STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375171	A. BUILDING _____ B. WING _____	11/14/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE HEALTH CARE CENTER	1709 SOUTH MAIN BROKEN ARROW, OK 74012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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, interview, and record review, it was determined the facility failed to promote care for a resident in a manner to maintain dignity for one (#10) of 13 sampled residents reviewed for dignity and respect. The facility staff failed to answer the resident's call light in a manner timely enough to prevent the resident from being incontinent of urine and bowel. The facility census and condition identified 28 residents who required assistance with ambulation. Findings: Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 09/11/14, documented the resident was cognitively intact for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident required assistance to transfer. The care plan, dated 09/17/14, documented the resident wore panties and did not want to wear a pull-up. The care plan also documented the resident was dependant on staff for toilet use. On 11/14/14 at 10:15 a.m., the resident was observed lying in bed, fully dressed with her call light in reach. The resident stated she had experienced accidents (urinated or had a bowel movement on self) in the bed several times because the staff had been slow to answer the call light. The resident stated she had to have help to get up to go to the bathroom. The resident stated she hated it because she could not hold her urine and bowel if staff was slow to answer her light. On 11/14/14 at 11:10 a.m., certified nurse aide (CNA) #1 was asked if the resident needed assistance to go to the bathroom. The CNA stated the resident needed the assistance of one staff member to go to the bathroom. On 11/14/14 at 11:30 a.m., licensed practical nurse (LPN) #1 was interviewed regarding the resident's complaints of the CNAs being slow to answer lights causing incontinent episodes. The LPN stated nothing on the ADL sheet documented the resident was incontinent.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide care according to the care plan for two (#1 and #2) of 15 sampled residents reviewed for care plans. The facility failed to: a) implement interventions for the prevention and care of pressure ulcers for resident #2, and b) administer pain medication and oxygen for resident #1. The facility's census and condition report documented 71 residents lived in the facility. Findings: The facility's pressure ulcer prevention policy documented the staff were to implement interventions to prevent the development of pressure ulcers which included repositioning for the resident. The policy documented the staff were to check the resident's skin during baths and document the findings on the bath sheets. The bath sheets were to be given to the charge nurse for review. The policy documented abnormal findings on the bath sheets were to be reported to the director of nurses (DON) and the physician. The facility's policy for wound care procedure documented the nurse was to remove and inspect the soiled dressing noting drainage, color, odor, and necrotic debris. The policy documented the nurse was to clean the wound with a wound cleaning solution and remove debris with gauze in a circular manner. The policy documented the wound was to be dried using the same procedure for cleaning. The policy documented the nurse was to reassess the condition of the wound after cleansing then redress the wound as ordered. 1. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 06/02/14, documented the resident weighed 114 pounds (lbs), required extensive assistance for bed mobility, had no skin abnormality, and received a regular diet. A physician's orders [REDACTED]. The comprehensive assessment, dated 06/15/14, documented the resident was severely impaired for daily decision-making, had delusions, required extensive assistance with the activities of daily living, required extensive assistance with bathing, and was incontinent of bowel and bladder. The assessment documented the resident had no pressure ulcers. The comprehensive care plan, dated 06/24/14, documented the resident had a a history of pressure ulcers. The care plan documented interventions to prevent pressure ulcers were for the staff to administer treatments as ordered and monitor the effectiveness, follow the facility's policy and procedures for the prevention of pressure ulcers, inform the family of new areas of skin breakdown, monitor nutritional status/record intake, notify the nurse immediately of skin redness, blisters, bruises, or discoloration noted during baths/daily care, and report any changes in skin status to the physician. The Braden Scale skin assessment, dated 06/24/14, documented the resident was at low risk for pressure ulcers. A physician's orders [REDACTED]. The nurse's notes, dated 06/02/14 through 07/27/14, were reviewed. The nurse's notes documented no details regarding the development of the resident's pressure ulcer. The nurse's notes had no documentation regarding the size, depth, location, drainage, or stage of the ulcer. The notes did not document the physician had been notified or the treatment orders which were received. The skin assessments/wound care sheets documented the resident's pressure ulcer was first observed on 08/01/14. The record documented the pressure ulcer was a stage three ulcer. The report documented no measurements or assessment of the ulcer on 08/01/14. The nurse's notes, dated 08/06/14, documented the resident was out of the facility for evaluation of rectal bleeding and returned to the facility on [DATE]. The skin assessment/wound record for 08/11/14 documented the wound was located on the coccyx, was a stage three ulcer, measured 2.5 centimeters (cm) by 1.0 cm and was 0.3 cm deep, was 40 percent granulation tissue, had no odor, and had light serous drainage. The skin assessments documented the first skin assessment was completed on 09/05/14. The assessment documented the skin was normal and no wounds were documented. The assessment documented the treatment was continued to healing coccyx. The skin assessments from 09/05/14 through 10/17/14 documented the same findings. A physician's orders [REDACTED]. A laboratory report, dated 09/16/17, documented the resident's pre-[MEDICATION NAME] (an indicator of nutritional status) level was low. A physician's orders [REDACTED]. The physician's orders [REDACTED]. The order documented the staff were to cleanse wound to coccyx with wound cleaner, pat the wound dry with a 4 by 4 gauze, apply GRX Hydrogel Gauze two inches by 2 inches, and cover with adhesive border dressing daily until resolved. The Braden Scale skin assessment, dated 11/04/14, documented the resident was at moderate risk for pressure ulcers. On 11/13/14 at 3:00 p.m., licensed practical nurse (LPN) #3 and certified nurse aide (CNA) #3 were observed providing wound care to the resident's coccyx. The CNA rolled the resident over on her left side and exposed the resident's buttocks. The resident's right buttocks was soiled with stool. The LPN assisted the CNA with peri-care by holding the resident over to her side. Without changing her gloves or sanitizing her hands, the LPN removed the resident's dressing and discarded the dressing in the trash. The LPN changed her gloves. The LPN squirted the wound with wound cleaner and without drying the wound and removing wound debris, the LPN packed the wound with Hydrogel gauze, and covered the wound with the border dressing. The LPN was asked to read the wound care order's. The LPN stated the order instructed for the wound to be dried after cleansing. The LPN stated she did not dry the wound. On 11/13/14 at 6:00 p.m., the director of nurses (DON) was interviewed regarding the residents' weekly skin assessment sheets. The DON stated no weekly skin assessment sheets were completed for the resident prior to 09/05/14. The DON stated they were unable to

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

