STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325044	A. BUILDING _____ B. WING _____	01/27/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION ARCH CENTER	3200 MISSION ARCH DRIVE ROSWELL, NM 88201

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 0166 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try to resolve each resident's complaints quickly.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to actively seek resolution for 1 (R#4) of 3 (R#4, #5, and #9) residents sampled for grievances. This deficient practice has the potential for residents to feel ignored and their needs not being met. The findings are: A. Record review of Resident #4's admission face sheet revealed an admission date of [DATE] with recent admission of 12/02/15. Admission [DIAGNOSES REDACTED]. B. Record Review of Resident #4's Physician Orders, dated 12/03/15, revealed: Custom order UTI, start Bactrim, 1 capsule by mouth twice a day for 7 days. Physician order, dated 12/06/15, revealed: Change catheter site, transparent dressing, indicate external catheter measurement change catheter securement device upon admission and weekly. Physician order, dated 12/07/15, revealed: UTI results reviewed. Discontinue Bactrim and [MEDICATION NAME]. Give [MEDICATION NAME], 1 milligram (mg) intramuscularly, four times a day for three days; Start [MEDICATION NAME], 2 capsules by mouth four times a day. C. On 12/17/15, at 3:45 p.m., during an interview with Licensed Practical Nurse (LPN) #1 , LPN #1 stated Resident #4 is independent and does not require extensive care from the staff. LPN #1 advised, The CNA's only go in to change (Name of Resident #4) Foley bag. The family changes it most often. LPN #1 stated the CNA's only check on Resident #4 at the beginning, mid and end of shift unless Resident #4 call for assistance. D. On 12/18/15, at 9:00 a.m., during an interview with Resident #4, Resident #4 advised My admission to the facility was for rehabilitation and strength building. I was diagnosed in July with [MEDICAL CONDITION] bladder, resulting in the need for a Foley catheter. I had an infection, prior to the November admission, from the bladder to the kidneys and have had trouble getting the infection cleared. Resident #4 stated On or around 12/07/15, the staff did not check on me for about 6 hours. I filed 2 grievances with the facility because of poor response and care. I have medications that are taken four times per day and I have to remind staff that it is time to take the medication because they do not round often enough. I can press the call light and 20 minutes later the CNA will come. If a nurse is needed, the wait is about 30 - 45 minutes. Resident #4 advised that (Name of LPN #1) stated that the wait was due to the staff checking on other residents in the dining hall. Resident #4 stated, I have come to the conclusion that I should not ask for anything on the 2:00 p.m. - 10:00 p.m. shift. No one should have to wait that long for a response from the nursing staff. However, I feel it is relative to the nurse on duty. Resident #4 described an incident, I was in the bathroom and my Foley had fallen out completely. I pulled the call light for assistance. The CNA responded appropriately and stated that the nurse would be needed. I waited and waited and I finally got tired of waiting so I retrieved the Foley from the toilet and went to my bed, put on a Depends, and I continued to wait. I waited almost 1.5 hours before anyone came to my room to help me. E. Record review of the facility grievance log from 10/01/15 to 12/18/15 did not reveal any grievances reported by Resident #4. F. On 12/21/15 at 8:45 a.m., during an interview with the Social Services Specialist (SSS), the SSS stated, I did the initial assessment and 72 hour meeting with (Name of Resident #4), but I was not aware of any grievances filed by the resident. The SSS outlined the grievance process adding that CNA's are primarily the ones who get the complaints and are responsible for writing them up and/or verbally reporting them to the Social Services Department, but sometimes the CNA's forget and the grievances do not get filed. The SSS stated, We have some residents who are highly functioning and they expect care right then and there. They are high maintenance; (Name of Resident #4) is like that. When asked about the call light protocol, SSS replied, Call lights should be answered within 5 minutes. SSS stated that 45 minutes would not be an acceptable wait time. G. On 12/21/15, during an interview with the Director of Nursing (DON) and the Administrator (ADM), DON and ADM both stated call lights should be answered within 5 minutes. DON stated if a nurse is needed, the response time should also be 5 minutes. The DON and ADM both stated they were not aware of any grievance filed by Resident #4.
F 0279 **Level of harm** - Actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to care plan for the care and monitoring of 1) [MEDICAL TREATMENT] complications: bleeding and infection of the [MEDICAL TREATMENT] (process of filtering blood to remove toxic materials in the blood when kidneys are not functioning) access site, weight gain and [MEDICAL CONDITION] (swelling caused by fluid retention) low or high blood pressure, fatigue or weakness, 2) failed to care plan for care and monitoring of a Foley catheter and 3) failed to care plan for the care of a Gastrostomy tube (tube in the stomach for nutrition ([DEVICE])) for 1 (R #10) of 4 (R #1, #2, #3, and #10) residents reviewed for care plans. This deficient practice has the potential for complications to be undetected and not acted on in a timely manner. The findings are: A. Record review of R #10's admission face sheet revealed, an admission date of [DATE] with a [DIAGNOSES REDACTED]. B. Record review of R #10's complete record revealed no initial care plan addressing care and monitoring for [MEDICAL TREATMENT], [DEVICE] or Foley catheter. C. On 01/07/15 at 2:00 pm, during an interview with Clinical Reimbursement Coordinator Nurse (CRCN) #1, stated that the care plan for R #10, did not have any initial interventions for [MEDICAL TREATMENT], [DEVICE] or Foley catheter care and monitoring. The CRCN #1 stated Yes ma'am, when asked if these issues should be on the initial care.
F 0282 **Level of harm** - Immediate jeopardy **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** The survey team received a complaint on 12/09/15 concerning skin issues. Resident #3 was added to the sample based on the facility 802, which is a resident roster that includes current resident conditions. This resident roster indicated R #3 had pressure ulcers. Based on record review and interview the following was discovered. 1. R #3 developed a facility acquired pressure ulcer on the coccyx (tail bone), that was not discovered until the pressure ulcer was a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle). 2. The Stage IV pressure ulcer increased in size from 2.5 cm (length) by 1.5 cm (width) by 1.5 cm (depth) on 10/15/15 to 4 cm by 2 cm by 2 cm on 12/10/15. 3. R #3's physician documented the resident was having increased pain related to the pressure ulcer on the coccyx. 4. R#3 was not being bathed on a regular basis. 5. The facility was not administrating a pain medication to make moving and bathing of R #3 more comfortable.

