STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365348	A. BUILDING _____ B. WING _____	05/05/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBORS AT GALLIPOLIS	170 PINECREST DRIVE GALLIPOLIS, OH 45631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure incidents of resident to resident altercations were reported to the State agency as potential allegations of abuse. This affected three residents (Resident #107, Resident #104 and Resident #132) of five residents reviewed who were involved in potential situations of physical abuse. Findings include: 1. Review of Resident #121's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #107's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #104's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. An observation of Resident #121 on 04/30/14 at 11:01 A.M. revealed the resident had wandered into the nurse's station. When State tested nursing assistant (STNA) #8 approached and tried to assist the resident from the station, Resident #121 slapped the STNA's hand and then proceeded to follow the STNA from the station. Further review of Resident #121's medical record revealed a progress noted dated 01/30/14 at 5:30 P.M. stating the resident's toe had been run over by another resident's wheelchair and Resident #121 had placed her hand over that resident's face and pushed. Documents provided by regional nurse (RgN)#9 on 04/30/14 revealed the resident in the wheelchair was Resident #107. The Witness Investigation Statement dated 01/30/14 indicated activities assistant (AA) #10 had witnessed the event. The AA indicated in the statement Resident #121 had pushed Resident #107's face forcefully. When the resident was being assisted away from the area she continued to then push the staff member. A hand written document dated 01/30/14 and signed 01/31/14 by the director of nursing (DON) indicated an investigation into the incident by the facility was completed with no injuries noted to either Resident #121 or Resident #107. Additionally, a progress note dated 01/31/14 revealed a social services entry which indicated Resident#121 was involved in an altercation, separated immediately and continued wandering the unit. Additional review of Resident #121's clinical record revealed a progress note dated 04/01/14 at 3:30 P.M. indicating that several residents had reported Resident #121 had struck another resident in the face. No investigative materials were provided by the facility regarding this accusation. On 04/11/14 at 5:30 P.M. a progress note in Resident #121's chart indicated the resident hit another resident in the face three times during an altercation. Investigative material dated 04/14/14 and signed by the DON showed the resident who was hit by Resident #121 was Resident #104. The DON documented no injury. A social services note dated 04/14/14 stated neither party could recall the altercation upon interview. A review of the facility Self-Reported Incidents (SRI's) for the last week of January 2014 and the first week of February 2014 revealed no reports of resident to resident altercations or resident to resident abuse. In an interview at 12:11 P.M. on 05/01/14 the DON verified no SRI's had been submitted by the facility for the altercation between Resident #121 and Resident #107. A review of the SRI's for the first two weeks of April 2014 revealed no reports of resident to resident altercations or physical abuse. In the same interview of 05/01/14 the DON verified no SRI's had been submitted by the facility regarding the allegation. And additionally, that no SRI's had been submitted regarding the event between Resident #121 and Resident #104. A review of the facility policy and procedure for Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property dated October 1999, revised April 2012; April 2013, provided by RgN#9 on 04/30/14, revealed the definition of physical abuse included hitting, slapping, and holding roughly. Further, the policy stated that all allegations that met the definition of abuse were to be reported to state agencies. 2. Resident #60 was admitted on [DATE] with the [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment, dated 02/20/14 revealed the resident was cognitively intact. On 04/28/14 at 10:36 A.M. an interview with Resident #60 revealed she felt like someone was being abused or mistreated. She stated she had filled out a form with this information and gave it to the director of nursing (DON), but thought the DON had thrown it out. Resident #60 stated she had been in the hallway assisting Resident #132 when a State tested nursing assistant (STNA) came up on the other side of Resident #132 and then another STNA came up and got on the side she had been on. She stated when the second aide had came up to the resident she had grabbed her by the arm, pulled her down the hall and drug her. She stated she did not know the name of the STNA walking her. Resident #60 did identify the resident being pulled down the hall as Resident #132. She again stated she had filed a complaint of what she observed. Review of a resident concern report form dated 04/10/14 revealed Resident #60 had stated to Speech Therapist (ST) #17 she felt like Resident #132 was being dragged around. The investigation report signed by the DON indicated Resident #132 required encouragement and coaching to allow staff to provide care. The form indicated the DON had observed the staff interacting with Resident #132 and never seen anything inappropriate. The form stated it instructed Resident #60 to notify the nurse immediately if she felt Resident #132 was being dragged around. The disposition of the form signed by the administrator and dated 04/10/14 revealed no further concerns noted and resident pleased with outcome. On 04/30/14 at 3:49 P.M. interview with the DON revealed Resident #60 had reported a concern related to an observed interaction between staff and Resident #132. The DON revealed this concern was not reported to the State agency as a potential allegation of abuse. Review of the facility's abuse policy dated 2013 revealed all alleged violations and all substantiated incidents were to be reported to the State agency. Under the section of investigation the policy was void related to how to or what to do to complete the investigation.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to promote a dignified dining experience for Resident #101 by failing to remove the resident's physical restraint during supervised meals. This affected one resident (Resident #101) of one resident reviewed for restraints. Findings Include: Review of Resident #101's medical record revealed the most current re-admitted was 03/04/14. The resident had [DIAGNOSES REDACTED]. Review of Resident #101's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status score of three which reflected severe cognitive impairment. Further review of the MDS revealed Resident #101 utilized a trunk restraint daily. Review of Resident #101's physician's orders [REDACTED]. The order indicated to release every two hours for ten minutes. Check lap tray every 30 minutes. Release the lap tray for meal times, activities of daily living, one on one,

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

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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F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) bathing and toileting. Review of Resident #101's safety device data collection form dated 03/19/14 revealed Resident #101 utilized the Broda wheelchair with a lap tray to promote optimal positioning, alignment and comfort when up in the wheelchair. Further review of the safety data collection revealed the lap tray was to be removed while at meals, with staff assisted ambulation, during visitor and/or family visits, with small group activities, during activities of daily living, while in therapy and with social services one on one. The safety device data collection was reviewed on 04/08/14 for the quarter with no recommended changes. On 04/28/14 at 11:52 A.M. Resident #101 was observed during the lunch meal. During the meal, the resident's lap tray was not removed. The lap tray was observed to remain in place during the entire meal. On 04/28/14 at 12:40 P.M. interview with State tested nursing assistant (STNA) #13 verified the lap tray to Resident #101's wheelchair was not removed during the entire lunch meal.