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F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) locate bath sheets for the resident for the months of June 2014 and July 2014. On 11/14/14 from 7:40 a.m., to 10:55 a.m., the resident was continuously observed. At 7:40 a.m., the resident reclined in a geri-chair in the common area. The resident was positioned on her back, her legs were elevated, and supported with pillows. A long thin blue cushion lined the geri-chair. No pillows were placed to the resident's back for positioning. The resident had soft booties on her feet. The staff provided no repositioning for the resident to relieve the pressure on the resident's coccyx. At 7:50 a.m., the resident was moved to a room to watch television. The staff provided no change in position for the resident. At 8:44 a.m., the resident was taken to the dining room. The staff repositioned the geri-chair from a reclining position to a sitting position. The staff did not reposition the resident. At 9:10 a.m., the resident was taken to her room. The staff repositioned the geri-chair to a reclining position. The staff did not reposition the resident off her coccyx with support of pillows. At 9:30 a.m., the resident was given a drink of water but no repositioning was provided. At 9:40 a.m., a CNA repositioned a pillow beneath the resident's head but no repositioning to relieve pressure on the coccyx was provided. At 10:55 a.m., the staff took the resident to the dining room. The staff positioned the geri-chair in sitting position. The staff provided no repositioning to relieve pressure on the resident's coccyx. On 11/14/14 at 12:15 p.m., CNA #4 asked at what time the resident was placed in the the geri-chair. The CNA stated night shift got the resident up before day shift arrived at 7:00 a.m. The CNA stated she was probably up about 6:00 a.m. The CNA stated pressure ulcer prevention included turning the resident while the resident was in the geri-chair and placing a cushion in the geri-chair. On 11/14/14 at 12:30 p.m., CNA #1 was interviewed regarding pressure ulcer prevention. The CNA stated pressure ulcer prevention included incontinent care and repositioning the resident every two hours . The CNA stated every two hours the resident was repositioned off her back and was supported with pillows while in the geri-chair. On 11/14/14 at 3:10 p.m., LPN #1 was interviewed regarding pressure ulcer prevention. The LPN stated the policy consisted of turning the resident every two hours, placing a pressure relieving mattress on the bed, incontinent care every two hours and as needed, completing weekly skin assessments, completing the Braden Scale assessments, following dietary recommendations, and monitoring the resident's weight. The LPN was asked how the staff was monitored to ensure the staff carried out their responsibilities regarding pressure ulcer prevention. The LPN stated she asked the staff if repositioning for the residents was completed. The LPN stated the nurses took turns checking the residents. The LPN stated in June 2014 and July 2014 it was the responsibility of the wound care nurse to complete skin assessments. The LPN stated the weekly bath sheets and skin assessments were not monitored when the DON position was vacant. The LPN stated resident #2 had no skin issues upon admission and the pressure ulcer developed on 07/27/14. The LPN was asked to review the nurse's notes. The LPN stated the notes did not document the pressure ulcer or notifications. The LPN stated the notes and treatment records did not document baseline measurements or the condition of the ulcer. The LPN stated she could not state the reason there were no documented details regarding the ulcer. The LPN was asked how the resident suddenly had a stage three pressure ulcer. The LPN stated she could not state the reason the resident had a stage three ulcer. The LPN was asked to review the Braden Scale skin assessments. The LPN stated the assessments were not correct and the resident was at high risk for pressure ulcers. 2. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, updated 09/17/14, documented the resident required oxygen therapy. The care plan documented the resident was to use oxygen according to the physician's orders [REDACTED]. The care plan documented the resident had acute/chronic pain related to arthritis and [MEDICAL CONDITION]. The care plan documented the resident received a [MEDICATION NAME] ([MEDICATION NAME]) patch routinely for pain and had as needed (PRN) pain medication. The care plan documented the staff should anticipate the resident's need for pain relief and evaluate the effectiveness of the pain interventions. The care plan documented the resident should be medicated for pain one hour before wound treatment. A quarterly assessment, dated 09/24/14, documented the resident had no cognitive impairment. The assessment documented the resident reported severe horrible pain almost constantly. The assessment documented the resident had wounds other than pressure sores. The assessment documented the resident required the use of oxygen. The physician's orders [REDACTED]. On 11/12/14 at 4:50 p.m., the resident was observed in her room sitting in the Geri-chair. The resident was using oxygen at that time. The oxygen humidifier bottle and tubing were dated 11/04/14. The hand held nebulizer tubing was not dated. On 11/12/14 at 5:40 p.m., the resident was observed in the dining room for the evening meal. The resident remained in the dining room for 20 minutes and did not use the oxygen during that time. On 11/13/14 at 11:55 a.m., the resident was observed in the dining room. The resident was not using the oxygen at that time. At 12:30 p.m., the resident was removed from the dining room and taken to her room. The oxygen was not applied at that time. The resident's oxygen tubing was lying on the floor with the nasal prongs touching the floor. At 12:45 p.m., certified nurse aide (CNA) #2 entered the resident's room and placed the oxygen tubing that had been touching the floor back in the resident's nose and adjusted the oxygen. The CNA was asked if the resident required oxygen continuously. The CNA stated she normally put the oxygen on the resident after the resident returned from the dining room. The CNA stated the resident always seemed to be a little short of breath after lunch. The CNA stated she did not think the resident had to wear oxygen all of the time. On 11/13/14 at 3:15 p.m., the resident was observed during treatment to the vascular wounds on the lower extremities. LPN #3 removed the dressings and cleaned the wounds. The resident moaned and winced during the treatment. The LPN proceeded with the treatment and the resident stated ouch that hurts and flinched with movement of the leg. The LPN proceeded with the treatment. The resident cried out oh that foot really hurts. LPN #3 was asked if the resident had been medicated prior to treatment to which she replied the resident had a routine pain patch. LPN #3 stated she did not know when the resident had received PRN pain medication and the surveyor would have to ask the med aide (certified medication aide). LPN #3 stated the resident hollered every time the dressings were changed. LPN #3 stated the resident always complained of pain when the left leg was moved. The Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. On 11/14/14 at 9:35 a.m., the resident was observed in the Geri-chair in her room. The resident was awake and alert. The surveyor asked the resident how she was feeling to which the resident replied, not too good. The surveyor stated to the resident, I noticed when the nurse was changing your dressing yesterday you said it hurt pretty bad. Do you hurt a lot? The resident stated, Yes it hurt really bad. I hurt really bad most of the time. The surveyor asked the resident if the staff gave her pain medication to which she replied sometimes. On 11/14/14 at 9:30 a.m., the resident was observed in her room. The oxygen was in use at that time. The date on the humidifier bottle and tubing was 11/14/14.