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

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) 6. R #3's right foot was pressing against the air pump of her mattress. 7. R #3 developed a Stage II (a pale pink wound bed and serous (fluid that is pale yellow and transparent) drainage and presents itself as an abrasion or blister) pressure ulcer to the lateral (outer) side of the right foot on 10/08/15. 8. Staff were not providing the proper care to R #3 because of her resistance. Staff were not trained on how to deal with R #3 and her behaviors. This resulted in an Immediate Jeopardy being called on 12/23/15 at 11:35 am. A plan of removal was received and approved on 12/23/15 at 5:20 pm. The Plan of Removal included: 1. Re-education of the nursing staff on the in house wound development, beginning 12/23/15 by the Director of Nursing Services (DNS). 2. Skin sweep to begin immediately 12/23/15, for residents in house by administrative nursing staff. This was completed 12/23/15. 3. The physician will be notified of any identified areas. Also, treatment orders will be obtained, if found, starting on 12/23/15. 4. The DNS, the Wound Nurse (WC) and Nurse Practitioner (NP) will complete wound rounds weekly to monitor progression of wounds and facilitate changing of the orders if wounds fail to progress. 5. The WN will enter all wound orders. 6. The Inter Disciplinary Team (IDT) will review all orders in the CARE meeting. 7. Care plans will be reviewed during the CARE meeting and updated as needed. 8. The WN will distribute a weekly wound report to member of the IDT. 9. The IDT will make walking rounds to assess if the residents require it following have: heels floated, boots, turned and repositioned, any pressure relieving device that is needed, completed by the WN on 12/23/15. As of 4:30 pm, on 12/23/15, all preventative measures are in place. 10. Subsequent checks will be performed on each hall on an un-announced/surprise schedule at least weekly. Based on the Plan of Removal, the scope and severity was decreased from a J to a H, Level 3. Based on record review and interview, the facility failed to implement the care plan for 1 (R #3) of 2 (R#2, and #3) residents reviewed for pressure ulcers (PU). This deficient practice is likely to cause residents who are identified and assessed at risk for pressure ulcers to develop pressure ulcers. The findings are: A. Record review of Resident #3's Admission Face Sheet revealed Resident #3 was admitted on [DATE] with a readmission of 01/12/15. [DIAGNOSES REDACTED]. B. Record review of Resident #3's care plan, with focus, goals, and interventions, dated 09/22/15 revealed Resident #3 is dependent for Activities of Daily Living (ADL) care in bathing, grooming, dressing, eating, bed mobility, transfer, locomotion, toileting due to chronic disease that compromises functional ability. Goals, initiated on 01/30/15, include Resident #3's ADL care needs will be anticipated and met in order to maintain the highest practicable level of functioning and well being. Interventions include: Will often refuse baths/showers or even allow staff to clean up after bowel movement. Administer [MEDICATION NAME] as ordered prior to moving/cleaning/bathing up to 3 times per week. Additional Focus revealed Resident #3 is at risk for skin breakdown (pressure ulcer) related to incontinence, friction and shear, and [MEDICAL CONDITION], refusing to turn and position, include, Resident will not show signs of skin breakdown. Interventions include: Evaluate for any localized skin problems, like dryness, redness, pustules, inflammation. Evaluate for skin risk factors per protocol. Monitor skin for signs/symptoms of skin breakdown, dryness, redness, cracking, blistering, decrease sensation and skin that does not blanche easily. Observe skin condition with ADL care daily and report abnormalities. C. Record Review of R #3's medication administration records (MAR) dated 06/01/15 - 10/15/15 indicated the following: 1. Order dated 05/29/15 [MEDICATION NAME] Solution 50 milligrams/milliliter (MG/ML) inject 1 ml intramuscularly as needed for pain; moderate pain, may give up to 3 times per week when needing to move or clean patient. 2. R #3's MAR indicated [REDACTED]. 3. R #3's MAR indicated [REDACTED]. 4. R #3's MAR, dated 08/01/15 to 08/31/15 revealed no evidence of [MEDICATION NAME] being administered during the month of August 2015. 5. R #3's MAR indicated [REDACTED]. 6. R #3's MAR, dated 10/01/15 to 10/30/15 revealed no evidence of [MEDICATION NAME] being administered between 10/01/15 to 10/15/15, prior to the order being discontinued. D. Record review of Resident #3's SBAR (Situation Background Assessment Recommendation/Request) form, dated 10/07/15 revealed at 9:20 pm, the Certified Nurse Assistant (CNA) informed the nurse of a pressure ulcer on Resident #3's coccyx (tail bone). Assessment revealed a stage 4 (full thickness tissue loss with exposed bone, tissue or muscle) pressure ulcer with tunneling (a wound progressing deeper into the body creating a sinkhole). E. On 01/14/16, at 12:10 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated that the MAR's do not show that Resident #3 was given [MEDICATION NAME] as an intervention, per the care plan. When asked about Resident #3's bathing/ADL record, the ADON stated I only see bed bath one time.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The survey team received a complaint from the state survey central intake on 12/09/15. The complaint revealed that R #10 had wounds to both thighs that appeared to be burns. Investigation of the complaint also revealed that residents were not being assessed by the facility upon return from [MEDICAL TREATMENT]. Based on record review and interviews the following was discovered: 1. R #10 was transported to a local emergency department on 11/24/15 by EMS (Emergency Medical Service). EMS personnel documented both of R #10's legs in the groin area appeared to be scorch marks with blistering. EMS personnel also documented that R #10 was experiencing pain in his groin area from the wounds. 2. ER (emergency room) physicians and nurses documented R #10 was found to have excoriated/eroded skin to both thighs. 3. ER personnel suspected R#10 had possibly been abused/neglected at the facility and reported the facility to Adult Protective Services and the State Survey Agency. 4. R #10 had a physician order [REDACTED]. 5. There was no documentation to indicate the facility followed the physician order [REDACTED]. 6. Documentation indicated the facility was not providing the treatment for the affected areas as ordered by the physician on 11/20/15. 7. The local [MEDICAL TREATMENT] center reported on 12/11/15 that R#10 had not received proper oral care, was agitated, and had feces on his hands. 8. Review of the facility [MEDICAL TREATMENT] communication form indicated the facility did not respond to the concerns of the [MEDICAL TREATMENT] center regarding R #10. 9. Review of the local [MEDICAL TREATMENT] center communication sheet to the facility indicated that on 12/04/15 R #1 arrived with a foul body odor. The [MEDICAL TREATMENT] center also documents that on 12/09/15 R #1's [DEVICE] ([DEVICE]) was crusted, red and the resident was complaining of pain. On 12/15/15 the [MEDICAL TREATMENT] center documented R #1 was constipated and gave the resident 30 millimeters of the medication [MEDICATION NAME]. 10. There was no documentation to indicate the facility responded to or acted upon the concerns from the [MEDICAL TREATMENT] center for R #1. This resulted in an Immediate Jeopardy being called on 12/23/15 at 11:35 am. A plan of removal was received and approved on 12/23/15 at 5:20 pm. The Plan of Removal included: 1. Re-education of the nursing staff on the in house wound development, beginning 12/23/15 by the Director of Nursing Services (DNS). 2. Skin sweep to begin immediately 12-23-15, for residents in house by administrative nursing staff. This was completed 12/23/15. 3. The physician will be notified of any identified areas. Also, treatment orders will be obtained, if found, starting on

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F 0309

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 2)
12/23/15.