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to honor Resident #60's preferences including likes and dislikes for meals. This affected one resident (Resident #60) of three reviewed for choices. Findings include: Resident #60 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment, dated 02/20/14 revealed the resident was cognitively intact. Review of the the undated food preference record signed by dietary manager #15, revealed the resident wanted coffee for breakfast and disliked liver, broccoli, brussel sprouts, spinach/greens, cottage cheese, yogurt and rice. On 04/30/14 at 12:49 P.M. an observation was made of the meal tray being delivered to Resident #60. Observed on the tray were greens. Review of the tray card revealed no written preferences or likes or dislikes. On 04/30/14 at 12:51 P.M. interview with Resident #60 revealed she did not like spinach or greens. On 04/30/14 at 12:55 P.M. interview with dietary manager #15 verified the tray card had no likes or dislikes written on it. On 04/30/14 at 12:54 P.M. interview with State tested nursing assistant (STNA) #16 revealed the residents never get what they want on their trays. On 04/30/14 at 3:46 P.M. interview with dietary manager #15 revealed the residents likes and dislikes were no longer in the computer for any resident because the facility had recently switched programs. The dietary manager #15 stated he would be putting them in on everyone individually. He verified the meal tray cards did not have the residents, including Resident #60's identified likes and dislikes on any meal tray card and he planned on getting the information from the chart and re-entering it into the computer.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observation, record review and interview the facility failed to ensure hot water temperatures were maintained at a comfortable (hot enough) temperatures for residents. This affected ten of 26 resident rooms observed on the second floor, Resident room 202, 204, 205, 206, 209, 210, 216, 219, 223, and 220. Findings include: Observation of hot water temperatures in the sinks in resident rooms on the second floor revealed the following temperatures: Room 202: On 04/28/14 at 10:16 A.M. was 92 degrees Fahrenheit (F) after running for three minutes. Room 204: On 04/28/14 at 10:21 A.M. was 94 degrees F; on 04/30/14 at 9:36 A.M. was 90 degrees F after running for three minutes. Room 209: On 04/28/14 at 10:27 A.M. was 96 degrees F after running for three minutes; on 04/29/14 at 7:33 A.M. was 88 degrees F after running for three minutes. Room 206: On 04/28/14 at 10:48 A.M. 98 degrees F. Room 210: On 04/28/14 at 11:13 A.M. 96 degrees F. Room 219: On 04/28/14 at 11:25 A.M. 98 degrees F. Room 205: On 04/28/14 at 12:35 P.M. 96 degrees F. Room 216: On 04/28/14 at 12:45 P.M. 100 degrees F. Room 220: On 04/29/14 at 7:36 A.M. 94 degrees F after running for three minutes. Room 223: On 04/29/14 at 11:10 A.M. 96 degrees F after running for three minutes. On 04/30/14 at 10:15 A.M. in Room 209 the surveyor measured the hot water temperature, which was noted to be 98 degrees F. Maintenance Director #1 used a laser type thermometer and got 102 degrees F at the same sink. (The surveyor thermometer was calibrated on 04/30/14). Interview with Maintenance Director #1 on 04/30/14 at 10:00 A.M. revealed the hot water temperatures were checked every day between 8:00 A.M. and 9:00 A.M. in one resident room using the laser type thermometer. He stated the laser type thermometer could not be calibrated. He stated he had been noticing the hot water temperatures on the second floor had been lower than those on third floor. Review of the facility water temperature log from 03/29/14 through 04/25/14 revealed the hot water temperatures were documented between 107-110 degrees when checked by the facility. Confidential interviews with six residents between 04/28/14 to 04/29/14 (four residing on the second floor and two residing on the third floor) revealed the hot water was not hot enough.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to develop comprehensive care plans in the areas of physical restraints, falls, urinary incontinence and pressure ulcers. This affected four residents (Resident #17,#100, #101 and #135) of 21 residents reviewed for care planning. Findings include: 1. Resident #135 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident did not have any pressure ulcers upon admission and was assessed as being at minimal risk for the development of pressure ulcers. The resident had a hospital stay from 04/08/14 through 04/12/14 [MEDICAL CONDITION], altered mental status, and [MEDICAL CONDITION] of the gastrostomy tube site. Review of hospital notes revealed a wound care note on 04/09/14 which stated that Resident #135 had a less than one centimeter suspected deep tissue injury on the right lateral ankle, a less than one centimeter suspected deep tissue injury on the right lateral foot, and a six by seven centimeter suspected deep tissue injury, which was purple with no breakdown, on the left heel. A hospital wound care note on 04/11/14 stated Resident #135 now had a suspected deep tissue injury to the right upper buttocks to coccyx. It was noted there was a tear in the center of the pressure ulcer that had scant serous drainage. Around the wound the skin was purple/red. The resident was readmitted to the facility 04/12/14. Review of an admission skin assessment on 04/12/14 revealed the resident had an eight by 20 centimeter blister on the left heel, a 0.5 by 4.0 by 0.25 centimeter deep Stage II ulcer on the right buttock, and 0.5 centimeter slit on the right outer ankle. Review of skin grids revealed on 04/12/14 the resident was noted to have an eight by 20 centimeter intact, dark purple/black blister that was described as a Stage I pressure ulcer. On 04/15/14 the skin grid indicated that the pressure ulcer on the left heel was a suspected deep tissue injury measuring 6.4 by 13.2 centimeters. On 04/27/14 the skin grid indicated that the pressure ulcer on the left heel was a Stage II area measuring 5 by 7 centimeters. No depth was listed. (The definition of a Stage II pressure ulcer included on the skin grid was a 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 blister.) A second skin grid indicated that on 04/12/14 the resident was readmitted with a Stage II pressure ulcer on the right buttock measuring 4 by 0.5 centimeters and was 0.25 centimeters deep. On 04/28/14 the resident was noted with a 4.5 by 5 centimeter Stage II pressure ulcer on the right buttock that was 0.1 centimeters deep. On 04/12/14 physician's orders [REDACTED]. Observation on 04/30/14 at 2:50 P.M. of Resident #135's skin revealed a Stage II pressure ulcer on the right outer ankle measuring 1.8 by 1.4 centimeters. The area was open on one end and was surrounded by a five centimeter diameter red area. Registered Nurse (RN) #2 confirmed the area was a Stage II pressure ulcer at the time of the observation. (Even though a treatment was being