STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. Building B. Wing	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Staunton Post Acute & Rehabilitation	512 Houston Street Staunton, VA 24401

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to complete a valid Durable Do Not Resuscitate Order (DDNR) for one of 34 residents in the survey sample. No resident representative signed the state approved DDNR form for Resident #122. The findings include: Resident #122 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Diagnoses for Resident #122 included end stage renal disease with hemodialysis, schizoaffective disorder, dementia, hypotension, dysphagia, anemia, neurocognitive disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed Resident #122 as cognitively intact. Resident #122's clinical record documented a DDNR order form dated 1/16/20 indicating the resident was incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. This form also documented the patient had not executed a written advance directive so signature of an authorized patient representative to consent to the DNR status was required. This DDNR form had the signature of a physician's assistant but no signature from an authorized resident representative. In the space for the authorized person's signature was documented, Verbal consent from [Resident #122's spouse]. Witness signatures were listed at the bottom of the DDNR by the facility's social worker (other staff #1) and a licensed practical nurse (LPN #1) caring for Resident #122. The resident's plan of care (revised 2/5/20) listed the resident's resuscitation status as DNR. On 2/10/20 at 8:38 a.m., LPN #1 caring for Resident #122 was interviewed about the resuscitation status. LPN #1 stated Resident #122 was a DNR. When asked about the lack of a representative's signature on the DDNR form, LPN #1 stated there was a verbal discussion with the resident's spouse and the social worker was responsible for getting signatures on the forms. Resident #122's Advance Directives Discussion Document dated 1/16/20 listed to withhold cardiopulmonary resuscitation but included no signature from the resident's representative indicating receipt of a copy of the Advance Directives policy. The form listed Verbal consent from [Resident #122's spouse] with signature by the facility's social worker. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/20 at 3:00 p.m., the social worker (other staff #1) was interviewed about no signature from an authorized representative on Resident #122's DDNR form or the discussion sheet. The social worker stated she completed an advanced directive discussion sheet with Resident #122's spouse on 1/16/20. The social worker stated since the spouse wanted the DNR status, a yellow/gold DDNR form was required. The social worker stated the physician and/or provider signed the gold DDNR form after discussion with the spouse and then she usually got the family representative to sign the form. The social worker stated Resident #122 was previously a full code and was changed to DNR on 1/16/20. The social worker stated she and the charge nurse verified the DNR status with the spouse over the telephone but did not get the spouse's signature. The social worker stated the resident's spouse did not drive and did not know when she would get to the facility to sign the forms. On 2/10/20 at 4:25 p.m., the physician's assistant (PA) that signed Resident #122's DDNR form was interviewed. The PA stated the form required a signature from the resident's representative in order to be valid. The PA stated he typically signed the form after a discussion with the family and then the facility staff got the family and/or representative's signature on the form. The facility's policy titled Advanced Directives (revised 11/14/18) documented, The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/or resident representative .No Center employee shall act as a witness or notary for advance directive forms, but staff can assist in ensuring documentation is properly executed .Upon completion of Advanced Directives Discussion Document, Social Services or nurse will notify the Physician of the resident's wishes and procure a state approved Do Not Resuscitate Order, if necessary . The instructions for completion of a durable do not resuscitate order include (Virginia code 12VAC5-66-70), . If the option of a Durable DNR Order is agreed upon, the physician shall have the following responsibilities . Obtain the signature of the patient or the person authorized to consent on the patient's behalf . (1) This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/11/20 at 11:10 a.m. (1) Durable DNR. How to Complete a Durable Do Not Resuscitate Order. Virginia Department of Health. 2/12/20. www.vdh.virginia.gov/emergency-medical-services/durable-dnr/

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on staff interview and clinical record review, the facility staff failed to ensure a CCP (comprehensive care plan) was reviewed and revised for two of 34 residents in the survey sample, Resident #66 and Resident #86. Findings include: Resident #86 was admitted to the facility on [DATE] with diagnoses that included diabetes II, muscle weakness, dementia without behavioral disturbance, depression, Alzheimer's disease, adult failure to thrive, hypertension and venous insufficiency. The most recent minimum data set (MDS) dated [DATE] was the annual assessment and assessed Resident #86 as severely impaired for daily decision making with a score of 7 out of 15. Resident #86's clinical record was reviewed on 02/10/20. Observed on the physician order sheet was the following order: 10/14/19: TX (treatment) - Compression Stockings for Bilateral Lower Extremities Ankle High. A review of Resident #86's care plans did not document the orders for the compression stockings. On 02/10/20 at 4:05 p.m., the MDS coordinator (RN #1) who was responsible for updating the care plans was interviewed. RN #1 stated the compression stockings should have been included on the care plan. These findings were reviewed with the Administrator, Director of Nursing (DON) and corporate staff during a meeting on 02/10/20 at 4:57 p.m. No additional information was provided to the survey team prior to the exit on 02/11/20.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on observation, staff interview and clinical record review, the facility staff failed to follow physician orders for the use of compression stockings for one of 34 in the survey sample, Resident #86. The findings include: Resident #86 was admitted to the facility on [DATE] with diagnoses that included diabetes II, muscle weakness, dementia without behavioral disturbance, depression, Alzheimer's disease, adult failure to thrive, hypertension and venous insufficiency. The most recent minimum data set (MDS) dated [DATE] was the annual assessment and assessed Resident #86 as severely impaired for daily decision making with a score of 7 out of 15. Resident #86's clinical record was reviewed on 02/10/20. Observed on the physician order sheet was the following order: 10/14/19: TX (treatment) - Compression Stockings for Bilateral Lower Extremities Ankle High. A review of Resident #86's treatment administration record (TAR) documented the application of the stockings dated 02/10/20. On 02/10/20 at 8:45 a.m., Resident #86 was observed sitting in a geri-chair on the 3rd floor New-West dining room. Resident #86 was observed reclined in the geri-chair with black ankle socks on; no compression stockings were observed. On 02/10/20 at 10: 45 a.m., Resident #86 was observed reclined in the geri-chair in her room, with black ankle socks on; no compression stockings were observed. On 02/10/20 at 10:50 a.m., Resident #86 was observed reclined in the geri-chair in her room, with black ankle sock on; no compression stockings were observed. Licensed practical nurse (LPN #6) who routinely provided care for Resident #86 was present in the resident's room. LPN #6 was interviewed about the order for the compression stockings. LPN #6 stated Resident #86 did have a current order for compression stockings and the third shift certified nursing assistant (CNA) who assisted the resident with dressing was responsible for placing the compression stockings on the resident. LPN #6 was asked about the signed TAR record documenting the compression stockings had been applied on 02/10/20. LPN #6 stated she had signed the TAR because she thought the compression stockings had been applied by the CNA. These findings were reviewed with the Administrator, Director of Nursing (DON) and corporate staff during a meeting on 02/10/20 at 4:57 p.m. No additional information was provided to the survey team prior to the exit on 02/11/20.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure proper treatment and assistive devices to maintain vision for one of 34 residents, Resident #66. Resident #66 was assessed and care planned for needing glasses, but the resident was not provided visual aids to assist and/or maintain vision. Findings include: Resident #66 was admitted to the facility on [DATE]. Diagnoses for this resident included, but were not limited to: dementia with behavioral disturbances, high blood pressure, Alzheimer's dementia, atrial fibrillation, depression and anxiety disorder. The most recent MDS (minimum data set) was a quarterly assessment dated [DATE]. This MDS assessed the resident as having short and long term memory impairment with severe impairment in daily decision making skills. This MDS also assessed the resident as having highly impaired vision, in addition to not having corrective lenses. A significant change assessment dated [DATE] was reviewed for comparison and for CAAS (care area assessment summary). This MDS assessed the resident with the same cognitive score. The resident was assessed as having highly impaired vision (as above), and documented that the resident did have corrective lenses. The CAAS worksheet for vision documented, .Visual Function .Blindness, visual field deficit, decreased vision acuity .unable to take vision test .peripheral vision or other visual problems .difficulty negotiating the environment .use of visual appliances .[no visual aids/appliances were marked as used or implemented] . Resident #66 was observed throughout the survey from 02/9/20 through 02/11/20, on the dementia unit. On 02/10/20 at 9:24 AM, Resident #66 was observed sitting in dining room area, in her wheelchair at a table. Resident #66 was attempting to stand up from her wheelchair and reach toward another resident's tray. CNA (certified nursing assistant) #10 went to Resident #66 and requested that she sit back down. Resident #66 stated, .what, I can't see you. CNA #10 then moved directly in front of Resident #66 and again called the resident's name and stated, Here I am. Resident #66 said, Oh and sat down after being prompted several more times. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/20 at 4:15 PM, the UM (unit manager), licensed practical nurse (LPN) #8 was interviewed regarding Resident #66 and her ability to see. LPN #8 stated that Resident #66 had glasses, but she doesn't anymore. LPN #8 was asked why? LPN #8 stated that Resident #66 had glasses at one time and that the resident misplaced them, they were found, and then after that the resident's family wanted to take them home. LPN #8 stated that was about three months ago and Resident #66 hasn't had glasses for about three months, if she had to guess. LPN #8 was asked if that information was documented. LPN #8 stated that it should be. LPN #8 was made aware that the no information was found regarding this and was asked for assistance in locating any information regarding the resident's glasses or when Resident #66 was last seen by the optometry. LPN #8 stated that she didn't know when Resident #66 was last seen. LPN #8 looked in the resident's chart and stated that if Resident #66 had been seen for vision, then it would have been before March of last year (2019), as there was nothing in the resident's chart. No other information and/or documentation as found regarding Resident #66 losing her glasses, misplacing her glasses or not wearing her glasses. There was no information or documentation regarding Resident #66's family taking the resident's glasses home. No information was found to evidence Resident #66 had any type of blindness as documented on the CAAS worksheet. Resident #66 had no diagnoses related to blindness or visual disease. On 02/10/20 at approximately 4:50 PM, the administrator, DON (director of nursing), corporate nurse and VP (vice president) of operations were made aware of the above information and were asked for any information about Resident #66's glasses and any information regarding the last time Resident #66 was seen by optometry. The resident's current physician's orders were reviewed and documented, .Treatments: 06/13/18 OPT/OPTH [optometry/ophthalmology], DENTIST, PODIATRY, PSYCH AS NEEDED . The resident's current CCP (comprehensive care plan) plan was reviewed and documented, .is at risk for impaired vision related to she is unable to take vision test .has glasses but does not always wear . monitor/document/report as needed any signs/symptoms of acute eye problems .remind resident to wear glasses when up .ensure resident is wearing glasses which are clean free from scratches and in good repair . Report any damage to nurse . On 02/11/20 at approximately 11:45 AM, the DON and corporate nurse were again asked for any additional information regarding Resident #66 and her glasses. On 02/11/20 at approximately 1:15 PM, the DON stated that no other information was found for Resident #66. The administrator stated that the resident would be seen next month for vision. No further information and/or documentation was presented prior to the exit conference on 02/11/20.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to assess and implement care for treatment of a blister for one of 34 residents (Resident #122) resulting in the development of an infected, necrotic pressure ulcer and failed to provide pressure ulcer dressing changes in a manner to prevent infection for two of 34 residents (Residents #122 and #112). The findings include: 1a) Resident #122 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Diagnoses for Resident #122 included end stage renal disease with hemodialysis, schizoaffective disorder, dementia, hypotension, dysphagia, anemia, neurocognitive disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed Resident #122 as cognitively intact, requiring the extensive assistance of two people for bed mobility and one person for dressing and daily hygiene. Resident #112's clinical record documented the resident was readmitted to the facility on [DATE] following a hospitalization . The re-admission nursing assessment dated [DATE] documented, .Edema noted to LUE [left upper extremity]. Resident has ace wrap in place to LUE . This re-admission assessment documented the resident's only skin impairments were scabs on his right toes and bruises to the right hand. The re-admission physician orders dated 10/25/19 included no orders regarding the ACE wrap to the left arm. The clinical record documented a physician's order dated 10/28/19 for an occupational therapy (OT) consult to fit the resident for a left arm compression sleeve with instructions to, Apply ACE wrap uniformly to left forearm and elbow and upper arm until compression sleeve arrives. A nursing note and skin evaluation sheet dated 10/29/19 documented the resident was assessed with a blister on his left hand. The nursing note dated 10/29/19 at 5:24 p.m. documented, .Intact blister in, (Thenar webspace) on left hand. 0 [No] tx [treatment] @ this time is needed Once the blister opens tx will begin if needed . There was no notification to the physician and/or provider about the blister and no treatment ordered or implemented. An occupational therapy (OT) note dated 10/30/19 documented, MD [physician] orders for left arm compression sleeve. Facility had ACE bandage in place this date. The ACE bandage has rubbed areas of pressure in thumb web space and opposite side lateral of pinky finger. Thumb web space has large intact blister from pressure of ACE wrap. Also area of pressure from ACE wrap at lateral aspect of wrist crease. Nursing notified of areas of pressure. It is recommended by the CLT [certified lymphedema therapist] for nursing not to replace ACE bandage. Measurements taken for left arm compression sleeve .Communication with nursing regarding this therapist recommendation with ACE as the potential for further skin breakdown and blisters to open is great. Resident #122's nursing notes from 10/30/19 through 1/9/20 included no assessment or mention of the intact blister and rubbed areas on the left hand as reported by OT. The ACE remained in use for four days after the OT recommendation to discontinue the wrap due to pressure areas on the left hand. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The record documented a physician's order dated 11/4/19 to discontinue the ACE wrap to the left forearm. A physician's order dated 11/22/19 documented, Compression arm sleeve and gauntlet (glove) to be donned [put on] after breakfast & doff [take off] after dinner for max 12 hrs [hours]/day with skin checks during & after wear Except on Tues/Thur/Sat - glove donned after dialysis + doff before 12 AM w/ [with] skin checks during and after wear. There were no skin assessments documented related to putting on and/or taking off the compression sleeve. Ten out of eighteen weekly skin audits for Resident #122 from 10/29/19 through 1/7/20 documented a skin impairment on the resident's left hand. The 10/29/19 skin check documented an intact blister on the left hand. The skin diagrams on assessments dated 11/8/19, 11/12/19, 11/29/19, 12/6/19, 12/10/19, 12/13/19, 12/20/19, 12/24/19, 1/3/20 and 1/7/20 marked a skin impairment on the resident's left hand but documented no description of the appearance, size, color or status of the impairment. These sheets listed the marked impairments as previously identified. The 11/12/19 assessment marked the resident with a scab on the left hand. The other weekly assessments (dated 11/1/19, 11/5/19, 11/15/19, 11/19/19, 11/26/19, 12/3/19 and 12/27/19) did not document a wound on the resident's left hand. The clinical record from 10/29/19 through 1/8/20 documented no notification to the physician regarding the left hand blister and pressure areas identified by OT. There were no physician's orders for treatment of the left hand blister when identified by nursing on 10/29/19 and assessed/reported by OT on 10/30/19. There were no documented assessments of the left hand blister after the OT note dated 10/30/19 other than scab on 11/12/19. A nursing note dated 1/9/20 documented the resident was sent to the emergency room (ER) from dialysis due to a change in condition. The resident was assessed at the emergency room with an infected, malodorous wound on the left hand. The emergency room record dated 1/9/20 documented the resident was received from dialysis after the resident became lethargic and had low blood pressure. The ER physician's examination dated 1/9/20 documented, .left hand between thumb and second index finger has open wound with purulent exudate malodorous . This ER physician's assessment documented, .with end-stage renal disease on hemodialysis, at baseline bedbound, debilitated presents with hypotension, lactic acidosis, hypoxia when he presented for dialysis today. A primary concern would be sepsis related to left hand wound that appears to be infected, versus complicated UTI [urinary tract infection] with chronic indwelling Foley catheter and history of complicated antibiotic resistant UTI in the past .Treat for sepsis with broad-spectrum antibiotics . The ER report listed, Infection of left hand .Patient with wound of left hand between first and second digit, purulent exudate .Broad-spectrum antibiotics with vancomycin and Zosyn IV [intravenous] . The resident was hospitalized for treatment of the infections and then readmitted to the facility on [DATE]. Readmission orders included daily dressing changes to the ulcer along with a topical debriding agent (Santyl). The physician's progress note dated 1/16/20 documented, .at dialysis was found to be hypotensive, encephalopathic, lethargic, and febrile and was admitted .He was found to have a left hand wound likely infected .Open wound of hand .this was felt to be infected status post 4 days of IV antibiotics now better . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The resident was referred to a wound clinic for ongoing treatment of the left hand ulcer. The wound physician's progress notes dated 1/16/20 documented the wound measured 1.6 x 0.8 x 0.4 (length x width x depth in centimeters), with moderate serosanguineous exudate, 30% thick devitalized necrotic tissue, 30% slough, 30% granulation tissue. The physician performed surgical debridement of the devitalized necrotic tissue with removal of 0.5 cm depth of tissue. The wound clinic physician documented additional assessments as follows. 