4. The DNS, the Wound Nurse (WN) and Nurse Practitioner (NP) will complete wound rounds weekly to monitor progression of wounds and facilitate changing of the orders if wounds fail to progress.
5. The WN will enter all wound orders.
6. The Inter disciplinary team (IDT) will review all orders in the CARE meeting.
7. Care plans will be reviewed during the CARE meeting and updated as needed.
8. The WN will distribute a weekly wound report to member of the IDT. 9. The IDT will make walking rounds to assess if the residents require it following have: heels floated, boots, turned and repositioned, any pressure relieving device that is needed, completed by the WN on 12/23/15. As of 4:30 pm on 12/23/15, all preventative measures are in place.
10. Subsequent checks will be performed on each hall on an un-announced/surprise schedule at least weekly.
[MEDICAL TREATMENT] - 1) The licensed staff will be re-educated by the DNS/Assist Director of Nursing Service (ADNS) beginning 12/23/15 on pre/post [MEDICAL TREATMENT] assessments. 2) The pre-[MEDICAL TREATMENT] assessment shall include:
Condition of the access site, complete set of vital signs, bruit, thrill, weight, medications administered, level of consciousness. 3) The post-[MEDICAL TREATMENT] assessments shall include: Residents level of consciousness upon returning to the facility, any complaints of pain or discomfort, bruit/thrill, condition of the access site, complete set of vital signs, weight upon return, any change of condition, level of consciousness. 4) The DNS/ADNS will validate the assessment has been completed after the resident returns from [MEDICAL TREATMENT] beginning 12/23/15. If anything was noted on the [MEDICAL TREATMENT] communication form from [MEDICAL TREATMENT], the IDT will ensure the charge nurse followed up with the
concerns noted by [MEDICAL TREATMENT].
Based on the plan of removal the scope and severity was decreased from a J to a G, Level 3.
Based on record review and interview, the facility failed to provide necessary care and services by:
1. Failing to follow a physician order [REDACTED].#10's thighs The physician had ordered foley catheter removal because of a possible allergic reaction to the plastic tubing. This deficient practice likely caused one (R #10) of one (R #10) residents reviewed for skin conditions to experience painful, excoriated, burn-like wounds to the groin/thigh area.
2. Failing to assess the [MEDICAL TREATMENT] catheter site and resident's physical condition and response to [MEDICAL TREATMENT] treatment for two (R #1 and R#10) of two (R#1 and R#10) reviewed for [MEDICAL TREATMENT]. The failure to assess
R #1 and R #10 upon return from [MEDICAL TREATMENT] has the potential for the facility to be unaware of possible severe flucations in blood pressure or bleeding from the [MEDICAL TREATMENT]. The findings are:
Findings for Resident #10
A. Record review of R #10's admission face sheet revealed, an admission date of [DATE] with a [DIAGNOSES REDACTED].
B. On 12/21/15 at 11:00 am, during an interview with R #10's Power of Attorney (POA) stated that R #10 had red areas on both thighs and when he was admitted to the (Name of Hospital) on 11/25/15 there were blisters.
C. Record review of the emergency department (ED) Nurse Documentation from (Name of Hospital) dated 11/25/15 revealed, page 2 of 5, assessment - general: 11/25/15 at 01:48 am, Pt's spouse states pt was here approximately 11/20/15. No wounds to inner thighs at that time, per spouse.
D. Record review of (Name of Hospital) General Information dated 11/25/15 revealed, On examination patient was found to have denuded (excoriated/eroded) skin in the medial aspect of both thighs. Questionable spilling of hot liquids and abuse at the nursing home is suspected and adult protective services contacted from the ED (emergency department).
E. Record review of the (Name of Ambulance) transport documentation dated 11/24/15, no time noted, revealed, Upon arrival to scene we found a male patient (pt) in the supine position laying in bed. The pt bed sheets that he was laying on appeared to be stained with brown liquid and had the appearance of being dirty. Below the pt groin on both legs appeared to be scorch marks with blister. The wound was not bandaged and did not appear to have any ointment on it. Staff at (name of nursing home) stated that the last time the pt went to [MEDICAL TREATMENT] the wound was not present but when he returned the wound was present. The nursing staff further stated that they believed it was from his sweat pants being too tight and because of this the rubbing from the sweat pants caused the wound. The staff also stated that they had been wrapping the wound with ace (trade name for elastic wrap) bandages but they stopped because the task was difficult for them. The pt would respond to questions by shaking his head up and down for yes and side to side for no. The pt signaled using this method that he was experiencing pain in his groin area from his wound.
G. Record review of the November 2015 treatment sheets for R #10 revealed, an order dated 11/20/15 for [MEDICATION NAME] cream to affected areas to both upper thighs bid (twice a day) for a rash that was not improving. There was no documentation to indicate treatment was provided as ordered on [DATE], 11/22/15 and 11/24/15.
H. On 12/22/15 at 4:10 pm, during an interview with the Director of Nursing Services (DNS) stated that the order for [MEDICATION NAME] for R #10, was not charted as done on 11/21/15, 11/22/15, 11/24/15.
I. Record review of a physician's orders [REDACTED].
J. Record review of nurse's notes for R #10 dated 11/23/15 until discharge to a local hospital on [DATE] revealed, no documentation that the physician order [REDACTED].
K. On 12/18/15 at 4:15 pm, during an interview with the DNS, stated that orders aren't always completed for several days and (R #10) was discharged to (Name of Hospital) before the order to remove the Foley catheter was carried through. The DNS further stated that the physician makes rounds and turns in all orders at the end of rounds, so there are just too many to complete on the day written.