provided to this area, there were no skin grids or documentation regarding a size or description of this area after readmission on 04/12/14). The resident was observed to have a Stage II pressure ulcer on the right buttock measuring 2.8 by 2.6 centimeters. The open area was superficial. The open area had a red center and was surrounded by a thin white section which was surrounded by a red open area. (The physician's orders [REDACTED]. However, the open area was on the right buttock and not the left buttock. This was confirmed by RN #2 at the time of the observation). The resident was observed to have a 6.8 cm by 10.6 (cm) centimeter dry blister with a 4 by 5.3 centimeter section of black eschar in the center on the left heel. (The skin grid on 04/27/14 did not indicate any eschar and stated the area was a Stage II pressure ulcer). The resident was observed to have a 2 cm by 1.8 centimeter purple blister area on the right mid outer foot. RN #2 stated this was a suspected deep tissue injury at the time of the observation. There was no evidence that this area had been identified by the facility prior to the treatment observation. Observations on 04/30/14 at 3:30 P.M. revealed staff to leave the

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) resident's room after finishing the treatments. Resident #135 was observed to be in bed on his right side. The resident had a wedge cushion under his legs but his heels were still touching the mattress on the bed. Review of the plan of care revealed a skin integrity prevention and treatment care plan dated 02/28/14 and revised 03/10/14 and 04/17/14. The plan of care stated the resident was at minimal risk of developing a pressure ulcer per the Braden Risk assessment score and the goal was for the resident to remain free of open areas. The plan of care did not indicate that the resident had pressure ulcers on the right outer ankle, right buttock, left heel, or right mid outer foot. The plan of care did not include a turning and repositioning program, did not include the use of the alternating air mattress, and did not address relieving pressure from the heels. Interview with the director of nursing (DON) on 05/01/14 at 8:45 A.M. revealed she had not seen Resident #135's pressure ulcers. She confirmed the plan of care did not address the resident had pressure ulcers on the right outer ankle, right buttock, left heel, or right mid outer foot. She confirmed the plan of care did not address how often the resident was to be turned or how to relieve pressure on the heels. She confirmed that the facility policy did not address what specific interventions were to be put in place for pressure reduction. 2. Resident #100 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident was occasionally incontinent of bladder (less than seven episodes of incontinence). A quarterly MDS completed on 02/01/14 revealed the resident was now frequently incontinent of bladder (seven or more episodes of urinary incontinence). An assessment of incontinence was completed on 02/05/14 and the resident was placed on an every two hour toileting schedule. Review of the resident's current plan of care revealed it did not include the every two hour toileting schedule. Interview with Registered Nurse #14 on 05/01/14 at 2:15 P.M. confirmed the plan of care was silent to the toileting schedule for Resident #100. 3. Review of Resident #101's medical record revealed the resident was re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status score of three which reflected the resident was severely cognitively impairment. Further review of the MDS revealed Resident #101 utilized a trunk restraint daily. Review of Resident #101's physician's orders [REDACTED]. The order indicated to release every two hours for ten minutes. Check lap tray every 30 minutes. Release the lap tray for meal times, activities of daily living, one on one, bathing and toileting. Review of Resident #101's safety device data collection dated 03/19/14 revealed Resident #101 utilized the Broda wheelchair with a lap tray to promote optimal positioning, alignment and comfort when up in the wheelchair. Further review of the safety data collection revealed the lap tray was to be reduced while at meals, with staff assisted ambulation, during visitor and or family visits, with small group activities. during activities of daily living, while in therapy and with social services one on one. The safety device data collection was reviewed on 04/08/14 for the quarter with no recommended changes. Review of Resident #101's physical restraint and or enabler plan of care implemented 03/19/14 with target date of 07/08/14 revealed the plan of care contained no interventions for the reduction and release of the lap tray. On 04/30/14 at 3:45 P.M. interview with Registered Nurse (RN) #11 verified the physical restraint and or enabler plan of care did not contain interventions for the reduction and release of the lap tray. 4. Review of Resident #17's medical record revealed a physician order, dated 04/05/14 for every fifteen minute checks for 24 hours, neurological checks for 72 hours, and a dycem above and below wheelchair cushion and to check every shift for placement. Review of an incident dated 04/24/14 for Resident #17 revealed the resident was found on the floor bedside bed. A fall investigation revealed all previously ordered fall interventions were in place as ordered at the time of the fall. Neurological checks and fifteen minute checks were initiated per facility protocol. The incident revealed to continue current interventions to prevent injuries from future falls. Review of a nursing information sheet, pocket care plan dated 04/28/14 used by the State tested nursing assistants (STNA's) to provide care revealed the resident was a one person assist with wheelchair transfers. The resident was to have a perimeter mattress top, quarter assist bars times two and the use of the hoyer lift for mobility and transfers, the resident was to have a low bed, with mats to floor, anti-roll back rear, anti-tippers to wheelchair with a sensor alarm to the wheelchair. Gripper socks were to be used and the resident was not to be left alone in the bedroom when up in wheelchair. The resident was to be put to bed thirty minutes after meals. It was noted the resident was confused at times, can be combative with care and hard to redirect at times. The dycem was not listed on the pocket plan. Review of the fall/injury assessment care plan revealed the dycem to upper and lower cushion was not noted on the resident's plan of care. On 04/30/14 at 11:36 A.M. an observation was made of Resident #17 being transferred with one staff members assistance in the bathroom. The resident's wheelchair was observed and there was a dycem observed on top of the sensor pad. There was no dycem under the cushion in the wheelchair. On 04/30/14 at 11:41 A.M. interview with registered nurse (RN) #11 revealed the dycem was supposed to be on top and on the bottom of the cushion in the wheelchair. The RN verified during observation there was no dycem placed on the bottom of the cushion there was one on top of pad sensor which was on top of the cushion. Review of fall investigation policy and procedure revised on 11/13 revealed to communicate interventions during shift report and daily clinical rounds to the care giving team. The care plan should be revised annually, quarterly, and with change of condition. On 05/01/14 at 7:40 A.M. interview with RN #11 verified the dycem to the lower and upper wheelchair cushion was not on the STNA pocket care plan nor the fall /injury assessment care plan.