F 0309 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined the facility failed to provide care to maintain the highest practicable well-being for two (#1 and #2) of 13 sampled residents reviewed for highest well-being. The facility failed to: a) thoroughly assess pain and implement measures to manage pain for resident #1. Resident #1 verbalized pain that was constant and really bad. The facility census and condition report documented 23 residents were on a pain management program. b) ensure the catheter tubing was positioned below the bladder for gravity drainage for resident #2. The facility census and condition report documented one resident required the use of an indwelling urinary catheter. Findings: 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A significant change assessment, dated 03/24/14, documented the resident's cognition was moderately impaired with memory problems. The assessment documented the resident reported severe horrible pain almost constantly. A quarterly pain evaluation, dated 04/21/14, documented the resident reported signs and symptoms of severe pain daily. The report was completed and signed by a registered nurse (RN). The facility could not provide documentation for monthly pain screenings completed by a licensed nurse. A quarterly pain evaluation, dated 08/17/14, documented the resident reported mild pain 3-4 days during the assessment period. The report documented the resident received routine [MEDICATION NAME] ([MEDICATION NAME]) patch for pain with effective results. The report was blank related to the use of PRN pain medications. The report was completed and signed by a licensed practical nurse (LPN). The facility could not provide documentation for monthly pain screenings completed by a licensed nurse. The care plan, updated 09/17/14, documented the resident had acute/chronic pain related to arthritis and [MEDICAL CONDITION]. The care plan documented the resident received a [MEDICATION NAME] ([MEDICATION NAME]) patch routinely for pain and had as needed (PRN) pain medication. The care plan documented the staff should anticipate the resident's need for pain relief and respond immediately to any complaint of pain and evaluate the effectiveness of the pain interventions. The care plan

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 2) documented the resident should be medicated for pain one hour before wound treatment. A quarterly assessment, dated 09/24/14, documented the resident had no cognitive impairment. The assessment documented the resident reported severe horrible pain almost constantly. A quarterly pain evaluation, dated 10/31/14, documented the resident reported almost constant moderate pain at an 8/10. The report documented the resident received routine [MEDICATION NAME] ([MEDICATION NAME]) patch for pain. The report was blank related to the use of PRN pain medications. The report was completed and signed by an RN. The physician's orders [REDACTED]. On 11/13/14 at 3:15 p.m., the resident was observed during treatment to the vascular wounds on the lower extremities. LPN #3 removed the dressings and cleaned the wounds. The resident moaned and winced during the treatment. The LPN proceeded with the treatment and the resident stated, Ouch that hurts. The resident flinched with movement of the leg. The LPN proceeded with the treatment. The resident cried out, Oh that foot really hurts. LPN #3 was asked if the resident had been medicated prior to treatment to which she replied the resident had a routine pain patch. LPN #3 stated she did not know when the resident had received PRN pain medication and the surveyor would have to ask the med aide (certified medication aide). LPN #3 stated the resident hollered every time the dressings were changed. LPN #3 stated the resident always complained of pain when the left leg was moved. The Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. On 11/14/14 at 9:35 a.m., the resident was observed in the Geri-chair in her room. The resident was awake and alert. The surveyor asked the resident how she was feeling to which the resident replied, Not too good. The surveyor stated to the resident, I noticed when the nurse was changing your dressing yesterday you said it hurt pretty bad. Do you hurt a lot? The resident stated, Yes it hurt really bad. I hurt really bad most of the time. The surveyor asked the resident if the staff gave her pain medication to which she replied sometimes. The surveyor asked the resident if she had told the nurse, to which the resident replied no. The surveyor asked the resident if would like the nurse to be notified, to which she replied yes. The surveyor reported the resident's complaint to the charge nurse. On 11/14/14 at 11:30 a.m., CMA #1 was asked when the resident had received PRN pain medication. The CMA stated she had not given the resident anything for pain. The CMA stated usually the certified nurse aide (CNA) would tell her if the resident was in pain but no one had said anything about the resident hurting. The CMA asked if the resident had said something to the surveyor. The surveyor stated the resident had complained of pain around 9:30 a.m. 2. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The comprehensive assessment, dated 06/15/14, documented the resident was severely impaired for daily decision-making and was incontinent of bowel and bladder. The nurse's notes, dated 08/06/14, documented the resident was out of the facility for evaluation of rectal bleeding and returned to the facility on [DATE]. The resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The comprehensive care plan, updated on 08/11/14, documented the resident had a indwelling urinary catheter due to [MEDICAL CONDITION]. The care plan documented the catheter bag and tubing was to be placed below the level of the bladder. A laboratory report, dated 09/26/14, documented the resident had a bladder infection and was to be treated with [MEDICATION NAME] 100 milligrams twice daily for seven days. On 11/13/14 at 9:00 a.m., the resident was reclined in a geri-chair in the common room. The catheter drainage bag was attached to the arm of the chair. The drainage bag was at or above bladder level. On 11/13/14 at 3:00 p.m., the certified nurse aide (CNA) repositioned the resident onto her left side in her bed. The catheter tubing was draped up and over the large bed bolster. The tubing went above bladder level. The CNA was asked about the positioning of the catheter bag and tubing. The CNA stated the urine flows to gravity. The CNA stated the urine flowed over the bolster into the bag. The CNA stated she was not aware the catheter tubing and bag were to be positioned below the bladder. On 11/14/14 at 7:40 a.m. the resident reclined in a geri-chair in the common area. The resident was positioned on her back, her legs were elevated, and supported with pillows. The catheter bag was positioned on the arm of the geri-chair. The drainage bag was at or above bladder level.
