STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING _____ B. WING _____	**09/17/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - BRANDYWOOD	**555 E BLEDSOE GALLATIN, TN 37066**

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 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep each resident's personal and medical records private and confidential.** Based on policy review, observation, and interview, the facility failed to provide care in a manner to provide privacy for the residents that received therapy services. The facility identified a census of 76 residents that resided on 6 halls. The findings included: The facility's policy for Preservation of Residents Rights dated 2/26/15 revealed the facility would ensure Living Center Systems are designed, implemented, and monitored to address the resident's right to privacy and confidentiality. Observations in the TV day area on 9/16/15 at 8:28 AM, revealed a resident received occupational therapy while other residents and visitors were present. Further observation at that time revealed residents received therapy in view of other residents and visitors. The therapy staff spoke in front of the other residents and visitors and asked how a resident's pain was and if the medication was working. Observations on 9/16/15 at 10:29 AM, revealed six residents and an out-patient received therapy in an area where other residents, visitors, and staff could watch and overhear what the residents and staff were talking about. Observations on 9/26/15 at 11:00 AM, revealed a therapist sat on the physical therapy table with a resident's spouse and discussed with the spouse the resident's treatment plan and presence of pain. Multiple people and residents were in the area and able to overhear the conversation. Interview with Licensed Nurse #9 on 9/17/15 at 10:30 AM, revealed he/she was aware of the privacy issue on the 600 hall where therapy was also located. The facility failed to ensure the residents received privacy with care.
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interview, the facility failed to allow the resident to chose the type and/or frequency of bathing the resident received for 2 (Resident #85 and 159) residents of the sample. The facility identified a census of 76 residents. Sample size included 31 residents of which 3 were reviewed for choices. The findings included: 1. Review of the facility policy on Bath/Shower dated 1/26/15 revealed assessments may include Resident's preference for time of day, frequency and type of bath. Care Plan documentation guidelines included the assistance the resident needs with bathing and any resident preferences, precautions, special soap or lotion to be used. The policy did not address the frequency of baths or showers to be given. 2. Review of the medical record for Resident #85 revealed he/she was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #85 was not interviewable and could not make his needs known. Review of the care plan for Resident #85 included personal hygiene assistance of setting up bathing needs and providing assistance with personal hygiene and care for resident by staff. There was no specific type of shower or bath noted and nothing listing days or frequency. A confidential interview with a resident advocate on 9/14/15 at 11:52 AM, revealed Resident #85 was not being showered as often as he/she would have liked. The resident liked to take a shower every other day when he/she was living at home and that was not happening in the facility. The confidential interview with the advocate further revealed that the facility staff had been made aware of his former preferences but the facility was very short staffed and not providing the care. Review of the Certified Nursing Assistant (CNA) assignment sheet for Resident #85 revealed he/she was assigned showers on Monday/Thursday night shift. Review of the CNA documentation for 7/1/15-9/15/15 revealed Resident #85 had not received any showers during that time frame. Bathing documentation was limited to a bed bath or partial bath. Interview with Direct Care Staff #20 on 9/16/15 at 9:30 AM, revealed each resident has a shower assignment twice a week and the CNA's can find the information on their daily assignment sheet. Documentation of showers and baths are entered into the daily tracker system. Interview with Nurse Staff #7 on 9/16/15 at 11:43 AM, revealed Resident #85 was total care and could not assist with anything. The resident can't help with bathing and you have to anticipate his/her needs because he/she doesn't communicate much. Interview with Administrative Staff #4 on 9/16/15 at 4:44 PM, revealed the showers are scheduled on the CNA kardex by room number. The resident can make a change if their preference is different. The CNA's will go over the shower schedule with residents or family on admission. We like for the resident to get a shower at least twice weekly. Administrative Staff #4 was not aware that Resident #85 was not being showered. Interview with Clinical Staff #21 on 9/17/15 at 10:45 AM, revealed there was no reason why Resident #85 could not be showered, even with a pressure ulcer. 3. The facility's policy for Social Services, Resident Rights dated 2/26/15 revealed the social service staff will gather information to assist the resident in being able to make individual decisions and choices regarding . bathing. The Bath, Shower policy dated 1/26/15 documented the assessment may include the resident's preference for time of day, frequency, and type of bath. Medical record review revealed Resident #159 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] revealed the resident did not have any cognitive impairments and it was very important for the resident to choose between a bed bath, shower, or sponge bath. The MDS revealed the resident required total assistance with bathing and utilized a wheelchair. The Activity of Daily Living (ADLs) Care Area assessment dated [DATE] revealed the resident was admitted related to a car accident that caused multiple fractures and caused the resident decreased mobility. The resident was admitted primarily for rehab services with nursing care until the fractures had healed and the resident could go home. The Admission assessment dated [DATE] did not address the resident's choice for bathing. The care plan with the initiation date of 7/10/15 listed the interventions: Encourage choices with care and extensive assistance of 2 staff for all aspects of ADLs except for eating. The care plan did not list the resident's preference for bathing. Interview with the resident on 9/14/15 at 11:11 AM, revealed the resident would like to have a shower at least 2 times a week but only gets one at the most when the therapist is here. The resident stated he/she could complete the shower

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

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F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) him/herself after the staff applied a bag over the cast on the lower leg to prevent it from getting wet. Review of the Bathing Type Detail Report from 8/2/15 to 9/15/15 revealed the resident received a shower on 8/16/15, 8/28/15, 9/8/15, and 9/11/15. The resident received 4 showers and should have received at least 13 showers. Interview with Direct Care Staff #10 on 9/16/15 at 4:35 PM, revealed the day shift was scheduled to do the bathing for this resident. Interview with Direct Care Staff #18 on 9/17/15 at 8:30 AM, revealed everybody on the unit got a shower 2 times a week unless the resident wanted more. The other days the resident received a bed bath. The facility failed to allow the resident to choose how many times a week the resident received a shower.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy/procedure review, observation, and interview, the facility failed to provide reasonable room accommodations based on resident preferences for 1 of the 31 sampled residents (Resident ##6) and 1 un-sampled resident. The facility identified a census of 76 residents, sample size included 31 residents. The findings included: Review of the facility's Preservation of Residents' Rights policy dated 2/24/15 revealed the social services staff will promote and advocate the preservation of all resident's rights. This includes the residents' personal privacy during personal care. Interview with Resident #6 on 9/14/15 at 11:00 AM, revealed he/she has to share a bathroom with 2 members of the opposite sex and he/she does not like it. Resident #6 stated there is no way of knowing when someone is in the bathroom and he/she just walks in on them. The resident further stated that he/she is very hard of hearing and even if he/she knocks on the door before entering, he/she cannot hear if there is a response. On 9/15/15 at approximately 3:00 PM, a male resident in room [ROOM NUMBER] motioned the surveyor into his room and requested assistance to get his bathroom door unlocked from the inside. Upon entering room [ROOM NUMBER] to access the shared bathroom, it was noted to be a room with female residents. The door was then unlocked. Interview with Administrative Staff #4 on 9/17/15 at 3:30 PM, revealed it was unknown if there was a facility policy about room assignments and sharing bathrooms with the opposite gender. The Administrative staff member stated he/she would be ok with sharing a bathroom if there was a lock on the door. Interview with Administrative Staff #1 and #8 on 9/17/15 at 6:50 PM, revealed the facility does not have a policy prohibiting room assignments with shared bathrooms to the opposite sex. Administrative Staff #8 stated the facility tries to accommodate resident preferences if at all possible but some residents will be sharing a bathroom with the opposite sex. Administrative Staff #1 stated that Resident #6 must have overheard her roommate complaining about sharing a bathroom with the opposite sex and now wanted a room change also.
