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BENTONVILLE MANOR NURSING HOME	224 SOUTH MAIN STREET BENTONVILLE, AR 72712

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F 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #19963 (AR00017980) was substantiated (all or in part) with a deficiency cited at F309. Complaint #19958 (AR00017971) was unsubstantiated. Complaint #20015 (AR00018043) was substantiated (all or in part) with deficiencies cited at F314 and F309 cited.	F 000		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #19963 (AR00017980) and complaint	F 309		

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 309	Continued From page 1 #20015 (AR00018043) were substantiated (all or in part) with these findings: Based on record review and interview, the facility failed to ensure necessary care and services were provided to attain or maintain the highest practicable physical and mental well-being, in accordance with the plan of care for Resident #2: The facility failed to ensure all physician orders were identified and implemented when verifying readmission orders to ensure residents received appropriate therapeutic interventions to prevent further complications for 1 of 1 (Resident #2) case mix residents who were admitted in the facility within the last 30 days with discharge orders for IV antibiotics therapy. The facility failed to ensure staff responsible for providing care for a peripherally inserted central catheter (PICC) line was knowledgeable in the care of PICC lines; staff was aware when and who to report problems to regarding the PICC line; and dressing changes were completed as ordered by the physician to prevent infections and complications for 1 (Resident #2) of 2 (Residents #2 and #6) case mix residents who had a PICC line. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #2 who was readmitted to the hospital with an elevated temperature, infection of the PICC line and infection of the wound and had the potential to affect 2 residents who had a PICC line and who was readmitted to the facility in the past 30 days with orders for IV antibiotics as identified by a list provided by the Administrator on 4/3/15 The	F 309		

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facility was informed of the Immediate Jeopardy on 3/24/15 at 9:55 a.m.

The findings are:

1. Resident #2 was admitted to the facility 1/9/15 and had diagnoses of Sepsis, Peripheral Vascular Disease (PVD), Guillain-Barre and Diabetes Mellitus (DM) Type 2. The Admission Minimum Data Set with an Assessment Reference Date of 1/16/15 documented the resident scored 12 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status had no pressure ulcers on admission; and had diabetic foot ulcers.

a. A Physician Clinic Note dated 1/28/15 documented, "Seen in the nursing home. He is seen in follow up for decubitus on his toes. He has had history of Guillain-Barre with significant motor loss. He has developed ulcers on his toes, he is moderately obese. Weakness of arms and legs, chronic pain, Chronic Obstructive Pulmonary Disease, Diabetes, Coronary Artery Disease..."

b. A Nurse's Note dated 2/13/15 at 1:00 a.m. documented, "Tx [treatment] done to foot as ordered. Presents very foul odor. Resident continues on antibiotic for wound infection... Noted resident coughing..."

c. A Nurse's Note dated 2/13/15 at 6:30 a.m. documented, "Resident heard mumbling, then yelling at unseen stimuli. When asked, resident yelled about green people and purple people. Resident noted pale, blood tinged green mucous noted in corner of mouth. MD [Medical Doctor] notified. New order received - send to [hospital Emergency Room] for decreased LOC [level of

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consciousness] with hallucinations..."

d. A Hospital Discharge Summary dated 2/20/15 documented, "Adm [Admitted]: 2/13/15 ...Upon arrival to the ED [Emergency Department] the patient was found to have a LLL [left lower lobe] pneumonia and to have infected right heel decubitus ulcer. A central line was placed due to poor access and the patient was started on IV [intravenous] vanc [Vancomycin], levaquin, and zosyn. According to the nursing home the patient has been on Bactrim DS [Double Strength] since 2/8/15 for the infection on his right heel. The patient has a known history of Guillain-Barre with significant motor weakness, diabetes, CAD [coronary artery disease], and HTN [hypertension]... Patient was admitted with sepsis and started on broad spectrum antibiotics... His source was found to be his infected RLE [right lower extremity] heel ulceration. Orthopedics was consulted and recommended amputation however patient refused. He was taken to OR [operating room] and had debridement and wound vac was placed. His cultures have grown proteus. (He also has culture from facility with MRSA [Methicillin-resistant Staphylococcus aureus])... There is a soft tissue defect overlying the right calcaneus with exposed calcaneus to the open environment... ID [Infectious Disease] was consulted and recommended long term antibiotics with IV vanc and invanz... Patient has had many discussions with physicians regarding possible need for amputation however he would like to continue to try to avoid this. Patient will continue IV antibiotics and wound care at the nursing home... Discharge medications and new prescriptions: Start taking these medications - ertapenem 1 gram Recon [reconstituted] Soln [solution], Commonly known as: INVANZ. Inject