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, interview, and record review, it was determined the facility failed to provide assistance with grooming for two (#8 and #10) of three sampled residents reviewed for assistance with activities of daily living (ADLs). The facility failed to trim and clean the residents' nails. The facility identified 24 residents as diabetic. Findings: 1. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The comprehensive assessment, dated 08/19/14, documented the resident was cognitively intact for daily decision making and required no assistance with activities of daily living (ADLs). A physician's orders [REDACTED]. The care plan, dated 11/07/14, did not address nail care. On 11/12/14 at 9:55 a.m., the resident was observed sitting in the recliner in her room. The resident had long, dirty, jagged fingernails. The resident stated she would like for the staff to cut her fingernails. The resident stated her hands were stiff and painful and she could not cut her own nails. On 11/14/14 at 11:10 a.m., certified nurse aide (CNA) #1 was asked who assisted the resident with nail care. The CNA stated nurses did nail care for diabetic residents. 2. Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 09/11/14, documented the resident was cognitively intact for daily decision making and required assistance with ADLs. The care plan, dated 09/17/14, documented the nurse was to monitor foot care problems and cut long nails. On 11/14/14 at 10:15 a.m., the resident was observed lying in bed, fully dressed, with jagged and sharp toenails that had very chipped pink polish. The resident stated her toenails had not been trimmed since she came to the facility to live back in August 2014. The resident stated she would love for someone to trim her toenails. On 11/14/14 at 12:00 p.m., licensed practical nurse (LPN) #2 stated nail care was not put in the computer correctly so it did not trigger on the treatment sheet. The LPN stated the nail care had not been done.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide care to prevent the development of pressure ulcers for one (#2) of one resident reviewed for pressure ulcers. The facility failed to: a) implement interventions for the prevention of pressure ulcers for the resident, and b) provide care and treatment in a manner to promote healing of pressure ulcers for the resident. On 07/27/14 documentation noted the resident had developed an open stage three pressure ulcer. The facility's census and condition report documented three residents had pressure ulcers which were in-house acquired. Findings: The facility's pressure ulcer prevention policy documented the staff were to complete a skin evaluation for the residents on admission to the facility. The policy documented the staff were to implement interventions to prevent the development of pressure ulcers which included a speciality mattress for the bed, positioning devices, and repositioning for the resident. The policy documented the staff were to check the resident's skin during baths and document the findings on the bath sheets. The bath sheets were to be given to the charge nurse for review. The policy documented abnormal findings on the bath sheets were to be reported to the director of nurses (DON) and the physician. The facility's policy for wound care procedure documented the nurse was to remove and inspect the soiled dressing noting drainage, color, odor, and necrotic debris. The policy documented the nurse was to clean the wound with a wound cleaning solution and remove debris with gauze in a circular manner. The policy documented the wound was to be dried using the same procedure for cleaning. The policy documented the nurse was to reassess the condition of the wound after cleansing then redress the wound as ordered. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 06/02/14, documented the resident weighed 114 pounds (lbs), required extensive assistance for bed mobility, had no skin abnormality, and received a regular diet. A physician's orders [REDACTED]. The comprehensive assessment, dated 06/15/14, documented the resident was severely impaired for daily decision-making, had delusions, required extensive assistance with the activities of daily living, required extensive assistance with bathing, and was incontinent of bowel and bladder. The assessment documented the resident had no pressure ulcers. The comprehensive care plan, dated 06/24/14, documented the resident had a a history of pressure ulcers. The care plan documented interventions to prevent pressure ulcers were for the staff to administer treatments as ordered and monitor the effectiveness, follow the facility's policy and procedures for the prevention of pressure ulcers, inform the family of new areas of skin breakdown,

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 3) monitor nutritional status/record intake, notify the nurse immediately of skin redness, blisters, bruises, or discoloration noted during baths/daily care, and report any changes in skin status to the physician. The Braden Scale skin assessment, dated 06/24/14, documented the resident was at low risk for pressure ulcers. The nurses' notes, dated 06/02/14 through 07/27/14, were reviewed. The nurse's notes documented no details regarding the development of the resident's pressure ulcer. The nurses' notes had no documentation regarding the size, depth, location, drainage, or stage of the ulcer. The notes did not document the physician had been notified or the treatment orders which were received. A physician's orders [REDACTED]. The skin assessments/wound care sheets documented the resident's pressure ulcer was first observed on 08/01/14. The record documented the pressure ulcer was a stage three ulcer. The report documented no measurements or assessment of the ulcer on 08/01/14. The nurse's notes, dated 08/06/14, documented the resident was out of the facility for evaluation of rectal bleeding and returned to the facility on [DATE]. The skin assessment/wound record for 08/11/14 documented the wound was located on the coccyx, was a stage three ulcer, measured 2.5 centimeters (cm) by 1.0 cm and was 0.3 cm deep, was 40 percent granulation tissue, had no odor, and had light serous drainage. A physician's orders [REDACTED]. The order documented for the staff to cleanse wound to coccyx with wound cleaner, pat the wound dry with 4 by 4 gauze, apply Santyl to wound, and cover with an adhesive border dressing daily. The skin assessments documented the first skin assessment was completed on 09/05/14. The assessment documented the skin was normal and no wounds were documented. The assessment documented the treatment was continued to healing coccyx. The skin assessments from 09/05/14 through 10/17/14 document the same findings. A physician's orders [REDACTED]. The skin assessment/wound record, dated 09/12/14, documented the wound was a stage three ulcer, measured 2.3 cm by 0.9 cm and was 0.2 cm deep, had 50 percent granulation tissue, had no odor, and had light yell drainage. A laboratory report, dated 