STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445308	A. BUILDING _____ B. WING _____	01/16/2014

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TRENTON CENTER	2036 HIGHWAY 45 BYPASS TRENTON, TN 38382

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F 000	INITIAL COMMENTS The recertifiction survey was conducted from 1/13/14 through 1/16/14. Two complaints were investigated during the recertification survey. Complaint #TN00032974 had harm level deficiencies cited at F282 G and F323 G. There was no deficient practice cited for complaint #TN00032828.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Trenton Place Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to document personal property and follow grievance policy for missing items for 1 of 30 (Resident #55) sampled residents included in the stage 2 review. The findings included: 1. Review of the facility's "Grievance/Concern policy documented "...Purpose... to assure prompt receipt and resolution of patient / representative grievance / concern... Process... 4. Upon receipt of the grievance / concern, the Grievance / Concern Form will be initiated by the staff member receiving the concern and documented on the Grievance / Concern Log... 5. The department manager will: 5.1 Contact the person filing the grievance to acknowledge Acceptable POC M 2/7/14 SPPitman	F 166	**F 166** Grievance/Concern form initiated by the Social Services Director regarding missing items of resident #55 1/15/14. Social Services Director and Activities Director completed Inventory of Personal Effects for resident #55 and placed in resident's chart 1/17/14. Inventory of Personal Effects will be completed and placed in charts of current residents by 2/6/14. Director of Nursing/Designee in-serviced CNAs regarding completing the Inventory of Personal Effects upon admission and readmission of residents on 1/21/14. Social Services Director will in-service staff regarding facility's Grievance policy and procedure by 2/6/14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janie D. McBride | TITLE: Administrator | (X6) DATE: 2/7/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FEB 10 2014

This same POC was faxed 2/7/14

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F 166	Continued From page 1 receipt... 5.2 Investigate the grievance... 5.4 Notify the person filing the grievance of resolution within 72 hours... 6. Completed Grievance / Concern will be reviewed and retained by the Administrator to assure the patients interests have been addressed..." Review of the facility's "Personal Property policy documented "...Personnel will identify and record the patients belongings upon admission... 3. a listing of all items brought into the Center will be kept in the patient's clinical chart... 6.1 Any loss or breakage of a patient's personal item will be properly documented on the property loss form... then referred to the Administrator... 6.2 The Administrator or designee will investigate the lost item..." 2. Medical record review for Resident # 55 documented an admission date 1/17/13 with diagnoses of Spinal Cord Injury, Closed Fracture Vertebra, Generalized Anxiety Disorder, Muscle Weakness, Lack of Coordination, Abnormality of Gait, Edema and Osteoporosis. Review of the Minimum Data Set Quarterly Assessment dated 10/24/13 documented Resident #55's with modified independence cognition. Resident #55's property list was blank. During an interview in Resident #55's room on 1/13/14 at 3:34 PM, Resident #55 stated, "My two wedding bands were stolen before Thanksgiving ...I told [named Nurse #1]... she would write it down for me... I have not got them back and I have not heard from her about it..." During an interview in the Social Worker's (SW) office on 1/16/14 at 8:50 AM, the SW was asked about the facility's policy regarding missing items.	F 166	Social Services Director will monitor/investigate grievances to ensure adherence to facility policy and procedures and report findings to the Quality Improvement Committee monthly for review/recommendations.	2/11/14

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F 166	Continued From page 2 The SW stated, "...a grievance report should be filled out by who ever it is reported to... check the inventory list... we would investigate it... call family... this is my first time hearing about any jewelry being missing... the inventory list should be filled out on admission and put in chart... there is nothing on her [Resident #55's property] sheet it is blank..." During an interview on the 200 hall on 1/16/13 at 8:55 AM, Nurse #1 was asked about the incident reported by the resident. Nurse #1 stated. "Yes, she did tell me she had some rings missing... don't remember exactly when it was... I reported it in our stand up meeting... I did not fill out a grievance form..." Nurse #1 failed to complete a grievance form as required. The facility failed to follow-up on Resident #55's reported grievance.	F 166		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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F 279	Continued From page 3 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to develop a comprehensive care plan that addressed problems of behaviors, depression and/or psychoactive, anticoagulant, antidepressant and diuretic medication use for 3 of 30 (Residents #12, 14 and 59) sampled residents included in the stage 2 review. The findings included: 1. Review of Care Plans policy documented, "A comprehensive, individualized care plan will be developed by the interdisciplinary team for each patient. The care plan will include measurable objectives to meet patient needs and goals as identified by the assessment process... Reviewed and revised... to reflect response to care and changing needs and goals... The care plan must be customized to each individual patient's needs..." 2. Medical record review for Resident #12 documented an admission date of 1/6/14 with diagnoses of aftercare of Traumatic Fracture Arm, Depressive Disorder, Hypertension, Allergy, Lupus Erythematosus, Hypothyroidism, Esophageal Reflux, Weakness, Fracture of Phalanges of Foot and Fracture of Lumbar 3 disc. Physician's orders dated 1/7/14 included the	F 279	F 279 Resident #59 has discharged from the facility. Care Plan for residents #12 and #14 updated/revised 1/16/14. MDS Coordinator will audit current resident care plans and update/revise as indicated by 2/6/14. Director of Nursing/Designee in-service licensed nurses regarding updating/revising resident care plans to reflect resident behaviors and medications 1/21/14. Director of Nursing/Designee and Interdisciplinary Team will review care plan updates/revisions for accuracy and completion in morning clinical stand up meetings and Director of Nursing/Designee will submit a summary of findings to the Quality Improvement Committee monthly times three months for review/recommendations.	

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F 279	Continued From page 4	F 279		

diuretic Furosemide 20 milligram daily, the anticoagulant Lovenox 40 milligrams subcutaneous daily for 10 days and the antidepressant Effexor XR 150 milligram twice a day. The care plan dated 1/7/14 did not address the diuretic medication, the anticoagulant medication or a diagnoses of Depression and use of an antidepressant.

3. Medical record for Resident #14 documented an admission date of 10/25/13 with diagnoses of Persistent Mental Disorder, Hypertension, Diabetes, Depressive Disorder, Hyperlipidemia, Anxiety, Lack of Coordination, History of Falls, Bilateral Prostatic Hypertrophy, Alzheimer's Dementia and Osteoarthritis. Physician orders dated 10/25/13 documented the resident was receiving Lorazepam 0.5 milligrams three times a day as needed for anxiety disorder and Sertraline 50 milligrams at bedtime for depressive disorder. The care plan dated 11/16/13 did not address the use of psychotropic medications.