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1,000 mg [milligrams] by intravenous injection every 24 hours... Vancomycin 1000 mg Recon Soln, Commonly known as VANCOCIN. Inject 1,500 mg by intravenous infection every 12 hours..."

e. A facility Admission Orders sheet dated 2/20/15 and completed by Licensed Practical Nurse (LPN) #1 documented a list of medications, including Vancomycin, however, the Invanz was not documented on the Admission Orders sheet. The Admission Orders sheet was signed by the Medical Director. The February 2015 MAR did not have Invanz listed as a medication to be administered.

1) On 3/17/15 at 1:44 p.m., LPN #1 was asked if he remembered Resident #2. He stated, "Yes. He was my first admission, and it was a complicated one." He was asked what he meant by that and he stated, "The hospital changed the report like three different times." He was asked what they changed and he stated, "It was all about the Vancomycin. First they wanted it given, then they changed their minds and wanted it held. It was all about the Vanc." He was asked about the process of getting information from the hospital and admitting a resident. He stated, "They fax the information and they call and give report." He was asked what kind of information the hospital faxed. He stated, "Discharge paperwork, orders for treatments..." He was asked if he remembered looking at the discharge orders from the hospital and he stated, "[Social] brought me the copy of the discharge orders from the hospital. I have to have the paperwork from the hospital in order to get the medication orders. They don't give that over the phone." At this time, the LPN was shown the discharge order sheet from the hospital and

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the IV Invanz that he did not add to the facility admission sheet. He stated, "I don't remember seeing that because I would have had to look that medication up to even know what it was."

As of 3/17/15 at 2:00 p.m., the hospital discharge information that the facility used to admit Resident #2 on 2/20/15 could not be located in the closed record. On 3/17/15 at 2:17 p.m., the Medical Records clerk was asked about the missing information. He stated, "That information normally goes in the back of the chart under miscellaneous. If it's not there, I don't know where it's at."

2) On 3/18/15 at 2:00 p.m., the Medical Director was asked if he remembered Resident #2. He stated, "I do." He was told about the IV Invanz being left off of the Admission Order sheet at the facility. He was asked about the process of signing the facility Admission Order sheet, specifically the readmission orders for 2/20/15, and if he compares the admission sheet to the hospital discharge orders. He stated, "I look at what the nurse writes down and that's what I sign. I would not know if the nurse left a medication off. Maybe I had better compare them starting today." He was asked if he was aware there had been a problem with this involving Resident #2. He stated, "I was aware there was a problem with the PICC line from the hospital. I did not know there was a medication problem. I work at the hospital too so I am notified from them also." He was asked if the facility has asked him to participate in any Quality Assurance meetings about any problems like this. He stated, "I have been to QA meetings about regular stuff, but nothing like this."

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f. The Plan of Care updated 2/20/15 documented, "Infection related to sepsis; gangrene, severe PVD ... interventions ...Administer meds, PO [by mouth] and via PICC [Peripheral Inserted Central Catheter] line per MD [Medical Doctor] orders... Change PICC line dressing per MD orders..."

g. A Physician Order dated 2/20/15 documented, "Sterile dressing change to PIC line every 3 days by RN [Registered Nurse]."

h. The February 2015 Treatment Administration Record [TAR] documented, "2/20/15 - Sterile dressing change every 3 days by RN [Registered Nurse] to LUE [Left Upper Extremity] PICC." The TAR documented the PICC line dressing was changed on 2/22/15 and 2/28/15.

i. A Physician Order dated 2/24/15 documented, "Clarification Order: Sterile dressing changes every 3 days to LUE PICC."

j. An SBAR (Situation Background Assessment Recommendation) Communication Form dated 2/28/15 at 8:00 a.m. and completed by LPN #2 documented, "Change in mental status, temperature, right foot 4+ [plus], PICC line not functioning... Temp 100.5... Wound vac to right heel... Stage 3 to 4 wound right heel, wound coccyx..."

k. A Nurse's Note dated 2/28/15 at 7:30 a.m. and written by LPN #2 documented, "Resident, definite change in mental status, unable to swallow breakfast, left side of mouth droopy, PICC line... not functioning, right foot to wound vac, right foot 4+ edema, left foot 4+ edema... [blood pressure] 118/94, [Temperature] 100.5, [Pulse] 86, [Respiration] 24. Pulse ox 94%... 8:40

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a.m. - EMTs [emergency medical technicians] here to transport to [hospital]..."

l. A Hospital ED [Emergency Department] Provider Note dated 2/28/15 documented, "...Male presents to the ED with a chief complaint of fever. Recently DC [discharged] from hospital for sepsis - cellulitis/decubitus - heels - has wound vac and pneumonia. Has Pic line but apparently has only been getting IV vanc and it is in question when his last dose was given - pic line is reported to not be functioning and is not bandaged or secured properly..."