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure Resident #23, who was dependent on staff for incontinence care, received timely and adequate incontinence care as per the resident's assessed needs. The facility also failed to ensure Resident #92 received adequate nail care. This affected two residents (Resident #23 and #92) of 11 reviewed for activities of daily living. Findings include: 1. Review of Resident #23's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #23's bladder data collection and assessment form dated 01/07/14 revealed the resident was frequently incontinent and was on an every two hour check and change schedule. The quarterly nursing data collection and assessment form dated 02/25/14 also revealed Resident #23 was assessed as incontinent. Review of the resident's physician orders [REDACTED]. Resident #23 was observed on 04/30/14 from 9:47 A.M. until 12:15 P.M. sitting in the same chair in the dining room area. At no time was the resident observed to be toileted or checked for incontinence by staff. At 12:15 P.M. State tested nursing assistant (STNA) #12 provided the resident with her lunch tray in the same chair the resident had been in since 9:47 A.M. without first assisting the resident with toileting or checking for incontinence. When asked if the STNA had toileted the resident that morning the STNA stated no, the resident was not on her assignment. On 04/30/14 at 12:15 P.M. interview with STNA #5 revealed he had not checked or changed Resident #23, he thought another STNA, STNA #13 had changed the resident. Interview with STNA #13 on 04/30/14 at 12:30 P.M. revealed she had not checked or changed Resident #23 that morning either. Review of the bowel and bladder detail report provided by Regional Nurse (RgN)#9 on 04/30/14 at 5:10 P.M. revealed no documentation of toileting or checking for incontinence for Resident #23 on 04/30/14 between 12:56 A.M. and 2:48 P.M. In an interview with the registered nurse (RN) #11, the RN confirmed Resident #23 was to be toileted every two hours and more frequently if needed. 2. On 04/26/14 at 9:56 A.M. Resident #92 was observed to have fingernails that were long and some were curled under. Additional observation on 04/30/14 at 3:16 P.M. revealed the resident's finger nails had not been trimmed the nails remained long and curled under at the tips of the nails. On 04/30/14 at 3:16 P.M., interview with Resident #92 revealed the resident did not like his finger nails long and would like them trimmed. ON 04/30/14 at 3:20 P.M. during interview and observation with director of nursing (DON), the DON verified the resident's nails were long and curling under. The DON asked the resident if he had any concerns with his nails and he responded he would like to have them trimmed. The DON asked the nurse to trim the resident's nails. Review of the quarterly Minimum Data Set (MDS) 3.0 dated 01/30/14 reveled the resident required extensive assistance of two staff for personal hygiene. Review of care plan revealed to provide nail care as needed.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure adequate interventions were in place to promote pressure ulcer healing and prevent Resident #135 from developing a new pressure ulcer to the foot. This resulted in harm, when Resident #135 developed an unstageable pressure ulcer to the foot. The facility also failed to ensure skin risk interventions were in place for Resident #101 who had a history of [REDACTED]. This affected two residents (Resident #135 and #101) of three residents reviewed for pressure ulcers. The facility identified five residents with pressure ulcers. Findings include: 1. Review of the medical record for Resident #135 revealed the resident was admitted to the facility 02/28/14 with [DIAGNOSES REDACTED]. The resident did not have any pressure ulcers upon admission and was assessed as being at minimal risk for the development of pressure ulcers. The resident had a hospital stay from 04/08/14 through 04/12/14 [MEDICAL CONDITION], altered mental status, and [MEDICAL CONDITION] of the gastrostomy tube site. Review of hospital notes revealed a wound care note on 04/09/14 which stated that Resident #135 had a less than one centimeter (cm) suspected deep tissue injury on the right lateral ankle, a less than one centimeter suspected deep tissue injury on the right lateral foot, and a six by seven centimeter suspected deep tissue injury, which was purple with no breakdown, on the left heel. The note stated the resident's heels were elevated and it was recommended the resident be turned every two hours and keep the heels elevated. A hospital wound care note on 04/11/14 stated Resident #135 now had a suspected deep tissue injury to the right upper buttocks to coccyx. It was noted there was a tear in the center of the pressure ulcer that had scant serous drainage. Around the wound the skin was purple/red. It was again recommended to turn every two hours and elevate heels. The resident was readmitted to the facility 04/12/14. Review of an admission skin assessment dated [DATE] revealed the resident had an eight by 20 centimeter blister on the left heel, a 0.5 by 4.0 by 0.25 centimeter deep Stage II ulcer on the right buttock, and 0.5 centimeter slit on the right outer ankle. No other pressure ulcers were noted on the admission assessment and no further description of the areas were noted on the admission skin assessment. Review of skin grids revealed on 04/12/14 the resident was noted to have an eight by 20 centimeter intact, dark purple/black blister that was described as a Stage I pressure ulcer. (The definition of a Stage I pressure ulcer on the skin grid form was intact skin with non-blanchable redness of a localized area usually over a bony prominence. The definition of a suspected deep tissue injury on the skin grid was a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear). On 04/15/14 the skin grid indicated the pressure ulcer on the left heel was a suspected deep tissue injury measuring 6.4 cm by 13.2 cm. On 04/27/14 the skin grid indicated the pressure ulcer on the left heel was a Stage II area measuring five cm by seven cm with no depth listed. (The definition of a Stage II pressure ulcer on the grid was a 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 blister.) A second skin grid indicated on 04/12/14 the resident was readmitted with a Stage II pressure