace had been checked, before finding the injury.

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F 314	Continued From page 26 On November 3, 2015 at 3:00 PM, E7, Certified Nurse Assistant (CNA) said R4 would fidget with the dial on his brace, and would twist and turn it. E7 said R4 fidgeted with the brace quite often, and he "was always playing with some part." and E5 (CNA) said she loosened R4's brace to wash his hands and then tighten it back up after she was done. On November 3, 2015 at 12:35 PM, E16 said when the necrotic area was found, the brace was all twisted and didn' t look like it was on correctly. E16 said at that time the tip of R4's fingers was necrotic. E16 said they would redirect R4 if they saw him playing with the brace but no interventions were in place to ensure the brace fit properly. On November 3, 2015 at 12:45 PM, E14, Licensed Practical Nurse (LPN) said the nurses should adjusted the brace. E14 said if R4's brace was tight enough he would not have been able to get his fingers inside the brace. On November 4, 2015 at 8:20 AM, Z2 (orthopedic surgeon) said, normally a resident would not get their hand inside the brace. Z2 said he was not aware R4 would mess or fidget with his brace and the first he was notified about that was after the injury occurred. Z2 said the brace could have been discontinued, and R4 could have been put in a cast. The October, 2006 facility policy "Preventative Skin Care" states "Ensure proper fit of wheelchairs, splints, braces, prosthesis, etc"	F 314		

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2. On November 2, 2015 at 8:06 PM, E4 and E8 (Certified Nurse Assistants-CNAs) transferred R4 from his wheelchair to the bed. E4 and E8 removed R4's pants, and incontinence brief. R4's incontinence brief was saturated with urine, and his bottom was red and discolored. E4 and E8 said R4 was toileted before supper (over 3 hours prior). E4 and E8 cleaned R4's bottom with a wet cloth and R4 said "oh my god that hurts, damn near killed me. E4 said yes, his bottom is usually red from sitting, and he doesn't have much of a bottom. E4 said they usually get R4 up around 2:30-3:00 PM and toilet him before supper. E4 said R4 stays in his wheelchair for meals, and is only out of his chair when he is toileted before going to bed at night.

On November 3, 2015 at 8:30 AM, R4 was in a wheelchair outside the nurse station asking for help with his "crotch" and saying "it hurts." E6 (CNA) and E14 (Licensed Practical Nurse-LPN) transferred R4 from his wheelchair to the toilet and R4 said "my crotch is killing me." E6 removed R4's incontinence brief and R4 was incontinent of stool and urine. E6 and E14 stood R4 in the bathroom and cleaned R4's bottom with a wet cloth. R4 yelled "ow, ouch" when cleaned between his bottom and scrotum. There was red blood on the cloth after wiping from the scrotum to the rectum. R4 had an open area between his scrotum and rectum and E14 said the blood was coming from an open spot below his scrotum, it looked like a tear, and "that could explain why his crotch hurts." E6 said R4 does not usually lay down after breakfast because he is too agitated, and R4 was transferred back to his wheelchair after toileting. E6 and E14 did not offer to lay R4 down prior to taking him out in the hall.

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F 314	Continued From page 28 On November 3, 2015 at 9:50 AM, E14 said R4 has redness around his rectum and an open area between his scrotum and rectum. E14 said this was caused because R4 is incontinent of stool and urine, and R4 should be toileted frequently, at least every 2 hours. R4's nurse notes dated November 3, 2015 at 10:30 AM shows "resident having complaints of pain to 'crotch' this am. Assessed area, observed small 0.25 cm open area between scrotum and rectum." On November 4, 2015 at 1:10 PM, E15 (Restorative Nurse) said bowel and bladder incontinence causes skin to become fragile and makes it easier for skin to breakdown and shear. R4's skin integrity care plan dated July 27, 2015 shows R4 is at risk for skin breakdown related to decline in mobility, and episodes of incontinence. The care plan shows interventions to assist to reposition at least every 2 hours and as needed, and offer naps in bed after meals. The October, 2006 facility policy "Preventative Skin Care" states "to provide preventive skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, and well groomed, and free from pressure ulcers." "Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two (2) hours." "Keep incontinent residents clean and dry."	F 314		