F 0272 **Level of harm** - Actual harm **Residents Affected** - Few	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation, and interview, the facility failed to conduct comprehensive and/or accurate resident assessments initially and/or periodically as necessary to assess each resident's functional capacity for 2 of 31 residents reviewed for comprehensive assessments (Resident #85 - pressure ulcers and 1 - psychosocial). The failure of the facility to properly assess Resident #85's skin condition, develop and implement an appropriate plan of care following the facility policy, resulted in Resident #85 developing a pressure ulcer, which resulted in actual harm to this resident. The facility identified a census of 76 residents. The sample included 31 residents. The findings included: 1. Review of the medical record for Resident #85 revealed he was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #85 was not interviewable. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was coded as being at risk for pressure ulcers but not having any unhealed pressure ulcers. Review of the MDS assessment dated [DATE] revealed the resident was coded as being at risk for pressure ulcers but not having any unhealed pressure ulcers even though the medical record indicated the resident had a pressure ulcer. Review of Resident #85's care plan dated 5/6/14 revealed a problem identified with altered skin integrity, not pressure related. Interventions included weekly skin inspection, monitor for signs and symptoms of infection, and provide pressure reduction/relieving mattress. The care plan did not contain any interventions for turning or positioning. Review of the weekly skin assessment sheets revealed on 4/20/15, a wound was noted on the right buttocks and was being labeled an abrasion. A wound evaluation flow sheet starting 6/15/15 labeled the wound as an abrasion but listed measurements of 1.5 centimeters (cm) by 2.2 cm and clear drainage. On 6/29/15, the wound had the same measurements but the classification was changed to a stage 2 pressure ulcer. On 7/28/15, the wound measurements were 1.5 cm x 1.5 cm x 0.5 cm and the classification was changed again to unstageable. Interview with Nursing Staff #24 on 9/14/15 at 3:00 PM, revealed Resident #85 had an unstageable pressure ulcer to his/her right hip. Wound care observations for Resident #85 on 9/15/15 at 3:50 PM, Nursing Staff #22 revealed that the resident developed the pressure ulcer on his/her right hip or buttocks from a poorly fitted geriatric chair. At first they called the wound an abrasion and then it was decided to call it a pressure ulcer. Nursing Staff #22 further revealed the wound was infected and now the resident was in isolation. Interview with Clinical Staff #21 on 9/17/15 at 9:53 AM, revealed he/she started coming back into the facility every 2 weeks and making rounds with the treatment nurses and assessing the wounds. Initially Resident #85 presented with what the facility was calling an abrasion. I think we determined it was a pressure ulcer when it opened up. We determined that it developed from the geriatric chair that wasn't fitted properly because of the increased contractions in his/her legs. The wound bed appears pink from what I can see but it doesn't go straight back, it tunnels upward. It wasn't healing and the cultures indicated there was an infection. Resident #85 is currently in isolation from the infection. He/she confirmed that this was the resident's first pressure ulcer. Interview with Administrative Staff #12 on 9/17/15 at 11:25 AM, revealed Resident #85 only has abrasions not pressure ulcers and that is why the last 2 MDS assessments do not have pressure ulcers listed. Administrative Staff #12 stated We identified that we had issues with assessing and staging of our wounds when the new Director of Nursing came. The last assessment was done on 8/2/15. I didn't have the information at that time calling it a pressure ulcer The Administrative Staff #12 confirmed that he/she does not do the actual physical assessments, he/she just gets the information off the chart documentation. Interview with Administrative Staff #4 on 9/17/15 at 2:18 P.M. revealed the facility had problems with identifying and assessing wounds when he/she started working in the building in July. Administrative Staff #4 could not confirm what Administrative Staff #12 looked at when completing the required assessments. Failure of the facility to properly assess Resident #85's skin condition, develop and implement an appropriate plan of care following the facility policy, resulted in Resident #85 developing a pressure ulcer, which resulted in actual harm to this resident. 2. The facility's Psychosocial Assessment policy (dated 2/26/15) was reviewed and indicated As members of the interdisciplinary care plan (ICP) team, the social services staff will participate in the development of a comprehensive assessment on each resident. The facility 's Psychosocial Assessment policy indicated The social services staff will complete a psychosocial assessment for each new resident in conjunction with the ARD (Assessment Reference Date) of the admission MDS/RAI (Minimum Data Set/Resident Assessment Instrument). Assessment information will be reviewed in conjunction with each subsequent MDS/RAI- quarterly assessment, annual reassessment, significant change in status reassessment, and/or as required . 3. Medical record review revealed Resident #1's most recent re-admitted was on 12/25/12. Resident #1 had diagnoses, of Hypertension, [MEDICAL CONDITIONS] Disorder, [MEDICAL CONDITION], Hypopotassemia, Vitamin D Deficiency, Dysphagia, Urinary Incontinence, and Joint contractures in multiple sites. This resident has resided at the facility for the past [AGE] years.