ulcer on the right buttock measuring four cm by 0.5 centimeters and was 0.25 centimeters deep. On 04/28/14 the resident was noted with a 4.5 cm by five cm Stage II pressure ulcer on the right buttock that was 0.1 centimeters deep. There was no further documentation or skin grids to indicate any other pressure ulcers present. Upon readmission on 04/12/14, a treatment was obtained from the physician for a dressing to the right outer ankle to be changed every three days. After the admission assessment, there was no further documentation of the size or description of the area. The treatment continued as of 04/30/14. On 04/12/14 the resident was assessed as being at moderate risk for the development of pressure ulcers. On 04/12/14 physician's orders were obtained for an alternating air mattress and to turn the resident every two hours. Review of an interdisciplinary team (IDT) progress note on 04/14/14 revealed the IDT had met to discuss the resident's readmission to the facility. The note was silent to the fact that the resident was readmitted with pressure ulcers. A Minimum Data Set (MDS) assessment completed 04/17/14 indicated the resident had a Brief Interview for Mental Status completed with a score of 3 which reflected severe cognitive impairment. The MDS revealed the resident required extensive assistance from two staff for bed mobility, transfers, toilet use, and personal hygiene, and it indicated that walking had not occurred. A physical therapy progress note on 04/22/14 stated that caregiver education continued with staff regarding positioning while in bed to aide with skin integrity by floating heels. A pressure ulcer risk assessment completed on 04/26/14 indicated the resident was only at a minimal risk of developing pressure ulcers, even though the resident currently had pressure ulcers. Observations on 04/28/14 at 9:23 A.M. and 11:15 A.M. revealed Resident #135 was in bed on his back with his feet and heels resting on a pillow. His heels were touching the pillow. Observation on 04/28/14 at 12:50 P.M. revealed the resident was up in a wheel chair in the hallway, his eyes were closed and his head was leaned back against the wall. The resident was wearing gripper socks on his feet and his feet were resting on the floor. On 04/28/14 at 3:35 P.M. the resident was observed in bed on his back. The resident had on socks and his heels were resting on the mattress of the bed. Observations on 04/29/14 at 7:25 A.M. revealed the resident was in bed on his back. The resident was wearing gripper socks and his heels were resting on the mattress of the bed. Observations on 04/29/14 at 9:13 A.M. and 11:00 A.M. revealed the resident was up in a wheelchair. The resident was wearing socks only and his feet were resting on the floor. On 04/29/14 at 1:50 P.M. the resident was observed in bed on his back. The resident was wearing gripper socks and his heels were resting on the mattress of the bed. Observation on 04/30/14 at 9:25 A.M. revealed the resident was in bed on his back. The resident had a gripper sock on the left foot only. The right foot was bare. His heels were laying on the mattress of the bed. On 04/30/14 at 10:43 A.M. the resident remained in bed on his back. His feet and heels were laying on a pillow with heels touching pillow. The resident continued with only a gripper sock on the left foot and a bare right foot. Observation on 04/30/14 at 2:50 P.M. of Resident #135's skin revealed a Stage II pressure ulcer on the right outer ankle measuring 1.8 cm by 1.4 centimeters. The area was open on one end and was surrounded by a five centimeter diameter red area. Registered nurse (RN) #2 confirmed the area was a Stage II pressure ulcer at the time of the observation. Even though a treatment was being provided to this area, there were no skin grids or documentation regarding a size or description of this area after readmission on 04/12/14. The resident was observed to have a Stage II pressure ulcer on the right buttock measuring 2.8 cm by 2.6 centimeters. The open area was superficial. The open area had a red center and was surrounded by a thin white section which was surrounded by a red open area. The physician's order for a treatment indicated the treatment was to be provided to the left buttock. However, the open area was on the right buttock and not the left buttock. This was confirmed by Registered Nurse #2 at the time of the observation. The resident was observed to have a 6.8 cm by 10.6 centimeter dry blister with a 4 cm by 5.3 centimeter section of black eschar in the center on the left heel. The skin grid on 04/27/14 did not indicate any eschar and stated the area was a Stage II pressure ulcer. The resident was observed to have a 2 cm by 1.8 centimeter purple blister area on the right mid outer foot. Registered Nurse #2 stated this was a suspected deep tissue injury at the time of the observation. There was no evidence that this area had been identified by the facility prior to the treatment observation. Observation on 04/30/14 at 3:30 P.M. revealed staff left the resident's room after finishing the treatments. Resident #135 was observed to be in bed on his right side. The resident had a wedge cushion under his legs but his heels were still touching the mattress on the bed. Review of the plan of care revealed a skin integrity prevention and treatment care plan dated 02/28/14 and revised 03/10/14 and 04/17/14. The plan of care stated the resident was at minimal risk of developing a pressure ulcer per the Braden Risk assessment score and the goal was for the resident to remain free of open areas. The plan of care did not indicate the resident had pressure ulcers on the right outer ankle, right buttock, left heel, or right mid outer foot. The plan of care did not include a turning and repositioning program, did not include the use of the alternating air mattress, and did not address relieving pressure from the heels. There was no evidence that the physician had seen the pressure ulcers or was aware of the eschar present in the left heel pressure ulcer. Review of the facility policy on wound prevention and treatment dated November 1998, revised January 2006 and April 2009 revealed the facility would consider all residents at risk for skin impairment and would implement interventions to prevent the development of pressure ulcers including reducing occurrence of pressure over bony prominences to minimize injury. The policy further stated a skin grid would be completed for each area of skin impairment and updated weekly and if the condition of the skin impairment changes, or with a dressing change. Interview with Physical Therapist #3 on 05/01/14 at 9:30 A.M. revealed Resident #135 had declined in mobility since admission on 02/28/14. She stated the resident was able to walk on admission and was no longer able to walk. She confirmed the staff education on floating the resident's heels. Interview with the director of nursing on 05/01/14 at 8:45 A.M. revealed she had not seen Resident #135's pressure ulcers. She confirmed there were no skin grid for the right outer ankle. She confirmed the left heel would not be a Stage II pressure ulcer if it had black eschar and would be unstageable. She confirmed although the treatment was written for the left buttock, it was actually the right buttock with the pressure ulcer. She confirmed a pressure ulcer to the right mid outer foot was not currently being addressed in the medical record. She confirmed the plan of care did not address the resident had pressure ulcers on the right outer ankle, right buttock,