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3. On November 2, 2015 at 7:30 PM, R11 was transferred to bed by E7 and E11 (Certified Nursing Assistant - CNA). The seat and crotch of R11's pants were wet when R11 was moved from the wheelchair to bed. The incontinence brief was saturated and had strong urine odor. R11's buttocks were creased from the incontinence brief. An approximate 1 inch opening with oozing red blood was noted on the left buttocks along a crease line from the brief. E7 cleansed the area, and stated R11 has very delicate skin. No barrier cream was applied to the buttocks. E7 stated R11 had been in his chair since the start of her shift at 2 PM. R11's wheelchair did not have a pressure relieving cushion.
On November 3, 2015 at 9:25 AM, E10 (CNA) and E2 (Director of Nurses - DON) observed an open area on R11's left buttock. The area was dry with crusty edges. E2 measured the open area at 2.5 cm in length. E10 (CNA) stated there was no report this morning of a new opening on R11's buttocks. E2 (DON) stated the facility procedure includes the CNA staff to report new openings to the nurse on duty. Barrier cream can be applied until the nurse obtains a treatment order from the physician. The nurse does the assessment initially and the wound is monitored weekly until healed.
On November 3, 2015 at 9:40 AM, E16 (Licensed Practical Nurse - LPN) stated she was not aware of a new opening on R11's buttock, nothing was said in report this morning. E16 reviewed R11's medical record and stated she found no documentation about a new wound.
The Minimum Data Set of August 26, 2015 shows R11 is at risk to develop pressure and has no unhealed pressure ulcers. The risk assessment

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for development of pressure ulcers shows R11's score of 16 (16 and less = high risk). The care plan for R11 shows to reposition R11 every 2 hours and to use a pressure reducing cushion in the wheelchair; and to apply house stock incontinent barrier cream to perineal area with every incontinent episode.

4. The facility's undated Profile Face Sheet show R3 was admitted to the facility on January 19, 2011 with the following diagnoses: Alzheimer's, difficulty walking, muscle weakness, and a personal history of falls. R3's MDS (Minimum Data Set) dated August 19, 2015 show R3 is dependent on 2 staff members for transfers, positioning side to side, and body positioning. The MDS also shows R3 is dependent on 2 staff for toileting and has impairments on both sides of his upper and lower extremities.

On November 2, 2015 at 7:40 PM, E8 and E4 (Certified Nursing Assistants-CNAs)transferred R3 using a mechanical lift. R3 was visibly saturated with stool and urine through his incontinence brief, pants, and the lift sling. E8 and E4 verified that R3 had soaked through his brief and pants, and that the sling under R3 was wet due to urine. E8 and E4 removed R3's pants and incontinence brief . R3 had a small irregular shaped opening to his left buttocks. E8 said it was open but it is better than it was. E4 said R3 got it from sitting. There was a pink healed irregular shaped area to R3's right buttocks.

On November 3, 2015 at 8:20 AM, R3 was sitting

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in the dining room. R3's cardiac chair was slightly reclined back. At 8:50 AM R3 was taken back to his room. At 9:00 AM, and again at 9:30 AM, R3 was sitting in his cardiac chair in his room with the chair slightly reclined. At 9:30 AM E6 and E14 were in the hallway on the C wing. E6 apologized that it was longer than she said it would be, stating, "I have just been busy." E6 said she would let this surveyor know when they were going to do care for R3. At 9:50 AM, 11:00 AM, and 11:50 AM, R3 was sitting in his cardiac chair in his room. R3's chair was slightly reclined and R3 was in the same position during all observations from 9:00 AM through 11:50 AM. At 11:50 AM, R3 was taken down to the dining room for lunch. At 1:00 PM, E6 and E9 (CNAs) transferred R3 from his cardiac chair to his bed using a mechanical lift. E6 was removing R3's incontinence brief and said R3 had a bowel movement. R3 had been incontinent of urine and there was a large amount of loose stool in R3's incontinence brief. E14 (LPN) entered R3's room and stated "We can look, but I checked the TAR (Treatment Administration Record) and the open area on his buttocks was healed." E6 wiped stool from R3's buttocks at that time and E14 said Oh, he does have an open area, I will go get the barrier cream. R3's left and right mid-buttocks had a dark reddened area. There was an open area located in the dark red area on R3's left buttocks. R3's right buttocks had an area in the middle of the dark red area that appeared to have been open in the past, but was healed at this time. E14 said she was not sure if R3 had a previous open area on his right buttocks because she just started working on this wing. E14 said she was usually on the other wing.