1/30/20 - measured 1.5 x 0.7 x 0.4 cm with moderate serosanguineous exudate, 20% necrotic tissue, 40% slough, 30% granulation, additional surgical debridement performed to remove necrotic tissue and slough 2/6/20 - measured 2.0 x 0.5 x 0.5 cm with moderate serous exudate with scab in place, treatment orders changed to collagen powder each day with daily dressing changes Resident #122's plan of care (initiated 8/5/19; revised 2/5/20) listed the resident had left arm edema, was totally dependent on staff for hygiene/dressing and was at risk of skin impairment. Interventions to prevent skin breakdown included, Observed for redness, open areas, scratches, cuts, bruises and report changes to the Nurse .Monitor/document/report PRN [as needed] any changes in skin status . There was no revision to the care plan about the left hand blister and/or scab until 1/17/20, after the resident's return from the hospital following IV antibiotic treatment for the infected ulcer and UTI. On 2/10/20 at 8:41 a.m., the licensed practical nurse (LPN #2) unit manager was interviewed about assessment and treatment for Resident #122's left hand pressure ulcer. LPN #2 stated the resident returned from the hospital in October 2019 with an ACE wrap on the left hand that was too tight. LPN #2 stated the blister at some point became a scab. LPN #2 stated the scab came off at dialysis (1/9/20) and there was a hole under it and dialysis sent him to the emergency room . LPN #2 stated the facility was not previously treating the scabbed area because it was not open. LPN #2 stated she was not sure when the scab started. On 2/10/20 at 9:00 a.m., LPN #1 that routinely cared for Resident #122 was interviewed about the left hand blister. LPN #1 stated the resident's left hand had a scab and when the scab came off there was a wound underneath. LPN #1 stated she was not sure what the scab was from or how the resident got the left hand ulcer. On 2/10/20 at 9:16 a.m., unit manager (LPN #2) stated she reviewed the clinical record and found a note on 10/29/19 indicating the wound started as a blister. LPN #2 stated she did not see any notification or treatment orders for the blister. On 2/10/20 at 10:00 a.m., LPN #2 stated she looked through all the notes again from 10/25/19 through 12/31/19. LPN #2 stated the only documentation about the blister was the 10/29/19 note listing an intact blister on the left hand. LPN #2 stated she found nothing about notification to the physician/provider of the left hand blister. LPN #2 stated again that the resident got the ulcer after his return from the hospital on 10/25/19 from an ACE wrap on the left hand that was too tight. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/10/20 at 11:00 a.m., the certified nurses' aide (CNA #2) that routinely cared for Resident #122 was interviewed. CNA #2 stated the resident had a scab on the left hand between his thumb and index finger. CNA #2 stated the resident had edema in the left arm and wore a compression sleeve/glove. CNA #2 stated the scab was on the left hand maybe a month before it came off and there was an open place under the scab. CNA #2 stated the scab was a little smaller than dime size and she reported it to the nurse but did not remember when she reported it. On 2/10/20 at 4:25 p.m., the physician's assistant (PA) that cared for Resident #122 was interviewed about the resident's left hand ulcer. The PA stated he was not aware of a wound on the resident's left hand until after he returned from the hospital on 1/13/20. On 2/11/20 at 9:40 a.m., accompanied by LPN #14, Resident #122's left hand ulcer was observed. The resident's pressure ulcer was in the space between the resident's left thumb and index finger. The ulcer was slightly smaller than the size of a quarter with irregular edges. There was black necrotic tissue along the wound edge near the thumb side with most of the remaining wound bed covered with light yellow colored slough. The visible wound bed was moist and beefy red in color. There was a small amount of reddish colored drainage on the removed dressing. On 2/11/20 at 8:40 a.m., the director of nursing (DON) was interviewed about any assessment and/or treatments for Resident #122's left hand ulcer. The DON stated the wound was identified by nursing as an intact blister on 12/29/19. The DON stated OT also assessed a large, intact pressure injury on 10/30/19 resulting from application of an ACE wrap. The DON stated she had no other documentation regarding the wound until it was identified at the emergency roiagnom on [DATE]. The DON stated the intact blister should have been assessed as a stage 2 pressure injury. The DON stated the physician should have been notified and treatment initiated when found. The DON stated from talking with the floor nurses, the wound waxed and waned from a blister to a scab. The DON stated the resident had chronic swelling in the left arm and her review indicated this was a pressure injury resulting from the ACE wrap in place for edema. The DON stated some of the skin assessments marked an impairment on the left hand but documented no description and/or assessment of the wound. The facility's policy titled Performance Improvement Skin Meeting (effective 11/30/14) documented, .The Interdisciplinary team will review residents weekly with the following: Any resident with Pressure wounds . team will review each resident to ensure that interventions are established to improve the clinical condition and outcome of the resident, and review the clinical documentation for the resident to ensure that it is completed .team will review the progress of healing and develop any additional interventions as need [needed] to facilitate continue healing Current treatment effectiveness will be reviewed and revised as indicated. Review of the Pressure Ulcer/Non-Pressure Ulcer Record, the resident's care plan, nutritional status and progress notes . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer as, .localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear . The NPUAP defines a stage 2 pressure injury as, .Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present . The NPUAP defines an unstageable pressure injury as, .Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar [necrotic tissue]. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed . NPUAP defines a medical device related pressure injury as, .injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system . (1) The NPUAP includes in best practices for the prevention of medical device-related pressure injuries (MDRPI), .Remove or move removable devices to assess skin at least daily .Educate staff on correct use of devices and prevention of skin breakdown .Be aware of edema under device(s) and potential for skin breakdown . (2) These findings were reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/10/20 at 5:00 p.m. and on 2/11/20 at 11:10 a.m. (1) NPUAP Pressure Injury Stages. National Pressure Injury Advisory Panel. 2/12/20. www.npiap.com (2) Long-Term Care Prevention of MDRPIs. 2017. National Pressure Injury Advisory Panel. 2/12/20. www.npiap.com 1b) On 2/11/20 at 9:40 a.m., licensed practical nurse (LPN #14) was observed performing a dressing change to the pressure ulcer on Resident #122's left hand. LPN #14 placed a plastic bag with dressing supplies on Resident #122's bed covers. LPN #14 removed the supplies (gauze pads, bottle of Dakin's cleansing solution, scissors) from the bag and placed them directly onto the bedspread. LPN #14 washed her hands, put on gloves and removed the soiled dressing from the ulcer located between the resident's left thumb and index finger. LPN #14 changed gloves, applied Dakin's solution to a clean gauze pad and cleansed the wound. LPN #14 put on new gloves and cut the prescribed alginate dressing with scissors. LPN #14 changed gloves again and placed opened gauze packages on the bed covers, cut the border gauze in half and then applied collagen powder to the wound bed. LPN #14 made an additional cut of the alginate dressing with scissors that had been placed directly onto the resident's bedspread. LPN #14 put on new gloves, applied the alginate dressing to the wound and then the border gauze. LPN #14 then placed the bottle of Dakin's solution into the plastic storage bag, discarded supplies in the treatment room, placed the bag of supplies back into the treatment cart and washed her hands. The resident's pressure ulcer was in the space between the resident's left thumb and index finger. The ulcer was slightly smaller than the size of a quarter with irregular edges. There was black necrotic tissue along the wound edge near the thumb side with most of the remaining wound bed covered with light yellow colored slough. The visible wound bed was moist and beefy red in color. There was a small amount of reddish colored drainage on the removed dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	LPN #14 prepared no clean space for the clean dressing change supplies as items, including scissors were placed directly on the resident's bedspread. LPN #14 performed no hand hygiene after removing the soiled dressing and prior to cleansing the wound. LPN #14 performed no hand hygiene after or between any of the glove changes during the dressing change observation. The scissors were not sanitized prior to cutting the dressing that was placed directly onto the wound and the scissors were placed on the resident's bed covers during the dressing change. On 2/11/20 at 9:50 a.m., LPN #14 was interviewed about lack of hand hygiene and placing supplies on the bedspread during the dressing change. LPN #14 stated she typically performed glove changes during dressing changes and did not think hand hygiene was required after removing gloves. LPN #14 stated she sanitized her scissors at times. Regarding placing clean supplies on the bedspread, LPN #14 stated the supplies were in a plastic bag and the opened gauze dressings were kept on the gauze papers. On 2/11/20 at 10:25 a.m., the director of nursing (DON) was interviewed about Resident #122's observed pressure ulcer dressing change. The DON stated hand hygiene was expected after removing soiled dressings, prior to cleaning the wound and before applying clean dressings. The DON stated hand hygiene was expected after glove changes and clean supplies were not supposed to be placed on the resident's bed. This finding was reviewed with the administrator and director of nursing during a meeting on 2/11/20 at 11:10 a.m. 28106 2. Resident #112 was admitted to the facility on [DATE] with a readmission of 2/7/20. Diagnoses for Resident #112 included; Pneumonia, septicemia, UTI, quadriplegia, stage four pressure ulcer to buttocks. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/20. Resident #112 was assessed with a cognitive score of 15 indicating cognitively intact. On 02/10/20 at 9:10 AM, Resident #112's dressing changes wre observed with three license practical nurses identified as LPN #4 (unit manager), LPN #5, LPN #6. Resident #112 was turned, then LPN #5 washed hands, put on gloves, removed a dressing to the buttocks, then applied wound cleanser to all three wounds using the same gauze. LPN #5 then removed gloves, and put on new gloves without washing hands between glove changes. LPN #5 then applied Dakin's solution and sure prep to the outer buttock wound, and applied Hydrogel Collegen mixture to the outer wound. LPN #5 then applied sure prep to middle and inner wound, applied Collogen powder to the middle and inner wound using the same applicator, then applied a cover dressing to all three wounds. LPN #5 then moved to the left foot wounds without changing gloves or washing hands. LPN #5 removed the dressing, applied skin prep to outer foot and wound cleanser to outer heel, opened up a Calcium Alginate dressing without washing hands or changing gloves, cut a piece of the dressing, handled the dressing with the same unclean gloves and applied it to the cover dressing, then applied Collagen powder to the heel wound and applied the dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/10/20 at 9:40 AM, LPN #5 and LPN #4 were interviewed concerning not washing hands when discarding unclean gloves and applying new gloves, cleaning three buttocks wounds using the same gauze, using the same applicator to distribute treatment to the middle and inner buttock wounds, moving to Resident #112's left foot wound without washing hands or putting on clean gloves and handling Calcium Alginate dressing with unclean gloves and applying the dressing directly to the wound. LPN #4 and #5 stated understanding. The facility's policy titled Dressing Change (effective 11/30/14) documented, A clean dressing will [be] applied by a nurse to a wound as ordered to promote healing . This policy included in procedures for a dressing change, .Assemble equipment as needed for dressing change .Place supplies on prepped work surface .Perform hand hygiene .Apply gloves .Remove and dispose of soiled dressing .Remove gloves . Perform hand hygiene .Apply gloves .Cleanse wound as ordered .Remove gloves and perform hand hygiene .Apply treatment as order and clean dressing .Discard gloves and perform hand hygiene . (Sic) On 02/10/20 at 5:21 PM, the above finding was discussed with the the administrator and director of nursing (DON). On 02/11/20 at 9:04 AM, the DON was interviewed regarding the dressing change observation. The DON stated that it was wrong to perform a dressing change that way. No other information was provided prior to exit conference on 2/11/20.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide supervision to prevent accidents for one of 34 residents, Resident #51. Kitchen staff opened a locked door giving Resident #51 access to the outside. The door locked behind her and she was unable to reenter the building. Findings were: Resident #51 was admitted to the facility on [DATE] with the following diagnoses, including, but not limited to: Cellulitis, Lupus, Chronic pain syndrome, hepatitis C, emphysema, and lung cancer. The admission MDS (minimum data set) with an ARD (assessment reference date) of 12/09/2019, assessed Resident #51 as cognitively intact with a summary score of 15. The clinical record was reviewed on 02/09/2020. The following information was observed in the nurse's notes section: 11/28/2019 6 A [6:00 a.m.] Resident rested will in bed .s/p [status post] fall this shift Pt [patient] reports she used her tight hand to break her fall. No skin break. Pt wrapped her need [sic-knee] per her choice. 12/02/2019 IDT [interdisciplinary team] met to discuss resident fall with abrasion to knees. Resident went outside after being let out by staff and fell .reeducated staff to courtyard smoking area and educate staff to identify persons before letting them outside . 12/04/2019 IDT met to review residents recent fall with abrasions to knees. Resident was let outside by staff and resident fell outside. Interventions included neuros and reeducate resident to courtyard and educate staff to check with nurse before letting a resident outside . An SBAR (Situation/Background/Appearance/Review) form dated 11/27/2019 at 8:30 p.m. was observed in the clinical record and contained the following: Skin Evaluation: Skinned knee; Pain Evaluation: New pain, left knee-Intensity-8 Resident #51 was interviewed on 02/10/2020 at approximately 8:15 a.m. about her fall. She stated,Yea, that happened right after I got here. I got turned around, this place is a [NAME]. I thought I was going out to the courtyard to smoke. I went up the hall to the door there .that's the kitchen but I didn't know that. Somebody up there opened the door for me and I went outside. When I got out there I realized I wasn't in the courtyard. The door was locked behind me and I couldn't get back in. It was dark and I fell down. I hurt my wrist and tore my knee up. I walked around to the front of the building and came back inside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unit manager, LPN (licensed practical nurse) #9 was interviewed on 02/10/2020 at approximately 8:30 a. m. She was asked about the door leading outside at the kitchen. She stated, It is locked, and it has a sensor on it if someone with a wander guard gets too close to it. She was asked if someone went out the door if it shut behind them and locked. She stated, Yes, it locks automatically when you shut it. A report of the incident was requested and received from the DON (director of nursing) on 02/11/2020. Per the investigation: Event date 11/27/2019 20:23 PM [8:23 p.m.] Per nursing staff, resident was let out the side door of 2NS by the kitchen staff who mistook her as a family member. Resident returned back inside and reported she fell . Skin tear to left knee Was the resident who fell attended by an employee: No; Location of event: Outside building on premises; Activity at time of event: Wandering aimlessly; Was the resident injured: Yes; What was the severity level of the injury? Minor injury . The above information was discussed during an end of the day meeting with the DON, the administrator, and corporate consultants on 02/10/2020. No further information was obtained prior to the exit conference on 02/11/2020.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27353 Based on observation, staff interview and clinical record review, the facility staff failed to ensure interventions were implemented to prevent weight loss for one of 34 residents in the survey sample, Resident #22. Resident #22 was not weighed for three months by facility staff. A weight was obtained on 02/11/20 and the resident had lost 5.45 % since the last weight completed in November 2019 (3 months). Findings include: Resident #22 was admitted to the facility on [DATE]. Diagnoses for this resident included, but were not limited to: dementia, anxiety disorder, depression, psoriasis, and hypothyroidism. The most recent MDS (minimum data set) was a quarterly assessment dated [DATE]. This MDS assessed the resident with short and long term memory impairment with severe impairment in daily decision making skills. The resident was assessed as requiring extensive assistance of one staff member for most all ADL's (activities of daily living), including consuming meals. The resident resident's height and weight on this MDS was documented as 65 inches tall and 178 lbs (pounds). Resident #22 was not assessed as having had a weight loss or a weight gain. Resident #22's last annual MDS assessment dated [DATE] documented that Resident #22 had a cognitive score of 1, indicating severe impairment in daily decision making skills. Resident #22 was assessed on this MDS as requiring supervision with set up only for consuming meals. Resident #22 was assessed as 66 inches tall and as 185 lbs. The CAAS (care assessment summary) were reviewed and triggered for cognitive loss, behavioral symptoms, and nutritional status. Resident #22 was not assessed as weight gain or weight loss on this MDS. The current CCP (comprehensive care plan) documented that Resident #22 was able to feed self after set (August 2019) .weight monitoring as ordered (02/20/19) .RD to evaluate and make diet change recommendations as needed (02/20/19) .provide, serve diet as ordered (02/20/19) . On 02/10/20 at 8:31 AM, Resident #22 was observed in the dining room. Resident #22 ate her breakfast meal, but did not use utensils. Resident #22 picked her food up with her hands and ate. Staff were observed to prompt Resident #22 to use utensils, but Resident #22 continued to eat with her hands. At approximately 9:45 AM the clinical record was reviewed. Resident #22's weight record revealed that no weight had been obtained since November 2019. The weight record documented that Resident #22 refused to be weighed on 12/03/19, 01/02/20, and on 02/04/20. There was no documentation that Resident #22 refused to be weighed more than once. There was no additional information in the nursing notes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/20 at 3:41 PM, LPN (Licensed Practical Nurse) #8 was asked about Resident #22 being weighed. LPN #8 stated that Resident #22 gets agitated and will refuse. LPN #8 was asked if staff attempt to weigh Resident #22 more than once, or is it just one time. LPN #8 stated that they will usually attempt to weigh more than once, but they document it only once. LPN #8 was asked how would you know how many times the staff attempted to weigh the resident. LPN #8 did not comment. LPN #8 was asked how often Resident #22 was supposed to be weighed. LPN #8 stated that for residents that do not have a specific physician's order, those residents get weighed monthly. LPN #8 was asked if Resident #22 was a monthly weight. LPN #8 stated, Yes. LPN #8 was asked if Resident #22 had been seen by the RD (Registered Dietitian). No RD notes were found, only CDM (certified dietary manager) notes. Resident #22 was last seen by the CDM on 11/15/19 and there were no documented issues or concerns. On 02/10/20 at 5:15 PM, the administrator, DON and corporate nurse were made aware of the above information. The staff were asked for documentation of when the resident was last seen by the RD. The staff were also asked for policy on nutritional management and the responsibilities of the RD. On 02/11/20 at 8:39 AM, Resident #22 was observed in dining room. OS [other staff] #12 stated that she would attempt to get a weight on Resident #22. On 02/11/20 at 9:00 AM, the clinical record was reviewed. A nursing note written by LPN #8 on 02/10/20 timed 10:00 PM documented, .resident spoke to about the importance of being weighed . The resident's nutritional records were again reviewed and included a RD note dated 02/10/20, which documented, .dementia, anxiety, depression .alert, confused .diet order: Regular .eating ability: varies . swallowing ability: within normal limits .SLP [speech language pathology] screen request 02/10/20 .1/29/20 DM [dietary manager] data shows food held in cheeks .1 isolated instance, will advise SLP .clothes fitting in usual manner .request BMP [basic metabolic panel], medpass 60 ml [milliliters] TID [three times daily] X 60 days .weekly weight attempt X 4 . The CDM had last documented on 11/15/19, which included that Resident #22 weighed 176 pounds and that the resident's weight was stable. It was also documented that there were no changes. No information or documentation was found in the resident's clinical records regarding the resident holding food in her cheeks. Resident #22 was weighed on 02/11/20, at approximately 10:00 AM. Her weight was 166.4 pounds, a 5.45% weight loss since her last weight in November 2019. The current CCP (comprehensive care plan) was documented, .is at nutritional risk related to self care deficit, dementia as evidenced by is dependent upon staff for provision of all foods and fluids .assist to dine as needed .monitor, document, report as needed signs and symptoms of dysphagia, pocketing, choking, holding food in mouth .several attempts to swallow .refusing to eat .appears concerned during meals .serve diet as ordered .RD to evaluate and make diet change recommendations .weight monitoring as ordered On 02/11/20 at 11:00 AM, a policy on nutritional management was presented and reviewed. The staff did not present any information regarding when Resident #22 was last seen the RD. The corporate nurse stated that they would look for that information. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled, Medical Nutrition Therapy: Assessment and Care Planning documented, .A Registered Dietitian/Nutritionist or other clinically qualified nutritional professional is responsible for .a comprehensive nutrition assessment for all residents .needs, goals, and preferences .status will be assessed upon admission and monitoring at least quarterly thereafter .changes in the nutrition plan of care will be communicated to .nursing team .ensuring follow up and appropriate documentation . No further information and/or documentation was presented prior to the exit conference on 02/11/20 to evidence that facility staff provided care and nutritional interventions for the prevention of weight loss for Resident #22.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on staff interview, family interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure that medication (Methadone) was available for administration for one of 34 residents, Resident #48. Findings were: Resident #48 was originally admitted to the facility on [DATE]. His current diagnoses included, but were not limited to: Dementia, Parkinson's Disease, Chronic Pain Syndrome, Cerebral Atherosclerosis, Hypothyroidism, and Depressive Disorder. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of [DATE], assessed Resident #48 as cognitively intact with a summary score of 14. The complainant was interviewed on [DATE] at approximately 10:55 a.m., she voiced concerns that the pharmacy had not delivered Resident #48's methadone. She stated, He gets it twice a day and he hasn't had it since yesterday morning. At approximately 11:15 a.m., LPN (licensed practical nurse) #11 was interviewed. She was asked if Resident #48 had been given his morning dose of Methadone. She stated, No. It wasn't delivered from the pharmacy. She was asked when he had received his last dose. She stated, Yesterday morning. She was asked how the medications were ordered. She stated, We take the sticker off of the card and send it to pharmacy, the sticker is off so I know it has been reordered. She was asked if Methadone was available in any of the stat boxes at the facility. She stated, No, it isn't. The unit manager, LPN #2 was then interviewed. She stated, The pharmacy says the prescription has run out they never called us or let us know that when we sent for the refill .we contacted the PA [physician assistant] [OS (other staff) #10] on call last night and she said she wasn't going to reorder it last night and it would be handled this morning .[Name of a different PA-OS #2] took care of it today. She was asked when the medication would be delivered and what was being given to Resident #48 in the meantime for pain. She stated, It will be here this evening, probably around 5:00 [p.m.]. We are giving him Tylenol for pain if he needs it. The PA (OS #2) was interviewed at approximately 11:30 a.m. regarding Resident #48's unavailable methadone and whether or not withdrawal was a possibility for the resident. He stated, He is on a very low dose, I think he will be okay. I haven't interviewed him yet today so I don't know about his pain. The clinical record was reviewed and contained the following physician orders: [DATE] Methadone 5 mg tablet. Take 0.5 [,d+[DATE]] tablet (s) [2.5 mg dosage] twice a day by oral route for 80 days. Dx: Chronic Pain Syndrome. The nurse's notes contained the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 2300 [11:00 p.m.] Resident's methadone 2.5 mg finished, the prescription was faxed to the pharmacy in the afternoon. When it didn't come with the night supply, pharmacy was called. They said that the refill order has expired. Dr on call was notified to reorder it, but she refused, said she will fax the order in the morning. [DATE] 2340 [11:40 p.m.] Dr. on call was called back to get a verbal order for pt [patient] to miss 2 doses of methadone since she was not reordering it. At 0100 [1:00 a.m.], Dr called back, stated that she will not be able to order the med at this time as it's already 0100 am or give verbal order to hold meds till tomorrow. She stated that she will order it in the morning. Resident was notified. No c/o [complaints of] pain or sign of distress noted. A meeting was held with the DON (director of nursing), the administrator, and the corporate consultants. The DON was asked when medications should be reordered from the pharmacy to make sure they were in house when needed. She stated, I would order it when we got down to a couple of doses. She was asked if there was a policy. She stated, I'll see what we have. The above information regarding the unavailability of Resident #48's methadone was discussed. The DON stated, I heard about that yesterday evening. The pharmacy never let us know that the prescription had expired. They called the PA on call and she wouldn't do anything. The DON was asked if the medical director should have been called if the PA was not of assistance. She stated, He brushes us off too. The DON was asked if the nurse giving the last dose yesterday ([DATE]) morning should have followed up with the pharmacy at that time. She stated, That's nursing judgement, but I would have. The PA [OS #2] came to the conference room at approximately 1;20 p.m. and stated, I ordered Norco 5 mg every 8 hours PRN [as needed] for the resident. He was asked if the resident was having pain. He stated, Yes, they are giving the Norco. He was asked about possible withdrawal since Resident #48 had gone over 24 hours without his Methadone and it was not expected to arrive until 5:00 p.m., or later. He stated, He won't go into withdrawal. The policy, Reordering, Changing, and Discontinuing Orders did not include guidance regarding a timeframe for the facility to reorder needed medications to ensure they were always available. The following was observed: [Pharmacy name] will indicate if the re-order is confirmed, if Pharmacy follow-up is required .If [name of pharmacy] indicates that Pharmacy follow-up is required, Pharmacy will contact Facility . The DON also presented verification that the medication had been ordered electronically on [DATE]. She stated, It was ordered on the computer .the pharmacy never contacted us that the prescription had run out. No further information was received prior to the exit conference on [DATE]. This is a complaint deficiency.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 27353 Based on a medication pass and pour observation, clinical record reviewed, staff interview and facility document review, the facility staff failed to ensure a medication error rate of less than 5% (five percent). The medication pass and pour observation consisted of 25 (twenty- five) medication opportunities with four medication errors, resulting in a medication error rate of 16% (sixteen percent). Findings include: On 02/09/20 at 04:19 PM, a medication pass and pour observation was conducted on Unit 3 NW (NorthWest) with LPN (Licensed Practical Nurse) #7. LPN #7 used hand sanitizer and began to prepare medications for Resident # 138. Medications prepared included the following: (1) Three Tegretol 100 mg (milligram) tablets for a total of 300 mg. (2) One calcium with vitamin D 600/400 mg tablet. (3) One ethosuximide 250 mg tablet. (4) One pravastatin 20 mg tablet. The medication pills were counted and verified with LPN #7; a total of six pills were counted. Resident #138 took the medications whole with water. LPN #7 cleansed his hands and exited the room. On 02/09/20 at 4:35 PM, LPN #7 then prepared medications for Resident #12. The medications prepared included: (1) One Namenda 10 mg tablet. (2) One metformin 1000 mg tablet. (3) Two pepcid 10 mg tablets for a total of 20 mg. The pills were counted and verified with LPN #7; a total of four pills were counted. LPN #7 administered the medications, washed his hands with soap and water and then exited the room. On 02/09/20 at 4:48 PM, LPN #7 then prepared medications for Resident #41. The medications prepared included: (1) One clonidine 0.2 mg tablet. (2) One colace 100 mg capsule. (3) Two pepcid 10 mg tablets for a total of 20 mg. (4) One metoprolol 25 mg tablet. The pills were counted and verified with the LPN #7; a total of five pills were counted. On 02/10/20 at 11:02 AM the medications for the above residents were reconciled. Resident #138's physician's orders documented that the resident was ordered pravastatin 20 mg to be administered at 9:00 PM. The Medication Administration Records (MARs) revealed that the medication pravastatin 20 mg was ordered to be given at 9:00 PM, but that was marked out and the number '5' was written in over top of the 9. This medication was administered at 5:00 PM, not 9:00 PM as ordered by the physician. This resulted in one medication error. Resident #12's physician's orders documented that the resident was ordered pepcid 20 mg at 9:00 AM and 9:00 PM. The MARS documented the same, but 9:00 PM was amrked thorugh and a 5 was written in over top of it. The resident was also ordered Buspar 5 mg at 9:00 AM and 5:00 PM. The MARs documented the same, but again the 5:00 PM dose was marked through and a number 9 was written over top of it. The resident was not administered the pepcid or the Buspar as ordered by the physician. This resulted in two medication errors. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 41's physician's orders were reviewed. The resident was ordered Gabapentin 100 mg (two capsules = 200 mg) at 9:00 AM and 5:00 PM. The MARs documented the same, but for the 5:00 PM dose was marked through the 5 and the number 1 written over top of it. Resident #41 did not get this medication as ordered at 5:00 PM, it was documented that the resident received the medication at 1:00 PM. The resulted in one medication error. LPN (Licensed Practical Nurse) #5 was the medication nurse for these residents. LPN #5 was asked to look at Resident #41's MAR and physician's order. LPN #5 stated that he didn't know what happened or how it got changed. LPN #5 stated, I came in one day and it was 1:00 PM and then it was changed to 5:00 PM. The LPN stated that he didn't know when that was or who did it. LPN #5 stated that he did not verify the physician's order to the MAR when he noticed it. On 02/10/20 at 2:49 PM, an interview with the UM (Unit manager), LPN #4, was conducted. The UM stated, We actually looked at this with one of the [Name of pharmacy] staff a few hours ago and she said that when it is prescribed as a BID [twice daily] order, it is automatically 9AM and 5PM. The UM stated that Resident # 41 had been taking the Gabapentin at 9:00AM and 1:00PM previously and wasn't sure who made that change. The UM stated, We should follow the physician's order. The UM stated that she did not know who keeps changing the times on the MARs, as they don't match the physician's orders. The UM stated, We [the unit manager/night shift nurse] will usually check the physician's orders and the MARs each month prior to putting them on the chart to ensure that the orders are correct and match, but these changes were made after the orders and MARs were checked. The UM stated that in regards to Resident #12's (Pepcid 20 mg order) that she (the UM) was the one who wrote that order on the order sheet and on the MARs for the medication to be administered at 9AM and 9PM. The UM stated, .but, I don't know who changed that [9PM] to a 5, I honestly don't. The UM stated that as far as the Buspar order, I don't' know anything about that one. The UM stated, I don't know who keeps changing it. On 02/10/20 at 5:41 PM, the administrator, DON (acting director of nursing), corporate nurse and corporate administrative staff were informed of the above information in a meeting with the survey team. The medication error rate was 16%, this included 25 opportunities with 4 medications errors. A policy was requested on medication administration and medication times. The policy titled, General Dose Preparation and Medication Administration documented, .should comply with applicable law and state operations manual when administering medications .should comply with facility policy .Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth .Confirm that the MAR reflects the most recent medication order .Administer medications within timeframes specified by facility policy . A policy Medication Administration Times documented, .administer medications according to times of administration as determined by facility's pharmacy .physician/prescriber .within 60 minutes before .60 minutes after the designated times . No further information and/or documentation was presented prior to the exit conference on 02/11/20.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on record review, staff interview and facility document review, the facility staff failed to prevent a significant medication error for one of 34 Residents. Resident #147 was given an extra dose of Methadone (classified as an opioid) which resulted in harm. The Findings Include: Resident #147 was admitted to the facility on [DATE] with a readmission of 2/7/20. Diagnoses for Resident #147 included; Osteoporosis, dementia, seizure disorder, and chronic pain. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/27/20. Resident #147 was assessed with a cognitive score of 7 indicating severe cognitive impairment. On 2/09/20 Resident #147's medical record was reviewed and evidenced a physician's progress note dated 1/20/20 that read [AGE] year old male who I am seeing today because of medication error. Patient was given double the dose of his methadone morning dose by mistake. This was quickly addressed and I was notified to monitor vitals. Patient had decreased respirations about 2 hours later, with a reported rate of 8 [per minute]. A stat order of 0.2 mg [milligrams] of naloxone [Narcan, opioid antagonist used for opioid overdoses] was given IM [intramuscularly], and this perked the patient immediately. He was back to his baseline the rest of the afternoon. His afternoon dose of methadone was skipped. He is now resting in his bed this evening. A physician's order for the time period of the incident indicated that Resident #147 was to receive Methadone 5 milligrams at 6:00 AM and at 5:00 PM for chronic pain syndrome. Resident #147's nursing notes or medication administration record (MAR) did not evidence any information regarding Resident #147's receiving an extra dose of Methadone. On 02/10/20 at 2:24 PM, unit manager (license practical nurse, LPN #4) was interviewed. LPN #4 said a nurse gave an extra dose of Methadone in error. When asked why the extra dose was given, LPN #4 said the night shift nurse gave the medication (Methadone) when it was scheduled then the day shift nurse gave another dose at around 9:30 AM. LPN #4 said that Resident #147 had already been declining and was lethargic prior to the extra medication dose, the physician was called did not come into assesses Resident #147 at that time but did order Narcan. LPN #4 was asked if an investigation was done. LPN #4 was not sure of an investigation but did say a medication error sheet was completed. On 02/10/20 at 4:12 PM the physician's assistant who wrote the physician's progress note (Other Staff, OS #2), was interviewed. OS #2 said, he was contacted via phone because an extra dose of Methadone had been given and Resident #147's respiratory rate was at 8 and Resident #147 was lethargic. OS #2 said because Resident #147's respiratory rate was not at baseline, he decided to give Narcan. OS #2 stated that Resident #147 responded quickly. OS #2 was asked if he knew how the medication was given in error. OS #2 took out his phone and read part of a text message indicating that a nurse had misread the MAR and gave the medication (Methadone) at 9:00 AM not realizing that a scheduled dose had been given prior. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 02/11/20 at 9:45 AM, staff provided a Medication Discrepancy Report that indicated Methadone was given at the wrong time. A narrative describing the incident read This nurse misread time beside of medication on MAR. Rsd [Resident] had scheduled dose Methadone 5 mg @ 6 AM, gave another dose @ 9:00 AM. Outcome to Resident, read in part [.] Rsd assessed @ 2 pm and Resp [respiratory] decreased to 8 [breaths per minute] with periods of apnea [cessation of breathing]. Corrective action taken, read in part Naloxone [Narcan] gave STAT dose 0.5 ml [milliliter] IM, rsd [Resident] alert and verbal 1 min [minute] after administration. Measures taken to prevent reoccurrence, read Pay closer attention to MAR. A policy titled General Dose Preparation and Medication Administration was obtained and read in part 4. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, [.] No other information was provided prior to exit conference on 2/11/20.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31454 Based on observation, staff interview, and facility document review, facility staff failed to store drugs and biologicals appropriately on two of four units in the facility. Findings included: Medication storage on 2-New [NAME] was observed on [DATE] at 8:10 a.m. In the locked, medication refrigerator behind the nurse's desk was a blue, plastic box with a black handle, not permanently affixed. The box was closed with a green zip tie. Labeling on the box included, Lorazepam Box. LPN (licensed practical nurse) #2, the unit manager, was interviewed regarding the box and verified the box did contain Lorazepam. LPN #2 stated, It just showed up on our unit. They [pharmacy] said [physician name] just wanted it in the building in case we needed it. We have never opened it. In a locked cabinet behind the nurse's desk, where the stat medication boxes were stored, was a red, plastic box with a black handle, not permanently affixed. The box was closed with a green zip tie and a small combination lock. Enclosed in the box was: Gabapentin 100 mg (milligrams) - 8, Gabapentin 300 mg - 8, Gabapentin 400 mg - 2, Gabapentin 600 mg - 2, Hydroc/APAP ,d+[DATE] mg (Norco) - 4, Hydromorphone 2 mg Tablet - 4, Lorazepam 0.5 mg Tablet - 5, Morphine Sulfate 20 mg/ml (milliliter) 15 ml (2), Oxycodone 5 mg Tablet - 6, Oxycodone/APAP ,d+[DATE] mg (Perco) - 4, Tramadol 50 mg Tablet - 5, Zolpidem 5 mg Tablet - 4. LPN #2 was interviewed regarding the red medication box. LPN #2 stated, It is the only stat narcotic box in the building. All the nurse's know it is kept on this unit. The medication cart being used by LPN #11 was observed on [DATE] at 8:25 a.m. Located inside the medication cart were two, opened insulin pens without dates. The first was Humalog 100u/ml (units per milliliter). LPN #11 stated, I think I opened that over the weekend, the seventh, no the eighth. LPN #11 proceeded to write [DATE] on the insulin pen with a permanent marker. The second was Lantus 100u/ml (3ml). LPN #11 also dated this insulin pen [DATE] with a permanent marker. The third opened medication without a date was a pen of Victoza with directions on the pen to Discard 30 days after opening. The pen was half empty. All three medication pens were placed back into the medication cart by LPN #11. Medication storage on 3-New [NAME] was observed at 8:45 a.m. Behind the nurse's desk was two cabinet doors with locks. These doors were not locked. Inside the unlocked cabinets was a large, plastic box of stat medications from the pharmacy and an open bin with cards of medications needing return to the pharmacy. At that time, LPN #4, Unit Manager, stated, If you want to see any of them, I don't have keys, the nurse's do. LPN #4 gestured towards the nurses working the medication carts. LPN #4 stated, I'm not sure if the cabinet needs to be locked, but I will find out for you. I know the fridge is locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #6 opened the locked refrigerator at 8:55 a.m. Inside the medication refrigerator was a bottle of Tuberculin, Purified Protein Derivative, dated [DATE]. The following statement was observed on the bottle of Tuberculin, Once entered, vial should be discarded after 30 days. The current date was [DATE]. A second bottle of Tuberculin was noted with the plastic cap removed and no date on the open container. LPN #6 stated, I don't think it's been used. LPN #4 viewed the two bottles of Tuberculin and stated, I agree this one is expired. I don't think the other has been used, but the plastic cap is gone and there is no date. Both bottles of Tuberculin were discarded by LPN #4. Facility policy 6.0 General Dose Preparation and Medication Administration, Effective Date: [DATE], Revision Date: XXX[DATE] . included .3. Dose Preparation: .3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, .etc.). 