09/16/17, documented the resident's pre-[MEDICATION NAME] (an indicator of nutritional status) level was low. A physician's orders [REDACTED]. The skin assessment/wound record, dated 09/26/14, documented the wound was a stage two ulcer, measured 2.9 cm by 1.2 cm and was 0.1 cm deep, had 90 percent granulation tissue, had no odor, and had light yell drainage. The physician's orders [REDACTED]. The order documented the staff was to cleanse wound to coccyx with wound cleaner, pat the wound dry with a 4 by 4 gauze, apply GRX Hydrogel Gauze two inches by 2 inches, and cover with an adhesive border dressing daily until resolved. The skin assessment/wound record, dated 10/10/14, documented the wound was a stage two ulcer, measured 3.0 cm by 1.2 cm and was 0.2 cm deep, was 90 percent granulation tissue, had no odor, and had light yellow drainage. The Braden Scale skin assessment, dated 11/04/14, documented the resident was at moderate risk for pressure ulcers. The skin assessment/wound record, dated 11/07/14, documented the wound was a stage two ulcer, measured 2.8 cm by 0.8 cm and was 0.1 cm deep, was 100 percent granulation tissue, had no odor, and had light yellow drainage. On 11/13/14 at 3:00 p.m., licensed practical nurse (LPN) #3 and certified nurse aide (CNA) #3 were observed providing wound care to the resident's coccyx. The CNA rolled the resident over on her left side and exposed the resident's buttocks. The resident right buttocks was soiled with stool. The LPN assisted the CNA with peri-care by holding the resident over to her side. Without changing her gloves or sanitizing her hands, the LPN removed the resident's dressing and discarded the dressing in the trash. The LPN changed her gloves. The LPN squirted the wound with wound cleaner and without drying the wound and removing wound debris, the LPN packed the wound with Hydrogel gauze, and covered the wound with the border dressing. The LPN was asked to read the wound care orders. The LPN stated the order instructed for the wound to be dried after cleansing. The LPN stated she did not dry the wound. On 11/13/14 at 6:00 p.m., the director of nurses (DON) was interviewed regarding the resident's weekly skin assessment sheets. The DON stated no weekly skin assessment sheets were completed for the resident prior to 09/05/14. The DON stated they were unable to locate bath sheets for the resident for the months of June 2014 and July 2014. On 11/14/14 from 7:40 a.m. to 10:55 a.m., the resident was continuously observed. At 7:40 a.m., the resident reclined in a geri-chair in the common area. The resident was positioned on her back, her legs were elevated, and supported with pillows. A long thin blue cushion lined the geri-chair. No pillows were placed to the resident's back for positioning. The resident had soft booties on her feet. The staff provided no repositioning for the resident to relieve pressure on the resident's coccyx. At 7:50 a.m., the resident was moved to a room to watch television. The staff provided no change in position for the resident. At 8:44 a.m., the resident was taken to the dining room. The staff repositioned the geri-chair from a reclining position to a sitting position. The staff did not reposition the resident off her buttocks. At 9:10 a.m., the resident was taken to her room. The staff repositioned the geri-chair to a reclining position. The staff did not reposition the resident off her coccyx with support of pillows. At 9:30 a.m., the resident was given a drink of water but no repositioning was provided. At 9:40 a.m., a CNA repositioned a pillow beneath the resident's head but no repositioning to relieve pressure on the coccyx was provided. At 10:55 a.m., the staff took the resident to the dining room. The staff positioned the geri-chair in sitting position. The staff provided no repositioning to relieve pressure on the resident's coccyx. On 11/14/14 at 12:15 p.m., CNA #4 was asked at what time the resident was placed in the the geri-chair. The CNA stated night shift got the resident up before day shift arrived at 7:00 a.m. The CNA stated she was probably up about 6:00 a.m. The CNA stated pressure ulcer prevention included turning the resident while in the geri-chair and placing a cushion in the geri-chair. On 11/14/14 at 12:30 p.m., CNA #1 was interviewed regarding pressure ulcer prevention. The CNA stated pressure ulcer prevention included incontinent care and repositioning the resident every two hours. The CNA stated every two hours the resident was repositioned off her back and was supported with pillows while in the geri-chair. On 11/14/14 at 3:10 p.m., LPN #1 was interviewed regarding pressure ulcer prevention. The LPN stated the policy consisted of turning the resident every two hours, placing a pressure relieving mattresses on the resident's bed, incontinent care every two hours and as needed, completing weekly skin assessments, completing the Braden Scale assessments, following dietary recommendations, and monitoring the resident's weight. The LPN was asked how the staff was monitored to ensure the staff carried out their responsibilities regarding pressure ulcer prevention. The LPN stated she asked the staff if repositioning for the residents was completed. The LPN stated the nurses took turns checking the residents. The LPN stated in June 2014 and July 2014 it was the responsibility of the wound care nurse to complete skin assessments. The LPN stated the weekly bath sheets and skin assessments were not monitored when the DON position was vacant. The LPN stated it was the responsibility of the registered nurses (RN) to complete the DON's responsibilities when the DON's position was vacant. The LPN stated resident #2 had no skin issues upon admission and the pressure ulcer developed on 07/27/14. The LPN was asked to review the nurses' notes. The LPN stated the notes did not document the pressure ulcer or notifications. The LPN stated the notes and treatment records did not document baseline measurements or the condition of the ulcer. The LPN stated she could not state the reason there were no documented details regarding the ulcer. The LPN was asked how the resident suddenly had a stage three pressure ulcer. The LPN stated she could not state the reason the resident had a stage three ulcer. The LPN was asked to review the Braden Scale skin assessments. The LPN stated the assessments were incorrect and the resident was at high risk for pressure ulcers.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, it was determined the facility failed to provide respiratory services for two (#1 and #11) of four sampled residents reviewed for respiratory services. The facility failed to: a) ensure oxygen was consistently provided according to physician's orders [REDACTED]. b) change the oxygen tubing and hand held nebulizer tubing according to physicians' orders for residents #1 and #11. The director of nurses provided a list of 12 residents with orders for oxygen and/or breathing treatments via a hand held nebulizer. Findings: The facility did not provide a written policy for changing oxygen or hand held nebulizer tubing. 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, updated 09/17/14, documented the resident required oxygen therapy. The care plan documented the resident was to use oxygen according to the physician's orders [REDACTED]. A quarterly assessment, dated 09/24/14, documented the resident had no cognitive impairment. The assessment documented the resident had wounds other than pressure sores. The assessment documented the resident required the use of oxygen. The physician's orders [REDACTED]. The treatment sheet for November 2014 documented the resident received wound treatment daily to the bilateral lower extremities. The treatment sheet documented the resident received oxygen and hand held nebulizer treatments. On 11/12/14 at 4:50 p.m., the resident was observed in her room sitting in the Geri-chair. The resident was using oxygen at that time. The oxygen humidifier bottle and tubing were dated 11/04/14. The hand held nebulizer tubing was not dated. On 11/12/14 at 5:40