On November 3, 2015 at 12:12 PM, E6 (CNA)

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said R3 is so stiff and cannot sit on the toilet. E6 said the CNAs usually provide incontinent care in the morning at wake up and then again after lunch. E6 said R3 is a mechanical lift and they put him in bed to provide incontinence care. E6 said she checked R3's incontinence brief between breakfast and lunch and she could tell by the color of the triangles on R3's briefs that he was not wet.

On November 4, 2015 at 9:50 AM, E2 (Director of Nursing- DON) said it is not acceptable for R3 to go from breakfast until after lunch without having incontinence care provided. E2 said that R3 should have been put in bed after breakfast and incontinence care provided. E2 also said it is not acceptable for any resident especially one with skin issues to be left in the cardiac chair in the same position from 8:30 AM until after lunch. E2 said it is not acceptable for the CNAs to rely on the color of the incontinent briefs to determine if the resident is incontinent.

On November 3, 2015 at 12:12 PM, E15 (MDS Coordinator/Restorative Nurse) said incontinence care for R3 is in the morning when they get him up, after meals, and at night. E15 stated, the "Day staff check to see if he is wet, if not, they reposition him."

On November 4, 2015 at 9:25 AM, E14 (LPN) said the TAR (Treatment Administration Record) showed that R3 had a 0.5 cm circle area on October 24, 2015 that was resolved on October 28, 2015. E14 stated the only treatment on the TAR in October was barrier cream as needed. E14 also stated, "I don't see any documentation on the TAR for skin checks." E14 said she did not see any documentation in the nursing notes

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regarding R3's open area until November 3, 2015 (after observing that the area on R3's left buttocks was open with this surveyor).

On November 4, 2015 at 9:50 AM, E2 (DON) said either herself, E15 (MDS Coordinator/Restorative Nurse), or E12 (2nd shift Registered Nurse) determine if an open area is due to pressure or other causes. E2 said they let the doctor know what the area looks like and sometimes the doctor will tell them (facility staff) if they (the doctor) think it is due to pressure or not.

On November 4, 2015 at 3:03 PM, E12 (2nd shift Registered Nurse) said she had not looked at R3's open area and documented on it. E12went to assess the open area on R3's left buttocks. E12 stated, "I think the cause of the open area on the left buttock is due to shear because he is always sliding down in the (cardiac) chair." E12 stated, "I would not expect him to be left in his chair from breakfast until 1:00 PM. He should be laid down after all meals, he has had chronic problems with that area." E2 pressed on the reddened area on R3's left buttocks to check for blanching. E2 had to press on the reddened area 2 times in order to return a very faint blanching. E2 said "it is very faint but it blanched."

On November 6, 2015 at 8:25 AM, E2 said the desired outcome is that you would want to see an immediate blanching response. E2 said having to press 2 times and only getting a faint response would indicate an inadequate blood supply to the area. E2 said she believed R3's incontinence/moisture caused the open area on R3's left buttocks. E2 said a decreased blood supply to an incontinent, moisture related area can decrease the skin's strength and contribute to

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the open area. E2 said if R3 is sitting in the same position for an extended period of time it could contribute to the decreased blood supply. E2 said she did not think the cause of R3's open area is solely due to pressure, but said pressure may have possibly played a part in the open area. E2 said there was no documentation regarding any previous open area to R3's right buttocks.