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	365348	A. BUILDING _____ B. WING _____	05/05/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBORS AT GALLIPOLIS	170 PINECREST DRIVE GALLIPOLIS, OH 45631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) left heel, or right mid outer foot. She confirmed the plan of care did not address how often the resident was to be turned or how to relieve pressure on the heels. She confirmed the facility policy did not address what specific interventions were to be put in place for pressure reduction. 2. Review of Resident #101's medical record revealed a re-admitted 03/04/14 with [DIAGNOSES REDACTED]. Review of Resident #101's admission skin assessment dated [DATE] revealed no evidence of skin breakdown or any type of deep tissue injury (SDTI) to the resident's right heel. Review of Resident #101's skin check shower sheets dated 03/07/14, 03/11/14, 03/14/1403/18/14,03/21/14, 03/25/14 and 03/28/14 on the evening shift revealed no documented evidence of skin impairment to the right heel. Review of Resident #101's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status score of three which revealed the resident exhibited severe cognitive impairment. Resident #101 required extensive assistance from two staff for activities of daily living. Further review of the MDS revealed Resident #101 was coded as being at risk of developing pressure ulcers. Resident #101 had no skin conditions coded on the MDS. Review of Resident #101's physician's orders revealed an order dated 04/08/14 for heel protectors to the resident's bilateral feet. The order indicated to remove for skin care, reapply and apply skin prep to bilateral heels twice daily. Further review of the residents physician's orders revealed an order dated 04/28/14 to float heels off pillows. Review of Resident #101's Braden skin risk assessment dated [DATE] revealed a score of 14 (13-14 moderate risk). Review of Resident #101's progress note dated 04/07/14 revealed the therapy department reported the resident had a bruise to the right heel area. Upon inspection of the right heel the resident was noted to have a SDTI from an old blister. Review of the skin grid revealed the SDTI measured 1.0 centimeter by 1.6 centimeters and was dark brown in color. Further review of the skin grid revealed the primary care physician assessed the right heel and was in agreement with the staging of SDTI. Further review of the skin grid revealed the SDTI to Resident #101's right heel was healed on 04/28/14. On 04/30/14 at 3:45 P.M. RN #11 was observed applying skin prep to the resident's right heel. The area, previously noted to be a SDTI was observed to be healed. On 04/30/14 interview with RN #11 verified the facility's therapy department noted the area to the resident's right heel and notified the nursing department. On 05/01/14 at 2:40 P.M. observation of Resident #101 revealed the resident's heels were not being floated while the resident was in bed as per ordered and care planned. On 05/01/14 at 2:40 P.M. interview with STNA #8 verified Resident #101's heels were not being floated while the resident was in bed.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure fall interventions were implemented and in place for Resident #17, following a fall to reduce the resident's risk of additional falls. This affected one resident (Resident #17) of three residents reviewed for accidents. Findings include: Record review revealed Resident #17 was at risk for falls. Record review revealed the resident had experienced 23 falls between 02/26/13 (the date of the last annual survey) and this survey. On 04/05/14, Resident #17 had a physician order [REDACTED]. Orders revealed to check the dycem every shift for placement. Record review revealed on 04/24/14 Resident #17 was found on the floor bedside the bed. Review of the investigation revealed all previously ordered fall interventions were in place as ordered at the time of the fall. Neurological checks and 15 minute checks were initiated per facility protocol. The incident revealed to continue current interventions to prevent injuries from future falls. However, no new interventions were initiated following the incident to reduce the resident's risk of additional falls. Review of a nursing information sheet pocket care plan, dated 04/28/14 used by the State tested nursing assistants (STNA's) to provide care revealed the resident required one person assistance with wheelchair transfers. The resident was to have a perimeter mattress top, quarter assist bars times two, the use of a Hoyer lift for mobility and transfers. The resident was to have a low bed with mats to the floor, anti-roll back rear, anti-tippers to wheelchair with a sensor alarm to the wheelchair. Gripper socks were to be used and the resident was not to be left alone in the bedroom when up in wheelchair. The resident was to be put to bed 30 minutes after meals. It was noted the resident was confused at times, could be combative with care and hard to redirect at times. The dycem was not listed on the pocket plan. On 04/30/14 at 11:36 A.M. Resident #17 was observed being transferred by one staff member in the bathroom. The resident's wheelchair was observed and there was a dycem on top of the sensor pad. However, no dycem was observed under the cushion in the wheelchair. On 04/30/14 at 11:41 A.M. interview with registered nurse (RN) #11 revealed the dycem was supposed to be on the top and on the bottom of the cushion in the wheelchair. RN #11 verified during the observation there was no dycem placed on the bottom of the cushion. Review of the fall/injury assessment care plan revealed that the dycem to upper and lower cushion was not included on the resident's care plan per, dated 04/05/14. Review of the fall investigation policy and procedure revised on 11/13 revealed to communicate interventions during shift report and daily clinical rounds to the care giving team. The care plan should be revised annually, quarterly, and with change of condition. On 05/01/14 at 7:40 A.M. interview with RN #11 verified the dycem to the lower and upper wheelchair cushion was not on the STNA pocket care plan nor the fall /injury assessment care plan. On 05/01/14 11:07 A.M. interview with director of nursing (DON) verified Resident #17 fell on [DATE]. The DON also verified no new interventions were implemented following the fall to reduce the resident's risk of additional falls.