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F 0272 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) Resident #1's annual MDS dated [DATE] indicated Resident #1's Brief Interview for Mental Status (BIMS) could not be completed due to resident is rarely/never understood. The MDS indicated Resident #1 was given the staff assessment for Mental Status which indicate Resident #1 was assessed as severely impaired - never/rarely made decisions. The MDS indicated Resident #1 had highly impaired - absence of useful hearing, had no speech - absence of spoken words, rarely/never understood by others, rarely/never understands others, and has highly impaired vision defined by object identification in question, but eyes appear to follow `objects. Resident #1's MDS indicated the resident was total dependence - full staff performance every time during entire 7-day period for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). The MDS indicated Resident #1 required complete staff assistance to perform transferring between surfaces including to or from: bed, chair, wheelchair, standing position. The MDS indicated Resident #1 required total staff assistance for locomotion on unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). Review of Resident #1's MDS for Functional Limitation in Range of Motion indicated impairment on both sides for both upper extremities and lower extremities. A review of an activities assessment dated [DATE] revealed the resident's preferences are, playing with chew toys, relaxation with hand massages, soothing music and wall toys. The facility was unable to provide more recent activities assessment. An additional review of the resident's medical record revealed [REDACTED]. The facility was unable to provide a Social Work assessment or Psychosocial assessment for Resident #1 who had been assessed as having severe cognitive and communication limitations. Interview on 9/17/15 at 9:02 AM with the Activity Director, revealed it was the responsibility of the floor staff and volunteers to ensure the bed bound residents received one-to-one visits and bedside activities. The Activities Director also stated that he/she was responsible for documenting the resident's participation in the activities program and was unable to explain why there was a lack of documentation of the resident's assessment and participation in activities. Interview with the Director of Social Service (DSS) on 9/17/15 at 4:54 PM, revealed Resident #1 had not had a recent social work assessment or a psychosocial assessment. The DSS indicated the psychosocial assessment was a part of the initial facility Social Work assessment. The DSS indicated Resident #1 did not have a status change and therefore, he/she was not reassessed. The DSS indicated no initial Social Work or Psychosocial assessment could be located for Resident #1. The facility failed to ensure Resident #1's psychosocial and activity needs were assessed in conjunction with each subsequent MDS/RAI .
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to complete an accurate assessment for behaviors and dental status for 2 (Resident #9 and 11) residents of the sample. The facility identified a census of 76 residents. Sample size included 31 residents. Findings included: 1. Medical record review revealed Resident #9 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment, and displayed no behaviors. The significant change MDS dated [DATE] revealed the BIMS score of 4, indicating severe cognitive impairment and the resident displayed verbal behavior 1 to 3 days of the 7 day observation period. The MDS also documented the answer to how does the resident's current behavior status, care rejection, or wandering compare to prior assessment, the staff answered with n/a because no prior MDS assessment. (even though there was one completed on 5/29/15). Interview with Licensed Nurse #12 on 9/16/15 at 5:07 PM, revealed each discipline completed their own section on the MDS. Social services would have completed the section about behaviors. The facility failed to complete an accurate assessment for this resident. 2. Medical record review revealed Resident #11's admitted was on 7/31/14 with [DIAGNOSES REDACTED]. Resident #11's annual MDS dated [DATE] indicated Resident #11's Oral/Dental Status marked with no dental concerns. Resident #11's annual MDS indicated he/she had natural teeth and did not indicate he/she was edentulous (without natural teeth). Resident #11's quarterly MDS assessments dated 3/12/15 and 9/2/15 also indicated he/she had no dental/oral concerns. Resident #11's quarterly MDS assessments did not indicate Resident #11 was edentulous (without natural teeth). Observations in Resident #1's room on 9/16/15 at 1:29 PM, Resident #11 was eating. Resident #11's meal ticket indicated the resident was to receive a meal with bite sized meats with no gravy. On 9/17/15 at 8:56 AM during observation, Resident #11 was eating breakfast in her room while in bed. Resident #11 had two (2) pieces of bacon on his/her breakfast plate. One (1) piece had been pulled in half with a small portion eaten. When interviewed, Resident #11 indicated the bacon was difficult to eat. Resident #11 indicated he/she does not have dentures. Resident #11 had indicated she/he had dentures at one time but did not know where they were. Resident #11 stated, Yes, sometimes they do hurt when asked whether he/she experienced any pain when chewing without dentures. Interview with Licensed Nursing Staff (LNS) #7 on 9/17/15 at 9:35 AM, LNS #7 stated Resident #11 said he/she used to have dentures but no longer had them. Interview with the MDS Coordinator on 9/17/15 at 2:54 PM, the MDS Coordinator indicated Resident #11's dental status had been assessed incorrectly on her initial MDS oral assessment. The MDS Coordinator indicated Resident #11's MDS oral assessment information needed to be modified. The MDS Coordinator indicated the Social Service staff would speak to Resident #11 regarding his/her dental status in regards to his/her preference for dentures. The facility failed to accurately assess Resident #11's dental/oral status to ensure her dental needs and preferences were met.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to develop an individualized and comprehensive care plan for 4 (Resident #9, 123, 159, 168) residents of the sample for nutrition, medications, choices, and oxygen use. The facility identified a census of 76 residents. Sample size included 31 residents. The findings included: 1. The facility's Resident Assessment Instrument (RAI) process policy dated [DATE] identified the RAI manual as what the facility followed for care planning. The RAI manual documents the care plan must document the services to be provided for the resident so the resident may attain the highest physical, mental, and psychosocial wellbeing. 2. Medical record review revealed Resident #9 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment, required extensive assistance of 2 people for transfers, and required limited assistance of 1 for eating. The MDS documented the resident had no swallowing issues (even though he had [DIAGNOSES REDACTED]. The resident received a mechanically altered therapeutic diet. The Care Area Assessment for cognition dated [DATE] revealed the resident was admitted for skilled services related to the [DIAGNOSES REDACTED]. The care plan listed the interventions initiated on [DATE]: regular mechanical soft diet, monitor meal consumption daily, proper positioning at meals, provide adaptive feeding devices as ordered, such as scoop plate and built up utensils, provide assistance with meals as needed, screen/evaluation by rehab services as indicated, assure resident is monitored during mealtime if needed, obtain and update food/beverage preferences, vitamin/mineral supplements as ordered, and weekly weights.