An ED Nurse's Note dated 2/28/15 documented, "PICC team was called to replace left arm picc line due to malfunction line. Upon inspection of picc line... the red port had an extension tubing without a leurlock on the port. [RN #1] at [nursing home] was called. [RN #1] is the acting DON of [nursing home]. Instructed that this was not the proper way to care for a central line."

m. A Hospital History and Physical (H&P) note dated 2/28/15 at 3:15 p.m. documented, "...Pt presents from SNF [skilled nursing facility] with fever. Recently discharged after being treated for sepsis due to right heel ulcer. He was discharged on vanc + ertapenem but apparently has not been getting the latter according to MAR and discussion with nurse at the facility. PICC line malfunctioning and not being maintained properly... Will send blood cx [culture] and cx cath tip. Wound care consult. Vanc + ertapenem."

A Hospital Inpatient H&P dated 2/28/15 documented, "...The patient was sent back to the nursing home on IV Vanc and Invanz with a wound vac on his right heel. This morning the

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patient was found to have a fever of 101 so he was sent to the ED. Upon arrival he was found to have a malfunctioning PICC line... Upon reviewing the patient's nursing home MAR it was discovered that the patient has been getting IV vancomycin but has not been getting Invanz."

A Hospital IV Catheter Culture dated 3/3/15 documented, "IV Cath tip; Cath PICC 2/28/15, 3:50 p.m. - Staphylococcus hominis subsp [subspecies] hominis, Staphylococcus epidermidis, Diphtheroids."

n. On 3/18/15 at 10:39 a.m., LPN #2 was asked about 2/28/14 when she sent (Resident #2) to the hospital. She stated, "He was running a temp, he was lethargic, his left face was drooping, his leg was swollen and his PICC was occluded." LPN #2 was asked about the condition of the PICC line when the resident was sent out to the hospital. She stated, "There was no dressing on his PICC and a hub was missing off of one. It was a double lumen. I don't know how or when it came off. There was one piece of tape holding it in place. The foot with the wound vac was terribly inflamed. [Physician] from the hospital called me really upset. She asked about the PICC. I told her I had been off. The Vanc was scheduled to be given that morning and I couldn't give it because it was occluded. Then the doctor called back and asked about when the Invanz was hung. I went to the MAR and there was no Invanz. So I went to the chart and the first medication on the hospital discharge orders was Invanz. I don't know how it got missed." LPN #2 was asked to clarify if she saw the hospital discharge orders and that the Invanz was on the order sheet. She stated, "Yes. I saw them. They were in the miscellaneous section of the chart and Invanz was the first

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medication listed." She was told the facility could not locate the hospital discharge orders now and she was asked if she had any idea where they might be. She stated, "I don't understand that. They were in the chart. I looked at them." LPN #2 was asked if she placed a dressing on the resident's PICC line before sending him out to the hospital. She stated, "I did not put a dressing on it. I left it just like it was. What I was told was if I couldn't show my IV certificate, I couldn't touch it. But that morning I asked [RN #2] if she was going to hang the Vanc and she told me to go ahead. The day before she told me no." LPN #2 was asked about the TAR and the initial on 2/28/15 documenting that the PICC line dressing had been done that day. She looked at the TAR and stated, "I've never seen that initial before. I have no idea who that is and I know everyone's initials. The dressing was not done because I am the one who sent him out that morning and there was no dressing on it." At this time, LPN #2 reviewed the resident's MAR and TAR and stated, "See? That initial is nowhere else on here. I don't know who that is." LPN #2 was asked if she ever did his PICC line dressing from 2/20/15-2/28/15. She stated, "No, I never did it."

o. On 3/18/15 at 2:10 p.m., RN #1 was asked about the phone call she received from the hospital on 2/28/15 concerning the resident's PICC line. She stated, "It was a short phone call... I think it was the ER supervisor and he wanted to know who had been caring for the PICC line. I told him the IV certified nurses, and he basically told me he didn't agree with the technique. That was pretty much it. I didn't know anything about it because I had been gone." She was asked if she did any of the PICC line dressing changes for the resident. She stated, "No." She was asked if she

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did any of the wound vac dressing changes for the resident. She stated, "No. I didn't do any of them."

p. On 3/18/15 at 2:30 p.m., the Administrator was asked if he was aware of the above issue involving Resident #2. He stated, "No."