During an interview in the conference room on 1/15/14 at 12:03 PM, Nurse #3 was asked if Resident #14's care plan addressed the use of psychotropic medications. Nurse #3 stated, "No." Nurse #3 was asked why the care plan did not address psychotropic medication usage, since the resident had orders for Lorazepam and Sertraline. Nurse #3 stated, "I don't have a valid explanation for that."

4. Medical record review for Resident #59 documented an admission date of 9/3/13 with diagnoses of Dementia with Behavioral Disturbance, Hypertension, Esophagus Disorder, Chronic Obstructive Asthma, Abnormal Gait, Weakness and Rehab. Nurses notes

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F 279	Continued From page 5 documented the following: a. 9/3/13 - "CNA [Certified Nursing Assistant] reported that res [resident] became sexually inappropriate while giving shower grabbing her breast and made verbal insinuations to her..." b. 9/9/13 - "Inappropriate sexual behavior noted per staff... aggressive behavior noted... Required one on one monitoring per staff d/t [due to] inappropriate behavior toward female res." c. 9/10/13 - "...while resdt [resident] in therapy resdt verbalized desire to have sexual relations c [with] therapy staff member..." The facility was unable to provide a care plan that addressed the sexual behaviors. During an interview in the conference room on 1/15/14 at 5:25 PM, the Director of Nursing stated, "...as you can tell by the following notes we made arrangements for him to transfer to the hospital."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 6 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan to address behaviors and the use of sedatives for 2 of 30 (Residents #40 and 47) sampled residents included in the stage 2 review. The findings included: 1. Review of facility's care plan policy documented, "A comprehensive, individualized care plan will be developed by the interdisciplinary team for each patient. The care plan will include measurable objectives to meet patient needs and goals as identified by the assessment process... Reviewed and revised... to reflect response to care and changing needs and goals... The care plan must be customized to each individual patient's needs..." 2. Medical record review for Resident #40 documented an admission date of 6/17/10 with diagnoses of Chronic Kidney Disease, Spasm of Muscle, Muscle Weakness, Muscular Wasting and Disuse Atrophy, Edema, Chronic Pain, Anemia, Diabetes, Hyperlipidemia, Insomnia, Hypertension, Angina, Anxiety, Morbid Obesity, Gout, Lack of Coordination and Varicose Veins. The Professional Health Services of (named city) Physician's Documentation form dated 10/31/13	F 280	280 Care Plan for residents #40 and #47 updated/revised 1/16/14. MDS Coordinator will audit current resident care plans and update/revise as indicated 2/6/14. Director of Nursing and Assistant Director of Nursing in-serviced licensed nurses regarding updating resident care plans to address behaviors and the use of sedatives 1/21/14. Director of Nursing/Designee and Interdisciplinary Team will review care plan updates/revisions for accuracy and completion in morning clinical stand up meeting and Director of Nursing/Designee will submit a summary of findings to the Quality Improvement Committee monthly times three months for review/recommendations.	2/11/14

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F 280	Continued From page 7	F 280		

documented, "...No new behavioral issues noted per staff... Mood is fair to good... He continues to c/o [complain of] sleeping problems sleeping at night... Recommend increasing Trazodone to 150mg [milligrams] po [by mouth] q [every] HS [hour of sleep] for sleep..." The care plan dated 11/16/13 did not address the use of Trazodone for insomnia.

During an interview in the conference room on 1/15/14 at 4:55 PM, Nurse #3 was asked why the care plan did not address insomnia and Trazodone use. Nurse #3 stated, "I don't have a valid excuse for that."

3. Medical record review for Resident #47 documented an admission date of 10/4/13 with diagnoses of Open Reduction Internal Fixation for Right Hip Fracture, Senile Dementia, Atrial Fibrillation, Weakness, Hypertension, Reflux, Weight loss, Dysphagia, History of fall, Osteoarthrosis, Chronic Obstructive Pulmonary Disease, Depressive Disorder and Anxiety. The 14 day Minimum Data Set (MDS) dated 10/18/13 and the 90 day MDS dated 1/3/14 documented Resident #47 was severely impaired cognitively and displayed physical and verbal behaviors 1 to (-) days a week. The care plan updated on 12/9/13 did not address agitation and aggressive behaviors exhibited during activity of daily living care provided.

Nurses notes documented the following:
a. 10/11/13 - "...combative with adls [activity of daily living]..."
b. 10/24/13 - "...combative with adls..."
c. 11/22/13 - "...behaviors observed when waking... no further combativeness observed..."
d. 1/5/14 - "resident observed hitting bedside

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F 280	Continued From page 8 cabinet c [with] L [left] arm this shift by multiple CNA's [certified nursing assistant]." e. 1/10/14 - "...resident observed swinging casted L arm @ [at] [named] CNA when waking @ shift start..." Observations in the 300 hall on 1/13/14 3:30 PM, revealed Resident #47 self propelling herself in a wheelchair. The resident was noted to be thin and frail, cast on the left arm and dark blue-purple bruising on right upper orbital and right cheek bone area. Observations in Resident #47's room on 1/15/14 at 7:30 AM, revealed Resident #47 seated in a wheelchair, with a frown on her face. There were 2 CNA's in the room making the bed and gathering the linens. CNA #1 was observed to pick up the hairbrush and started brushing the resident's hair (from behind). Resident #47 frowned and grabbed at the brush. CNA #1 continued brushing and did not explain what she was going to do before starting the task. During an interview in the conference room on 1/13/14 at 4:00 PM, Nurse #3 stated, "She [Resident #47] does swing at the staff with adl care." During an interview at the nurses' station on 1/14/14 at 4:00 PM, Nurse #1 stated, "She does get combative with adl care." During an interview in the conference room on 1/14/14 at 4:30 PM, Nurse #3 stated, "[Named Resident #47] does have behaviors, gets resistant with adl care.." During an interview in the conference room on	F 280		