F 0329 **Level of harm** - Actual harm **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure Resident #135's medication regimen was free from unnecessary medications. This resulted in harm to Resident #135 as the resident was sedated and experienced a decline in activities of daily living related to transfers and ambulation. The resident also developed a suspected deep tissue injury (SDTI) pressure ulcer as a result in the decline in condition attributed to the use of unnecessary medication. The facility failed to ensure Resident #121 was adequately monitored related to the use of an anti-psychotic medication. This affected two residents (Resident #135 and #121) of five residents reviewed for unnecessary medication use. Findings include: 1. Review of the medical record for Resident #135 revealed the resident was admitted to the facility 02/28/14 with [DIAGNOSES REDACTED]. The resident did not have any pressure ulcers upon admission and was assessed as being at minimal risk for the development of pressure ulcers. Record review revealed the resident had a physician's orders [REDACTED]. The resident was being monitored for a target behavior of resisting care. An admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) was conducted with a score of seven, which indicated severe cognitive impairment. Review of a physical therapy note on 03/12/14 revealed the resident performed multiple sit to stands from wheelchair to wheeled walker with stand by assistance. Performed about 50 feet with wheeled walker with frequent standing breaks. On 03/17/14 physical therapy documented that the resident had met his gait training goal as the resident had ambulated about 50 feet two times that week. Record review revealed the resident had a hospital stay to replace a gastrostomy tube from 03/16/14 to 03/18/14. Upon readmission on 03/18/14, the resident no longer had a physician's orders [REDACTED]. Review of a physician readmission history and physical, dated 03/27/14 revealed it was documented that the resident just had an inpatient admission at the hospital. He had replacement of gastrostomy tube and they changed his psychoactive medications. Staff and family stated that he had been sedated and difficult to arouse ever since being changed and would like it changed back to the [MEDICATION NAME] which he was on prior. The physician documented that the patient was difficult to arouse. Review of nurse's notes revealed on 03/19/14 at 5:00 A.M. it was documented the resident was not easily aroused when transferred. There was no evidence the physician was aware and there were no further nurse's notes regarding signs of sedation until the physician's history and physical note on 03/27/14. On 03/27/14 the physician discontinued the anti-psychotic medication, [MEDICATION NAME] and restarted the anti-psychotic medication, [MEDICATION NAME] 20 mg twice per day. The physician's note on 03/27/14 did not address what type of behaviors the resident was experiencing to require the use of the anti-psychotic medication at that time. The note only stated that the resident had dementia with behavioral disturbance. Record review revealed the resident had a hospital stay from 04/08/14 through

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F 0329 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) 04/12/14 [MEDICAL CONDITION], altered mental status, and [MEDICAL CONDITION] of the gastrostomy tube site. When the resident returned from the hospital on [DATE] the admission orders [REDACTED]. Review of a pain data and collection assessment dated [DATE] revealed the resident denied any pain or discomfort and none was noted by staff. Review of nurse's notes from 04/12/14 to 04/24/14 did not reveal any documentation of signs of or complaints of pain. On 04/24/14 the physician started the resident on an opioid [MEDICATION NAME] pain medication, [MEDICATION NAME] 7.5 mg three times per day for pain. An MDS completed on 04/17/14 revealed the resident's BIMS score was now a 3. Review of physical therapy notes revealed that on 04/16/14 it was documented the resident lived at home with his wife and was independent with all mobility without device, in and outside home, and was independent with all activities of daily living prior to December 2013. Has been a long term care resident the last few months (admitted [DATE]) and when last seen for physical therapy was hand held assist to maximal assist of two for transfers. Since last on the physical therapy case load (about one month ago), the resident has had decline in range of motion, multiple skin concerns, and overall decline in mobility. On 04/18/14 occupational therapy documented that the resident was very lethargic and difficult to arouse. On 04/24/14 physical therapy documented that the resident was hard to arouse. On 04/24/14 occupational therapy documented that the resident was very lethargic and difficult to remain awake and alert. Unable to arouse during treatment session. On 04/28/14 physical therapy documented that they were unable to arouse patient this date, startle reflex at times. On 04/28/14 occupational therapy documented difficulty arousing resident. Discussed wheelchair concerns with director of nursing (DON). DON concerned patient was poorly positioned and would like patient in a different wheelchair. Educated DON that wheelchair was a good fit for patient when he was not medicated to this extent. On 04/29/14 physical therapy documented the resident attempted sit to stand parallel bars with maximum assist of two and was unable. Patient lethargic and opens eyes at times for standing attempts. On 04/29/14 occupational therapy documented that the patient was very lethargic and difficult to arouse. Observations on 04/28/14 at 9:23 A.M. and 11:15 A.M. revealed Resident #135 was in bed. On 04/28/14 at 12:09 P.M. the resident was taken in a wheelchair to the dining room for lunch. The resident's eyes were closed and his head leaned back. State tested nursing assistant (STNA) #4 attempted to get the resident to wake up but there was no response from the resident. He kept his eyes closed. On 04/28/14 at 12:20 P.M. STNA #5 attempted to wake the resident up. STNA #5 said lets wake up and eat, but there was no response from the resident. He kept his eyes closed. On 04/28/14 at 12:40 P.M. STNA #4 attempted to feed the resident his lunch. The resident's eyes were closed and his head tilted back. He refused to drink from a straw and did not open his eyes. On 04/28/14 at 12:50 P.M. the resident was observed sitting in the wheelchair in the hallway. His eyes were closed and his head was tilted back against the wall. Another surveyor