STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375519	A. BUILDING _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALERA MANOR, LLC	1061 NORTH ACCESS ROAD CALERA, OK 74730

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F 000	INITIAL COMMENTS A recertification and relicensure survey was conducted on 07/20/15, 07/21/15, 07/22/15, and 07/23/15.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	**F 157** RECEIVED AUG 17 2015 Long Term Care 1. Resident #25 has completed antibiotics and no wound odor is present at this time. Wound care will continue to be provided daily per her physician's orders. Physician will be notified promptly of any decline. On 7/24/15 all licensed nurses were inserviced regarding pressure ulcers, wounds, wound odors and prompt notification of physician.	08/18/15

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

Heather Mitchell | Administrator | 8/13/15

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, it was determined the facility failed to ensure the physician was notified when there was a potential for a required physician ordered intervention for one (#25) of 29 residents sampled whose medical records were reviewed. The facility failed to notify the physician after noticing a wound odor from a pressure ulcer which delayed a treatment for ten days. The Director of Nursing (DON) identified 49 residents who resided in the facility. Findings: The facility's 'Care and Prevention of Pressure Ulcer' policy documented the following: "...If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and color as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective." 1. Resident #25 was admitted to the facility on 01/02/13. Diagnoses included pressure ulcers, cellulitis/abscess, skin and subcutaneous tissue disorders, pain, abnormal loss of weight, muscle weakness, muscular disuse atrophy, anxiety, and Alzheimer's Disease. A significant change assessment, dated 11/17/14, documented the resident's cognition was severely impaired; required extensive assistance with activities of daily living (ADLs) and did not	F 157	2. All residents are potentially affected by this alleged deficient practice. 3. DON, ADON, and MDS Nurse will do weekly measurements of all pressure areas together. Staging of wounds will be done by DON or RN only. DON or RN will monitor the skin book daily for compliance and to ensure the physician has been notified promptly of any decline. QA committee will monitor monthly for compliance. RECEIVED AUG 17 2015 Long Term Care	

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F 157	Continued From page 2 ambulate; was always incontinent of bowel and bladder; and had two stage II pressure ulcers with eschar being the most severe tissue type. A skin assessment, dated 01/19/15, documented a stage II pressure ulcer on the resident's right hip which measured 2.5 x 2.0 x 2.2 centimeter (cm) with granulation, undermining, and drainage. The following were skin assessments and physician's orders for the pressure ulcer on the resident's right hip: A physician's order, dated 01/22/15, documented to clean the area to the right hip with wound cleanser (WC), pat dry, apply Santyl to wound bed, pack with Santyl cover gauze; cover with non border foam dressing and secure with tape daily x 14 days. 01/26/15---stage II---2.3 x 1.5 x 2.0 cm with slough, undermining, drainage and odor. (There was no documentation of the physician being notified about the odor to the pressure ulcer.) 02/02/15---stage II---2.3 x 1.5 x 2.0 cm with slough and drainage. A physician's order, dated 02/05/15, documented to continue the previous order. A physician's order, dated 03/20/15, documented to clean the right hip wound with WC, pat dry, apply Santyl to wound bed, pack with Santyl covered gauze; cover with non border foam and abdominal (ABD) pad and secure with tape daily x 14 days. 03/30/15---stage II---1.3 x 1.0 x 3.0 cm with	F 157		

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F 157	Continued From page 3 undermining and drainage. 04/06/15---stage II---1.3 x 1.0 x 2.5 cm with slough, undermining, drainage, and odor. (There was no documentation of the physician being notified about the odor to the pressure ulcer at this time.) 04/13/15---stage II---1.3 x 1.0 x 2.0 cm with slough, undermining, drainage, and odor. A physician's order, dated 04/16/15, documented the resident was to receive Bactrim DS 800-160 milligram one tablet twice a day for hip pressure ulcer. (The treatment for the pressure ulcer was obtained ten days after the odor was first noticed on 04/06/15.) A physician's order, dated 04/20/15, documented to clean the right hip wound with WC, apply thin layer of Vasolex ointment and Vaseline gauze; cover with 4x4 and ABD pad daily x 14 days. 04/23/15---stage II---1.0 x 0.5 x 1.0 cm with slough, undermining, drainage and odor. On 07/23/15 at 10:15 am, the DON was asked why the physician had not been contacted until ten days later after the odor from the pressure ulcer had first been noticed. The DON stated she did not feel the odor had been from an infection but had been from necrotic tissue.	F 157		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 4 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to ensure resident assessments accurately reflected the residents' status for two (#25 and #47) of 29 sampled residents whose assessments were reviewed. The quarterly assessment, dated 05/20/15, and the significant change assessments, dated 11/17/14 and 07/05/15, had inaccurately staged the pressure sores for resident #25. The admission assessment, dated 03/22/15, had inaccurately assessed resident #47	F 278	**F 278** 1. On 7/27/15 a significant change assessment was completed on Resident #25 to correct the staging of wounds from stage II to unstageable. On 7/27/15 a bladder assessment was completed on Resident #47. Resident #47 was found to be frequently incontinent. The 3/22/15 assessment for Resident #47 was modified to correct the inaccuracy. On 7/27/15 DON, ADON, and MDS Nurse measured all pressure areas together. DON checked the accuracy of the staging of all pressure areas at that time. As of 8/12/15 all residents have had a new bowl and	08/18/15