[MEDICAL TREATMENT] - The [MEDICAL TREATMENT] deficiency is a repeat deficiency from a survey conducted on 08/19/15.
Findings for Resident #1
L. Record review of R #1's admission face sheet revealed, an admission date of [DATE] with [DIAGNOSES REDACTED]. The resident is dependent on nutrition being provided via a [DEVICE] (a tube inserted through a small incision into the stomach and is used for long-term enteral nutrition), and is also dependent on [MEDICAL TREATMENT] (a process that uses a man-made membrane to remove wastes such as urea, from the blood).
M. Record review of the Care Plan for R#1 dated 10/19/15 revealed: Focus- Resident #1 exhibits of is at risk for impaired renal function and is at risk for complications related to [MEDICAL CONDITION], [MEDICAL TREATMENT]. Interventions- Send
communication form to [MEDICAL TREATMENT] and review upon return. Transfer to (name of [MEDICAL TREATMENT] center) on
Monday, Wednesday, and Friday at scheduled time for treatment.
N. [MEDICAL TREATMENT] Communication Records for the month of November 2015 were not available in the Medical Record. [MEDICAL TREATMENT] Communications Records for the month of December 2015 revealed the following:
1. [MEDICAL TREATMENT] treatments were completed 12/02/15, 12/04/15, 12/07/15, 12/09/15, 12/11/15, 12/16/15, 12/18/15, 12/21/15.
2. Recorded problems following [MEDICAL TREATMENT] and noted on the [MEDICAL TREATMENT] Communication Sheets were: 1)
12/04/15, Arrived with foul body odor. 2) 12/09/15, [DEVICE] contains crust reddened area, complained of hurting. 3) 12/11/15, Foot check, dry and cold, needs cream. 4) 12/15/15, Patient constipated, [MEDICATION NAME] 30 ml. today and continue Tums with each meal.
O. Record review of the medical record revealed no evidence that these areas of concern were acted upon when R#1 returned to the facility following [MEDICAL TREATMENT] treatment.
P. On 12/17/15 at 2:55 pm, during an interview Licensed Practical Nurse (LPN) #1 stated that they do vitals when R#1 leaves to go to [MEDICAL TREATMENT], however doesn't check anything when the resident returns to the facility. The LPN stated, Frankly I just hook her back up to her tube-feeding. The LPN was asked if the [MEDICAL TREATMENT] Communication Sheet was
checked for any problems that occurred at [MEDICAL TREATMENT] the LPN stated, No I don't, I am usually slammed with admissions.
Findings for Resident #10

Q. Record review of R #10's admission face sheet revealed, an admission date of [DATE] with a [DIAGNOSES REDACTED].
R. Record review of a physician order [REDACTED].#10 revealed, [MEDICAL TREATMENT] days: Monday, Wednesday, Friday; Pick up:
1315 (1:15). 1. An order dated 11/07/15 revealed, Monitor AV (arteriovenous) fistual/graft (artificial vessel used to join the artery and vein for [MEDICAL TREATMENT]) site for S/S (signs/symptoms) infection, [MEDICAL CONDITION], bleeding and
upon return from [MEDICAL TREATMENT]. Notify primary care physician and [MEDICAL TREATMENT] unit if there are S/S of
infection if AV fistual/graft site is bleeding apply pressure for 15 minutes and notify MD/Physician extender if bleeding

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) does not stop. Ever shift. 2. Record review of R #10's Medication Administration Record [REDACTED]. The MAR for this order is not initialed as done by the nurse for the 10 pm-6 am shift for 11/9/15, 11/10/15, 11/11/15 and all shifts from 11/12/15 through 11/24/15. S. Record review of the facility [MEDICAL TREATMENT] communication record for R #10 revealed the following from the [MEDICAL TREATMENT] center: 1. 11/11/15 - BS (blood sugar) taken at 4:00 pm, 152. Blood Pressure (B/P) did increase as treatment (tx) continued, as high as 215/105. discharged stable. 2. 12/11/15 - Terrible oral care, needs it frequently, agitated pulling on Gastrostomy tube ([DEVICE] in the stomach for liquid feeding)/Catheter (tube in the bladder for draining urine)lines. Has feces on his hands needs to be cleaned. Access Condition: fair. T. Record review of the [MEDICAL TREATMENT] Communication Record revealed R #10 had [MEDICAL TREATMENT] treatments on 11/09/15, 11/11/15, 11/16/15, 11/18/15, 11/24/15 and 12/11/15. The Nurses Notes (NN) had no documentation for these dates for the return from [MEDICAL TREATMENT], or that a nursing assessment was completed for the access site for bleeding, vital signs, or general condition. NN's for the concerns the [MEDICAL TREATMENT] center noted on 11/11/15 and 12/11/15 show no documentation that the facility acted on the recommendation. U. On 12/21/15 at 10:50 am, during an interview with the DNS when asked about the charting for [MEDICAL TREATMENT] he stated that the facility had an in service (no date stated) but didn't have any [MEDICAL TREATMENT] patients until recently and had not done an audit on the charting. V. Record review of an education sheet, undated, revealed, If a resident is on [MEDICAL TREATMENT], we need to take special considerations. Please fill out and send with transportation the [MEDICAL TREATMENT] sheet. Upon the return of the resident, ensure the sheet made it back. If not, call the [MEDICAL TREATMENT] center and have them fax it over. Also, you must chart the resident back in with a short assessment summary. This goes for all residents coming back into the facility for whatever reason, with a set of vitals signs. Also, when assessing the resident, pay particular attention to the catheter site. Chart appearance, pain, and any dressing changes, etc. X. On 12/17/15 at 5:00 pm, during an interview with LPN #1, stated When they come back I don't usually reassess. LPN #1 further stated that they were told to be sure when they come back to put the [MEDICAL TREATMENT] sheet in the chart.