3.11.1 Facility staff may record the expiration date based on date opened on the label of medications with shortened expiration dates . Facility policy 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles, Effective Date: [DATE], Revision Date: XXX[DATE] . included .3. General Storage Procedures: .3.3 Facility should ensure that all medications and biologicals, .are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors .4. Facility should ensure that medications and biologicals that: . (2) have been retained longer than recommended by manufacturer or supplier guidelines; .are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility staff may record the calculated expiration date based on date opened to the medication container .9. Facility should ensure that resident medication and biological storage areas are locked .12. Controlled Substances Storage: 12.1 Facility should ensure that Schedule II - V controlled substances are only accessible to licensed nursing, Pharmacy, and medical personnel designated by Facility. 12.2 After receiving controlled substances and adding to inventory, Facility should ensure that Schedule II-V controlled substances are immediately placed into a secured storage area .in all cases in accordance with Applicable Law) . The Administrator and DON (director of nursing) were informed of the above findings during a meeting with survey team on [DATE] at approximately 11:10 a.m. No further information was received prior to the exit conference.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09404 Based on observations, clinical record review, resident interview, staff interview, the facility staff failed, for two of 34 residents in the survey sample (Residents # 59 and 137), to provide routine and emergency dental services. Resident # 137 lost a natural tooth and was not provided with emergency dental services to treat the loss. Resident # 59 was not provided routine dental care for tooth decay and a broken partial plate. The findings include: 1. Resident # 137 was admitted to the facility on [DATE], and most recently readmitted on [DATE] with diagnoses that included coronary artery disease, deep vein thrombosis, heart failure, hypertension, cirrhosis, diabetes mellitus, gastroesophageal reflux disease, Non-Alzheimer's dementia, chronic obstructive pulmonary disease, and palliative care. According to an Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/2020, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. At 2:30 p.m. on 2/9/2020, Resident #137 was interviewed. While talking with Resident #137, the resident was observed covering her mouth with her left hand as she spoke. After several minutes of conversation, Resident #137 moved her left hand to reveal a missing front tooth. Asked if those were her natural teeth, the resident said, Yes. Asked when the tooth went missing, Resident #137 said, About six months ago. When asked if she had seen a dentist since she lost the tooth, Resident #137 said, No, Asked what the facility had done for her, she replied, They haven't done anything. They said it would cost too much, about $2000. Resident # 137 went on to say that she has occasional pain, but that the facility doesn't give her anything. It (the lost tooth) is embarrassing. That's why I hold my hand in front of my mouth. Resident # 137's care plan, initiated and revised on 8/7/19, included the following problem, (Name of resident) has loose front tooth and cavities. Refused to have tooth extracted. The goal for the problem was, (Name of resident) will be free of infection, pain or bleeding in the oral cavity by review date. Interventions to the stated problem were, Administer medications as ordered. Monitor/document for side effects and effectiveness; Coordinate arrangements for dental care, transportation as needed/as ordered; Diet as ordered. Consult with dietitian and change if chewing/swallowing problems are noted; Monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of oral/dental problems needing attention; Provide mouth care as per ADL (Activities of Daily Living) personal hygiene. At 9:00 a.m. on 2/10/2020, LPN # 10 (Licensed Practical Nurse), the Charge Nurse on the section of Unit 2 North-South where the resident's room was located, was interviewed about the missing tooth. Asked when the resident lost the tooth, LPN # 10 said, It has been a while. I couldn't say for sure. When asked about the lack of documentation in the Nurse's Notes section of the resident's clinical record, LPN # 10 said, It has been long enough, they (the Nurse's Notes) may have been thinned out of the chart. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN # 10 was then asked who schedules dental appointments for residents. Us (nursing) and transportation. LPN # 10 was unable to say if the resident had seen the dentist for the missing tooth, but did say that, I know she has seen the dentist. At 10:35 a.m. on 2/10/2020, LPN # 9 (Licensed Practical Nurse), the Unit Manager on the 2 North-South Unit where Resident # 137's room was located, was interviewed. Asked when Resident # 137 lost the tooth, LPN # 9 said, The tooth came out in the last couple of weeks. LPN # 9 agreed there there was no documentation in the resident's clinical record about the loss of the tooth. Asked specifically if the MD and the resident's RP were notified, LPN # 9 said, No. LPN # 9 went on to say that, She was put on the list to see the dentist, they come to the facility. I will check the list to see when she was put on. At approximately 2:30 p.m. on 2/10/2020, the Director of Nursing (DON) provided a copy of the facility's Policies and Procedures for Dental Services. Review of the policy noted the following: The center will contract with a dentist licensed by the Board of Dentistry to provide routine and 24-hour emergency dental services. The policy also included the following procedures: Obtain order for dental consult. The nurse or designee will if necessary or if requested assist the patient/resident in making the appointment and arranging for transportation to and from the dentist's office. If a referral does not occur within 3 days the nurse will evaluate and document changes in ability to eat and drink. Review ability with physician and obtain orders as indicated. Medicare and private pay residents may be charged for the services. The facility will provide Medicaid residents services and routine services covered under the State plan at no charge. If any resident of the facility is unable to pay for needed dental services, the facility will attempt to find alternate funding sources or alternative service delivery systems to ensure the resident maintains his/her highest practicable level of well-being. The DON also provided a copy of a handwritten page containing the names of residents scheduled for a Dental, Podiatry, or Eye exam, and the date of the exam. Resident #137 was scheduled to see the dentist on February 18 or 19, 2020. The following notation was next to her name, 2-7-20 lost front tooth. The DON was unable to say when the resident's name was added to the list. The DON also said, The dentist who comes to the facility does not do any treatment, only examines, does fluoride treatments. During a meeting at 5:15 p.m. on 2/10/2020, that included the facility's administrative staff, the matter of dental services was discussed. The Administrator said The resident (Resident # 137) is a Medicaid recipient. It is difficult to find a dentist to do any work. We don't have a dentist at the present time that could provide the services the resident needs. We have a dental service, but they do not provide treatment services. 21875 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #59 was admitted to the facility on [DATE] with a re-admission on 11/12/19. Diagnoses for Resident #59 included urinary tract infection, chronic pain, hyponatremia, hepatic encephalopathy, sciatica and liver failure. The minimum data set (MDS) dated [DATE] assessed Resident #59 as cognitively intact. On 2/9/20 at 3:20 p.m., Resident #59 was interviewed about quality of care in the facility. Resident #59 stated she had cavities, broken teeth and a damaged partial plate and had not seen a dentist in over six months. Resident #59 was observed at this time with missing upper and lower teeth and decayed edges on her lower front teeth. Resident #59 stated she saw a dentist last summer (2019) but the dentist that came to the facility on ly cleaned teeth and did not perform any repairs or extractions. Resident #59 stated she wanted to fix her teeth before they became painful. Resident #59's clinical record documented the resident's last dentist visit was 7/18/19. The resident was assessed with a broken front tooth. The dentist placed a composite restoration on the tooth. No further dental visits were documented since 7/18/19. Resident #59's annual MDS dated [DATE] assessed the resident with obvious or likely cavity or broken teeth. The resident's plan of care (revised 9/6/19) documented the resident had oral/dental problems and had experienced a toothache. Interventions for dental problems included, Coordinate arrangements for dental care, transportation as needed/as ordered. The clinical record documented a physician's order dated 10/16/19 for dentist consultation as needed. On 2/10/20 at 2:50 p.m., the licensed practical nurse (LPN #1) caring for Resident #59 was interviewed. LPN #1 stated a dentist came to the facility periodically but she did not know what services were performed. On 2/10/20 at 3:00 p.m., the facility's social worker (other staff #1) was interviewed about dental services for Resident #59. The social worker stated the transportation coordinator was responsible for dental consults/visits. On 2/10/20 at 3:11 p.m., the transportation assistant (other staff #3) was interviewed about dental services for Resident #59. The transportation assistant stated Resident #59's payer source was Medicaid and they currently had no local providers that would take Medicaid residents. The transportation assistant stated the dentist that periodically came to the facility performed exams and cleanings and did not provide extractions, repairs or denture work. The transportation assistant stated, We are in-limbo with getting people seen. The transportation assistant stated the facility was working to find a new provider but had been unsuccessful. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/10/20 at 5:00 p.