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F 278	Continued From page 5 as always continent of urine. The facility identified five residents with pressure sores and 30 residents occasionally or frequently incontinent of urine. Findings: 1. Resident #47 was admitted to the facility on 03/09/15. The resident's diagnoses included overactive bladder, congestive heart failure, and edema. A bowel and bladder evaluation, dated 03/09/15, documented the resident had a total score of 18. A score of 21-15 indicated the resident may be a candidate for bowel and bladder training. The admission assessment, dated 03/22/15, documented the resident's cognition was intact and was always continent. A bowel and bladder evaluation, dated 06/07/15, documented the resident had scored 18, was frequently incontinent of bladder and may be a good candidate for bowel and bladder training. A significant change assessment, dated 06/22/15, documented the resident's cognition was intact and was frequently incontinent of urine. A care plan, dated 06/22/15, documented the resident had an overactive bladder and experienced incontinent episodes of dribbling. On 07/22/15 at 12:36 p.m., the minimum data set (MDS) coordinator was interviewed regarding the resident becoming incontinent of urine per the 06/22/15 assessment after being in the facility for	F 278	bladder evaluation completed to ensure the accuracy of their assessments. 2. 35 residents are potentially affected by this alleged deficient practice. 3. DON, ADON, and MDS Nurse will measure all pressure areas together weekly. Staging of wounds will be done by DON or RN only. Bladder evaluations will be completed by MDS Nurse and DON will review for accuracy. QA committee will monitor monthly for compliance.	

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F 278	Continued From page 6 just three months. The MDS coordinator was shown the two MDS assessments with the admission assessment, dated 03/22/15, documenting the resident was always continent of urine and three months later the significant assessment, dated 06/22/15, documenting the resident was frequently incontinent of urine. The MDS coordinator said she thought the confusion between the two assessments was due to the fact the resident would wet her depends at night but would change them before the staff knew she had been incontinent. The MDS coordinator said the resident did her own care. On 07/23/15 at 11:30 a.m., the Director of Nursing (DON) was shown the two assessments. The DON said the admission assessment, dated 03/22/15, was probably wrong. The DON said the resident's briefs in the mornings have always been wet with urine. On 07/23/15 at 11:49 a.m., the MDS coordinator looked at the admission assessment, dated 03/22/15, documenting the resident was always continent of urine. The MDS coordinator stated, " I was asking the wrong question and they did not understand what I was asking. I think the admission assessment was wrong." She said the resident had not been continent of urine since the resident was admitted to the facility. 2. Resident #25 was admitted to the facility on 01/02/13. Diagnoses included pressure ulcers, cellulitis/abscess, skin and subcutaneous tissue disorders, pain, abnormal loss of weight, muscle weakness, muscular disuse atrophy, anxiety, and Alzheimer's Disease. A skin assessment, dated 11/17/14, documented	F 278		

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F 278	Continued From page 7 a stage II pressure ulcer to the resident's right hip which measured 3.0 x 2.0 x <0.1 cm with eschar, slough, and drainage. (A pressure ulcer with eschar and slough is considered unstageable.) A significant change assessment, dated 11/17/14, documented the resident's cognition was severly impaired; needed extensive assistance with activities of daily living (ADLs) and did not ambulate; was always incontinent of bowel and bladder; two stage II pressure ulcers with eschar being the most severe tissue type. (The assessment did not include an unstageable pressure ulcer or the pressure ulcer dimensions.) The following are skin assessments for the pressure ulcer on the resident's right hip: 11/24/14---stage II---2.0 x 2.0 x <0.1 cm with eschar, slough, and drainage. 12/01/14---stage II---2.0 x 2.5 x <0.1 cm with eschar, slough, and drainage. 12/15/14---stage II---2.5 x 3.0 x <0.1 cm with eschar and slough. 12/22/14---stage II---3.0 x 3.5 x <0.1 cm with eschar and slough. 12/29/14---stage II---3.0 x 3.0 x <0.1 cm with granulation and slough. 01/05/15---stage II---2.8 x 2.5 cm with granulation, slough and drainage. 01/12/15---stage II---2.5 x 2.0 x 2.0 cm with granulation and drainage. (A pressure ulcer with a 2.0 cm depth and granulation and no slough is	F 278		