2. The facility's policy for Dressing Change for Vascular Access Devices received from the Registered Nurse Consultant on 3/17/15 documented, "Policy: To prevent local and systemic infection related to the IV site... For Midlines and all CVADs [Central Venous Access Devices]... Apply Biopatch around catheter at insertion site after alcohol has dried. [Biopatch is a small dressing containing cholrhexidene] A transparent dressing must be placed over the Biopatch dressing..."

3. The immediate jeopardy was removed and the scope and severity lowered to an "E" when the facility implemented the following plan of removal:

a. The following plan constitutes our abatement of the immediate jeopardy deficiency cited on 3/24/15:

Reeducation was conducted by DON [Director of Nursing]/Designee with nursing staff regarding following: changing and dressing PICC lines, ensuring discharge orders for antibiotics are implemented, performing treatments as ordered by physician, following physician orders, immediately assessing condition of wounds and obtaining treatment orders, performing treatments utilizing proper technique. This was initiated on 3/24/15 at 10:30. This will be completed by 3/24/15 at 11:00 p.m.

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b. Any nursing staff member not completing the above required reeducation will not be allowed to return to work until the reeducation is complete.

c. Facility wide skin reviews conducted for each resident, initiated 3/24/15 at 10:30 a.m. by DON/Designee and will be completed 3/24/15 by 11:00 p.m.

d. Any wounds identified during skin reviews will be communicated with physician and treatment orders will be obtained by DON/Designee by 3/24/15 at 11:00 p.m.

e. Dressing change/treatment observations, including PICC line dressing changes at 3x/week x 4 weeks, then weekly x 4 weeks will be conducted by DON/Designee starting 3/24/15 at 1300 [2:00 p.m.].

f. Admissions from last 30 days will be reviewed by Medical Records/Designee to ensure any orders for antibiotics were implemented. This will be initiated on 3/24/15 at 2 pm and will be completed by 11:00 p.m. DON/Nurse management will review readmit orders weekly x 6 weeks.

g. Treatment Administration Records will be reviewed daily by nurse management to ensure treatments are performed according to physician orders. Negative findings will be corrected immediately and reported to DON.

h. Physician orders will be reviewed daily in start up meeting to ensure orders have been carried out and followed. Negative findings will be corrected immediately and reported to

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F 309	Continued From page 12 Administrator. i. In all of the above steps, negative findings will be reported to QAPI [Quality Assurance Performance Improvement] committee for further review and/or recommendations.	F 309		
F 314 SS=K	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #19963 and #20015 was substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure necessary treatment and services to promote healing of pressure sores, to prevent/decrease infection, and to prevent continued skin breakdown was provided to Residents #2 and #6. The facility failed to ensure intravenous (IV) antibiotics were administered as prescribed upon discharge from hospital for a wound infection for 1 (Resident #2) of 2 (Residents #2 and #6) case mix residents who had a pressure ulcer. The facility failed to ensure a thorough skin assessment was completed and documented upon	F 314		

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admission/readmission and at least weekly to enable prompt identification and prompt consultation with physician regarding treatment of any existing or new skin breakdown for 1 (Resident #2)) of 2 (Residents #2 and #6) case mix residents who had a pressure ulcer. The facility failed to ensure pressure ulcer treatments were provided as ordered by the physician to promote healing for 1 (Resident #2)) of 2 (Residents #2 and #6) case mix residents who had a pressure ulcer.

The facility also failed to ensure correct technique was provided when cleansing a wound to prevent potential spread of infection for 1 [Resident #6] of 2 [Resident #2 and #6] case mix residents who had pressure sores.

The failures to ensure IV antibiotics were administered as prescribed and that orders for treatments were promptly obtained resulted in immediately jeopardy which caused or could have cause serious harm, injury, or death to Resident #2 who experienced further deterioration in his wounds resulting in hospitalization and had a potential to cause more than minimal harm to 3 residents with pressure sores according to a list provided by the Administrator on 3/24/15 at 11:40 a.m. The Administrator was informed of the Immediate Jeopardy on 3/24/15 at 11:40 a.m.