F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**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** The survey team received a complaint on 12/09/15 concerning skin issues. Resident #3 was added to the sample based on the facility 802, which is a resident roster that includes current resident conditions. This resident roster indicated R #3 had pressure ulcers. Based on record review and interview the following was discovered. 1. R #3 developed a facility acquired pressure ulcer on the coccyx (tail bone), that was not discovered until the pressure ulcer was a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle). 2. The Stage IV pressure ulcer increased in size from 2.5 cm (length) by 1.5 cm (width) by 1.5 cm (depth) on 10/15/15 to 4 cm by 2 cm by 2 cm on 12/10/15. 3. R #3's physician documented the resident was having increased pain related to the pressure ulcer on the coccyx. 4. R#3 was not being bathed on a regular basis. 5. The facility was not administrating a pain medication to make moving and bathing of R #3 more comfortable. 6. R #3's right foot was pressing against the air pump of her mattress. 7. R #3 developed a Stage II (a pale pink wound bed and serous (fluid that is pale yellow and transparent) drainage and presents itself as an abrasion or blister) pressure ulcer to the lateral (outer) side of the right foot on 10/08/15. 8. Staff were not providing the proper care to R #3 because of her resistance. Staff were not trained on how to deal with R #3 and her behaviors. This resulted in an Immediate Jeopardy being called on 12/23/15 at 11:35 am. A plan of removal was received and approved on 12/23/15 at 5:20 pm. The Plan of Removal included: 1. Re-education of the nursing staff on the in house wound development, beginning 12/23/15 by the Director of Nursing Services (DNS). 2. Skin sweep to begin immediately 12/23/15, for residents in house by administrative nursing staff. This was completed 12/23/15. 3. The physician will be notified of any identified areas. Also, treatment orders will be obtained, if found, starting on 12/23/15. 4. The DNS, the Wound Nurse (WC) and Nurse Practitioner (NP) will complete wound rounds weekly to monitor progression of wounds and facilitate changing of the orders if wounds fail to progress. 5. The WN will enter all wound orders. 6. The Inter Disciplinary Team (IDT) will review all orders in the CARE meeting. 7. Care plans will be reviewed during the CARE meeting and updated as needed. 8. The WN will distribute a weekly wound report to member of the IDT. 9. The IDT will make walking rounds to assess if the residents require it following have: heels floated, boots, turned and repositioned, any pressure relieving device that is needed, completed by the WN on 12/23/15. As of 4:30 pm, on 12/23/15, all preventative measures are in place. 10. Subsequent checks will be performed on each hall on an un-announced/surprise schedule at least weekly. Based on the Plan of Removal, the scope and severity was decreased from a J to a H, Level 3. Based on record review, observation, and interview, the facility failed to 1) identify the presence of a pressure ulcer on the coccyx until the pressure ulcer was a Stage IV, 2) failed to provide routine bathing, 3) failed to appropriately clean after incontinence episodes, 4) failed to reposition R#3 off coccyx, 5) failed to position the resident so the right foot would not rub against the mattress air pump, resulting in a Stage II pressure ulcer to the lateral side of the right foot for 1 (R #3) of 2 (R #2 and #3) residents reviewed for pressure ulcers. This deficient practice likely caused R #3 to suffer avoidable pressure ulcers. The findings are: A. On 12/18/15 at 10:10 am, observation of wound care for R #3, was conducted with the facility Wound Nurse (WN). Observation revealed, a Stage IV pressure ulcer on R #3's coccyx, measured - length 4 centimeters (cm), width 2 cm, depth 2 cm, slough (dead tissue with a yellowish appearance) was noted to the upper third part of the wound on the the tail bone and a healing Stage II pressure ulcer to R #3's right lateral foot, with minimal serosanguineous (drainage consisting of both blood and serous (pale yellow and transparent) fluid) drainage, 50 % slough, and measured - length 2.2 cm, width 2.0 cm. During observation the wound measurements and description were stated by the WN. B. On 12/18/15 at 10:10 am, during an interview with the WN, the WN stated that R #3's Stage IV pressure ulcer on the coccyx was in house acquired and was not found until it was a Stage IV. The WN stated that R #3 was non-compliant and refused to be turned. The WN also stated the Stage II pressure on R #3's right foot was caused by the resident's foot rubbing against the air mattress pump. C. Record review of the October 2015 Wound Management Tracking Tool (WMTT), revealed the following for R #3's Stage IV coccyx pressure wound: 1. Week 10/15/2015 revealed, Wound onset date 10/09/15, wound location - coccyx, type of wound - pressure, measures 2.5 cm (length) by 1.5 cm (width) by 1.5 cm (depth), with moderate exudate (drainage), slough, in house acquired (INA), Stage IV. 2. Week 10/22/15 and 10/29/15 revealed, measures 2.5 cm by 1.5 cm by 2 cm. These measurements revealed an increase in depth of the pressure ulcer. 3. The WMTT for November 2015 revealed, the coccyx wound documentation was not dated but revealed, measurements of 3 cm by 1.5 cm by 3 cm. These measurements revealed an increase in the length and depth of the pressure ulcer. 4. The WMTT for December 2015 revealed, for the weeks of 12/03/15 and 12/10/15 measurements of 4 cm by 2 cm by 2 cm. These measurements revealed an increase in the length and width of the pressure ulcer. D. Record review for R #3's WMTT revealed, Right lateral foot Stage II pressure wound.