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F 278	Continued From page 8 considered a stage three (III) pressure ulcer.) 01/26/15---stage II---2.3 x 1.5 x 2.0 cm with slough, undermining, drainage and odor. 02/02/15---stage II---2.3 x 1.5 x 2.0 cm with slough and drainage. 02/09/15---stage II---2.3 x 1.5 x 2.5 cm with granulation, slough and drainage. 02/16/15---stage II---2.3 x 1.5 x 2.0 cm with granulation, slough and drainage. A significant change assessment, dated 02/17/15, documented the resident had one stage one (I) pressure ulcer, two stage II pressure ulcers, and one deep tissue injury pressure ulcer with slough being the most severe tissue type. (The significant change assessment did not include an unstageable pressure ulcer or the pressure ulcer dimensions.) The following are skin assessments for the pressure ulcer on the resident's right hip: 02/23/15---stage II---2.3 x 1.5 x 2.0 cm with granulation, slough and drainage. 04/06/15---stage II---1.3 x 1.0 x 2.5 cm with slough, undermining, drainage, and odor. 04/13/15---stage II---1.3 x 1.0 x 2.0 cm with slough, undermining, drainage, and odor. 04/23/15---stage II---1.0 x 0.5 x 1.0 cm with slough, undermining, drainage and odor. 05/12/15---stage II---0.8 x 0.5 cm with slough and	F 278		

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F 278	Continued From page 9 drainage. 05/18/15---stage II---0.7 x 0.5 cm with slough and drainage. A quarterly assessment, dated 05/20/15, documented the resident had four stage II pressure ulcers with eschar being the most severe tissue type. (The quarterly assessment did not include an unstageable pressure ulcer or the pressure ulcer dimensions.) On 07/20/15 at 8:58 am, licensed practical nurse (LPN) #1 was asked why the resident's pressure ulcer was staged as a stage II when the ulcer had a 2.0 cm depth. The LPN said she did not know she could up-stage the wounds. She said she thought a registered nurse was supposed to stage the pressure ulcers. On 07/22/15 at 4:14 pm, the DON was asked about the inaccurate staging and incomplete documentation of the pressure ulcers. She stated she inserviced the nurses yesterday about the issues. She said the pressure ulcers with slough or eschar should have been staged as unstageable. The DON said she explained to the nurses they could increase stage severity of the pressure ulcers but the pressure ulcers could not be staged down to lower stage. On 07/23/15 at 9:05 am, the resident was observed receiving a pressure ulcer treatment to her right hip. The pressure ulcer was an approximate 0.2 cm pink open area. On 07/23/15 at 10:00 am, the minimum data set (MDS) coordinator was asked why the MDS assessments, dated 11/17/14, 05/20/15, and	F 278		

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F 278	Continued From page 10 07/05/15, did not include the unstageable pressure ulcer. She reviewed the skin assessments and said she should have documented an unstageable pressure ulcer instead of a stage II ulcer. The MDS coordinator was asked if she actually viewed the resident's skin and ulcers. She said, "Yes". 3. Resident #25 was admitted to the facility on 01/02/13 and had diagnoses which included pressure ulcers, cellulitis/abscess, skin and subcutaneous tissue disorders, pain, abnormal loss of weight, muscle weakness, muscular disuse atrophy, anxiety, and Alzheimer's disease. A significant change assessment, dated 02/17/15, documented the resident's cognition was severly impaired; needed extensive assistance with activities of daily living (ADLs) and did not ambulate; was always incontinent of bowel and bladder; and had one stage one (I) pressure ulcer, two stage II pressure ulcers, and one deep tissue injury pressure ulcer with slough being the most severe tissue type. (The significant change assessment did not include an unstageable pressure ulcer or the pressure ulcer dimensions.) A skin assessment, dated 04/09/15, documented the resident had a stage two (II) pressure ulcer on the right ball of her foot which measured 4.5 x 4.0 centimeters (cm) x unable to determined (UTD) with a purple/red blister with a yellow soft center. (The pressure ulcer was stagged as a stage II instead of an unstageable pressure ulcer.) The following are skin assessments for the resident's right foot: 04/13/15---stage II---4.5. x 4.0 cm with a red area	F 278		