The findings are:

1. Resident #2 was admitted to the facility on 1/9/15 and had diagnoses of Sepsis, Peripheral Vascular Disease (PVD), Guillain-Barre, and Diabetes Mellitus (DM) Type 2. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/16/15 documented

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the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive to total assistance for activities of daily living; had diabetic foot ulcers; had no pressure ulcers and was at risk for developing pressure ulcers.

The hospital history and physical examination form dated 12/19/14 documented, "...Assessment /Plan: Dry ulcer of the medial aspect of the right heel and blister formation of the medial aspect of the left heel. Stage II coccygeal ulcer..." The resident's hospital discharge orders for continued services dated 1/9/15 documented, "...Wound/skin Care (described): Pressure off load relief to sacral wound, turn as much as possible. Heels sheepskin boots..."

The facility's admission-data collection form dated 1/9/15 documented, ".... [Resident's] Skin: Pressure Sore [Stage I-IV] toes, Bilat [bilateral] Heels, Coccyx..." The Braden Scale assessment form dated 1/9/15 documented the resident had a score of 13; with a total score between 13-14 indicating moderate pressure sore risk.

a. The January 2015 Physician's order sheet documented, " ...1/11/15: Send to wound care clinic for bilateral feet wounds." The resident's initial visit to the wound clinic was dated 2/5/15; 25 days after the order had been written.

b. The first treatment order for the pressure sores to the lower extremities which were present upon admission (1/9/15) documented, "1/15/15 N.O. [new order] written 1/14/15 ... 1) clean all 10 toes with Saf-clens and apply betadine daily ... 2) Clean (L) [left] heel/diabetic ulcer with Saf-clens and apply skin prep ... 3) clean R [right]

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heel/diabetic ulcer with Saf-clens and apply skin prep." The order did not include a treatment order for the coccyx area also noted on admission.

c. The February 2015 Physicians Orders dated documented, "2/5/15 Clean wound to Rt. [right] heel with NaCl [sodium chloride], pat dry, apply 50/50 mix Gentamicin ointment [and] Santyl ointment to wound bed only. Apply moist gauze, cover [with] foam, wrap [with] cling gauze. Secure with tape daily and PRN [as necessary]."

As of 3/24/15 there was no order found in the clinical record or on the current physician orders for a treatment for the coccyx area nor was the treatment for the coccyx area on the Treatment Administration Record (TAR) for the coccyx .

d. The wound care measurement from 1/9/15 through 2/11/15 documented on Wound Care reports as follows:

1) 1/9/15 - " Right Heel Stage III 4 [centimeters (cm)] x 1.5 [cm] heavy yellow drainage." This measurement was not documented on the facility's admission data-collection form dated 1/9/15.

1/13/15, 1/22/15, and 1/29/15 - " ...Right Heel-Stage III 4 x 1.5 cm"1/29/15,

2/6/15, and 2/11/15 - " ...Right Heel, Stage III 4 x 2 cm"

2) 1/9/15, 1/13/15, 1/22/15, 1/26/15 - " ...Left Heel, NAS [not able to stage] -1.5 x 1.5cm."

1/29/15, 2/6/15, and 2/11/15 - " ...Left Heel, NAS

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F 314	Continued From page 16 - 2 x 2cm." 3) 2/4/15 - " ...Toes times 10 - NAS scattered area of necrosis with worsening to (B) [bilateral] fifth toe." 4) The Wound Care Report did not address the size of the coccyx wound from 1/9/15 through 2/11/15. e. A Nurse's Note dated 2/13/15 at 6:30 a.m. documented, " ...Resident heard mumbling, then yelling at unseen stimuli. When asked, resident yelled about green people and purple people. Resident noted pale, blood tinged green mucous noted in corner of mouth. MD [Medical Doctor] notified. New order received, 'send to [hospital] ER [emergency room] for decreased LOC [level of consciousness] with hallucinations'..." f. A Hospital Discharge Summary dated 2/20/15 documented, "Adm [Admitted]: 2/13/15 ...Upon arrival to the ED [Emergency Department] the patient was found to have a LLL [left lower lobe] pneumonia and to have infected right heel decubitus ulcer. A central line was placed due to poor access and the patient was started on IV [intravenous] vanc [Vancomycin], levaquin, and zosyn. According to the nursing home the patient has been on Bactrim DS [Double Strength] since 2/8/15 for the infection on his right heel. The patient has a known history of Guillain-Barre with significant motor weakness, diabetes, CAD [coronary artery disease], and HTN [hypertension]... Patient was admitted with sepsis and started on broad spectrum antibiotics... His source was found to be his infected RLE [right lower extremity] heel ulceration. Orthopedics was consulted and recommended amputation	F 314		