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F 280	Continued From page 9 1/14/14 at 5:00 PM, Nurse #2 stated, "[Named Resident #47] is resistant with adls at times. We have inserviced the staff to approach her and make sure she is awake and explain to her. You cannot just go in and start with her. We also have a 15 to 30 minute calm down time with her, wait 15 to 30 minutes and then reapproach her. She usually will forget what she was upset about and you can complete the care. We also have 2 CNA's do her care." During an interview in Resident #47's room on 1/15/14 at 7:30 AM, CNA #1 stated, "We talk with her, make sure she is awake..." During an interview in the conference room on 1/15/14 at 8:30 AM, Nurse #3 stated, "Combative with care should be on the care plan... but we make sure she is awake, approach calm, explain things, tell the charge nurse and reapproach her..." During an interview in the conference room on 1/15/14 at 9:20 AM, the DON stated, "I would expect behaviors to be care planned..."	F 280		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the	F 282		

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F 282	Continued From page 10 facility failed to follow the comprehensive care plan for providing pressure relief for a wound for 1 of 6 (Resident #19) sampled residents reviewed with a pressure ulcer and failed to consistently implement the intervention to keep the wardrobe away from the resident's bed for 1 of 4 (Resident #47) sampled residents with accidents of the 30 sampled residents included in the stage 2 review. The failure of the facility to provide pressure relief to the left elbow resulted in actual harm when Resident #19's wound worsened. The failure to consistently follow the intervention to keep the wardrobe away from the resident's bed resulted in actual harm when Resident #47 sustained a second fracture to the left wrist. The findings included: 1. Review of the facility's care plan policy documented, "A comprehensive, individualized care plan will be developed by the interdisciplinary team for each patient. The care plan will include measurable objectives to meet patient needs and goals as identified by the assessment process... Reviewed and revised... to reflect response to care and changing needs and goals... The care plan must be customized to each individual patient's needs..." 2. Medical record review for Resident #19 documented an admission date 6/9/13 with diagnoses Alzheimer's Disease, Dementia with Behavior Disturbances, Edema, Rheumatoid Arthritis, Depressive Type Psychosis, Chronic Airway Obstruction, Chronic Ischemic Heart Disease, Cardiac Pacemaker, Depressive Disorder, Hypertension, Symbolic Dysfunction, Anxiety, Dementia, Muscle Weakness and Joint Pain.	F 282	282 Resident #19 pressure relief device in place 1/16/14. Wardrobe removed from resident #47's room 1/15/14. MDS Coordinator will review current resident care plans and care cards and update/revise as indicated 2/6/14 Director of Nursing and Assistant Director of Nursing in-serviced licensed nurses and CNAs regarding following care plans/care cards to provide resident care 1/24/14. Administrator/Department Managers will perform daily per shift rounds times 14 days to monitor care plans followed regarding pressure relieving devices and accidents/hazards 2/6/14. Then daily rounds three times per week on-going. Director of Nursing/Designee will submit a summary of monitoring results to the Quality Improvement Committee monthly times three months for review/recommendations.	2/11/14

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F 282	Continued From page 11 Review of the skin integrity reports documented the following: a. 8/14/13 - initial assessment of a new pressure wound on the left elbow as follows: "...pressure ulcer stage- UN [stageable], appearance-pink/red and slough, length- 2.0 centimeters [cm], width-2.0 cm, depth- ? [unable to determine], Tunneling-no, Drainage-Min [minimal] P [purulent], and IHA [in house acquired]. b. 8/28/13 - wound has worsened and measures "length- 2.2 cm, width 1.5 cm, depth 0.1 cm"... with a note "^ [changed] classification to ST [skin tear] per DON [Director of Nursing]..." c. 10/23/13 - wound is now "length-1.3 cm, width-1.2 cm, Depth 0.1cm with mod (moderate) drainage." d. 12/10/13 - wound was reclassified as a pressure sore, inhouse acquired, and documented deteriorization as follows: "...Stage III, Pain-yes, appearance-tan > [greater than] 75% [percent], pink < [less than] 25%, length-1.0 cm, Width-1.0 cm, depth-0.4 cm, tunneling-1.2 cm @ [at] 12:00, drainage-min [minimal] S [serous]. e. 1/15/14 - continued deteriorization - stage III, appearance- pink, length-0.7 cm, width-0.4 cm, depth- 0.3 cm, tunneling- 1.5 cm @ 12:00, drainage- min S, Surrounding Tissue- IF [Inflamed/Indurated]. The care plan dated 8/14/13 and revised on 12/11/13 documented "Alteration in Skin Integrity r/t [related to]: wound to left elbow, as of 8/28/13 area classified as a skin tear Reclassified 12/10/13... Goals. Wound will decrease in size by next review. Wound will show no s/s [signs or symptoms] of infection... Interventions... offload pressure to left elbow via large stuffed bear, staff	F 282		

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F 282	Continued From page 12 to encourage placement of stuffed bear in lap under left elbow, check to ensure placement as resident will remove... monitor daily for s/s of infection. report abnormalities to MD [Medical Doctor]..." Observations of Resident #19 on 1/13/14 3:38 PM, revealed the resident sitting, in a wheelchair, at the nurses' desk, oxygen in place, yells at persons passing by and states "I'm scared", appears very anxious. There was no stuffed bear observed offloading pressure under her left elbow as care planned. Observations in Resident #19's room on 1/14/14 at 8:37 AM, revealed Resident #19 sitting in a wheelchair. There was no stuffed bear observed under her left elbow as care planned. Observations in Resident #19's room on 1/15/14 at 3:50 PM, revealed Resident #19 in bed, with no large stuffed bear present offloading the pressure to the left elbow as care planned. During an interview in the conference room on 1/16/14 at 12:01 PM, the Director of Nursing (DON) was asked about the pressure wound of the elbow. The DON stated, "...it was found on August 14, 2013. I assessed it and labeled it an unstageable pressure sore, later the DON at that time reclassified it as a skin tear. On assessment by the Assistant Director of Nursing (ADON) on 12/10/13 we changed it back to a pressure ulcer. We now have tunneling that was not there prior. We don't know what happened in between." The facility failed to ensure interventions to promote healing by relieving pressure was provided as care planned resulted in actual harm	F 282		