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F 278	Continued From page 11 and yellow blister. 04/23/15---stage II---1.5 x 2.0 x <0.1 cm with a blister and white slough. 04/27/15---stage II---1.5 x 2.0 x 0.1 cm with white slough. 05/04/15---stage II---1.8 x 2.0 cm with slough. 05/18/15---stage II---3.0 x 2.0 cm with unopened red eschar and slough. (The pressure ulcer with eschar and slough continues to be staged as a stage II instead of an unstageable pressure ulcer.) A quarterly assessment, dated 05/20/15, documented the resident had four stage II pressure ulcers with eschar being the most severe tissue type. (The quarterly assessment did not include an unstageable pressure ulcer or the pressure ulcer dimensions.) The following are skin assessments for the resident's right foot: 05/25/15---stage II---2.7 x 2.0 cm with eschar and slough. 06/01/15---stage II---2.5 x 2.0 cm with eschar and slough. 06/08/15---stage II---2.5 x 2.5 cm with eschar and slough. 06/15/15---stage II---3.5 x 4.0 cm with black necrotic tissue, eschar, and drainage. 06/22/15---stage II---4.0 x 4.0 cm with slough and	F 278		

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F 278	Continued From page 12 drainage. 06/29/15---stage three (III)---4.0 x 3.5 x UTD with slough and drainage. A significant change assessment, dated 07/05/15, documented the resident had two stage II pressure ulcers with slough being the most severe tissue type and received hospice services. (The significant change assessment did not include an unstageable pressure ulcer/stage III or the pressure ulcer dimensions.) On 07/20/15 at 8:58 am, licensed practical nurse (LPN) #1 was asked why the resident's pressure ulcer was staged as a stage II and stage III when the pressure ulcer had slough and eschar. She stated the pressure ulcer should have been staged as unstageable. On 07/22/15 at 4:14 pm, the DON was asked about the inaccurate staging and incomplete documentation of the pressure ulcers. She stated she inserviced the nurses yesterday about the issues. The DON said the pressure ulcers with slough or eschar should have been staged as unstageable. The DON said she explained to the nurses they could increase the stage severity of the pressure ulcers but the pressure ulcers could not be staged down to a lower stage. On 07/23/15 at 9:05 am, the resident was observed receiving a pressure ulcer treatment to her right foot. The pressure ulcer was approximately 4 x 4 cm with slough. Registered nurse (RN) #1 was asked what was the stage of the pressure ulcer. She said it was a stage III. On 07/23/15 at 10:00 am, the minimum data set	F 278		

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F 278	Continued From page 13 (MDS) coordinator was asked why the MDS assessments, dated 05/20/15 and 07/05/15 did not include the unstageable pressure ulcer. She reviewed the skin assessments and said she should have documented an unstageable pressure ulcer instead of a stage II ulcer. The MDS coordinator was asked if she actually viewed the resident's skin and ulcers. She said, "Yes".	F 278		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, it was determined the facility failed to ensure a resident with pressure ulcers received treatment and services to promote healing for one (#25) of three residents sampled for pressure ulcers. The facility failed to: a) accurately stage pressure ulcers. b) consistently describe the wound beds of the pressure ulcers. c) notify the physician about an odor from a	F 314	**F 314** 1. (a) On 7/27/15 a significant change assessment was completed on resident #25 to correct the staging of wounds from Stage II to unstageable. On 8/3/15 all licensed nurses were inserviced by our Wound Care Consultant Nurse regarding wound stages. 2. 5 residents are potentially affected by this alleged deficient practice.	08/18/15

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F 314	Continued From page 14 pressure ulcer for ten days which delayed the treatment. The Director of Nursing (DON) identified five residents residing in the facility with pressure ulcers. Findings: The facility's 'Care and Prevention of Pressure Ulcer' policy documented the following: "...If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and color as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective. 1. Resident #25 was admitted to the facility on 01/02/13 and had diagnoses which included pressure ulcers, cellulitis/abscess, skin and subcutaneous tissue disorders, pain, abnormal loss of weight, muscle weakness, muscular disuse atrophy, anxiety, and Alzheimer's disease. A quarterly assessment, dated 10/14/14, documented the resident's cognition was severly impaired; needed extensive assistance with activities of daily living (ADLs) and did not ambulate; was always incontinent of bowel and bladder; and had no pressure ulcers. A skin assessment, dated 11/10/14, documented the resident's right hip had a stage II pressure ulcer which measured 2.8 x 1.5 x <0.1 centimeters (cm) with granulation tissue. A physician's order, dated 11/10/14, documented	F 314	3. DON, ADON, and MDS Nurse will do weekly measurements of all pressure areas together. Staging of wounds will be done by DON or RN only. DON or RN will monitor the skin book daily for compliance. QA Committee will review monthly for compliance. 1. (b) On 7/27/15 DON, ADON, and MDS Nurse measured all pressure areas together. DON checked the accuracy of the staging of all pressure areas and ensured that the wound beds on all pressure areas were correctly described. On	