On November 6, 2015 at 8:20 AM, E15 said R3 was not able to communicate his needs. E15 said "His speech is mostly incoherent; occasionally you might be able to understand a word or two." E15 said staff have to anticipate R3's needs and monitor for non-verbal cues."

The facility's Weekly Wound Tracking sheet dated October 24, 2015 shows R3 had a 0.5 cm circle on his left buttocks. The document shows the area was resolved on October 28, 2015.

The facility's Weekly Wound Tracking sheet dated November 3, 2015 shows R3 had an area measuring 0.5 x 0.5 cm on his left buttocks. The area is listed as reopen. There is no determination on the sheet that identifies the type of wound or characteristics of the wound site.

The facility's Braden Scale for Predicting Pressure Ulcer Risk dated August 12, 2015 shows R3 was at high risk for the development of a pressure ulcer.

The facility's Preventative Skin Care Policy revised October 2006 shows "To provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from

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pressure ulcers." The policy shows "any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every 2 hours."

R3's ADL (Activities of Daily Living) Care Plan dated August 18, 2015 shows R3 needs extensive assistance for repositioning/bed mobility and needs help to reposition in wheelchair every 2 hours. The care plan also shows that R3 has no control of bowel or bladder and wears incontinence briefs during the day and has an incontinence pad on his bed at night. The care plan also shows that R3 is unable to sit on the toilet or commode due to poor trunk control/rigidity and is dependent on staff for incontinence care and application of barrier cream.

R3's Skin Breakdown Care Plan dated November 4, 2015 shows R3 should be repositioned at least every 2 hours and R3's incontinent brief should be changed when wet and upon rising, at night before going to sleep and after meals. The plan shows R3 should be transferred out of his cardiac chair into bed after breakfast and lunch to change position and off-load pressure.

R3's TAR (Treatment Administration Record) from October 1, 2015 through October 31, 2015 shows R3 should have a daily skin check and the nurses should chart on the back of the TAR. The TAR was signed off by the nursing staff, however, the only documentation on the skin check was either a "C" for clear, or an "O" for other. R3's TAR dated October 1, 2015 through October 31, 2015 does not show a treatment for R3's left buttocks.

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R3's TAR dated November 1, 2015 through November 30, 2015 show orders for barrier cream to R3's left buttocks and to monitor the open area to left buttocks until healed was started on November 3, 2015.

On November 4, 2015 at 9:50 AM, E2 said charting "O" (other) after doing the skin checks on the TAR could mean anything. E2 said the nurses should document what it is they see during the skin check.

The facility's Skin Condition Monitoring sheet revised January 2002 shows "Upon notification of a skin lesion, wound, stasis ulcer or other skin abnormality, the Charge Nurse will assess and document the findings. The document shows "Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include the following: size, shape depth, color, presence of granulation tissue or necrotic tissue, treatment, and response to treatment."

The facility's Decubitus Care/Pressure Areas sheet revised May 2007 shows all areas of the TAR should be completed and the size, stage, site, depth, drainage, color, odor, and treatment should be documented.

5. On November 2, 2015, at 7:25 PM and from 7:55 PM-9 PM, R9 was sitting in his chair in his room . On November 3, 2015 at 7:25 AM, 7:30 AM, 8:15 AM, 8:45 AM, 8:55 AM, 9:00 AM, 9:05 AM, 9:55 AM, 10:05 AM, 10:20 AM, 10:30 AM, 10:45 AM, 11:30 AM-11:45 AM, 12:00 PM, 12:15 PM, 12:30 PM, 12:45 PM, 1:15 PM and from 2:40 PM-3:45 PM , R9 was sitting in his chair . On