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F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) p.m., the resident was observed in the dining room for the evening meal. The resident remained in the dining room for 20 minutes and did not use the oxygen during that time. On 11/13/14 at 11:55 a.m., the resident was observed in the dining room. The resident was not using the oxygen at that time. At 12:30 p.m., the resident was removed from the dining room and taken to her room. The oxygen was not applied at that time. The resident's oxygen tubing was lying on the floor with the nasal prongs touching the floor. At 12:45 p.m., certified nurse aide (CNA) #2 entered the resident's room and placed the oxygen tubing that had been touching the floor back in the resident's nose and adjusted the oxygen. The CNA was asked if the resident required oxygen continuously. The CNA stated she normally put the oxygen on the resident after the resident returned from the dining room. The CNA stated the resident always seemed to be a little short of breath after lunch. The CNA stated she did not think the resident had to wear oxygen all of the time. On 11/14/14 at 9:30 a.m., the resident was observed in her room. The oxygen was in use at that time. The date on the humidifier bottle and tubing was 11/14/14. On 11/14/14 at 2:40 p.m., LPN #3 was asked who was responsible for changing the oxygen tubing and humidifier bottles. The LPN stated she was responsible but had been unable to change the tubing and bottles on Tuesday as ordered. 2. Resident # 11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. On 11/13/14 at 8:26 a.m., licensed practical nurse (LPN) #3 was observed administering an [MEDICATION NAME] sulfate hand held nebulizer treatment to the resident. The resident's nebulizer tubing had a small piece of white tape attached with the date 11/04/14 written on it. On 11/14/14 at 2:40 p.m., the LPN was interviewed regarding the nebulizer tubing. The LPN stated nebulizer tubing was supposed to be changed on Tuesday every week by the day shift nurse. The LPN stated the date the tubing was changed was written on a small piece of white tape which was attached to the tubing. The LPN stated the nebulizer tubing had not been changed that week.
F 0354 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Use a registered nurse at least 8 hours a day, 7 days a week.** Based on record review and interview, it was determined the facility failed to designate a registered nurse (RN) to serve as the director of nurses (DON) for 71 of 71 residents who lived at the facility. The facility failed to maintain a registered nurse in the position of director of nurses for greater than three months. Findings: The staffing schedules from April through November 2014 documented the facility did not identify a designated RN to serve as DON from 05/02/14 through 08/25/14. On 11/14/14 at 12:30 p.m., the DON was asked who had been acting DON prior to her employment. The DON stated as far as she knew no one had been acting as DON. The DON stated the RN coverage had been on the night shift. On 11/14/14 at 12:35 p.m., licensed practical nurse (LPN) #2 presented the surveyor with requested pain assessments for resident #1. LPN #2 stated she had found three assessments in the computer for the resident. LPN #2 was asked if the person that completed the assessment on 08/17/14 was an RN. LPN #2 stated the assessment had been completed by an LPN. LPN #2 was asked who had been acting as the DON prior the current DON who reportedly began employment in August 2014. The LPN stated no one had been acting DON. The LPN was asked if the facility had daily RN coverage. The LPN stated the RNs only worked on the night shift but worked seven days per week. On 11/14/14 at 3:25 p.m., LPN #1 was asked who had been acting as the DON prior to the current DON's employment. The LPN stated, really no one had been designated as the DON. The LPN stated, We just had the RNs that worked at night. We just did what we know to do. On 11/14/14 at 3:50 p.m., the administrator was interviewed regarding the person designated as the DON prior to the current DON's employment. The administrator stated the RNs worked the night shift and no RN was specifically designated to be in the position of DON.
F 0367 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that special or therapeutic diets are ordered by the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide the therapeutic diet prescribed by the physician for one (#4) of four sampled residents whose diet orders were reviewed. The facility failed to provide a pureed diet for the resident as ordered by the physician. The facility identified 15 residents who received pureed diets. Findings: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A significant change assessment, dated 08/28/14, documented the resident was severely impaired for daily decision making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident was on a therapeutic diet. A physician's orders [REDACTED]. The care plan, dated 11/12/14, documented the resident was to receive a pureed diet. On 11/14/14 at 12:35 p.m., the resident was observed in her geri chair in the dining room. The resident's lunch tray was provided and contained ground chicken, a bowl of macaroni with tomato chunks, a slice of bread, a glass of tea, coffee, and water, and for desert a piece of strawberry short cake with chunks of fresh strawberries. The resident's dietary card documented the resident was to receive a regular mechanical soft diet. On 11/14/14 at 12:45 p.m., the dietary cook (#1) was interviewed regarding the resident's diet orders. The cook stated the resident had been on a pureed diet due to problems with her teeth but was on a mechanical soft diet at this time. On 11/14/14 at 12:51 p.m., licensed practical nurse (LPN) #1/ charge nurse was interviewed regarding the resident's diet orders. The LPN stated the resident did not have dentures and had a limited number of her own teeth. The LPN stated the resident should have been provided a pureed diet.