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F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) The [DATE] Nutrition Data Form revealed the resident weighed 165.2 pounds and had not had a change in weight. The resident used a scoop plate and built up utensils. The resident was admitted on a concentrated carbohydrate, mechanical soft diet and the resident received Ensure with lunch. The resident had a blister on the right heel. A full nutritional assessment to follow and no recommendations made. The physician's orders [REDACTED]. Observations on [DATE] at 12:51 PM, revealed the staff served the resident a mechanical soft diet of broccoli, macaroni and cheese, fish, fruit bake, water, tea, and 1 can of Glucerna. The resident did not have built up silverware or a scoop plate. Observations on [DATE] at 8:15 AM, revealed the resident ate breakfast in bed, unsupervised. The staff served the resident scrambled eggs, cube potatoes, hot cereal, 1 piece of toast, milk, water, and juice. The resident did not have a scoop plate or built-up silverware. Interview with Dietary staff #11 on [DATE] at 4:57 PM, revealed the dietician completes the Dietary Data form and within 14 days completes the admission assessment. Dietary staff do not document the resident's likes or dislikes unless they are very distinct and then would document them on the dietary sheet. Interview with Dietary Staff #15 on [DATE] at 9:16 AM, revealed occupational therapy on [DATE] ordered the scoop plate and built-up silverware and the order was not restarted when the resident returned from the hospital on [DATE]. The facility failed to develop an individualized and comprehensive assessment for the monitoring of the weights, use of scoop plate and built-up silverware, and the documentation of the resident's likes and dislikes. 3. Medical record review revealed Resident #123 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission Minimum (MDS) data set [DATE] revealed the resident had a BIMS of 15, indicating cognitively intact, displayed no behaviors, and received 7 days of antidepressants out of the 7 days reviewed. The Care Area Assessment for [MEDICAL CONDITION] dated [DATE] revealed the resident had depression and required antidepressants to control his/her depression. The [DATE] physician orders [REDACTED]. Cyclopean 2.5 milligrams (mg) at hour of sleep (hs) for muscle spasm with the start date of [DATE] [MEDICATION NAME] 50 mg at hs for anxiety related to [MEDICAL CONDITION] with the start date of [DATE] [MEDICATION NAME] 50 mg at hs for [MEDICAL CONDITION] with the start date of [DATE] Ambien (used for [MEDICAL CONDITION]) 5 mg at hs with the start date of [DATE] The care plan dated [DATE] listed the interventions: Medications as ordered by the physician and observe use and effectiveness The resident has the potential for drug related complications associated with use of [MEDICAL CONDITION] medications related to antidepressants The resident will be free of [MEDICAL CONDITION] drug related complications Monitor for side effects and report to physician: Antidepressant - sedation, drowsiness, dry mouth, blurred vision, [MEDICAL CONDITIONS] muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain, monthly pharmacy review of medication regimen Provide medications as ordered by physician and evaluate for effectiveness [MEDICAL CONDITION] medication risk/benefit and reduction plan as recommended by physician and pharmacist Refer to psychologist/psychiatrist for medication and behavior intervention recommendations. The care plan lacked non-pharmacological interventions for [MEDICAL CONDITION] or anxiety. Observations on [DATE] at 3:35 PM, revealed the resident laid in bed with his/her sleepers on and covered with blankets. Interview with the resident at that time revealed he/she had a dental appointment but he/she was too tired to go to the dentist that day. Interview with Staff #8 on [DATE] at 10:00 AM, revealed there were no social service notes or care plan interventions (beside medications) for this resident with depression, anxiety, and [MEDICAL CONDITION]. The facility failed to develop a comprehensive and individualized care plan for this resident. 4. Medical record review revealed Resident #159 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission MDS dated [DATE] revealed the resident did not have any cognitive impairments and it was very important for the resident to choose between a bed bath, shower, or sponge bath. The MDS revealed the resident required total assistance with bathing and utilized a wheelchair. The Activity of Daily Living (ADLs) Care Area assessment dated [DATE] revealed the resident was admitted related to car accident that caused multiple fractures and caused the resident decreased mobility. The resident was admitted primarily for rehab services with nursing care until the fractures have healed and the resident can go home. The Admission assessment dated [DATE] did not address the resident's choice for bathing. The care plan with the initiation date of [DATE] listed the interventions: Encourage choices with care and extensive assistance of 2 staff for all aspects of ADLs except for eating The care plan did not list the resident's preference for bathing. Interview with the resident on [DATE] at 11:11 AM, revealed the resident would like to have a shower at least 2 times a week but only gets one at the most when the therapist is here. The resident stated he/she could complete the shower him/herself after the staff applied a bag over the cast on the lower leg to prevent it from getting wet. Observations on [DATE] at 4:03 PM, revealed the resident laid in bed on his/her back and no odor noted. The facility failed to develop an individualized care plan for this resident's preference in bathing. 5. Medical record review revealed Resident #168 was admitted to the facility on [DATE] and was discharged on [DATE]. The [DIAGNOSES REDACTED]. The [DATE] admission Minimum Data Set revealed the resident was cognitively intact, required extensive assistance with activities of daily living except for eating, and received oxygen therapy. The physician progress notes [REDACTED]. The care plan initiated on [DATE] listed the respiratory interventions: Administer diuretic per physician orders [REDACTED]. Check vital signs and auscultate breath sounds as needed, more frequently if indicated Encourage rest periods as needed Monitor weight per physician order [REDACTED]. Notify physician of signs/symptoms of excess/fluid deficit Observe and report signs of chest pain, [MEDICAL CONDITION], shortness of breath, abnormal pedal pulse, restlessness, and fatigue Oxygen as ordered The care plan did not list the interventions for oxygen use and monitoring of oxygen saturations. The physician Discharge Summary for the stay from [DATE] to [DATE] revealed the resident was admitted for therapy related to exacerbation of [MEDICAL CONDITION] with Pneumonia. The resident was dependent on oxygen and upon discharge (to the hospital the resident was not breathing and) CPR was in progress. Interview with Licensed Nurse #12 on [DATE] at 5:07 PM, revealed each discipline completes their part of the care plan. He/she completed the nursing part of the care plan and would of completed the care plan regarding the oxygen and oxygen saturations. The facility failed to develop a comprehensive and individualized care plan for this resident.