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F 314	Continued From page 15 to cleanse open area to right hip with wound cleanser (WC), pat dry, apply Triple Antibiotic Ointment (TAO), and cover with border foam every (q) day times (x) 14 days, then re-evaluate. A physician's order, dated 11/14/14, documented to clean area to right hip with WC, pat dry, apply Santyl and TAO, and cover with border foam dressing daily x 14 days. A skin assessment, dated 11/17/14, documented a stage II pressure ulcer measuring 3.0 x 2.0 x <0.1 cm with eschar, slough, and drainage. (A pressure ulcer with slough is considered unstageable.) A significant change assessment, dated 11/17/14, documented the resident had two stage II pressure ulcers with eschar being the most severe tissue type. The following are skin assessments and physician's orders for the pressure ulcer on the resident's right hip: 11/24/14---stage II---2.0 x 2.0 x <0.1 cm with eschar, slough, and drainage. A physician's order, dated 11/29/14, documented to continue with the previous order. 12/01/14---stage II---2.0 x 2.5 x <0.1 cm with eschar, slough, and drainage. 12/08/14---(no stage)---3.0 x 3.0 cm---(no description of wound bed). 12/15/14---stage II---2.5 x 3.0 x <0.1 cm with eschar and slough.	F 314	8/3/15 all licensed nurses were inserviced by Wound Care Consultant Nurse regarding staging of wounds and proper documentation of wound bed descriptions. 2. 5 residents are potentially affected by this alleged deficient practice. 3. DON, ADON, and MDS Nurse will do weekly measurements of all pressure areas together. Staging of wounds will be done by DON or RN only. DON or RN will monitor the skin book daily for compliance and to ensure that the wound bed is consistently described. QA Committee will review monthly for compliance.	

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F 314	Continued From page 16 A physician's order, dated 12/15/14, documented to clean area to right hip with WC, pat dry, apply Santyl; cover with gauze and Bactroban and cover with border foam daily x 14 days. 12/22/14---stage II---3.0 x 3.5 x <0.1 cm with eschar and slough. A physician's order, dated 12/23/14, documented to administer Bactrim DS 800-160 milligrams (mg) one tablet twice a day for skin disorder. 12/29/14---stage II---3.0 x 3.0 x <0.1 cm with granulation and slough. 01/05/15---stage II---2.8 x 2.5 cm with granulation, slough and drainage. A physician's order, dated 01/07/15, documented to clean the area to the right hip with WC, pat dry, apply Santyl, cover with gauze, and cover with border foam dressing daily x 14 days. 01/12/15---stage II---2.5 x 2.0 x 2.0 cm with granulation and drainage. (The pressure ulcer with a 2.0 cm depth and granulation and no slough or eschar is considered a stage three (III) pressure ulcer.) 01/19/15---stage II---2.5 x 2.0 x 2.2 cm with granulation, undermining, and drainage. A physician's order, dated 01/22/15, documented to clean the area to the right hip with WC, pat dry, apply Santyl to wound bed, pack with Santyl cover gauze; cover with non border foam dressing and secure with tape daily x 14 days.	F 314	1. (c) Resident #25 has completed antibiotics and no wound odor is present at this time. On 7/24/15 all licensed nurses were inserviced on pressure ulcers, wounds, wound orders, and prompt notification of physician. 2. 5 residents are potentially affected by this alleged deficient practice. 3. DON, ADON, and MDS Nurse will do weekly measurements of all pressure areas together. Staging of wounds will be done by DON or RN only. DON or RN will monitor the skin book daily for compliance and to ensure the physician has been promptly notified of any decline. QA Committee will review monthly for compliance.	

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F 314	Continued From page 17 01/26/15---stage II---2.3 x 1.5 x 2.0 cm with slough, undermining, drainage and odor. (The pressure ulcer with slough should be staged as an unstageable pressure ulcer. There was no documentation of the physician being notified about the odor to the pressure ulcer.) 02/02/15---stage II---2.3 x 1.5 x 2.0 cm with slough and drainage. A physician's order, dated 02/05/15, documented to continue the previous order. 02/09/15---stage II---2.3 x 1.5 x 2.5 cm with granulation, slough and drainage. 02/16/15---stage II---2.3 x 1.5 x 2.0 cm with granulation, slough and drainage. A significant change assessment, dated 02/17/15, documented the resident had one stage one (I) pressure ulcer, two stage II pressure ulcers, and one deep tissue injury pressure ulcer with slough being the most severe tissue type. The following are skin assessments and physician's orders for the pressure ulcer on the resident's right hip: A physician's order, dated 02/20/15, documented to continue the previous order. 02/23/15---stage II---2.3 x 1.5 x 2.0 cm with granulation, slough and drainage. 03/02/15---stage II---2.0 x 1.5 x 3.3 cm with undermining and drainage. (The documentation does not describe the pressure ulcer's wound bed.)	F 314		