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F 314	Continued From page 37 November 4, 2015, at 7:30 AM, 7:50 AM, 8:00 AM, 8:10 AM and 8:20 AM, R9 was in his chair. No repositioning pressure relieving or toileting was observed during these times. On November 3, 2015 at 3:30 PM, E10 (Certified Nurse ' s Aide-CNA) stated that she was assigned to R9 ' s hall on this date and he was out of bed when she began her shift at 6:00 AM and she did not remove him from his chair for repositioning or toileting until 1:40 PM. E10 stated R9 ' s incontinent brief was wet when he was toileted at 1:40 PM and it takes two people to transfer/toilet this resident. On November 4, 2015 at 7:40 AM, E2 (Director of Nursing-DON) stated residents who are unable to communicate toileting needs should be toileted or incontinence care provided with am and has care, after every meal, as needed and should be checked on hourly rounds to see if incontinence care is needed. E2 stated if this toileting/incontinence care is not done skin breakdown, resident dignity and overall care becomes a concern. E2 stated repositioning of residents should occur during rounds if resident appears uncomfortable or agitated. E2 stated repositioning can occur by standing residents of offloading pressure with pillows to relieve areas that residents have been resting on. E2 stated if this repositioning does not occur skin breakdown, increased behaviors and overall care suffers. On November 4, 2015 at 10:30 AM, Z1 (Family Nurse Practitioner-FNP) stated R9 ' s right buttock wound would be a Stage II since the area is open and incontinence and failure to reposition contributed to wound formation. The undated facility-provided list of residents with decubitus ulcers shows R9 acquired a Stage II pressure wound to his right lower buttock while residing in this home.	F 314		

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F 314	Continued From page 38 The October 1, 2015 nursing admission assessment shows R9 had no open areas to his buttocks. The October 1 and 12, 2015 Braden score for R9 was 14 which indicates R9 is a high risk for pressure ulcer development. R9 ' s October 2, 2015 ADL (activity of daily living) care plan shows he should be assisted to turn and/or reposition in chair at least every two hours. R9 ' s October 7, 2015 care plan shows R9 should be out of his chair at least two times per shift, assisted to reposition at least every two hours and toileting/change brief when wet and after meals. This care plan shows a shearing open area to R9 ' s right buttock on October 26, 2015. The facility October 2006 preventative skin care policy shows that any resident identified as being high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two hours. The October 12, 2015 Minimum Data Set for R9 shows he is always incontinent of bowel and bladder and requires extensive assistance of two people to transfer ,toileting, hygiene, bathing and mobility. This MDS shows R9 is rarely/never understood and rarely/never understands others, is aphasic (cannot speak) and has non-Alzheimer ' s dementia The October 25, 2015 wound tracking flow sheet shows R9 acquired a new open area to his right lower buttock on October 25, 2015 that measured 2.3 cm X 1.1 cm (24 days after admission).	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 39 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the safety of a resident at high risk for falls, by leaving a resident in facility hallway without wearing footwear to prevent slipping and falls. The facility failed to ensure staff performed a safe transfer with a resident at high risk for falls. This applies to 1 of 12 residents (R4) reviewed for safety in a sample of 12 and 1 resident (R13) in the supplemental sample. The findings include: 1. On November 2, 2015 at 8:25 PM, R13 was seated in a reclining wheeled geriatric chair with a safety alarm clipped to his shirt in front of a public men ' s restroom in the hallway. R13 was wearing soft white socks; the socks did not have gripper strips. R13 stood up from the chair and set off the safety alarm, he took a few steps reaching toward the bathroom door handle and lost his balance and fell to the floor. R13 was transferred to his room and a pair of athletic shoes was on the floor near his bed. E5 (CNA) stated R13 did not have his shoes on because he does not leave them on; they have to repeatedly put them back on. On November 3, 2015 at 12:45 PM, E16 (Licensed Practical Nurse - LPN) stated R13 has had a couple of falls previously, but lately had been good. E16 stated fall prevention interventions for R13 include a low bed, alarm,	F 323		