F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide care and services in accordance with the written care plan for one (1) resident (Resident #1) from a sampled 31 residents. The findings included: Medical record review revealed Resident #1's most recent re-admitted was on 12/25/12. Resident #1 had [DIAGNOSES REDACTED]. This resident has resided at the facility for the past [AGE] years. Resident #1's annual Minimum Data Set ((MDS) dated [DATE] indicated Resident #1's Brief Interview for Mental Status (BIMS) could not be completed due to resident is rarely/never understood. The MDS indicated Resident #1 was given the staff

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) assessment for Mental Status which indicate Resident #1 was assessed as severely impaired - never/rarely made decisions. The MDS indicated Resident #1 had highly impaired - absence of useful hearing , had no speech - absence of spoken words , rarely/never understood by others, rarely/never understands others, and has highly impaired vision defined by object identification in question, but eyes appear to follow `objects. Resident #1's MDS indicated the resident was total dependence - full staff performance every time during entire 7-day period, for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). The MDS indicated Resident #1 required complete staff assistance to perform transferring between surfaces including to or from: bed, chair, wheelchair, standing position. The MDS indicated Resident #1 required total staff assistance for locomotion on unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). Review of Resident #1's MDS for Functional Limitation in Range of Motion indicated impairment on both sides for both upper extremities and lower extremities. Record review revealed Resident #1 had a care plan dated 9/17/10 for activities which indicated he/she was unable to take part in physical and mental impairment related to a head injury . The plan indicated Resident #1's simple pleasure is country music and watching TV in my room. The activity care plan indicated the goal to continue to be able to turn mu (my) head towards recreation staff/volunteers or other stimuli presented to me during 1:1 visits x 90 days. In addition I will listen to country music and watch my favorite shows on TV during waking hours. The activities care plan indicated the following interventions : · Encourage me to maintain eye contact with you during 1:1 activities to help keep me focused on what we ' re doing. · Have my T.V. on in room for stimulation if I desire since this is one of my simple pleasures I like. · Provide me with activities involving tactile stimulation or manipulation: touch or hold etc. · Utilize sensory materials during 1:1 visits with me. Record review indicated Resident #1 had a care plan initiated 9/17/12 which indicated he/she had a poor response to others and the environment not aware of surroundings, limited ability to react. The care plan indicated the goals of continuing to be able to turn my head towards Recreation Staff/Volunteers or other stimuli presented to me during 1:1 visits and to continue to be able to look at, handle, pick-up or pass back materials presented to me during 1:1 interventions with Recreation Staff or other providers. Resident #1's care plan had the interventions of call my name or gently touch my arm or hand to help me maintain awareness of the activity going on around me and make sure I have my things with me that make me comfortable. The facility was unable to provide a more recent activities care plan. On 9/14/15 at 10:15 AM, Resident #1 was observed in his/her room laying in a supine position in bed at a 30 degree angle with knees bent. From Resident #1's position, he could see personal pictures on the wall. Resident #1's television was not on. At 10:37 AM, Resident #1 was still in his bed without the television on and awake in the same position. At 4:24 PM, Resident #1 continued to be in his bed at approximately a 25 degree angle and awake with no television on and no activities present. On 9/15/15 at 8:50 AM, Resident #1 was observed in bed. Resident #1's television was not on nor were any activities occurring. Interview on with the Activity Director on 9/17/15 at 9:02 AM, revealed it was the responsibility of the floor staff and volunteers to ensure the bed bound residents received one-to-one visits and bedside activities. The facility failed to ensure Resident #1's activities care plan was implemented consistently and with a frequency which would ensure Resident #1's activities needs were met based on assessment.
F 0309 **Level of harm** - Actual harm **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** Based on policy review, record review, observation, and interview, the facility failed to monitor and provide treatment to prevent impactions for 1 (Resident #9) resident that resulted in the resident requiring manual removal of stool on two occasions causing harm to this resident. The facility identified a census of 76 residents. Sample size included 31 residents. The findings included: 1. The facility's policy for bowel monitoring which was called Clinical Start-Up, revealed the Director of Nursing or designee will complete a comprehensive overview of care delivery every morning at a minimum. The nurse will review the 24 Hour Report and Clinical Startup application's Observation Alerts which included the resident that had not had a BM in 3 days. 2. Medical record review revealed Resident #9 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission Minimum (MDS) data set [DATE] revealed the resident had a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment, required extensive assistance of 2 people for transfers, and required extensive assistance of 1 staff with toileting. The care plan listed the interventions for toileting assistance as needed and regular mechanical soft diet with the initiation date of 6/9/15. Review of the Bowel and Bladder Detail Report, Progress Notes and Medication Administration Records from 5/22/15 to 9/16/15 revealed: 6/1/15 the resident had an extra large bowel movement (BM) and then did not have another BM until 6/6/15, 5 days later. The staff did not administer an as needed (prn) medication for constipation from 6/1/15 to 6/6/15. 7/16/15 the resident had a medium BM and did not have another BM until 7/24/15, 8 days later. The resident had orders for Senna two times a day prn for constipation and [MEDICATION NAME] Powder prn for constipation. The staff did not administer either of these medications from 7/16/15 to 7/24/15. 7/24/15 the resident had 2 large BMs and did not have another BM until 7/31/15, 7 days later. The staff did not administer the prn Senna or the [MEDICATION NAME] Powder for constipation from 7/24/15 to 7/31/15. 8/2/15 the resident had a medium BM and did not have another BM until 8/8/15, 6 days later. The resident had orders for Senna prn and Milk of Magnesia prn for constipation and the staff did not administer the Senna and did not administer the prn Milk of Magnesia until 8/6/15. 8/10/15 the resident had an extra large BM and did not have another BM until 8/17/15, 7 days later. The staff did not administer the prn Senna or the Milk of Magnesia as ordered during this time period. Review of the progress note dated 8/10/15 and timed 2:02 PM, revealed the resident attempted to have a bowel movement and was unable to push it out. The nurse removed and extra large impaction and then received an order to give the resident a soap suds enema. 8/17/115 the resident had a BM and did not have another BM until 8/22/15, 5 days later. The staff did not administer the prn Senna or the Milk of Magnesia as ordered during this time period. The progress note dated 8/17/15 and timed 1:13 PM, revealed the resident sat on the toilet several times that day attempting to have a BM. The nurse manually removed a large impaction. The nurse documented there was still stool felt up high. The nurse received and order for an enema. The nurse administered the enema and then manually removed another extra large amount of stool. 9/4/15 the resident had a small BM and did not have another BM until 9/10/15, 6 days later. The resident had prn orders for the Senna and Milk of Magnesia for constipation and the staff did not administer them during this time frame. Interview with Licensed Nurses #13 and #14 on 9/17/15 at 8:34 AM, revealed the direct care staff document the BMs in the Kiosk (computer program), the night nurse prints off the report that notifies the staff which residents have not had a BM in 3 days. Management also prints off the report and reviews it at their morning meeting. There are not standing orders for the treatment of [REDACTED]. Interview with Licensed Nurse #9 on 9/17/15 at 1:59 PM, revealed if a resident does not have a BM within 3 days it will flag on a report that is ran every morning and will continue to flag on the report until the resident has a BM. This nurse was unsure why the resident went so many days without a BM. The facility failed to monitor and provide preventive treatment multiple times for this resident with a [DIAGNOSES REDACTED].