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F 314	Continued From page 18 03/09/15---stage II---1.5 x 1.4 x 3.3 cm with undermining and drainage. 03/16/15---stage II---1.5 x 1.4 x 3.4 cm with undermining and drainage. A physician's order, dated 03/20/15, documented to clean the right hip wound with WC, pat dry, apply Santyl to wound bed, pack with Santyl covered gauze; cover with non border foam and abdomen (ABD) pad and secure with tape daily x 14 days. 03/23/15---stage II---2.2 x 1.5 x 3.4 cm with undermining and drainage. 03/30/15---stage II---1.3 x 1.0 x 3.0 cm with undermining and drainage. 04/06/15---stage II---1.3 x 1.0 x 2.5 cm with slough, undermining, drainage, and odor. (The physician was not notified of the odor from the pressure ulcer at this time.) 04/13/15---stage II---1.3 x 1.0 x 2.0 cm with slough, undermining, drainage, and odor. A physician's order, dated 04/16/15, documented Bactrim DS 800-160 mg, one tab, twice a day for diagnosis of hip pressure ulcer. (The treatment for the pressure ulcer was obtained ten days after the odor was noticed.) A physician's order, dated 04/20/15, documented to clean the right hip wound with WC, apply thin layer of Vasolex ointment and Vaseline gauze; cover with 4x4 and ABD pad daily x 14 days.	F 314		

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F 314	Continued From page 19 04/23/15---stage II---1.0 x 0.5 x 1.0 cm with slough, undermining, drainage and odor. 04/27/15---stage II---1.0 x 0.5 x 1.0 cm with undermining and drainage. A physician's order, dated 04/28/15, documented to administer a Decubivite capsule every (q) morning. 05/04/15---stage II---0.8 x 0.5 cm with drainage. 05/12/15---stage II---0.8 x 0.5 cm with slough and drainage. 05/18/15---stage II---0.7 x 0.5 cm with slough and drainage. A physician's order, dated 05/20/15, documented to clean the right hip pressure ulcer with WC, pat dry, apply a thin layer of Vasolex ointment, cover with 4x4 and ABD pad; and secure with tape daily x 14 days. A quarterly assessment, dated 05/20/15, documented the resident had four stage II pressure ulcers with eschar being the most severe tissue type. The following are skin assessments and physician's orders for the pressure ulcer on the resident's right hip: 05/25/15----stage II---0.5 x 0.7 cm with drainage. 06/01/15---stage II---0.5 x 0.5 cm with a scab and drainage. 06/08/15---stage II---0.4 x 0.4 cm with a scab and	F 314		

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F 314	Continued From page 20 drainage. 06/15/15---stage II---0.4 x 0.4 cm with a scab. A physician's order, dated 06/18/2015, documented to clean the right hip with WC, pat dry, apply a thin layer of Vasolex, and cover with border foam dressing daily x 14 days. 06/22/15---stage II---0.4 x 0.4 cm with redness and a scab. 06/29/15---stage II---0.4 x 0.4 cm with a scab. A physician's order, dated 07/02/15, documented to continue the previous order. A significant change assessment, dated 07/05/15, documented the resident had two stage II pressure ulcers with slough being the most severe tissue type and received hospice services. The care plan, dated 07/05/15, documented the resident had a stage II pressure ulcer to the right hip which will heal by the next evaluation period. The following interventions were to: Keep the skin clean and dry. Perform treatment per order and if no improvement within two weeks notify the physician. Monitor for an increase in breakdown and signs/symptoms of infection. Assess for verbal and non-verbal signs of pain. Administer pain medications as ordered and assess for effectiveness. Provide pressure relieving device for bed and wheel chair. Assist with turning/repositioning every two hours	F 314		

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F 314	Continued From page 21 and as needed. Encourage food and fluid intake within dietary limits. Keep family and physician informed of her progress. The following are skin assessments for the pressure ulcer on the resident's right hip: 07/06/15---stage II---0.3 x 0.2 cm with a scab. 07/13/15---stage II---0.3 x 0.2 cm with a scab 07/20/15---stage II---0.3 x 0.2 cm with a scab. On 07/20/15 at 8:58 am, licensed practical nurse (LPN) #1 was asked why the resident's pressure ulcer was staged as a stage II when the ulcer had a 2.0 cm depth. The LPN said she did not know she could up-stage the wounds. She said she thought a registered nurse was supposed to stage the pressure ulcers. On 07/22/15 at 4:14 pm, the DON was asked about the inaccurate staging and incomplete documentation of the pressure ulcers. She stated she inserviced the nurses yesterday about the issues. She said the pressure ulcers with slough or eschar should have been staged as unstageable. The DON said she explained to the nurses they could increase stage severity of the pressure ulcers but the pressure ulcers could not be staged down to lower stage. On 07/23/15 at 9:05 am, the resident was observed receiving a pressure ulcer treatment to her right hip. The pressure ulcer was an approximate 0.2 cm pink open area.	F 314		