F 0428 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**At least once a month, have a licensed pharmacist review each resident's medication(s) and report any irregularities to the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to document the clinical rationale for the use of medication for one (#4) of four sampled residents whose medications were reviewed. The facility census and condition identified 71 who resided in the facility. Findings: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A significant change assessment, dated 08/28/14, documented the resident was severely impaired for daily decision making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had delusions and behaviors toward others. A pharmacy recommendation, dated 09/25/14, documented the resident received resperidone 1 milligram (mg) three times a day since 06/11/14. The recommendation was to reduce resperidone to 1 mg twice a day. The recommendation was declined by the physcian with no rationale. A pharmacy recommendation, dated 10/22/14, documented a request for a follow up with the physician concerning a rationale for the declined recommendation for a gradual dose reduction of resperidone. The consolidated orders for November 2014, documented the resident received resperidone 1 mg three times a day for psychosis. The care plan, dated 11/12/14, documented the resident had cognitive impairment and behavior toward others. On 11/13/14 at 9:42 a.m., the resident was observed sitting in a geri chair in her room. The resident was calm and able to answer questions without difficulty. On 11/14/14 at 8:35 a.m., the director of nurses (DON) was interviewed regarding the pharmacy gradual dose reduction recommendation for resident #4. The DON stated the clinical rationale for the decline of the recommendation was not documented and should have been.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to maintain an infection control program to prevent the development and transmission of infection for three (#1, #10, and #11) of five sampled residents reviewed for infection control. The facility failed to: a) prevent cross contamination during the medication pass for two (#10 and #11) of three sampled residents who were observed to receive medications during the medication passes. b) prevent cross contamination during wound care for one (#1) of two sampled residents who were observed receiving wound care. The facility identified 71 residents who resided at the facility. Findings: The facility policy for infection control and handwashing documented all employees were to wash their hands prior to and after providing resident care. 1. Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 09/11/14, documented the resident was cognitively intact for daily decision making and required assistance with activities of daily living (ADLs). The assessment documented the resident had impaired vision. The care plan, dated 09/17/14, documented the resident had impaired visual function. On 11/13/14 at 8:40 a.m., licensed practical nurse (LPN) #3 was observed to administer eye drops to the resident. The LPN unlocked the medication cart and obtained the bottle of eye drops. The LPN was then observed to touch the handles of the resident's wheelchair while moving the resident from the dining room to the treatment room. The LPN was then observed to administer the eye drops to the resident. The LPN then touched the handles of the wheelchair to take the resident back to the dining room. The LPN did not wash or sanitize her hands prior to or after the administration

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) of the eye drops. The LPN returned to the medication cart, unlocked the cart, and obtained the vial of nebulizer medicine for resident #11. The LPN was not observed to sanitize or wash her hands between the administration of the medications between residents #10 and #11. On 11/14/14 at 2:40 p.m. LPN #3 was asked if she washed or sanitized her hands between residents during medication pass. The LPN stated she did not always wash or sanitize her hands between residents. 2. Resident # 11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 11/13/14 at 8:43 a.m., licensed practical nurse (LPN) #3 was observed administering a respiratory hand held nebulizer treatment to the resident. LPN #3 was observed to unlock the medication cart. The LPN obtained the vial of nebulizer medicine and touched the handles of the wheelchair to take the resident from the dining room to the resident's room. The LPN opened the nebulizer cannister and put the vial of medication in it. The nebulizer cannister was in a plastic bag taped to the resident's bedside table. The LPN handed the nebulizer to the resident and left the room. The LPN did not wash or sanitize her hands prior to or after the administration of the nebulizer treatment. On 11/14/14 at 2:40 p.m., the LPN was interviewed regarding the facility policy for how to prevent cross contamination between residents. The LPN stated she usually washed or sanitized her hands right after giving a nebulizer treatment. 3. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan, updated 09/17/14, documented the resident had a history of [REDACTED]. A quarterly assessment, dated 09/24/14, documented the resident had no cognitive impairment. The assessment documented the resident had wounds other than pressure sores. The assessment documented the resident required the use of oxygen. The treatment sheet for November 2014 documented the resident received wound treatment daily to the bilateral lower extremities. The treatment sheet documented the resident received oxygen and hand held nebulizer treatments. On 11/13/14 at 11:55 a.m., the resident was observed in the dining room. The resident was not using the oxygen at that time. At 12:30 p.m., the resident was removed from the dining room and taken to her room. The oxygen was not applied at that time. The resident's oxygen tubing was lying on the floor with the nasal prongs touching the floor. At 12:45 p.m., certified nurse aide (CNA) #2 entered the resident's room and placed the oxygen tubing that had been touching the floor back in the resident's nose and adjusted the oxygen. On 11/13/14 at 3:15 p.m., licensed practical nurse (LPN) #3 gathered the supplies in preparation for wound treatment for [REDACTED]. The LPN entered the resident's room with the supplies in her left hand and arm. The LPN placed the wound cleanser bottle and unopened packages of gauze, [MEDICATION NAME], and Hydrogel on a folded blue pad on the bedside table. The LPN picked the floor mat from beside the bed, folded it, and placed the mat behind the door. The LPN pulled the resident's Geri-chair next to the bed and placed the blue pad on top of a cloth incontinent pad that lined the seat of the Geri-chair. The LPN used her bare hands and placed the roll of gauze on the blue pad, opened the remainder of the packages of supplies and laid the packages on the blue pad. The LPN put her hand in her pocket and stated she was looking for her scissors. The LPN left the room and went to the nurses' station looking for her scissors. As the LPN was walking down the hall back to the resident's room, the LPN was observed rubbing her nose. The LPN approached the treatment cart, removed her keys from the elastic arm strap, unlocked the cart, removed a cleaning wipe from the drawer, and wiped her scissors. The LPN was asked what she had used to clean her scissors, to which she replied a Glucochlor wipe like she used to clean the glucometers. The LPN opened the door to the resident's room, placed her glasses on her face, and opened the Hydrogel packets and placed them on the blue pad on the Geri-chair. The LPN had not washed her hands or used hand sanitizer from the time she had started gathering supplies before entering the resident's room. The LPN donned a glove on the right hand and adjusted the resident's bed using the electric controls with the bare left hand before donning the left glove. The LPN did not wash