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy/procedure review, clinical record review, observation, and interview, the facility failed to accurately assess, monitor, and provide care and services to ensure that a resident without a pressure ulcer did not develop them. Failure to provide appropriate care and services to prevent 2 residents (Resident #85 and 1) from developing a pressure ulcer and 1 (Resident #85) developed a pressure ulcer and ultimate infection, of 4 residents reviewed for pressure ulcers, which resulted in actual harm for Resident #85. The facility identified a census of 76 residents, sample size included 31 residents. The findings included: 1. Review of the facility's Skin Integrity Guideline policy revealed the following documentation and care interventions for skin integrity: 1. Evaluation/Observation is to be completed within the first twenty four hours of admission/quarterly/significant change of condition using the Clinical Health Status Tool. 2. If identified risk present, the interventions will be documented in the Immediate Plan of Care or Comprehensive Care Plan. 3. Patients/Residents utilizing a wheelchair as a primary mode of transportation will have a pressure redistribution device in place as indicated by the individualized plan of care. 4. Pressure redistribution mattresses are in place as indicated by the individualized plan of care. 5. If there is decline in skin integrity, pressure redistribution surfaces will be reviewed for appropriateness and implemented as indicated by the individualized plan of care. 6. Patients/Residents will be observed by the CNA daily for reddened/open areas, [MEDICAL CONDITION] of feet or sacrum. Changes will be reported to the licensed nurse and documented. 7. Reposition every two hours, or as needed and tolerated, taking into consideration patient/resident tolerance and choice, tissue tolerance, current condition of skin. Indicate frequency in the individualized plan of care. 8. Initiate positioning schedule to meet individual patient/resident needs and minimize concentrated pressure to skin as indicated by the individualized plan of care. 9. If identified at risk or with actual alterations in skin integrity of feet, footwear will be addressed for appropriateness. 10. Positioning devices such as pillows or foam wedges are recommended to keep bony prominences from direct contact with one another. 2. Review of the medical record for Resident #85 revealed he was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident had no pressure ulcers on admission. Resident #85 was not interviewable. A confidential interview on 9/14/15 at 11:52 AM, revealed Resident #85 had developed a pressure ulcer on the right hip or buttocks and now it was infected and the resident had been placed in isolation. The interview further revealed that the resident was not being showered or turned often enough to promote healing. Interview with Nursing Staff #24 on 9/14/15 at 3:00 PM, revealed Resident #85 had an unstageable pressure ulcer to the right hip. The wound was now infected and the resident was in isolation. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was coded as being at risk for pressure ulcers but not having any unhealed pressure ulcers. Review of the MDS assessment dated [DATE] revealed the resident was coded as being at risk for pressure ulcers but not having any unhealed pressure ulcers even though the medical record indicated the resident had a pressure ulcer. Review of Resident #85's care plan dated 5/6/14 revealed a problem identified with altered skin integrity, not pressure related. Interventions included weekly skin inspection, monitor for signs and symptoms of infection, and provide pressure reduction/relieving mattress. The care plan did not contain any interventions for turning or positioning. Review of Resident #85's care plan dated 7/21/15 revealed a pressure ulcer actual, or at risk, due to a pressure ulcer being present. Interventions included an air mattress, weekly skin inspection, provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress, provide thorough skin care after incontinent episodes and apply barrier cream, skin assessment to be completed per Living Center Policy, treatments as ordered, and weekly wound assessment. The care plan included 2 types of mattress, 3 references to skin or wound assessments, and no mention of turning or positioning of the resident. Review of the Certified Nursing Aide (CNA) plan of care dated 9/14/15 for Resident #85 did not include any identified turning or positioning schedule. The residents shower schedule was Monday/Thursday, on the night shift but review of the shower documentation for 7/1/15 - 9/14/15 revealed the resident had not received any showers during that time period. Review of the weekly skin assessment sheets revealed on 4/20/15, a wound was noted on the right buttocks and was being labeled an abrasion. A wound evaluation flow sheet starting 6/15/15 labeled the wound as an abrasion but listed measurements of 1.5 centimeters (cm) by 2.2 cm and clear drainage. On 6/29/15, the wound had the same measurements but the classification was changed to a stage 2 pressure ulcer. On 7/28/15, the wound measurements were 1.5 cm x 1.5 cm x 0.5 cm and the classification was changed again to unstageable. Review of the Quarterly Interdisciplinary Resident Review dated 8/1/15 revealed there was nothing coded under skin conditions. A wound care observation was conducted with Nursing Staff #22 on 9/15/15 at 3:50 PM, for Resident #85. While providing wound care, the nurse removed the old dressing and packing from Resident #85's pressure ulcer. The nurse then proceeded to remove her soiled gloves and don new gloves without washing her hands. Measurements of the wound were taken including the tunneling and the nurse proceeded to remove her soiled gloves and don new gloves without washing her hands. Lack of hand washing during wound care could contribute to infection and cross contamination. Observations of Resident #85 on 9/16/15 at 9:00 AM, revealed the resident to be lying on his/her left side in bed. He was wearing the same blue shirt from 9/15/15. He/she did not respond to questions. Observations of Resident #85 on 9/16/15 at 10:00 AM, revealed the resident continued to lie on the left side. Observations of Resident #85 on 9/16/15 at 11:30 AM, revealed the resident to be in the same position. There was no evidence of turning or positioning by staff. During the wound care observation for Resident #85 on 9/15/15 at 3:50 PM, Nursing Staff #22 revealed that the resident developed the pressure ulcer on his/her right hip or buttocks from a poorly fitted geriatric chair. At first they called the wound an abrasion and then it was decided to call it a pressure ulcer. Nursing Staff #22 further revealed the wound was infected and now the resident was in isolation. Interview with Direct Care Staff #20 on 9/16/15 at 9:30 AM, revealed each resident has a shower assignment twice a week. Direct Care Staff #20 also revealed that the CNA assigned to Resident #85 did not show up for work today and he/she was pulled from restorative to help out. He/she was waiting for another CNA to come in and take over the assignment. At 12:30 PM, on 9/16/15, Direct Care Staff #20 informed the surveyor that he/she had partially bathed and repositioned Resident #85 because the other CNA never showed up. Interview with Nurse Staff #7 on 9/16/15 at 11:43 AM, revealed Resident #85 was total care and could not assist with anything. The resident can't help with bathing and you have to anticipate his/her needs because he/she doesn't communicate much. Interview with Clinical Staff #21 on 9/17/15 at 9:53 AM, revealed he/she started coming back into the facility every 2 weeks and making rounds with the treatment nurses and assessing the wounds. Initially Resident #85 presented with what the facility was calling an abrasion. I think we determined it was a pressure ulcer when it opened up. We determined that it developed from the geriatric chair that wasn't fitted properly because of the increased contractions in his/her legs. The wound bed appears pink from what I can see but it doesn't go straight back, it tunnels upward. The wound wasn't healing and the cultures indicated it was infected. The resident was placed in isolation due to the infection. Clinical Staff #21 confirmed that this was the resident's first pressure ulcer. Interview with Administrative Staff #4 on 9/17/15 at 2:45 PM, revealed staff are to wash their hands prior to a treatment, prior to donning gloves, after removing soiled gloves, and before and after any contact with a resident. He/she stated that hand washing education is mandatory on hire but beyond that he/she isn't sure what the education program entails. Interview with Nursing Staff #22 on 9/17/15 at 5:30 PM, Nursing Staff #22 confirmed that hand washing was lacking during the wound care observation.