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) 1. Week 10/08/2015 revealed, Wound onset date 10/05/15, wound location - right lateral foot, type of wound - pressure, measures 5 cm (length) by 3.5 cm (width), with light exudate, INA, Stage II. 2. Week 10/22/15 revealed, measurements of 4.5 cm by 3 cm by 0.1 cm with light exudate and tissue type slough, unstageable, progress - Decline: necrosis (dying tissue). 3. The WMTT for November 2015 revealed measurements of 2.5 cm by 2.5 cm by 0.7 cm. These measurements revealed an increase in the depth. 4. The WMTT for December 2015 revealed measurements of 2.7 cm by 2 by 0.6 cm. These measurements revealed an increase in the length. E. Record review of the Activities of daily living (ADL) care plan dated 01/20/15 and revised 05/04/15 revealed, Focus: dependent for care in bathing, grooming, bed mobility, transfer, and toileting due to chronic disease that compromises functional ability. Interventions: Administer [MEDICATION NAME] as ordered prior to moving/cleaning/bathing up to 3 times per week. Notify Nurse of refusals. F. Record review of the Activity of Daily Living Record (ADL) Records dated June 2015 through October 2015 revealed the following: l. June 2015 no documentation of any form of bathing. 2. July 2015 documentation show one shower on 07/27/15. 3. August 2015 documentation show one bed bath on 08/22/15. 4. September 2015 no documented of any form of bathing. 5. October 2015 no documentation of any form of bathing. G. Record Review of R #3's medication administration records (MAR) dated 06/01/15 - 10/15/15 indicated the following: 1. Order dated 05/29/15 [MEDICATION NAME] Solution 50 milligrams/milliliter (MG/ML) inject 1 ml intramuscularly as needed for pain; moderate pain, may give up to 3 times per week when needing to move or clean patient. 2. R #3's MAR indicated [REDACTED]. 3. R #3's MAR indicated [REDACTED]. 4. R #3's MAR, dated 08/01/15 to 08/31/15 revealed no evidence of [MEDICATION NAME] being administered during the month of August 2015. 5. R #3's MAR indicated [REDACTED]. 6. R #3's MAR, dated 10/01/15 to 10/30/15 revealed no evidence of [MEDICATION NAME] being administered between 10/01/15 to 10/15/15, prior to the order being discontinued. H. On 12/21/15 at 3:42 pm, during an interview with the Director of Nursing Services (DNS), the DNS stated that R #3 refuses care regularly and went months refusing to be turned, take showers or get out of bed. The DNS also stated the facility would call R #3's Power of Attorney (POA) to come to the facility and try to convince the resident to take a bath. I. On 12/21/15 at 2:35 pm, during an interview with R #3's (POA) stated she was aware that (R #3) refused care and states it was due to her mental status decline at the time. The POA stated she advised facility to bathe (R #3) regardless, but states(R #3) was not getting bathed regularly. R #3's POA stated she discovered the ones on her feet when she was painting resident's toenails. The POA stated (R #3) scoots down and feet hit the foot board and the air mattress pump rubs her feet. The POA stated that she feels this is the cause of the pressure sores on the feet. The POA further stated the coccyx pressure ulcer is between skin folds of buttocks and feels it was not found because they were not pulling the skin apart during baths. J. On 01/07/16 at 2:45 pm, during an interview with the Medical Director (MD), the MD stated that the CNAs did not open up the gluteal cleft (groove between the buttocks) when giving pericare or cleaning after incontinent episode. K. Record review of a physician order [REDACTED].#3) is on back, please make sure she is put on her sides more, pt beginning to get feeling and due to pressure ulcer experiencing more pain. L. On 12/22/15 at 10:39 am, during an interview with Registered Nurse (RN) #3, when asked about R #3's pressure ulcers, stated that the pressure ulcer on the resident's coccyx was not discovered until it opened up. She also stated when the pressure ulcer was discovered it was a Stage IV pressure ulcer.
F 0315 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to 1) maintain aseptic (free from contamination caused by harmful bacteria , viruses or other microorganisms) condition of a indwelling catheter by not changing catheter and bag when showing signs of crusting or having feces on tubing, 2) and failed to monitor for complications of Foley catheter use - signs and symptoms of Urinary tract infections (UTI'S) for 1 (R #10) of 3 (R #2, #10, and #5) residents reviewed for indwelling urinary catheters. This deficient practice likely resulted in R #10 developing a UTI with a strain of [DIAGNOSES REDACTED] (a bacteria which is resistant to several types of antibiotics). The findings are: A. Record review of the admission face sheet and nursing assessment dated [DATE] for R #10 revealed [DIAGNOSES REDACTED]. Further review of these records indicated R #10 had a indwelling urinary catheter because of immobility and skin breakdown. B. Record review of the facility Treatment Administration Record (TAR) dated 11/01/15 through 11/30/15 revealed an order dated 11/07/15 that indicated, Change Foley drainage bag when occluded (obstructed) or when Foley catheter is changed as needed. There was no documentation on the TAR to indicate the urinary catheter and bag had been changed. C. Record review of the facility's policies and procedures dated 06/01/1996 with revision date of 01/02/04 for Care of Indwelling Urinary catheter, revealed, 1) Perform catheter care twice a day and PRN, and 11.3) Change drainage bag with any catheter change or as needed. D. Record review of Nurse's Notes (NN) for R #10, from 11/07/15 through 11/24/15 revealed, no documentation about R #10's condition of the indwelling catheter, tubing or bag after 11/09/15. E. Record review from the (Name of Hospital) documentation revealed the following: 1. ED (Emergency Department) Nurse Documentation on 11/25/15 at 1:48 am, revealed, Emergency Medical Service (EMS) also reported facility requested ER (emergency room) to look at patient's (pt) Foley catheter because pt was pulling at catheter. Feces noted on catheter, dark yellow thick crystallized appearance to urine in Foley tube. 2. Documentation dated 11/25/15 from the (Name of Hospital) titled History of Present Illness, on examination patient Foley was found to have dirty urine and urine bag was changed, signed by (Name of Physician). 3. A Urinalysis report from (Name of Hospital) dated 11/25/15 revealed the following results indicating a urinary tract infection: Blood 4+ High - normal is negative, Leukocyte esterase (enzyme produced by white blood cells) 3+ High - normal is N (none), Red Blood Cells 5-9 high - normal is 0, White Blood Cells 10-15 High - normal is 0, and Bacteria 1+ High - normal is none'. 4. Record review of the (Name of Hospital) ED Nurse Documentation on 11/25/15 at 1:34 am, revealed, Assessment for neglect: Signs of neglect: poor hygiene observed. 5. Record review of the (Name of Hospital) ED Nurse Documentation on 11/25/15 at 3:27 am, Notified Adult Protective services at 2:58 am (for signs of neglect). 6. Record review of the (Name of Hospital) Physician Discharge Summary dated 12/03/15 for the hospital admission of 11/25/15 revealed, Hospital Course: abuse at the nursing home is suspected and adult protective services contacted from the ED. F. On 01/14/15 at 3:00 pm, during an interview with the Assistant Director of Nursing Service (ADNS), stated A Foley bag should be changed if occluded or leaking. The ADON also stated if the tubing was crusty and the urine bag had sediment in

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F 0315 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) the urine, it should be changed. The ADON stated Absolutely, the nurse should be assessing and use their nursing judgement to provide catheter care as needed.