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F 282	Continued From page 13 when Resident #19's wound worsened. 3. Review of Accidents, Incidents, and Adverse Events policy documented: "All accidents, incidents or adverse events occurring on... premises should be reported, reviewed, and, if indicated, investigated without fear of reprisal... An adverse event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof... Purpose To provide a safe and healthful environment for patients... To define causative / contributing factors and institute preventive measures to avoid further occurrences... Adverse events require the completion of a thorough root cause analysis... Initiate actions to prevent further incidents..." Medical record review for Resident #47 documented an admission date of 10/4/13 with diagnoses of Open Reduction Internal Fixation for Right Hip Fracture, Senile Dementia, Atrial Fibrillation, Weakness, Hypertension, Reflux, Weight loss, Dysphagia, History of fall, Osteoarthrosis, Chronic Obstructive Pulmonary Disease, Depressive Disorder and Anxiety. Nurses notes documented the following: a. 10/11/13 - "...combative with adls [activities of daily living]..." b. 10/24/13 - "...combative with adls..." c. 11/22/13 - "...behaviors observed when waking... no further combativeness observed..." d. 11/24/13 - "[Named physician] contacted concerning swelling & [and] disalignment of left wrist, Hematoma observed, golf ball size... sons c[with] resident... and states I bet she hit is [it] on the cabinet beside her bed, it's on that side..." The care plan updated on 11/24/13 documented,	F 282		

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F 282	Continued From page 14 "pain @ L [left] wrist... keep wardrobe away from bed." The minimum data set (MDS) kardex care plan used by Certified Nursing Assistants (CNA's) updated on 11/24/13 documented, "...wardrobe cabinet pushed in corner not against bed." A physician's progress note dated 11/27/13 documented, "...Left distal radius fracture..." Nurse note date 12/30/13 documented, "LOA [leave of absence] to MD appt [appointment]... brace removed from Lt. [left] wrist." A change of condition documentation form dated 1/3/14 documented, "...found L wrist swollen recent splint removed from fx. [fracture] of that wrist.." Nurses note documented the following: a. 1/4/14 at 0515 - "...arm L where brace taken off recently swollen 2t [plus]..." b. 1/5/14 - "resident observed hitting bedside cabinet c [with] L arm this shift by multiple CNA's." c. 1/6/14 - "...son stated that he feels his Mother probably hit her arm on wardrobe when in bed, Furniture rearranged to distance wardrobe from bed vicinity." A radiology report of left wrist dated 1/3/14 documented, "...Fracture of distal ulnar shaft... Fracture of the radial styloid process..." Observations on 1/13/14 3:30 PM, revealed Resident #47 seated in wheelchair self propelling in hallway. Resident #19 had a cast on her left wrist and forearm. Observations in Resident #47's room on 1/15/14	F 282		

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at 7:30 AM, revealed Resident #47 in a wheelchair with a cast on left arm. The wardrobe was against the wall away from the bed.

During an interview in the conference room on 1/14/14 at 4:30 PM, Nurse #3 stated, "[Named Resident #47] does have behaviors, gets resistant with adl care, her son suggested she might have hit her arm on the wardrobe that was beside the bed and injured her arm... we did rearrange her furniture..."

During an interview in the conference room on 1/14/14 at 5:20 PM, the DON stated, "...she [Resident #47] has had 2 fractures, same wrist different areas..."

During an interview in the conference room on 1/14/14 at 5:30 PM, the Administrator stated, "After first fracture [11/24/13] we moved her wardrobe away from the bed to prevent her from hitting it. We neglected to inservice housekeeping and when they cleaned her room they moved it [wardrobe] back [not sure when]. We took care of that and inserviced them after the second fracture [1/3/14] happened. "

During an interview in the conference room on 1/15/14 at 9:20 AM, the DON stated, "...We did move the wardrobe right after the first fracture... it got moved back against the bed we think housekeeping did it during cleaning that is the normal area for those to be placed, we think it was moved back shortly after... we put the intervention on the CNA care plan card, we just did not think of housekeeping."

During an interview in the conference room on 1/15/14 at 9:50 AM, the DON was asked if staff

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F 282	Continued From page 16 should have recognized and addressed that the wardrobe had been moved back next to the bed. The DON stated, "Yes, I would expect staff to monitor and address it." The failure to consistently follow the care plan intervention to keep the wardrobe away from the resident's bed resulted in actual harm when Resident #47 sustained a second fracture to the left wrist.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on review of the "National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention QUICK REFERENCE GUIDE", policy review, medical record review, observation and interview, it was determined the facility failed to provide the necessary care to prevent the development of pressure sores, failed to provide timely treatment to promote the healing of pressure sores and/or failed to identify a pressure before it developed into a state III for 2 of 6 (Residents #19 and 63) sampled residents reviewed with a pressure sore. The failure of the	F 314		

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F 314	Continued From page 17 facility to follow a care plan intervention for pressure relief resulted in actual harm when Resident #19 developed an avoidable in house acquired pressure sore that worsened to a stage III with tunneling. The failure of the facility timely identify avoidable in house acquired pressure sores (stage III left heel and stage II penis) and failure to provide timely treatments resulted in actual harm to Resident #63. The findings included: 1. Review of the "National Pressure Ulcer Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "[page] 8 ...Category/Stage III: Fullthickness skin loss involving damageor necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia... deep crater with or without undermining of adjancent tissue... Stage II... Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation... [page] 12... 3. Inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals with darkly pigmented skin... [page] 13... 6. Observe the skin for pressure damage caused by medical devices... Many different types of medical devices have been reported as having caused pressure	F 314	314 Resident #63 has discharged from the facility. Director of Nursing and Assistant Director of Nursing completed a full body skin assessment on resident #19. No new pressure ulcers noted 1/20/14. Nurse management staff will complete skin audit of residents currently in the facility 1/24/14. Director of Nursing and Assistant Director of Nursing in-serviced licensed nursing staff regarding admissions process, body audits and skin assessments utilizing the skin integrity care delivery process 1/21/14. Licensed Nurses will complete skin assessment for each new admission/readmission and quarterly skin assessments on current residents on an on-going basis. Director of Nursing and Assistant Director of Nursing will in-service CNAs regarding skin care delivery process 1/24/14. Regional Nurse Practice Educator will in-service licensed nursing staff regarding Wound Basics 1/21 – 1/28/14.	