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) Interview with Administrative Staff #12 on 9/17/15 at 11:25 AM, revealed Resident #85 only had abrasions not pressure ulcers and that is why the last 2 MDS assessments do not have pressure ulcers listed. Administrative Staff #12 stated We identified that we had issues with assessing and staging of our wounds when the new Director of Nursing came. The last assessment was done on 8/2/15. I didn't have the information at that time calling it a pressure ulcer. The Administrative Staff #12 confirmed that he/she does not do the actual physical assessments, he/she just gets the information off the chart documentation. Interview with Administrative Staff #4 on 9/17/15 at 2:18 PM, revealed the facility had problems with identifying and assessing wounds when he/she started working in the building. Administrative Staff #4 could not confirm what Administrative Staff #12 looked at when completing the required assessments. Failure of the facility to properly assess Resident #85's skin condition, develop and implement an appropriate plan of care following the facility policy, that included a turning and positioning schedule, resulted in Resident #85 developing a pressure ulcer and ultimate infection, which resulted in actual harm for this resident. 3. Medical record review revealed Resident #1's most recent re-admitted was on 12/25/12. Resident #1 had [DIAGNOSES REDACTED]. This resident has resided at the facility for the past [AGE] years. Resident #1's annual MDS dated [DATE] indicated Resident #1's Brief Interview for Mental Status (BIMS) could not be completed due to resident is rarely/never understood. The MDS indicated Resident #1 was given the staff assessment for Mental Status which indicate Resident #1 was assessed as severely impaired - never/rarely made decisions. The MDS indicated Resident #1 had highly impaired - absence of useful hearing , had no speech - absence of spoken words, rarely/never understood my others, rarely/never understands others, and has highly impaired. Resident #1's MDS indicated the resident was total dependence for bed mobility and required complete staff assistance to perform transferring between surfaces. The MDS dated [DATE] indicated Resident #1 had an unhealed stage II pressure ulcer and had one unstageable pressure ulcers with suspected deep tissue injury in evolution. Resident #1's MDS for Functional Limitation in Range of Motion indicated impairment on both sides for both upper extremities and lower extremities. Resident #1's MDS dated [DATE] indicated he/she had no Range of motion (passive), had no Range of motion (active), and had no use of splint or brace assistance performed (for at least 15 minutes a day) in the last 7 calendar days. The physician's orders [REDACTED]. Apply TAO (Triple Antibiotic Ointment) and non-adherent dressing to 2nd digit on left hand, insert rolled washcloth daily and PRN (as needed) one time a day. The physician's orders [REDACTED]. Record review revealed Resident #1 had a care plan initiated on 3/6/14 for Pressure ulcer actual or at risk due to: Assistance required in bed mobility, Bowel incontinence. The care plan goal was Skin will remain intact. Resident #1's skin integrity (pressure related) care plan indicated the following interventions: · 8/3/14 SDTI (Suspected Deep Tissue Injury) noted on top of L (left) foot at metacarpal area. Skin prep daily. · 8/27/15 Stage 2 (pressure ulcer) to left hand 2nd digit (finger). · 9/8/15 SDTI top lateral foot. · Complete Braden Scale per Living Center Policy. · Conduct weekly skin inspection. · Monitor skin under braces and splints. · Nutritional and Hydration support. · Provide pressure reducing wheelchair cushion. · Provide pressure reducing wheelchair cushion. · Provide pressure reduction/relieving mattress. · Provide thorough skin care after incontinent episodes and apply barrier cream. · Skin assessment to be completed per Living Center Policy. Resident #1's record review indicated a care plan for range of motion (ROM) dated 1/29/15 which indicated Resident #1 had a physical functioning deficit related ROM limitations of left hand and elbow related to contractures. A revision dated 4/22/15 indicted Resident #1 had a palm wound has healed/ need for splint left arm. Resident #1's ROM care plan's goal was the following: · Will be able to wear left arm splint 1-2 hrs (hours) daily. · Will be able to wear palm protectors when not having ROM. · No skin issues with splint or palm protectors. · I will maintain my current ROM. Resident #1's ROM care plan indicated the following interventions: · 4/22 apply arm splint for 1-2 hr daily. · Apply palm protectors following cleansing and PROM to left hand. Apply in AM shift as resident will allow. · Dry hand and notify wound nurse when completed to have treatment to hand. Make sure that after she has done wound care that there is a rolled wash cloth or gauze in the hand to prevent moisture build up. · Inspect skin with care. Report reddened areas, rashes, bruising, or open areas and report to charge nurse and restorative Director. · Monitor and report changes in ROM ability. · Soak hand in warm water and massage before doing range of motion. · Use caution when applying wash cloth or gauze to hand to prevent sheering of hand. The record review for Resident #1's wound flow sheets initiated for a Stage II Pressure Ulcer (In-house acquired) on Resident #1's left hand (palm) indicated the following: · Wound Evaluation Flow Sheet dated 8/30/15 indicated a Left hand (palm) had a Stage II (pressure ulcer measured 1.5 cm (centimeter) x (by) 1.5 cm x (by) 0.0 cm discovered on 8/25/15. The entry indicated hand contracted. Area caused by friction from placing a cloth in hand. · Wound evaluation dated 9/6/15 indicated the Stage II pressure ulcer measured 1.3 cm x 1.5 cm x 0.0 cm. The evaluation indicated wound stable, no changes. · Wound evaluation dated 9/11/15 indicated the stage II pressure ulcer measured 0.5 cm x 0.5 cm x 0.0 cm and indicated wound healing. Continue current interventions. A review of Resident #1's Restorative by Day Report from 1/1/15 to 9/08/15 which indicated the following dates for Range of Motion - Passive: · January 2015: None · February 2015: None · March 2015: 3/15, 3/17, 3/18, 3/19, 3/20, 3/25, 3/26, 3/30, and 3/31/15. · April 2015: 4/1, 4/2, 4/3, 4/8, 4/9, 4/12, 4/13, 4/16-4/24, 4/27, and 4/28/15. · May 2015: 5/4, 5/7, 5/8, 5/14-5/17 and 5/27/15. · June 2015: 6/10, 6/12, 6/13, 6/19, 6/22-6/25, and 6/26/15. · July 2015: 7/10, 7/17, 7/18. 7/25, and 7/29/15. · August 2015: 8/6, 8/8, 8/14, 8/18, 8/19, 8/27 and 8/31/15. Record review of Resident #1's Restorative Program Summary Report for the program Passive ROM to left hand daily with initiation date of 3/20/15 indicated the following entries: · 04/07/15 - (Resident #1) continues to receive PROM (passive range of motion) to his left hand. The application of splint was stopped until the pressure area on his palm healed. (He/she) continues to resist having his hand held or soaked. It is necessary to use warm water to soak his hand in prior to doing PROM. This helps to relax his fingers. The hand is then dried and wound nurse dresses and treats the wound. The area is healing but continues to have moisture build up. A hand roll of gauze or a rolled wash cloth is placed between the fingers following the treatment. Restorative will continue to do PROM for 60-90 days to continue to work with the contractures. · 04/22/15 - Wound in left hand has healed. Pressure relieving hand rolls have been used at this time to prevent finger contractures. We will attempt to apply the splint to maintain wrist and fingers at present level. · 5/29/15 - Continue have PROM daily. No signs of changed (change). Needs to have hand soaked ad (and) cleansed prior PROM. There is still resistance in his fingers. (He/she) was in the hospital over the week end related to aspiration penemonia (Pneumonia). We have resued (resumed) (his/her) treatment since (his/her) return. This will continue to be a functional maintenance with (him/her) at this time.