F 0322 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to administer a Gastrostomy (tube in the stomach for nutrition) tube feeding per the physician's orders [REDACTED].#10) of 3 (R #1, 6, & 10) residents reviewed with [DEVICE]s, by giving a bolus feeding (an feeding poured down the tube at a faster rate). This failed practice could likely result in harm to the resident resulting in abdominal distention, or cramping from the faster infusion. The findings are: A. Record review of R #10's admission face sheet revealed, an admission date of [DATE] with a [DIAGNOSES REDACTED]. B. Record review of the Nurses Notes (NN) for R #10 revealed, 11/23 (no year) 2:00 am - Pt (patient) biting on feeding tube ([DEVICE]). Pulled over (feeding pump) 3 x (times) on to self and spilled formula. Unhooked and given bolus feeding. C. Record review of Physician order [REDACTED].# 10 revealed, Enteral (a way to provide food through a tube) Feed Order, every shift enteral feed formula: Nepro with carbohydrate steady at 50 milliliters per hour (ml/hr). Continuous. There was no evidence of a physician order [REDACTED]. D. Record review of the facility's policy titled Enteral Feeding: Administration by pump with revision dated 01/02/14 revealed, 1. Verify order. Order should include: 1.2 Method of administration - pump; 1.7 Method of delivery with time specifications - Bolus, Intermittent, Cyclic or Continuous. E. On 01/05/15 at 9:30 am, the Director of Nursing Services (DNS) was asked for the physician's orders [REDACTED]. At 2:20 pm, the DNS returned with an order dated 12/10/15 Enteral feed: Flush tube with 50 ml of water before each medication pass three times a day or 50 ml of water between each medication. After reviewing the order, the DNS was asked about the order for the bolus feeding. The DNS had no response and could not produce a physician order [REDACTED]. F. On 01/07/16 at 2:45 pm, during an interview with the Medical Director (MD) for the facility, the MD stated The nurse would need an order for [REDACTED].
F 0329 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The survey team received an onsite complaint from a family member of Resident #12 on [DATE] at 8:45 am. The family member was concerned that R #12 had recently returned to the facility and died shortly thereafter. Based on record review and interviews the following was discovered: 1. R #12 was being administered the medication, [MEDICATION NAME] (blood thinning medication given to prevent clots). 2. R #12 had a physician order [REDACTED]. 3. R #12 did not have a [MEDICATION NAME] Time/International Normalized Ratio (PT/INR) (a laboratory test that measures the balance in the blood between preventing clots and causing excessive bleeding), for the month of [DATE]. 4. R #12 had a fall at the facility on [DATE] at 4:30 am. 5. R #12 did not receive treatment for [REDACTED]. 6. Hospital documentation indicated R #12 sustained a right subdural hematoma and PT/INR lab results were abnormal. R #12 was given fresh frozen plasma and Vitamin K. The resident then required transport to a higher level of care. This resulted in an Immediate Jeopardy being called on [DATE] at 9:45 am. A plan of removal was received and approved on [DATE] at 9:30 am. The Plan of Removal included: 1. Dates for draws of the [MEDICATION NAME] Time/International Normalized Ratio (PT/INR) (a laboratory test that measures the balance in the blood between preventing clots and causing excessive bleeding), have been placed on the Medication Administration Record [REDACTED]. 2. The Physician is to be notified of the result of the PT/INR or the refusal to have the labs drawn with documentation. 3. All critical lab results will be called to the physician within one hour of receipt. 4. The laboratory book has been revised with directions on completing the required paperwork needed by the lab to process the lab draw. 5. This process will be monitored by the DNS/Designee for compliance 5 times a week to insure labs are being obtained and the Physician is notified. 6. The 24 hour report will be used by the off going nurse to give report to the oncoming nurse for changes and updates for the residents. Based on the plan of removal the scope and severity was decreased from a J to a G, Level 3. Based on record review and interview, the facility failed to monitor the effects of a blood thinning medication with laboratory monitoring from [DATE] to [DATE] for 1 (R#12) of 1 R(#12) residents reviewed for PT/INR (([MEDICATION NAME] Time and International Normalize Ratio to determine the clotting tendency of blood) . The PT/INR is used to monitor residents taking [MEDICATION NAME] (a blood thinning medication). This failure had the potential to cause abnormal bleeding and likely caused R # 12 to have to receive fresh frozen plasma (blood cells) as a result from an injury after a fall. The findings are: A. Record review for Resident #12 revealed the following: 1. physician's orders [REDACTED]. 2. Medication Administration Record [REDACTED]. [MEDICATION NAME] 6 mg. one time a day was given every Monday, Wednesday, and Friday, during the month of [DATE]. 3. physician's orders [REDACTED]. 4. Review of the laboratory section of the chart revealed no results related to the [MEDICATION NAME] for therapeutic monitoring. 5. Interdisciplinary Progress Note dated [DATE] revealed that the lab was not completed related to a lack of a physician's signature on the order. 6. There was no record that a PT/INR was completed for the month of [DATE]. B. Record review of the Emergency Department (ED) History and Physical Physician documentation dated [DATE] at 9:37 am, revealed that Resident #12 fell at (name of nursing home) and sustained a right-sided subdural hematoma (a collection of blood outside the brain usually caused by severe head injuries). Lab results obtained at that time revealed the resident had a PT of 76.8 (normal 9XXX,[DATE].90) and an INR of 6.36 (normal 1XXX,[DATE].30). Related to the injury and the abnormal PT/INR the resident was given fresh frozen plasma and Vitamin K. R #12 was transferred to another hospital for a higher level of care. C. Record review of a medical record Neurology Consultation dated [DATE] at a (name of local hospital) revealed that Resident received 4 units of of vitamin K (plays a key role in helping the blood clot preventing excessive bleeding), and 1 unit of Fresh Frozen Plasma (the fluid portion of one unit of human blood). D. On [DATE] at 12:30 pm, during an interview, the facility Nurse Practice Educator/Registered Nurse (NPE/RN) stated that the lab orders for the December PT/INR had been overlooked and not acted upon. The NPE/RN stated, They were just thrown in the basket with other lab orders and the PT/INR was not done for Resident #12. The NPE/RN stated that the nursing staff is responsible for notifying the physician that if lab results are not obtained or if they are abnormal.
F 0387 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that doctors visit residents regularly, as required.**

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F 0387 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that a physician provided an initial assessment/visit within 30 days and not physically visiting every 60 days thereafter for three Residents (R#2, #8 and #9) of thirteen (R#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) Residents sampled for initial physician assessments/visits and visits every 60 days. This deficient practice is likely to result in residents not receiving appropriate medical assessments, interventions, and treatments. The findings are: A. Record review of the Admission Face Sheet dated 03/21/14 for Resident #2 revealed that the resident had an admitting [DIAGNOSES REDACTED]. B. Record review of the medical record revealed no evidence that a physician performed an initial assessment/visit within 30 days of admission or any documentation that a physician personally visited with R #2 every 60 days thereafter, as required. The resident had regular visits from the Nurse Practictioner (NP) not the Physician. C. Record review of the Admission Face Sheet revealed Resident #8 was admitted to the facility on [DATE]. with a medical [DIAGNOSES REDACTED]. D. Record review of the medical record dated back to 08/19/15 revealed no evidence/documentation that a physician made visits to R #8 every 60 days. The NP visited with the resident not the Physician. E. Record review of the Admission Face Sheet for revealed Resident #9 was admitted to the facility 06/12/15 with a medical [DIAGNOSES REDACTED]. F. Record review of the medical record revealed no evidence that a physician performed an initial assessment/visit within 30 days of admission or any documentation that a physician personally visited with R #9 every 60 days thereafter, as required. The resident had regular visits from the Nurse Practitioner (NP) not the Physician. G. On 01/07/16 at 2:45 pm, during an interview the Medical Director (MD) stated that he was also the primary physician for most of the residents at the facility. The MD was asked if he or another physician performed an initial assessment/visit within 30 days and physically visited with every resident 60 days thereafter. The MD stated, I am here every Monday and Thursday. I follow the North Hall and the Skilled Unit. My Nurse Practitioner sees the residents that are in the Special Unit (Alzheimer's Unit) and the South Hall. The MD was asked if he did the initial assessment/visit and followed up every 60 days thereafter for the Special Unit and the South Hall the MD stated that he did not. The MD stated that he understood all beds in the facility were dually certified, but did not understand that he had the responsibility to visit with all the residents.