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however patient refused. He was taken to OR [operating room] and had debridement and wound vac was placed. His cultures have grown proteus. (He also has culture from facility with MRSA [Methicillin-resistant Staphylococcus aureus])... There is a soft tissue defect overlying the right calcaneus with exposed calcaneus to the open environment... ID [Infectious Disease] was consulted and recommended long term antibiotics with IV vanc and invanz... Patient has had many discussions with physicians regarding possible need for amputation however he would like to continue to try to avoid this. Patient will continue IV antibiotics and wound care at the nursing home... Discharge medications and new prescriptions: Start taking these medications - ertapenem 1 gram Recon [reconstituted] Soln [solution], Commonly known as: INVANZ. Inject 1,000 mg [milligrams] by intravenous injection every 24 hours... Vancomycin 1000 mg Recon Soln, Commonly known as VANCOCIN. Inject 1,500 mg by intravenous infection every 12 hours..."

g. The resident was readmitted to the facility on 2/20/15. The facility Admission Orders sheet dated 2/20/15 and completed by Licensed Practical Nurse (LPN) #1did not document any treatment orders for the resident's toes, his left and right heel or his coccyx.

The facility Admission Orders sheet dated 2/20/15 and completed by Licensed Practical Nurse (LPN) #1 documented a list of medications, including Vancomycin, however, the Invanz was not documented on the Admission Orders sheet. The Admission Orders sheet was signed by the Medical Director. The February 2015 MAR did not have Invanz listed as a medication to be

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F 314	Continued From page 18 administered. 1) On 3/17/15 at 1:44 p.m., LPN #1 was asked if he remembered Resident #2. He stated, "Yes. He was my first admission, and it was a complicated one." He was asked what he meant by that and he stated, "The hospital changed the report like three different times." He was asked what they changed and he stated, "It was all about the Vancomycin. First they wanted it given, then they changed their minds and wanted it held. It was all about the Vanc." He was asked about the process of getting information from the hospital and admitting a resident. He stated, "They fax the information and they call and give report." He was asked what kind of information the hospital faxed. He stated, "Discharge paperwork, orders for treatments..." He was asked if he remembered looking at the discharge orders from the hospital and he stated, "[Social] brought me the copy of the discharge orders from the hospital. I have to have the paperwork from the hospital in order to get the medication orders. They don't give that over the phone." At this time, the LPN was shown the discharge order sheet from the hospital and the IV Invanz that he did not add to the facility admission sheet. He stated, "I don't remember seeing that because I would have had to look that medication up to even know what it was." 2) On 3/18/15 at 10:39 a.m., LPN #2 was asked about 2/28/14 when she sent (Resident #2) to the hospital. She stated, "He was running a temp, he was lethargic, his left face was drooping, his leg was swollen and his PICC was occluded." LPN #2 was asked about the condition of the PICC line when the resident was sent out to the hospital. She stated, " .... The foot with the wound vac was terribly inflamed. [Physician] from the	F 314		

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F 314	Continued From page 19 hospital called me really upset. She asked about the PICC. I told her I had been off. The Vanc was scheduled to be given that morning and I couldn't give it because it was occluded. Then the doctor called back and asked about when the Invanz was hung. I went to the MAR and there was no Invanz. So I went to the chart and the first medication on the hospital discharge orders was Invanz. I don't know how it got missed." LPN #2 was asked to clarify if she saw the hospital discharge orders and that the Invanz was on the order sheet. She stated, "Yes. I saw them. They were in the miscellaneous section of the chart and Invanz was the first medication listed." She was told the facility could not locate the hospital discharge orders now and she was asked if she had any idea where they might be. She stated, "I don't understand that. They were in the chart. I looked at them ...." h. The care plan dated 2/20/15 documented, " ...Problem: Impaired skin integrity R/T [related to] PVD, occlusion of femoral vein. ...Interventions: A: Change wound vac dressing per MD order B: wound vac place to R [right] heel pressure area C: cleanse diabetic ulcer on R foot per MD order D: Treat F/U [follow up] to coccyx per MD order." i. A Nurses Note dated 2/20/15 at 4:45 p.m. documented, "Resident admitted back to here. Wound vac on (R) heel change dressing M,W, F [Monday, Wednesday, Friday] till healed ..." There was no documentation of a skin assessment to determine current status of skin breakdown. A Telephone order dated 2/20/15 documented "Change wound vac dressing M, W, F til Dr. [doctor] DC [discontinue] wound vac."	F 314		