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F 314	Continued From page 18 damage... 7. Document all skin assessments, noting details of any pain possibly related to pressure damage..." 2. Review of the facility's wound care evaluation policy for pressure ulcers documented "...Check for pressure related to positioning, shoes, contractures, deformities, or medical devices... [such as catheters]..." Review of the facility's pressure ulcer prevention guideline policy documented, "Basic Prevention Interventions for all patients at risk...Avoid/limit skin to skin contact, friction, or shearing forces. May use pillows, heel, or elbow protectors to keep bony prominence's from rubbing...Position body with pillows and foam support devices...Utilize pressure redistributing surface. include cushion for chair/seating..." 3. Medical record review for Resident #19 documented an admission date 6/9/13 with diagnoses Alzheimer's Disease, Dementia with Behavior Disturbances, Edema, Rheumatoid Arthritis, Depressive Type Psychosis, Chronic Airway Obstruction, Chronic Ischemic Heart Disease, Cardiac Pacemaker, Depressive Disorder, Hypertension, Symbolic Dysfunction, Anxiety, Dementia, Muscle Weakness and Joint Pain. Review of the skin integrity reports documented the following: a. 8/14/13 - initial assessment of a new pressure wound on the left elbow as follows: "...pressure ulcer stage- UN [stageable], appearance-pink/red and slough, length- 2.0 centimeters [cm], width-2.0 cm, depth- ? [unable to determine], Tunneling-no, Drainage-Min [minimal] P	F 314	Director of Nursing and Assistant Director of Nursing will in-service licensed nurses and CNAs regarding catheter care and observe and document competencies via simulation with manikin 1/24/14. Director of Nursing and Interdisciplinary Team will review audit findings in morning stand up meetings and Director of Nursing/Designee will submit summary of audit findings to the Quality Performance Committee monthly times three months for review/recommendations.	2/11/14

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[purulent], and IHA [in house acquired].
b. 8/28/13 - wound has worsened and measures "length- 2.2 cm, width 1.5 cm, depth 0.1 cm"... with a note "^ [changed] classification to ST [skin tear] per DON [Director of Nursing]..."
c. 10/23/13 - wound is now "length-1.3 cm, width-1.2 cm, Depth 0.1cm with mod (moderate) drainage."
d. 12/10/13 - wound was reclassified as a pressure sore, inhouse acquired, and documented deteriorization as follows: "...Stage III, Pain-yes, appearance-tan > [greater than] 75% [percent], pink < [less than] 25%, length-1.0 cm, Width-1.0 cm, depth-0.4 cm, tunneling-1.2 cm @ [at] 12:00, drainage-min [minimal] S [serous].
e. 1/15/14 - continued deteriorization - stage III, appearance- pink, length-0.7 cm, width-0.4 cm, depth- 0.3 cm, tunneling- 1.5 cm @ 12:00, drainage- min S, Surrounding Tissue- IF [Inflamed/Indurated].

The care plan dated 8/14/13 and revised on 12/11/13 documented "Alteration in Skin Integrity r/t [related to]: wound to left elbow, as of 8/28/13 area classified as a skin tear Reclassified 12/10/13... Goals. Wound will decrease in size by next review. Wound will show no s/s [signs or symptoms] of infection... Interventions... offload pressure to left elbow via large stuffed bear, staff to encourage placement of stuffed bear in lap under left elbow, check to ensure placement as resident will remove... monitor daily for s/s of infection. report abnormalities to MD [Medical Doctor]..."

Observations of Resident #19 on 1/13/14 3:38 PM, revealed the resident sitting, in a wheelchair, at the nurses' desk, oxygen in place, yells at

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F 314	Continued From page 20 persons passing by and states "I'm scared", appears very anxious. There was no stuffed bear observed offloading pressure under her left elbow as care planned. Observations in Resident #19's room on 1/14/14 at 8:37 AM, revealed Resident #19 sitting in a wheelchair. There was no stuffed bear observed under her left elbow as care planned. Observations in Resident #19's room on 1/15/14 at 3:50 PM, revealed Resident #19 in bed, with no large stuffed bear present offloading the pressure to the left elbow as care planned. During an interview in the conference room on 1/16/14 at 12:01 PM, the Director of Nursing (DON) was asked about the pressure wound of the elbow. The DON stated, "...it was found on August 14, 2013. I assessed it and labeled it an unstageable pressure sore, later the DON at that time reclassified it as a skin tear. On assessment by the Assistant Director of Nursing (ADON) on 12/10/13 we changed it back to a pressure ulcer. We now have tunneling that was not there prior. We don't know what happened in between." The failure of the facility to follow a care plan intervention for pressure relief resulted in actual harm when Resident #19 developed an avoidable in house acquired pressure sore that worsened to a stage III with tunneling. 4. Medical record review for Resident #63 documented an admission date of 10/2/2013 with diagnoses Osteoarthrosis, Post Laminectomy, Spinal Stenosis in cervical region, Abnormality of Gait, Lack of Coordination and Muscle Weakness. Review of the "BRADEN SCALE- For	F 314		

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F 314	Continued From page 21 Predicting Pressure Sore Risk" revealed Resident #63 had a score of 17, which indicated the resident was a high risk for developing pressure sores. Admission physician order dated 10/2/13 documented, "Indwelling catheter 16 fr [french] with 10 cc (cubic centimeters) balloon to bedside drainage - Every Shift Everyday Indwelling catheter care every shift." Review of the skin integrity reports documented the following: a. 10/2/13 - initial report admitted with "stage 2 on entire buttocks." b. 10/18/13 - a new area on left heel staged as Deep Tissue Injury (DTI) that was intact and deep purple that measured (L) [length] 4.6 cm x [by] (W) [width] 4.5 cm. There was no documentation of treatment to this new wound until 10/23/13. Review of rehabilitation service therapy note dated 11/14/13 documented, "...continues to utilize catheter. He has wound on left heel and bottom. Penis has dressing..." Review of the "Change of Condition Documentation" dated 11/5/13 documented a new pressure ulcer, "...ulcerated area approx. 10cm to side of penis with yellowish/greenish drainage... CNA [Certified Nursing Assistant] reported ulcer to penis hidden under folds of skin c [with] yellowish/greenish drainage... Foley cath [catheter]..." There was no documentation of treatment to this new wound until 11/8/13. This was a three day delay of treatment. The resident was discharged from the facility on 11/15/13. During an interview in the DON's office on	F 314		

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F 314	Continued From page 22 1/15/14 at 1:49 PM, the DON was asked about the delay in treatments. The DON stated, "Can't tell you, it says treatment started on 11/8[2013], they probably were cleaning it with catheter care." The failure of the facility timely identify avoidable in house acquired pressure sores (stage III left heel and stage II penis) and failure to provide timely treatments resulted in actual harm to Resident #63.	F 314		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure care and treatment for behaviors was implemented for 2 of 30 (Residents #47 and 59) sampled residents included in the stage 2 review. The findings included: 1. Review of Evaluating the "Difficult" Behavior policy documented, "...The team evaluates the behaviors(s) and determines whether or not it rises to the level of being a "problem" requiring attention... Harmful behaviors are those that may violate the rights of others, psoe a threat to the resident or someone else, or make it significantly	F 319		