her hands or use hand sanitizer prior to donning the gloves. The LPN did not place a protective pad under the resident's legs. The LPN removed the slightly soiled outer dressings and placed them directly on the resident's bed underneath her legs. The LPN stated she usually put the soiled dressings on the bed to catch anything that drained from the wounds when the wound cleanser was applied. The LPN sprayed wound cleanser to loosen the [MEDICATION NAME] dressing. The wound on the right leg was observed bleeding when the [MEDICATION NAME] was removed. The blood and wound cleanser dripped onto the resident's bed as well as the soiled gauze. The LPN removed the dressing from the left leg, soaked the [MEDICATION NAME] with wound cleanser, wiped the open area with a non-sterile gauze pad, and placed the dressings in the trash can. The LPN removed her gloves but did not wash her hands or use hand sanitizer. The LPN donned clean gloves and applied the hydrogel dressings to the wounds. The LPN picked up the large plastic bag that had contained the packages of supplies, placed her gloved hand into the bag, retrieved additional packages of supplies, opened the [MEDICATION NAME] dressings and placed over the Hydrogel. The LPN picked up the soiled dressing off of the resident's bed and placed the dressing in the trash can. The LPN wrapped the resident's lower leg with gauze and taped the gauze in place. The LPN stated she would have to get someone to change the resident's bed because the sheet had blood on it. The LPN had visible blood on the gloves. The gloves were removed and the LPN dated and initialed the dressing. The LPN placed the resident's socks and heel protectors on the resident's feet, turned on the resident's call light, and lowered the resident's bed. The LPN applied hand sanitizer for the first time after all of the supplies had been removed from the Geri-chair but before the trash bag had been removed from the trash can. The LPN left the room with the trash bag and placed the bag in the soiled utility room. The LPN was not observed washing her hands during the entire procedure. On 11/14/14 at 2:30 p.m., LPN #3 was interviewed regarding infection control practices during wound treatment for [REDACTED]. The LPN stated the facility policy documented it was okay to use hand sanitizer 5 times before washing hands. The LPN stated she did not like to use the resident's bathroom to wash her hands. The LPN was asked if it was the usual practice to use the Geri-chair to place the supplies. The LPN stated usually the resident was in her Geri-chair at the time the treatment was done and she used the bed as the table. The LPN stated she usually used hand sanitizer and did not always wash her hands between residents.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to accurately and completely document assessments and care related to pressure ulcers for one (#2) of one resident reviewed for pressure ulcers. The facility's census and condition report documented three residents had pressure ulcers which were in-house acquired. Findings: The facility's pressure ulcer prevention policy documented the staff were to complete a skin evaluation for the residents on admission to the facility. The policy documented the staff were to check the resident's skin during baths and document the findings on the bath sheets. The bath sheets were to be given to the charge nurse for review. The policy documented abnormal findings were to be reported to the director of nurses (DON) and the physician. The facility's policy for wound care procedure documented the nurse was to remove and inspect the soiled dressing noting drainage color, odor, and necrotic debris. The policy documented the nurse was to reassess the condition of the wound after cleansing then redress the wound as ordered. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission assessment, dated 06/02/14, documented the resident weighted 114 pounds (lbs), required extensive assistance for bed mobility, had no skin abnormality, and received a regular diet. A physician's orders [REDACTED]. The comprehensive assessment, dated 06/15/14, documented the resident was severely impaired for daily decision-making, had delusions, required extensive assistance with the activities of daily living, required extensive assistance with bathing, and was incontinent of bowel and bladder. The assessment documented the resident had no pressure ulcers. The comprehensive care plan, dated 06/24/14, documented the resident had a a history of pressure ulcers. The care plan documented interventions to prevent pressure ulcers were for the staff to administer treatments as ordered and monitor the effectiveness, follow the facility's policy and procedures for the prevention of pressure ulcers, inform the family of new area of skin breakdown, monitor nutritional status/record intake, notify the nurse immediately of skin redness, blisters, bruises, or discoloration noted during baths/daily care, and report any changes in skin status to the physician. The Braden Scale skin assessment, dated 06/24/14, documented the resident was at low risk for pressure ulcers. A physician's orders [REDACTED]. The nurse's notes, dated 06/02/14 through 07/27/14, were reviewed. The nurse's notes documented no details regarding the development of the resident's pressure ulcer. The nurse's notes had no documentation regarding the size, depth, location, drainage, or stage of the ulcer. The notes did not document the physician had been notified or the treatment orders which were received. The skin assessments/wound care sheets documented the resident's pressure ulcer was first observed on 08/01/14. The record documented the pressure ulcer was a stage three ulcer. The report documented no measurements or assessment of the ulcer on

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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 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) 08/01/14. The skin assessment/wound record for 08/11/14 documented the first wound assessment. The record documented the wound was located on the coccyx, was a stage three ulcer, measured 2.5 centimeters (cm) by 1.0 cm and was 0.3 cm deep, was 40 percent granulation tissue, had no odor, and had light serous drainage. The skin assessments documented the first skin assessment was completed on 09/05/14. The assessment documented the skin was normal and no wounds were documented. The assessment documented the treatment was continued to healing coccyx. The skin assessments from 09/05/14 through 10/17/14 document the same findings. The Braden Scale skin assessment, dated 11/04/14, documented the resident was at moderate risk for pressure ulcers. On 11/13/14 at 6:00 p.m., the director of nurses (DON) was interviewed regarding the resident's weekly skin assessment sheets. The DON stated no weekly skin assessment sheets were completed for the resident prior to 09/05/14. The DON stated they were unable to locate bath sheets for the resident for the months of June 2014 and July 2014. On 11/14/14 at 3:10 p.m., licensed practical nurse (LPN) #1 was interviewed regarding pressure ulcer care/prevention and documentation. The LPN stated in June 2014 and July 2014 it was the responsibility of the wound care nurse to complete skin assessments. The LPN stated the weekly bath sheets and skin assessments were not monitored when the DON position was vacant. The LPN stated resident #2 had no skin issues upon admission and the pressure ulcer developed on 07/27/14. The LPN was asked to review the nurse's notes. The LPN stated the notes did not document the pressure ulcer or notifications. The LPN stated the notes and treatment records did not document baseline measurements or the condition of the ulcer. The LPN stated she could not state the reason there were no documented details regarding the ulcer. The LPN was asked to review the Braden Scale skin assessments. The LPN stated the assessments were not correct and the resident was at high risk for pressure ulcers.