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mats on the floor, low wheelchair and safety alarm; R13 should wear his shoes. E16 stated R13 gets his shoes off about once a day, but if he is not wearing his shoes he should wear gripper socks.
The fall risk assessment for R13 dated September 18, 2015 shows he has a risk score of 13 (greater than 10 = high risk). The care plan interventions to prevent falls include to encourage and assist the resident to wear non-skid footwear
The physician follow up visit dated September 16, 2015 documents R13 is a fall risk, continue to monitor and provide safety per the facility protocol. The nurses ' notes dated August 31, 2015 shows R13's gait is unstable. On September 12, 2015, R13 was attempting an unsafe self transfer and on September 18, 2015, R13 was observed on the floor next to his bed.
The facility policy for fall prevention shows to provide resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility.
2. R4's Physician Order Sheet dated October 1, 2015 shows diagnoses to include: Dementia with impaired safety awareness, delirium, fracture of right metacarpal, and Parkinson's and dementia with poor trunk control and poor safety awareness.

R4's Minimum Data Set of October 9, 2015 shows R4 is cognitively impaired and requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting.

R4's Fall Risk Assessment dated October 7, 2015 shows R4 is a high risk for falls and R4 has a loss of balance with sitting, and standing.

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R4's Activities of Daily Living Care Plan dated July 27, 2015, shows R4 requires assistance with transfers and ambulation.

On November 2, 2015 at 8:06PM, E4 and E8 (Certified Nurse Assistants-CNAs) placed their arm under R4's arm and stood R4 from his wheelchair, and pulled him backwards to his bed without using a gait belt. R4's gait was unsteady, and E4 said "that was actually pretty good" after R4 was assisted to sit on the side of the bed.

On November 3, 2015 at 8:30 AM, E6 (CNA) and E14 (Licensed Practical Nurse-LPN) transferred R4 from his wheelchair to the toilet without the use of a gait belt. E6 pushed R4 up to the assist bar in the bathroom, and stood to the right side of R4's wheelchair. E6 cued R4 to grab the bar and, E6 pulled on the back of R4's pants to help him to a standing position. E6 said R4 was incontinent of urine and stool, and had him sit back in his wheelchair. E6 then stood R4 again without a gait belt and transferred him from his wheelchair to the toilet. After providing incontinence care, E6 stood R4 again without a gait belt with both her arms under R4's arms, facing the resident. E14 then pulled on the back of R4's pants to help guide him far enough back into the wheelchair as E6 pivoted him towards the chair.

On November 4, 2015 at 1:10 PM, E15 (Restorative Nurse/MDS) said R4 should be transferred with two staff assists and a gait belt.

On November 5, 2015 at 9:10 AM, E16 (LPN) said R4 should be transferred with two assist and a gait belt at all times because he is very weak.

The facility April, 10, 2006 facility policy "Transfer

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F 323	Continued From page 42 Belts/Gait Belts" states: "All certified nursing assistants and licensed nursing personnel engaged in the lifting and transferring of residents will use gait belts." "The use of gait belts and mechanical lifts is essential to reduce the risk of accident and injury to both residents and employees...GAIT BELTS ARE MANDATORY." "Grasp the secured gait belt to provide stability and balance during the transfer."	F 323		
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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 43 (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 prevent cross-contamination during incontinence care, and failed to wash hands after providing incontinence care. The facility also failed to ensure soiled linens were not placed on clean resident linen. This applies to 1 resident (R7) in the sample of 12 reviewed for infection control, and 2 residents (R14, R15) in the supplemental sample. 1. The facility's undated Profile Face Sheet for R7 shows he was admitted on April 14, 2011. The profile sheet shows that R7's diagnoses include: heart failure, difficulty walking, acute kidney failure, diabetes, anemia, and muscle weakness. R7's Minimum Data Set (MDS) dated March 11, 3015, shows R7 requires extensive assist of 2 staff for toileting and extensive assist of 1 staff for bathing. R3's MDS dated August 26, 2015 shows R7 is frequently incontinent of urine. On November 2, 2015 at 7:00 PM, E7 and E11 (Certified Nursing Assistants- CNAs) were	F 441		