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F 319	Continued From page 23 difficult to provide care and typically include agitation and agression and other socially inappropriate actions... The team evaluates the cause(s) of behaviors to minimize drug use as much as possible and when necessary, use the least amount of medication to help manage the behavior. Examples: 1. Agitation: Vocal or motor activity that is excessive and inappropriate for the situation... repetitively banging a table... 2. Agression... hitting, kicking... A reaction may occur when a resident's need is not understood or met... 4. Sexual Behavior... Verbal and/or Physically Unwanted Sexual Advances Includes any unwanted verbal and or physical advances made toward other residents, associates, visitors... Monitor behavioral triggers to see if there are common themes to certain behaviors on all shifts, days, and with certain groups of staff... Planning & [and] Implementation... an individualized care plan is designed to accommodate and/or manage the resident's behavior... Nurses, nursing assistants, and the entire interdisciplinary team must ensure that planned interventions are carried out as written in the care plan... Understand the unmet needs which may drive the behavior." 2. Medical record review for Resident #47 documented an admission date of 10/4/13 with diagnoses of Open Reduction Internal Fixation for Right Hip Fracture, Senile Dementia, Atrial Fibrillation, Weakness, Hypertension, Reflux, Weight loss, Dysphagia, History of fall, Osteoarthrosis, Chronic Obstructive Pulmonary Disease, Depressive Disorder and Anxiety. The 14 day Minimum Data Set (MDS) dated 10/18/13 and the 90 day MDS dated 1/3/14 documented Resident #47 was severely impaired cognitively and displayed physical and verbal behaviors 1 to	F 319	319 Resident #59 has been discharged from the facility. Resident #47 was reviewed by psych services with no new orders 1/23/14. Activities Director assessed resident #47and update/revise resident's plan of care as indicated 1/23/14. Social Services Director will review MDS, Care Plans and psych consultations to ensure other resident behaviors are identified and addressed as indicated 1/31/14. Social Services Director will in-service staff regarding resident behaviors utilizing A Guide to Problem Behaviors 1/31/14. Changes in resident behaviors and treatments will be reviewed by the Social Services Director and Interdisciplinary team in morning stand up meeting and Social Services Director will submit a summary of findings to the Quality Improvement Committee monthly times three months for review/recommendations.	2/11/14

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F 319	Continued From page 24 (-) days a week. The care plan updated on 12/9/13 did not address agitation and aggressive behaviors exhibited during activity of daily living care provided. Nurses notes documented the following: a. 10/11/13 - "...combative with adls [activity of daily living]..." b. 10/24/13 - "...combative with adls..." c. 11/22/13 - "...behaviors observed when waking... no further combativeness observed..." d. 1/5/14 - "resident observed hitting bedside cabinet c [with] L [left] arm this shift by multiple CNA's [certified nursing assistant]." e. 1/10/14 - "...resident observed swinging casted L arm @ [at] [named] CNA when waking @ shift start..." Observations in the 300 hall on 1/13/14 3:30 PM, revealed Resident #47 self propelling herself in a wheelchair. The resident was noted to be thin and frail, cast on the left arm and dark blue-purple bruising on right upper orbital and right cheek bone area. Observations in Resident #47's room on 1/15/14 at 7:30 AM, revealed Resident #47 seated in a wheelchair, with a frown on her face. There were 2 CNA's in the room making the bed and gathering the linens. CNA #1 was observed to pick up the hairbrush and started brushing the resident's hair (from behind). Resident #47 frowned and grabbed at the brush. CNA #1 continued brushing and did not explain what she was going to do before starting the task. During an interview in the conference room on 1/13/14 at 4:00 PM, Nurse #3 stated, "She [Resident #47] does swing at the staff with adl	F 319		

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F 319	Continued From page 25 care." During an interview at the nurses' station on 1/14/14 at 4:00 PM, Nurse #1 stated, "She does get combative with adl care." During an interview in the conference room on 1/14/14 at 4:30 PM, Nurse #3 stated, "[Named Resident #47] does have behaviors, gets resistant with adl care.." During an interview in the conference room on 1/14/14 at 5:00 PM, Nurse #2 stated, "[Named Resident #47] is resistant with adls at times. We have inserviced the staff to approach her and make sure she is awake and explain to her. You cannot just go in and start with her. We also have a 15 to 30 minute calm down time with her, wait 15 to 30 minutes and then reapproach her. She usually will forget what she was upset about and you can complete the care. We also have 2 CNA's do her care." During an interview in Resident #47's room on 1/15/14 at 7:30 AM, CNA #1 stated, "We talk with her, make sure she is awake..." During an interview in the conference room on 1/15/14 at 8:30 AM, Nurse #3 stated, "Combative with care should be on the care plan... but we make sure she is awake, approach calm, explain things, tell the charge nurse and reapproach her..." During an interview in the conference room on 1/15/14 at 9:20 AM, the DON stated, "I would expect behaviors to be care planned..." 3. Medical record review for Resident #59	F 319		