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F 314	Continued From page 22 On 07/23/15 at 10:15 am, the DON was asked why the physician was not contacted about the odor from the pressure ulcer until ten days later on 04/16/15. She stated she did not feel the odor was from an infection but was from necrotic tissue. 2. Resident #25 was admitted to the facility on 01/02/13 and had diagnoses which included pressure ulcers, cellulitis/abscess, skin and subcutaneous tissue disorders, pain, abnormal loss of weight, muscle weakness, muscular disuse atrophy, anxiety, and Alzheimer's disease. A significant change assessment, dated 02/17/15, documented the resident's cognition was severly impaired; needed extensive assistance with activities of daily living (ADLs) and did not ambulate; was always incontinent of bowel and bladder; and had one stage one (I) pressure ulcer, two stage II pressure ulcers, and one deep tissue injury pressure ulcer with slough being the most severe tissue type. A skin assessment, dated 04/09/15, documented the resident had a stage two (II) pressure ulcer on the right ball of her foot which measured 4.5 x 4.0 centimeters (cm) x unable to determined (UTD) with a purple/red blister with a yellow soft center. (The pressure ulcer was stagged as a stage II instead of an unstageable pressure ulcer.) A physician's order, dated 04/09/15, documented to apply border foam to the ball of the right foot daily x 14 days for the stage II pressure ulcer. The following are skin assessments and physician's orders for the resident's right foot:	F 314		

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F 314	Continued From page 23 04/13/15---stage II---4.5. x 4.0 cm with a red area and yellow blister. 04/23/15---stage II---1.5 x 2.0 x <0.1 cm with a blister and white slough. A physician's order, dated 04/23/2015, documented to clean the area to the ball of the right foot with wound cleanser (WC), pat dry, apply Granulex, and cover with border foam dressing daily x 14 days. 04/27/15---stage II---1.5 x 2.0 x 0.1 cm with white slough. A physician's order, dated 04/28/15, documented to administer a Decubivite capsule daily. 05/04/15---stage II---1.8 x 2.0 cm with slough. A physician's order, dated 05/06/15, documented to continue to clean the area to the ball of the right foot with WC, pat dry, apply Granulex, cover with boarder foam dressing daily x 14 days. 05/12/15---stage II---1.8 x 2.0 cm with dry skin and a scab. 05/18/15---stage II---3.0 x 2.0 cm with unopened red eschar and slough. (The pressure ulcer with eschar and slough continues to be staged as a stage II instead of an unstageable pressure ulcer.) A quarterly assessment, dated 05/20/15, documented the resident had four stage II pressure ulcers with eschar being the most severe tissue type.	F 314		

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F 314	Continued From page 24 The following are skin assessments and physician's orders for the resident's right foot: A physician's order, dated 05/22/15, documented to clean the area to the ball of the right foot with WC, pat dry, apply Santyl, and cover with boarder foam daily x 14 days for the stage II pressure ulcer.. 05/25/15---stage II---2.7 x 2.0 cm with eschar and slough. 06/01/15---stage II---2.5 x 2.0 cm with eschar and slough. A physician's order, dated 06/04/15, documented to continue to clean area to the ball of right foot with WC, pat and dry, apply Santyl, and cover with border foam daily x 14. 06/08/15---stage II---2.5 x 2.5 cm with eschar and slough. 06/15/15---stage II---3.5 x 4.0 cm with black necrotic tissue, eschar, and drainage. A physician's order, dated 06/18/15, documented to clean the right ball of foot with WC, pat dry, apply Santyl and Bactoban; and cover with calcium alginate and border foam daily x 14 days. 06/22/15---stage II---4.0 x 4.0 cm with slough and drainage. A physician's order, dated 06/23/15, documented to obtain an x-ray to right ball of foot for diagnosis of wound. A laboratory report, dated 06/26/15, documented	F 314		

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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 25 the culture was positive for fluoroquinolone-resistant enterobacteriaceae. A physician's order, dated 06/26/15, documented to start Augmentin 875 milligrams (mg) two times a day x 10 days. 06/29/15---stage three (III)---4.0 x 3.5 x UTD with slough and drainage. (The pressure ulcer with slough was documented as a stage III and did not document whether the sloth had covered the wound bed.) A physician's order, dated 07/02/15, documented to clean the right ball of the foot with WC, pat dry, apply Santyl and Bactoban; cover with calcium alginate, 4x4 abdomen (ABD) pad, and tape daily x 14 days. A significant change assessment, dated 07/05/15, documented the resident had two stage II pressure ulcers with slough being the most severe tissue type; and received hospice services. The care plan, dated 07/05/15, documented the resident had a stage II pressure ulcer to the ball of her right foot which will heal by next evaluation period. The following interventions were to: Keep the skin clean and dry. Perform treatment per order and if no improvement within two weeks notify the physician. Monitor for an increase in breakdown and signs/symptoms of infection. Assess for verbal and non-verbal signs of pain. Administer pain medications as ordered and assess for effectiveness.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375519	A. BUILDING _____ B. WING _____	07/23/2015