F 0497 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Review the work of each nurse aide every year; and 2) give regular in-service training based upon these reviews.** Based on record review and interview the facility failed to ensure that current Certified Nurse Aides (CNAs) received 1) 12 hours of in-service education, 2) ensure cognitive in-service education, and 3) complete performance reviews for 5 of 5 CNA personnel records reviewed for in service education and Annual Performance reviews. This failure had the potential for CNAs to not provide adequate care to the 109 residents of the facility as indicated by the Resident Census provided by the Administrator on 12/17/15. The findings are: A. On 01/07/16 review of the personnel files for CNA #3, 4, and 5 revealed the following: 1. CNA #3 - had 8 hours of in service training from 11/06/14 to 12/2015. 2. CNA #4 - had 7 hours of in service training from 07/11/14 to 12/2015. 3. CNA #5 - had 11 hours of in service training from to 10/17/15 to 12/2015. B. On 01/07/16 review of the personnel files for CNA #1, 2, 3, 4 and 5 revealed these CNA's did not attend an in service training for dementia management for the year of 2015. C. On 01/07/16 at 3:30 pm, during an interview with the Nurse Practice Educator stated that there was no in service training specific for dementia management and that these CNA's were short in service hours. D. Record review of the personnel files for CNA #1 with hire date of 09/04/14, CNA #2 with hire date of 10/23/14, CNA #3 with a hire date of 11/06/14, CNA #4 with a hire date of 07/11/14 and CNA #5 with a hire date of 10/17/03 revealed these CNA's did not have an annual performance review. D. On 01/08/16 at 3:40 pm, during an interview, the Director of Nursing Service (DNS) stated that the annual performance reviews were not done.
F 0502 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that laboratory (lab) tests were completed for 1 (R #7) of 5 (R#3, #4, #5, #7, #12) residents reviewed for lab results. By not completing an ordered lab test, the physician cannot accurately assess the resident's condition which is likely to result in a delayed [DIAGNOSES REDACTED]. A. Record Review of Resident #7's face sheet revealed an admission date of [DATE] with a readmission date of [DATE]. [DIAGNOSES REDACTED]. B. Record Review of Resident #7's Care Plan with focus, goals and interventions, dated 04/06/15, revealed Resident #7 has a [DIAGNOSES REDACTED]. Appropriate interventions include: access and record blood glucose levels as ordered and PRN (as needed), labs as ordered and report results to physician , monitor for signs and symptoms of hyper/[DIAGNOSES REDACTED] and report abnormal findings to physician. C. Record Review of Resident #7's physician progress notes [REDACTED].#7's last HgbA1c (glycated hemoglobin test that provides an average of blood sugar control over a period of 3 months and is used to make adjustments in diabetic medications) was 7.2 on 04/24/15, check HgbA1c and CMP every 3 months .THIS WAS DUE IN JULY! PLEASE CHECK ON THIS!! physician progress notes [REDACTED].THIS WAS DUE IN JULY! PLEASE CHECK ON THIS!! SECOND REQUEST!! D. Record Review of Resident #7's Physician Orders, dated 11/25/15, revealed: Requested Studies: Custom order (DM (Diabetes Mellitus): last HgbA1c 7.2 on 04/24/15, check HgbA1c and CMP every 3 months .THIS WAS DUE IN JULY! PLEASE CHECK ON THIS!! SECOND REQUEST!!) E. Record Review of Resident #7's lab results does not reveal any results for an HgbA1c for the month of July or for the order dated 11/25/15. F. On 1/11/16, at 3:30 pm, during an interview with the Medical Director, the Medical Director stated that the HgbA1c for Resident #7 is a standing order that is due every three months. The Medical Director agreed there were no results for the month of July or the Month of November, and stated, Her labs were up to date on her readmission from (Name of Hospital) on 12/02/15 and I have not referenced them again. G. On 1/15/16, at 9:27 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated that Resident #7's HgbA1c was last drawn on 12/02/15, which was her readmitted . The ADON stated, The lab was drawn in this facility on 4/24/15, and although it was supposed to be drawn every 3 months, it was not.
F 0505 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Quickly tell the resident's doctor the results of lab tests.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify the physician of the results of a urine culture in a timely manner for 1 (R #3) of 5 (R#3, #4, #5, #7, #12) residents reviewed for laboratory results. This failed practice had the potential for R #3 to not receive appropriate treatment in a timely manner. The findings are: A. Record review for R #3 Nurses Notes (NN) dated 10/26/15 revealed, N/O (new order) for UA (urinalysis). B. Record review of R #3's medical record revealed no laboratory results for the 10/26/15 ordered UA. C. Record review of the physician progress notes [REDACTED].#3, dated 11/09/15, revealed Please check on all pending labs (this included the UA results). PPN dated 11/12/15 revealed, Please check on all pending labs(this included the UA results), second request. PPN dated 11/16/15 revealed, Please make sure labs were done if not (this included the UA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325044	A. BUILDING _____ B. WING _____	**01/27/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION ARCH CENTER	**3200 MISSION ARCH DRIVE ROSWELL, NM 88201**

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 0505 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) results), for the third request please. D. On 01/05/16 at 11:35 am, during an interview with the Assistant Director of Nursing (ADON), when asked if R #3's physician had been informed of the UA collected on 10/27/15, the ADON stated that it was put in the physician folder on 10/30/15. When asked for the documentation that the physician had received the results, the ADON looked through the PPN and stated that it was not addressed until 11/19/15.