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F 319	Continued From page 26 documented an admission date of 9/3/13 with diagnoses of Dementia with Behavioral Disturbance, Hypertension, Esophagus Disorder, Chronic Obstructive Asthma, Abnormal Gait, Weakness and Rehab. Nurses notes documented the following: a. 9/3/13 - "CNA [Certified Nursing Assistant] reported that res [resident] became sexually inappropriate while giving shower grabbing her breast and made verbal insinuations to her..." b. 9/9/13 - "Inappropriate sexual behavior noted per staff... aggressive behavior noted... Required one on one monitoring per staff d/t [due to] inappropriate behavior toward female res." c. 9/10/13 - "...while resdt [resident] in therapy resdt verbalized desire to have sexual relations c [with] therapy staff member..." The facility was unable to provide a care plan that addressed the sexual behaviors. During an interview in the conference room on 1/15/14 at 5:25 PM, the Director of Nursing stated, "...as you can tell by the following notes we made arrangements for him to transfer to the hospital."	F 319		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure a resident's environment remain free of accident hazards when the staff failed to consistently implement the intervention to keep the wardrobe away from the resident's bed for 1 of 4 (Resident #47) sampled residents with accidents of the 30 sampled residents included in the stage 2 review. The failure to ensure the wardrobe was placed away from the resident's bed after being determined the probable cause of the resident's first fractured left wrist resulted in actual harm when Resident #47 sustained a second fracture to the left wrist. The findings included: Review of Accidents, Incidents, and Adverse Events policy documented: "All accidents, incidents or adverse events occurring on... premises should be reported, reviewed, and, if indicated, investigated without fear of reprisal... An adverse event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof... Purpose To provide a safe and healthful environment for patients... To define causative / contributing factors and institute preventive measures to avoid further occurrences... Adverse events require the completion of a thorough root cause analysis... Initiate actions to prevent further incidents..." Medical record review for Resident #47 documented an admission date of 10/4/13 with diagnoses of Open Reduction Internal Fixation for Right Hip Fracture, Senile Dementia, Atrial Fibrillation, Weakness, Hypertension, Reflux,	F 323	323 Maintenance Director and Social Services Director assessed room of resident #47 for accident hazards 1/15/14. Wardrobe removed from resident #47's room 1/15/14. Regional Vice President, Maintenance Director and Administrator viewed resident rooms and common areas of the facility to identify possible accident hazards. None noted 1/16/14. Nursing staff in-serviced by the Director of Nursing and the Assistant Director of Nursing regarding following resident care plans for supervision to prevent accidents 1/24/14. Administrator and Department Managers will monitor resident rooms and common areas for accident hazards and observe staff supervision of residents seven days per week for two weeks then three times per week on-going. Maintenance Director will submit a summary of findings to the Quality Improvement Committee monthly for review/recommendations.	2/11/14

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F 323	Continued From page 28 Weight loss, Dysphagia, History of fall, Osteoarthrosis, Chronic Obstructive Pulmonary Disease, Depressive Disorder and Anxiety. Nurses notes documented the following: a. 10/11/13 - "...combative with adls [activities of daily living]..." b. 10/24/13 - "...combative with adls..." c. 11/22/13 - "...behaviors observed when waking... no further combativeness observed..." d. 11/24/13 - "[Named physician] contacted concerning swelling & [and] disalignment of left wrist, Hematoma observed, golf ball size... sons c[with] resident... and states I bet she hit is [it] on the cabinet beside her bed, it's on that side..." The care plan updated on 11/24/13 documented, "pain @ [at] L [left] wrist... keep wardrobe away from bed." The minimum data set (MDS) kardex care plan used by Certified Nursing Assistants (CNA's) updated on 11/24/13 documented, "...wardrobe cabinet pushed in corner not against bed." A physician's progress note dated 11/27/13 documented, "...Left distal radius fracture..." Nurse note date 12/30/13 documented, "LOA [leave of absence] to MD appt [appointment]... brace removed from Lt. [left] wrist." A change of condition documentation form dated 1/3/14 documented, "...found L wrist swollen recent splint removed from fx. [fracture] of that wrist.." Nurses note documented the following: a. 1/4/14 at 0515 - "...arm L where brace taken off recently swollen 2t [plus]..."	F 323		

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F 323	Continued From page 29 b. 1/5/14 - "resident observed hitting bedside cabinet c [with] L arm this shift by multiple CNA's." c. 1/6/14 - "...son stated that he feels his Mother probably hit her arm on wardrobe when in bed, Furniture rearranged to distance wardrobe from bed vicinity." A radiology report of left wrist dated 1/3/14 documented, "...Fracture of distal ulnar shaft... Fracture of the radial styloid process..." Observations on 1/13/14 3:30 PM, revealed Resident #47 seated in wheelchair self propelling in hallway. Resident #19 had a cast on her left wrist and forearm. Observations in Resident #47's room on 1/15/14 at 7:30 AM, revealed Resident #47 in a wheelchair with a cast on left arm. The wardrobe was against the wall away from the bed. During an interview in the conference room on 1/14/14 at 4:30 PM, Nurse #3 stated, "[Named Resident #47] does have behaviors, gets resistant with adl care, her son suggested she might have hit her arm on the wardrobe that was beside the bed and injured her arm... we did rearrange her furniture..." During an interview in the conference room on 1/14/14 at 5:20 PM, the DON stated, "...she [Resident #47] has had 2 fractures, same wrist different areas..." During an interview in the conference room on 1/14/14 at 5:30 PM, the Administrator stated, "After first fracture [11/24/13] we moved her wardrobe away from the bed to prevent her from	F 323		

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F 323	Continued From page 30 hitting it. We neglected to inservice housekeeping and when they cleaned her room they moved it [wardrobe] back [not sure when]. We took care of that and inserviced them after the second fracture [1/3/14] happened. " During an interview in the conference room on 1/15/14 at 9:20 AM, the DON stated, "...We did move the wardrobe right after the first fracture... it got moved back against the bed we think housekeeping did it during cleaning that is the normal area for those to be placed, we think it was moved back shortly after... we put the intervention on the CNA care plan card, we just did not think of housekeeping." During an interview in the conference room on 1/15/14 at 9:50 AM, the DON was asked if staff should have recognized and addressed that the wardrobe had been moved back next to the bed. The DON stated, "Yes, I would expect staff to monitor and address it." The failure to consistently follow the care plan intervention to keep the wardrobe away from the resident's bed resulted in actual harm when Resident #47 sustained a second fracture to the left wrist.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		

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F 441	Continued From page 31 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the federal regulations interpretative guidelines standard precautions, medical record review, observation and interview, it was determined the facility failed to ensure an infection control program that prevents, recognizes and controls to the extent possible the onset and spread of infection within	F 441	441 Director of Nursing and Assistant Director of Nursing assessed resident #19 for negative outcome related to the observed dressing change. None noted 1/20/14. Current residents with orders for dressing change assessed by Director of Nursing and Assistant Director of Nursing for negative outcomes related to dressing change. None noted 1/21/14. Assistant Director of Nursing in-serviced by Regional Nurse Practice Educator regarding dressing change procedures on 1/24/14. Regional Nurse Practice Educator will in-service licensed nursing staff regarding Wound Basics 1/22 – 1/28/14. Director of Nursing/Designee will complete competency review with all licensed nursing staff by 2/6/14. Director of Nursing/Designee will submit a summary of results to the Quality Improvement Committee monthly times three months for review/recommendations	2/11/14