attempted to interact with the resident by talking to him. He did not respond verbally and did not open his eyes. Observation on 04/29/14 at 7:25 A.M. revealed the resident was in bed with his eyes closed. On 04/29/14 at 9:13 A.M. the resident was observed up in the wheelchair in his room. His eyes were closed. He did not open his eyes when his name was called or when he was touched lightly on the shoulder. Observation on 04/29/14 at 11:00 A.M. revealed the resident was up in a wheelchair in therapy. The resident's eyes were closed. At that time, occupational therapy assistant #6 stated the resident had started being more sleepy last week and was awake more prior to that. Observations on 04/30/14 at 9:25 A.M. and 10:43 A.M. revealed the resident was in bed with his eyes closed. Observation on 04/30/14 at 11:50 A.M. revealed the resident was up in a wheelchair in the dining room. The resident's eyes were closed and his mouth open. Observation on 04/30/14 at 2:50 P.M. of the resident's skin revealed that the resident currently had three pressure ulcers including the right outer ankle, the right buttock, and the left heel. The left heel had a four centimeter (cm) by 5.3 cm pressure ulcer with black eschar present. The resident had also developed a new two cm by 1.8 cm purple blister (suspected deep tissue injury) on the right mid outer foot which had not been identified by the facility. Review of the plan of care, dated 03/04/14 and 04/14/14 revealed the resident had a potential for side effects related to [MEDICAL CONDITION] drug use. The goal was for no negative outcomes resulting from the use of the [MEDICAL CONDITION] medications. The interventions included monitoring for periods of lethargy. Review of nurse's notes from 04/12/14 to 05/01/14 did not reveal any documentation regarding the resident showing any signs of sedation. Interview with STNA #7 on 04/30/14 at 2:45 P.M. revealed Resident #135 had been acting more sleepy since he came back from the hospital the last time. He confirmed the resident sits with his eyes closed. Interview with Registered Nurse #2 on 04/28/14 at 2:50 P.M. revealed she was wondering if the pain medication was making Resident #135 more sleepy. She stated that after she gives him the pain medication at 9:00 A.M., then the rest of the day he has his eyes closed. She confirmed she had also given him pain medication at 2:00 P.M. Interview with Physical Therapist #3 on 05/01/14 at 9:30 A.M. revealed Resident #135 had declined in his ability to walk since admission. She stated he was able to walk initially and now can no longer walk. Record review revealed there was no evidence the physician was aware of the resident's continued lethargy and no evidence the resident's medications had been reviewed for possible reductions. This was verified by the DON on 05/01/14 at 10:38 A.M. 2. Review of Resident #121 's clinical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Current physician orders [REDACTED]. Review of the April 2014 medication administration records revealed the resident received the medication four times in April 2014, none in March 2014, once in February 2014 and once in January 2014. Review of the consultant pharmacist report, dated 02/18/14 through 02/18/14 the pharmacist documented a recommendation for the resident to have an electrocardiogram (ECG) to monitor the side effects of the medication, [MEDICATION NAME]. The physician's signature on 02/21/14 stated acceptance of the recommendation and to please implement the monitoring plan outlined on the form. No indication of a plan was documented on the form. Record review revealed no evidence the ECG was performed in accordance with the physician order. The only documentation of an ECG performed on the resident was dated 12/11/13, prior to the resident's admission to the facility. On 05/05/14 at 8:21 A.M., interview with the DON revealed an ECG had not been completed for the resident following the recommendation of the pharmacist review, which was accepted by the physician in February 2014.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observation and staff interview the facility failed to ensure the hand sink in the kitchen had soap and paper towels available to the kitchen employees. This had the potential to affect 97 of 98 residents residing in the facility who received meal tray from the kitchen. Findings Include: On 04/28/14 at 7:15 A.M. observation made during the initial tour of the facility's kitchen revealed the employee hand sink was without soap and paper towels. On 04/28/14 at 7:20 A.M. interview with Cook #18 verified the employee hand sink was without soap and paper towels and the kitchen employees were utilizing hand sanitizer.
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure a comprehensive quality assurance program was in place for the prompt identification and correction of quality concerns including the care areas of abuse, the development and treatment of [REDACTED]. This had the potential to affect all 98 residents residing in the facility at the time of the annual survey. Findings include: During the annual survey process concerns were identified through observation, medical record review, staff interview and policy review in areas including resident assessments, care planning, pressure ulcer prevention and falls. On 05/05/14 at 10:06 A.M., interview with the administrator revealed the facility quality assurance (QA) committee had previously identified areas of concern with falls, notification and skin. She stated since skin was an identified issue during last year's annual State inspection survey, it was maintained on the quality process with no new issues identified. She stated skin was just a chronic area to review and they keep it on there. She stated they were working on care plan issues and stated the issues were nothing specific. She also identified restorative and notification of change as areas identified in the quality assurance process. She stated the facility had been cited for abuse four years in a row and they had not identified any concerns with abuse. The administrator stated they had not identified any issues with over sedation and again stated there had been issues identified for care plans and they had an action plan in place. The administrator then stated they had identified pressure ulcers as a concern and had an action plan in place. During the interview, the administrator was unable to explain how the current action plans for the above areas were effective in correcting the identified care concerns.

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F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 6)