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21875 Based on observation, facility document review and staff interview, the facility staff failed to store food in a sanitary manner. Two large pans of plain cake were stored in the walk-refrigerator uncovered. The findings include: On 2/9/20 at 2:23 p.m., accompanied by a dietary employee (other staff #5), the food items in the walk-in refrigerator were inspected. Stored near the bottom of a portable food tray rack were two large pans of plain cake. The cakes were not covered or sealed to protect against contamination. The dietary employee was interviewed at the time of the observation about the uncovered cakes. The dietary worker stated she made the cakes yesterday (2/8/20) for use tomorrow (2/10/20). The dietary worker stated the cakes were usually covered with another pan to protect them from contamination. On 2/9/20 at 2:45 p.m., the dietary manager (other staff #6) was interviewed about the cakes stored in the refrigerator without a seal or cover. The dietary manager stated food items were supposed to be covered and dated when made. The facility's policy titled Food Storage: Cold Foods (revised 4/2018) documented regarding storage of refrigerated foods, All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 2/10/20 at 5:00 p.m.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09404 Based on observations, clinical record review, resident interview, and staff interview, the facility staff failed, for one of 34 residents in the survey sample (Resident # 137), to maintain a complete and accurate clinical record. Facility staff failed to document Resident # 137's loss of a natural tooth in the clinical record. The findings were: Resident # 137 was admitted to the facility on [DATE], and most recently readmitted on [DATE] with diagnoses that included coronary artery disease, deep vein thrombosis, heart failure, hypertension, cirrhosis, diabetes mellitus, gastroesophageal reflux disease, Non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, chronic obstructive pulmonary disease, and palliative care. According to an Annual Minimum Data Set with an Assessment Reference Date of 1/22/2020, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. At 2:30 p.m. on 2/9/2020, Resident #137 was interviewed. While talking with Resident #137, the resident was observed covering her mouth with her left hand as she spoke. After several minutes of conversation, Resident #137 moved her left hand to reveal a missing front tooth. Asked if those were her natural teeth, the resident said, Yes. Asked when the tooth went missing, Resident #137 said, About six months ago. At 9:00 a.m. on 2/10/2020, LPN # 10 (Licensed Practical Nurse), the Charge Nurse on the section of Unit 2 North-South where the resident's room was located, was interviewed about the missing tooth. Asked when the resident lost the tooth, LPN # 10 said, It has been a while. I couldn't say for sure. When asked about the lack of documentation in the Nurse's Notes section of the resident's clinical record, LPN # 10 said, It has been long enough, they (the Nurse's Notes) may have been thinned out of the chart. A thorough review of Resident # 137's thinned clinical record, including Nurse's Notes dating back to September 2019, failed to reveal any documentation of the lost tooth. At 10:35 a.m. on 2/10/2020, LPN # 9, the Unit Manager on the 2 North-South Unit where Resident # 137's room was located, was interviewed. Asked when Resident # 137 lost the tooth, LPN # 9 said, The tooth came out in the last couple of weeks. LPN # 9 agreed there there was no documentation in the resident's clinical record about the loss of the tooth. At approximately 2:30 p.m. on 2/10/2020, the Director of Nursing (DON) provided a copy of the facility's Policies and Procedures for Dental Services. Review of the policy noted the following: The center will contract with a dentist licensed by the Board of Dentistry to provide routine and 24-hour emergency dental services. The policy also included the following procedures: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain order for dental consult. The nurse or designee will if necessary or if requested assist the patient/resident in making the appointment and arranging for transportation to and from the dentist's office. If a referral does not occur within 3 days the nurse will evaluate and document changes in ability to eat and drink. Review ability with physician and obtain orders as indicated. During a meeting at 5:15 p.m. on 2/10/2020, that included the facility's administrative staff and the survey team, the lack of documentation regarding Resident # 137's loss of a tooth was discussed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, facility document review, staff interview and clinical record review, the facility staff failed to follow infection control practices during dressing changes for two of 34 residents in the survey sample (Residents #122 and #112). The findings include: 1. Resident #122 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Diagnoses for Resident #122 included end stage renal disease with hemodialysis, schizoaffective disorder, dementia, hypotension, dysphagia, anemia, neurocognitive disorder and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed Resident #122 as cognitively intact. On 2/11/20 at 9:40 a.m., licensed practical nurse (LPN #14) was observed performing a dressing change to the pressure ulcer on Resident #122's left hand. LPN #14 placed a plastic bag with dressing supplies on Resident #122's bed covers. LPN removed supplies (gauze pads, bottle of Dakin's cleansing solution, scissors) from the bag and placed them directly onto the bedspread. LPN #14 washed her hands, put on gloves and removed the soiled dressing from the ulcer located between the resident's left thumb and index finger. LPN #14 changed gloves, applied Dakin's solution to a clean gauze pad and cleansed the wound. LPN #14 put on new gloves and cut the prescribed alginate dressing with scissors. LPN #14 changed gloves again and placed opened gauze packages on the bed covers, cut the border gauze in half and then applied collagen powder to the wound bed. LPN #14 made an additional cut of the alginate dressing with scissors that had been placed directly onto the resident's bedspread. LPN #14 put on new gloves, applied the alginate dressing to the wound and then the border gauze. LPN #14 then placed the bottle of Dakin's solution into the plastic storage bag, discarded supplies in the treatment room, placed the bag of supplies back into the treatment cart and washed her hands. LPN #14 prepared no clean space for the clean dressing change supplies as items, including scissors were placed directly on the resident's bedspread. LPN #14 performed no hand hygiene after removing the soiled dressing and prior to cleansing the wound. LPN #14 performed no hand hygiene after and/or between any of the glove changes during the dressing change observation. The scissors were not sanitized prior to cutting the dressing that was placed directly onto the wound and the scissors were placed on the resident's bed covers during the dressing change. On 2/11/20 at 9:50 a.m., LPN #14 was interviewed about lack of hand hygiene and placing supplies on the bedspread during the dressing change. LPN #14 stated she typically performed glove changes during dressing changes and did not think hand hygiene was required after removing gloves. LPN #14 stated she sanitized her scissors at times. Regarding placing clean supplies on the bedspread, LPN #14 stated the supplies were in a plastic bag and the opened gauze dressings were kept on the gauze papers. On 2/11/20 at 10:25 a.m., the director of nursing (DON) was interviewed about Resident #122's observed pressure ulcer dressing change. The DON stated hand hygiene was expected after removing soiled dressings, prior to cleaning the wound and before applying clean dressings. The DON stated hand hygiene was expected after glove changes and clean supplies were not supposed to be placed on the resident's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator and director of nursing during a meeting on 2/11/20 at 11:10 a.m. 28106 2. Resident #112 was admitted to the facility on [DATE] with a readmission of 2/7/20. Diagnoses for Resident #112 included; Pneumonia, septicemia, UTI, quadriplegia, stage four pressure ulcer to buttocks. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/20. Resident #112 was assessed with a cognitive score of 15 indicating cognitively intact. On 02/10/20 at 9:10 AM, Resident #112's dressing changes wre observed with three license practical nurses identified as LPN #4 (unit manager), LPN #5, LPN #6. Resident #112 was turned, then LPN #5 washed hands, put on gloves, removed a dressing to the buttocks, then applied wound cleanser to all three wounds using the same gauze. LPN #5 then removed gloves, and put on new gloves without washing hands between glove changes. LPN #5 then applied Dakin's solution and sure prep to the outer buttock wound, and applied Hydrogel Collegen mixture to the outer wound. LPN #5 then applied sure prep to middle and inner wound, applied Collogen powder to the middle and inner wound using the same applicator, then applied a cover dressing to all three wounds. LPN #5 then moved to the left foot wounds without changing gloves or washing hands. LPN #5 removed the dressing, applied skin prep to outer foot and wound cleanser to outer heel, opened up a Calcium Alginate dressing without washing hands or changing gloves, cut a piece of the dressing, handled the dressing with the same unclean gloves and applied it to the cover dressing, then applied Collagen powder to the heel wound and applied the dressing. On 02/10/20 at 9:40 AM, LPN #5 and LPN #4 were interviewed concerning not washing hands when discarding unclean gloves and applying new gloves, cleaning three buttocks wounds using the same gauze, using the same applicator to distribute treatment to the middle and inner buttock wounds, moving to Resident #112's left foot wound without washing hands or putting on clean gloves and handling Calcium Alginate dressing with unclean gloves and applying the dressing directly to the wound. LPN #4 and #5 stated understanding. The facility's policy titled Dressing Change (effective 11/30/14) documented, A clean dressing will [be] applied by a nurse to a wound as ordered to promote healing . This policy included in procedures for a dressing change, .Assemble equipment as needed for dressing change .Place supplies on prepped work surface .Perform hand hygiene .Apply gloves .Remove and dispose of soiled dressing .Remove gloves . Perform hand hygiene .Apply gloves .Cleanse wound as ordered .Remove gloves and perform hand hygiene .Apply treatment as order and clean dressing .Discard gloves and perform hand hygiene . (Sic) On 02/10/20 at 5:21 PM, the above finding was discussed with the the administrator and director of nursing (DON). On 02/11/20 at 9:04 AM, the DON was interviewed regarding the dressing change observation. The DON stated that it was wrong to perform a dressing change that way. No other information was provided prior to exit conference on 2/11/20.