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F 441	Continued From page 32 the facility for 1 of 6 (Resident #19) sampled residents reviewed with pressure sores included in the stage 2 review. The findings included: Review of facility's Dressing: Aseptic policy documented, "...All wound care...performed using aseptic (medical asepsis) technique... Purpose To decrease the risk of wound contamination and cross contamination during dressing changes. Procedure... Individual resident supplies may be placed on the bedside table which has been disinfected and has a protective barrier... Cleanse your hands. Open dressings to be used without touching the dressing/gauze. Keep the dressing/gauze within the open packet and place it directly on top of the barrier... set appropriate supplies onto the barrier. Do not contaminate supplies or devices in any way... Do not touch the dressing in any way... Apply clean gloves and remove the soiled dressing. Place the dressing and gloves into a plastic bag. Cleanse your hands. apply clean gloves. Cleanse or irrigate wound... Apply treatment medication as ordered using a cotton tipped applicator... onto which the medication has been applied. Apply clean dressing, touching only the edges of the dressing. Secure the dressing. Remove gloves and place them in a plastic bag. Cleanse your hands... Discard supplies according to infection control policy..." Review of facility's waste management policy documented, "The Center's waste disposal system includes separate methods for handling regulated and non-regulated waste. These different types of waste are segregated... Regulated waste is also referred to as infective,	F 441		

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F 441	Continued From page 33 infectious, or medical waste... The Occupational Safety and Health Administration (OSHA) defines regulated waste as: Any liquid or semi-liquid blood or other potentially infectious material; Contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid stat if compressed... Process Maintain appropriate regulated waste container... Labeled with biohazard symbol or color coded in red..." Review of the federal regulation 483.65 (F441) infection control interpretive guidelines standard precautions documented the following: "Standard precautions are based upon the principle that all blood, body fluids, secretions, excretions... non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions are intended to be applied to the care of all persons in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of standard precautions constitutes the primary strategy for preventing healthcare-associated transmission of infectious agents among residents and healthcare personnel. Appropriate infection control measures should be used in each resident interaction. Standard precautions include but are not limited to hand hygiene, safe injection practices, the proper use of... gloves... care of the environment... Also, equipment or items in the resident environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents, (...wear gloves for handling soiled equipment... In addition to proper hand hygiene, it is important for staff to use appropriate protective equipment as a barrier to exposure to any body fluids (whether known to be infected or	F 441		

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F 441	Continued From page 34 not)... Standard precautions are also intended to protect residents by ensuring that healthcare personnel do not carry infectious agents to residents on their hands or via equipment used during resident care Disposal of waste is also handled as though all body fluids are infectious. Potentially contaminated articles are stored and disposed of in appropriate containers (...biohazard bags...)" Medical record review for Resident #19 documented an admission date 6/9/13 with diagnoses Alzheimer's Disease, Dementia with Behavior Disturbances, Edema, Rheumatoid Arthritis, Depressive Type Psychosis, Chronic Airway Obstruction, Chronic Ischemic Heart Disease, Cardiac Pacemaker, Depressive Disorder, Hypertension, Symbolic Dysfunction, Anxiety, Dementia, Muscle Weakness and Joint Pain. The skin integrity report dated 1/15/14 documented continued deteriorization as follows: stage III, appearance- pink, length-0.7 cm [centimeter], width-0.4 cm, depth-0.3 cm, tunneling- 1.5 cm @ [at] 12:00, drainage- min [minimal] S [serous], Surrounding Tissue- IF [Inflamed / Indurated]. The care plan dated 8/14/13 and revised on 12/11/13 documented, "...Observe standard precautions..." Observations of a dressing change in Resident #19's room on 1/15/14 at 3:50 PM, the Assistant Director of Nursing (ADON) gathered supplies and entered the room. The ADON laid a folded drape on the bed and laid gauze/pad, scissors, trash bag, gloves, qtips and alcohol pads on the folded drape. The ADON laid the treatment administration record (TAR) on the foot of the bed. She washed her hands and then moved all items from the barrier on the bed to the table top	F 441		

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F 441	Continued From page 35 and laid them on a barrier. She spread another barrier on the bed and laid the trash bag on it and then moved all the items back on the barrier on the bed from the table top. She donned gloves, removed the old dressing from the elbow that included gel packing from the tunneling, removed gloves and washed her hands. The ADON then opened the gauze sponges, omnifoam, cleaned her scissors with alcohol pad picked up and dated the omnifoam (contaminating her hands when she picked up the dirty scissors to clean them and picking up a marker used to date the dressing.) She donned new gloves, without washing her hands after handling the contaminated scissors and marker. She then soaked gauzes with normal saline, cleaned the wound center out in circles, dried the wound, measured the wound length-0.7 cm, width-0.4 cm, depth-0.3 cm, used a Qtip wooden end to measure the tunneling at 12 o'clock at 1.5 cm. She failed to wash her hands and change her gloves after cleaning the wound. She soaked a gauze with normal saline and placed it on the wound. She then placed hydrogel gauze on the wooden tip of the Qtip and packed into the tunneling area, laid the contaminated Qtip on the clean barrier, opened the omnifoam and placed it over the left elbow. The ADON then folded the barrier on the bed and table top and put them in the trash bag. She removed her gloves, cleaned the scissors with alcohol, gathered the trash bag, laid the TAR on the treatment cart, put scissors and marker on treatment cart, washed hands and cleaned the scissors with alcohol again. She placed the trash bag into the trash container on the treatment cart and took it to the soiled utility room and placed it into a gray trash barrel. She did not place the bag in a biohazard bag.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445308	A. BUILDING _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRENTON CENTER	2036 HIGHWAY 45 BYPASS TRENTON, TN 38382

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36 During an interview in the conference room on 1/16/14 at 10:50 AM, the Assistant Director of Nursing (ADON) was asked about skin/wound infection trends on the infection control log and the cross contamination during the dressing change. The ADON stated, "...seems to be infections with the skin... redness and warmth... signs of infection... a lot of it was prophylactic for some wounds... increased redness or drainage... we would call and try to get an antibiotic for them... I don't think I had to change gloves then... will check the policy... we don't have red bags... I couldn't remember if I put it in the gray container or the red..." The ADON checked the policy and stated she "didn't have to change gloves after cleansing the wound according to the policy." The ADON was asked if there was potential for her gloves and hands to be contaminated with matter from the wound after cleansing the wound. The ADON stated, "...there is potential but there wasn't any drainage..." The facility staff failed to follow the care plan for standard precautions during wound care and failed to discard the soiled dressing and used cleaning/dressing supplies into a biohazard container per policy.	F 441		