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j. The Nurse's note dated 2/21/15 documented, "0500 - Eval. [evaluated] R [resident] bottom during pericare by CNA's [Certified Nursing Assistants], dirty drsg [dressing]. noted to coccyx dated 2/16/15. Removed drsg., several open areas clustered in area approx. [approximately] 5cm x 6cm, Stage II PU [pressure ulcer]. Obtained Tx [treatment] order -" ...1) clean with wound cleanser, pat dry, apply collagen drsg. cover with dry drsg, and change every day and PRN [as necessary] - also noted 2 skin tears to top of (R) foot, no drsg. noted. Obtained Tx order - 1) clean wound [with] wound cleanser, pat dry, apply TAO [triple antibiotic ointment] and cover with dry drsg. QD [everyday] and PRN orders noted. Will notify POA [power of attorney] later in am [morning]..."

A Telephone order dated 2/21/15 documented, " ...Clean wound to coccyx [with] wound cleaner, pat dry, apply collagen drsg [dressing] cover [with] dry drsg [and] [change every] 3 days [and] prn [as needed] soiling or dislodgement." A Telephone order dated 2/21/15 documented, " ...Clean wound to top of R [right] foot [with] wound cleaner, pat dry, apply TAO [triple antibiotic] [and] cover [with] dry drsg. QD [every day] [and] prn soiling or dislodgement ..."

k. The February 2015 TAR did not document the ordered treatment as being provided for the resident's coccyx area on the following dates: 2/23/15, 2/24/15, 2/25/15 and 2/26/15. The wound vac to the right heel pressure sore was scheduled to be changed on 2/25/15; the date was blank on the February 2015 TAR.

1) On 3/17/15 at 1:44 p.m., LPN #1 who was scheduled to work with the resident on 2/23/15

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and 2/26/15 was shown the resident's TAR. When asked about the reason for the blanks on the TAR for the resident's coccyx treatment on 2/23/15 and 2/26/15, LPN #1 had no comment.

2) On 3/18/15 at 10:39 a.m., LPN #2 who was scheduled to work with Resident #2 on 2/25/15 was shown the February 2015 TAR and the blanks on the TAR. When asked why the TAR was blank for the resident's coccyx and right heel treatment and the wound vac change on Wednesday 2/25/15 LPN #2 stated, "The ADON [Assistant Director of Nursing] asked me if I was okay with doing the wound vac dressing and I told her I wasn't comfortable with doing it. I asked her [ADON] if she would show me how [to change wound vac]. She [ADON] never came down [to resident's room] so it [wound vac change] wasn't done." LPN #2 was asked about the blanks on the TAR for the coccyx wound treatments for 2/23/15 and 2/26/15?" LPN #2 stated, "I know. There's no excuse for that."

3) On 3/18/15 at 2:10 p.m., Registered Nurse (RN) #1 was asked if she had done any of the wound vac dressing changes for Resident #2. She stated, "No. I didn't do any of them."

I. A Situation Background Assessment Recommendation (SBAR) Communication Form dated 2/28/15 [not timed] and completed by LPN #2 documented, " ...Change in mental status, temperature, right foot 4+[edema]... Temp 100.5... Wound vac to right heel... Stage 3 to 4 wound right heel, wound coccyx..."

A Nurse's Note dated 2/28/15 at 7:30 a.m. by LPN #2 documented, "Resident, definite change in mental status, unable to swallow breakfast, left

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side of mouth droopy, ...right foot 4+ edema, left foot 4+ edema... 118/94, 100.5, 86, 24. Pulse ox [oximeter] 94%... 8:40 a.m. - EMTs [emergency medical technicians] here to transport to [hospital]..."

m. A hospital history and physical dated 2/28/15 at 3:15 p.m. documented, "...Pt. [patient] presents from SNF [Skilled Nursing Facility] with fever. Recently discharge after being treated for sepsis due to R heel ulcer. He was discharged on vanc + Ertapenem but apparently has not been getting the latter according to MAR [medication administration record] and discussion with nurse at the facility... Wound Care Consult: Coccyx, dorsal right foot, and Stage IV right heel. Wound Assessment: Right Dorsal foot dry abrasion covered with 4x4 [gauge] Mepilex. Moisture skin damage to sacrum... Removed wet to dry dressing from Stage IV Right Heel. Debrided portion of wound improving, 7.8 x 8.3 x 2.8cm, beefy red, moist, clear drainage with no odor. Peri-wound distal to open wound non-viable necrotic tissue area 5 x 9 cm unable to determine depth at this time. ...Wound vac dressing noted to right heel dated 2/23/15."