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providing incontinence care to R7. E7 removed R7's incontinence brief. R7 had been incontinent of urine. E7 washed R7's Left groin, pubic area, and right groin, then washed the tip of R7's penis, down the shaft and then washed R7's testicles. E7 used the same wash cloth, the same area of the wash cloth to wash all areas. E7 changed wash cloths to rinse the front areas using the same technique as she did for washing. E7 used the same wash cloth that was just used for rinsing R7's front side to clean R7's buttocks. There was visible stool on the wash cloth when E7 cleaned R7's buttocks. E7 put the soiled wash cloth into the dirty linen bag and removed the gloves used to provide incontinence care. Without washing her hands, E7 pulled the sheet up onto R7, adjusted R7's pillow, and held out her right hand (the same hand that held the soiled wash cloth) for R7 to place his hand into. R7 put his hand into E7's hand and E7 repositioned R7 in the bed. E7 pulled the rest of R7's blankets over him and then placed both hands on R7's over the bed table to move it close to his bed. E7 did not wash hands or use alcohol based hand rub after providing incontinence care to R7 before touching the R7's bedding, over the bed table, and R7's hands. E7 also did not wash R7's hands after providing care.

On November 2, 2015 at 8:43 PM, E7 stated , "I should have folded the wash cloth or (have) gotten a new one." E7 also stated, "I should have washed my hands before touching (R7) and the blankets, and the pillow."

On November 4, 2015 at 10:00 AM, E2 (Director of Nursing- DON) said the CNAs should not use the same side of the wash cloth on repeated areas. E2 stated, "Going from groin, pubic, groin

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areas to the tip of the penis without folding or getting a new cloth is not acceptable." E2 stated, "CNAs should be washing hands when they remove gloves and when they are going from dirty to clean." E2 said that touching a resident's sheets, pillows, and the resident's hand after providing incontinence care without cleaning their hands "is not acceptable."

2. The facility's undated Profile Face Sheet shows R15 was admitted to the facility on February 01, 2015. The profile sheet shows R15's diagnoses include: abnormal involuntary movements, difficulty walking, female stress incontinence, and muscle weakness. R15's MDS dated September 3, 2015 show R15 is always incontinent of urine and stool and is dependent on 2 staff for toileting and bathing.

On November 2, 2015 at 8:05 PM, E7 and E11(CNAs) were providing incontinence care for R15. R15 was incontinent of urine and stool. After providing incontinence care to R15's perineal area, E7 rolled R15 onto her left side and wiped R15's buttocks. There was visible stool on the wash cloth. E7 placed the soiled wash cloth on R15's incontinence pad (that was under R15) to fold the wash cloth. E7 then wiped R15's buttocks again and there was visible stool on the wash cloth. E7 placed the soiled wash cloth on the incontinence pad a second time to fold the wash cloth and wiped R15's buttocks again. E7 finished providing incontinence care for R15. The incontinence pad, located under R15, that the soiled wash cloth was placed on to fold, was not changed after incontinence care was provided.

On November 2, 2015 at 8:43 PM, when asked by this surveyor about placing the soiled wash

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cloth on the incontinent pad to fold the wash cloth, E7 stated, "I probably should'nt have done that."

On November 4, 2015 at 10:00 AM, E2 (Director of Nursing- DON) said it is not acceptable to place a soiled cloth on the resident's incontinence pad. E2 said if the CNAs are holding the cloth right, they should be able to fold it in their hand without resting it on anything. E2 said if the cloth had a lot of visible stool on it after the first wipe, the CNAs should have gotten a clean wash cloth.

The facility's Policy on Perineal Cleansing revised on September 21, 2010 shows that after washing, rinsing, and drying the area, staff should remove gloves and wash hands with soap and water, cleansing gel or skin cleanser. The policy also shows "The basic infection control concept for peri-care is to wash from the cleanest to the dirties area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items."

The facility's Hand Washing Policy revised December 2008 shows "All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions and equipment or articles contaminated by them is an important component of the infection control and isolation precautions."