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F 314	Continued From page 26 Provide pressure relieving device for bed and wheel chair. Assist with turning/repositioning every two hours and as needed. Encourage food and fluid intake within dietary limits. Keep family and physician informed of her progress. The following are skin assessments and physician's orders for the resident's right foot: 07/06/15----stage III---4.0 x 4.0 x UTD with slough and drainage. 07/13/15---stage III---4.0 x 4.0 x UTD with slough, necrotic tissue and purulent. A physician's order, dated 07/16/15, documented to continue to clean with WC, pat dry, apply Santyl, and Bactoban; cover with calcium alginate, 4 x 4 gauze, and border foam daily x 14 days. 07/20/15---stage III---4.0 x 4.0 x UTD with slough and purulent. On 07/20/15 at 8:58 am, licensed practical nurse (LPN) #1 was asked why the resident's pressure ulcer was staged as a stage II and stage III when the pressure ulcer had slough and eschar. She stated the pressure ulcer should have been staged as unstageable. On 07/22/15 at 4:14 pm, the DON was asked about the inaccurate staging and incomplete documentation of the pressure ulcers. She stated she inserviced the nurses yesterday about the issues. She said the pressure ulcers with	F 314		

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F 314	Continued From page 27 slough or eschar should have been staged as unstageable. The DON said she explained to the nurses they could increase the stage severity of the pressure ulcers but the pressure ulcers could not be staged down to a lower stage. On 07/23/15 at 9:05 am, the resident was observed receiving a pressure ulcer treatment to her right foot. The pressure ulcer was approximately 4 x 4 cm with slough. Registered nurse (RN) #1 was asked what was the stage of the pressure ulcer. She said it was a stage III.	F 314		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	**F 425** 1. On 7/23/15 the expired Phenergan suppositories belonging to resident #44 were removed from active inventory. On 7/23/15 the three boxes of expired flu vaccine that was facility stock were removed from active inventory. On 8/3/15 all licensed nurses and CMA's were inserviced by a pharmacy employee	08/18/15

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F 425	Continued From page 28 by: Based on record review, observation, and interview, it was determined the facility failed to ensure timely identification and removal of expired medications from the current medication supply for one (#44) of six residents sampled for medications. The facility failed to remove 12 expired Phenergan suppositories and 24 expired doses of flu vaccine from the medication room's refrigerator. This had the potential to affect all 49 residents residing in the facility who received medications per the Director of Nursing. Findings: The facility's policy and procedure documented: "Pharmacy Policies and Procedures...insure that all product (medication/supplies) in the Pharmacy's inventory is rotated and/or reviewed on a consistent basis to prevent having expired medication/supply...The Pharmacy Manager will delegate to appropriate personnel the task of ensuring that all 'out dated' or 'expired' product/drug/supplies are removed from the pharmacy's inventory. This process will be done on at least a monthly basis. All expired medications/supplies will be removed from the active inventory and destroyed or returned for credit per the pharmacy's standard of practice in compliance with the State Board of Pharmacy Rules and Regulations." On 07/23/15 at 10:42 a.m., a tour of the medication storage room was conducted. The refrigerator was observed to contain a plastic package containing 12 Phenergan suppositories. The label on the package identified the	F 425	regarding checking of expiration dates and the process of reordering medications. On 8/5/15 our Pharmacy Technician did a complete audit of all medications in house. 2. All residents are potentially affected by this alleged deficient practice. 3. Pharmacy Technician or DON will audit all in house medications monthly to ensure all medications are removed from active inventory prior to reaching their expiration date. CMA's will check expiration dates prior to giving a medication to a resident. QA Committee will review monthly for compliance.	

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F 425	Continued From page 29 medication belonged to resident #44 and had been obtained from the pharmacy in November 2014. The expiration date on the 12.5 milligram (mg) suppositories was October 2014. The medication room refrigerator also contained three boxes (24 doses) of Fluarix (flu vaccine) that was facility stock. The expiration date on the flu vaccine was 06/30/15. On 07/23/15 at 10:44 a.m., Certified Medication Aide (CMA) #1 was asked who was responsible for checking the medications expiration dates. The CMA reported the company which supplied the facility's medications had a staff member who came and checked the medications every month. The CMA was asked when the medications had been last checked. She stated, "This month." On 07/23/15 at 11:20 a.m., the Administrator (ADM) was informed of the observed expired medications found in the medication room's refrigerator. The ADM reported the facility would take care of the problem.	F 425		