The hospital's Physician's Progress notes dated 3/1/15 at 1:04 p.m. documented, "...Assessment: Fever: likely due to untreated R heel decub [decubitus] with cellulitis and osteomyelitis; wound cx [culture] previously with proteus and MRSA [Methicillin-resistant Staphylococcus Aureus]."

2. Resident #6 had diagnoses of Senile Dementia, Atrial Fibrillation and Decubitus ulcer. The Quarterly MDS with an ARD of 12/23/14 documented the resident scored 9 (8-12 indicates

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moderately impaired) on the BIMS; required extensive assistance from staff for activities of daily living; and had no pressure ulcers.

a. The Plan of Care updated 3/11/14 documented "9/30/13 - Resident is at risk for skin breakdown and pressure ulcers related to incontinence, decreased mobility, fragile skin."

b. A Physician Order dated 3/11/15 documented, "Clean wound to coccyx with NS [normal saline], fill wound bed with collagen fluff, apply skin prep to edges, cover with foam dressing, change every day."

c. On 3/18/15 at 1:39 p.m., LPN #2 provided wound care to the resident's coccyx area. The open area measured approximately 2 centimeters (cm) x 2 cm. The LPN used Kerlix and normal saline to clean the wound. She stated the facility was out of 4x4s. When cleaning the wound , the LPN wiped across the wound bed five times instead of starting in the center of the wound and working outward away from the open area. Collagen fluff was placed in the wound bed, skin prep was applied around the wound and it was covered with a foam dressing. There were no signs of infection. The LPN was asked if she had ever been taught to clean wounds by starting in the center and using a circular pattern while going outward away from the wound. She stated, "No."

3. The immediate jeopardy was removed and the scope and severity lowered to an "E" when the facility implemented the following plan of removal:

a. The following plan constitutes our abatement of the immediate jeopardy deficiency cited on 3/24/15:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24	F 314		

Reeducation was conducted by DON [Director of Nursing]/Designee with nursing staff regarding following: changing and dressing PICC lines, ensuring discharge orders for antibiotics are implemented, performing treatments as ordered by physician, following physician orders, immediately assessing condition of wounds and obtaining treatment orders, performing treatments utilizing proper technique. This was initiated on 3/24/15 at 10:30. This will be completed by 3/24/15 at 11:00 p.m.

b. Any nursing staff member not completing the above required reeducation will not be allowed to return to work until the reeducation is complete.

c. Facility wide skin reviews conducted for each resident, initiated 3/24/15 at 10:30 a.m. by DON/Designee and will be completed 3/24/15 by 11:00 p.m.

d. Any wounds identified during skin reviews will be communicated with physician and treatment orders will be obtained by DON/Designee by 3/24/15 at 11:00 p.m.

e. Dressing change/treatment observations, including PICC line dressing changes at 3x/week x 4 weeks, then weekly x 4 weeks will be conducted by DON/Designee starting 3/24/15 at 1300 [2:00 p.m.].

f. Admissions from last 30 days will be reviewed by Medical Records/Designee to ensure any orders for antibiotics were implemented. This will be initiated on 3/24/15 at 2 pm and will be completed by 11:00 p.m. DON/Nurse management will review readmit orders weekly x

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045361	A. BUILDING _____ B. WING _____	C 03/24/2015

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F 314	Continued From page 25 6 weeks. g. Treatment Administration Records will be reviewed daily by nurse management to ensure treatments are performed according to physician orders. Negative findings will be corrected immediately and reported to DON. h. Physician orders will be reviewed daily in start up meeting to ensure orders have been carried out and followed. Negative findings will be corrected immediately and reported to Administrator. i. In all of the above steps, negative findings will be reported to QAPI [Quality Assurance Performance Improvement] committee for further review and/or recommendations.	F 314		