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) · 6/25/15 - Continues to be stable at this time. We continue to do treatment to maintain his function and to prevent further contractures. · 8/25/15 - Continue functional maintane (maintenance) with (him/her) with the splinting. (He/she) has an open areal (area) on his palm and is being treated by the wound care nurse at this time. On 9/14/15 at 10:15 AM, Resident #1 was observed in his/her room lying in a supine position in bed at a 30 degree angle with knees bent. Resident #1 had a fall mat next to his bed. Resident #1 had contractures of both upper extremities and both lower extremities. At 4:24 PM, Resident #1 continued to be in bed at with no splint or adaptive/protective devices in place. On 9/15/15 at 8:50 AM, Resident #1 was observed in bed. Resident #1 was not wearing any splints, adaptive, or protective equipment. At 1:55 PM, Resident #1 was observed in bed. He/she had a left arm splint in place and a washcloth being held in his/her left hand in the palm. On 9/16/15 at 9: 54 AM, Resident #1 was wearing a splint to the left arm in a 90 degree angle and had a washcloth in his/her left hand being held in the palm. Interview with the Director of Restorative Services on 9/17/14 at 4:17 PM, indicated Resident #1's ROM was not done in accordance with the frequency assessed as necessary to assist in the maintenance of current level range of motion and to prevent recurrent and newly acquired pressure ulcers of Resident #1's left hand. The facility failed to adhere to the care plan interventions developed to prevent the reoccurrence of Stage II pressure ulcer for Resident #1's left hand contracture.
F 0325 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interview, the facility failed to prevent the significant weight loss for 1 (Resident #9) resident of the sample. The failure to prevent significant weight loss for this resident resulted in actual harm. The facility identified a census of 76 residents. Sample size included 31 residents of which 3 were reviewed for nutrition. The findings included: 1. The facility's policy for Nutrition Care Process dated 2/12/15 listed the 4 steps in the Nutrition Care Process: nutrition assessment, nutrition diagnosis, nutrition intervention, and nutrition monitoring and evaluation. Nutrition intervention consists of 2 interrelated components, planning and implementation. Implementing the nutrition intervention is the action phase which includes: carrying out and communicating the plan of care, continued data collection and revising interventions if warranted by resident response. Nutrition monitoring and evaluation is to determine the amount of progress made to reach the specified goals and tracking of resident outcomes relevant to the nutrition [DIAGNOSES REDACTED]. 2. Medical record review revealed Resident #9 was admitted to the facility on [DATE] and the [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status score (BIMS) of 10, indicating moderate cognitive impairment, required extensive assistance of 2 people for transfers, and required limited assistance of 1 for eating. The MDS documented the resident had no swallowing issues (even though the resident had the [DIAGNOSES REDACTED]. The resident received a mechanically altered therapeutic diet. The Care Area Assessment for cognition dated 6/3/15 revealed the resident was admitted for skilled services related to the [DIAGNOSES REDACTED]. The care plan listed the interventions initiated on 6/9/15: regular mechanical soft diet, monitor meal consumption daily, proper positioning at meals, provide adaptive feeding devices as ordered, such as scoop plate and built up utensils, provide assistance with meals as needed, screen/evaluation by rehab services as indicated, assure resident is monitored during mealtime if needed, obtain and update food/beverage preferences, vitamin/mineral supplements as ordered, and weekly weights. The care plan revealed the resident had self-feeding difficulty and chewing difficulty as related to history of [MEDICAL CONDITION] with deficits. The Weight Record listed the following: 5/22/15 - 167.4 pounds (#) 5/25/15 - 165.2 # 6/2/15 - 164 # 6/8/15 - 164 # 6/29/15 - 163 # 7/15/15 - 145.4 # 7/16/15 - 146 # 7/20/15 - 142.6 # 7/27/15 - 141 # 8/4/15 - 143.7 # 8/12/15 - 144.8 # 8/17/15 - 144.5 # 9/7/15 - 145 # Consisting of a 22.4 pound or 13.3 percent weight loss in less than 5 months. The resident's total protein 7/8/15 was 6.3 with the normal range of 6.7 to 8.5 grams/deciliter and the [MEDICATION NAME] was 2.1 with the normal range of 3.4 to 5.0 grams/deciliter. The 7/15/15 hemoglobin level was 9.9 with the normal range of 13 to 16 grams/deciliter. The hematocrit was 30.5 with the normal range of 39 to 50 percent. The 5/28/15 Nutrition Data Form revealed the resident weighed 165.2 pounds and had not had a change in weight. The resident used a scoop plate and built up utensils. The resident was admitted on a concentrated carbohydrate, mechanical soft diet and the resident received Ensure with lunch. The resident had a blister on the right heel. The 6/9/15 Nutrition Assessment revealed the resident required increased protein related to wound healing. The resident received a concentrated carbohydrate, mechanical soft diet, staff to monitor intake, weight, and labs. The resident received Ensure daily and vitamin supplements. The resident had lost 3.4 # since admission but not a significant change. Resident to have a frozen nutritional treats (high calorie supplement) added two times a day. No other recommendations made. Review of the clinical record lacked evidence the resident received the frozen nutritional treats two times a day. The 7/16/15 timed 2:43 PM Change of Condition Situation form revealed the resident had a 17 # weight loss in 2 weeks a 10 percent weight loss since readmission from the hospital. Staff to add Glucerna (high calorie supplement) 1 can two times a day. Review of the clinical record lacked evidence the resident received the Glucerna two times a day. The 7/23/2015 timed 2:16 PM Change of Condition Situation form revealed this resident weighed 142.6 #. The resident lost 2.8 # this week and continues to be a significant weight loss. Recommended to add 2 Cal (high calorie supplement) 60 milliliters two times a day. Review of the clinical record lacked evidence the resident received the 2 Cal two times a day. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The quarterly Nutrition/Wound Review dated 8/25/2015 and timed 10:24 AM, revealed the resident continues to receive treatments to multiple wounds. The resident continues to receive a regular mechanical soft diet and has a history of a significant weight loss since admission. The dietician recommended to add a multivitamin with minerals daily and Prostat 30 milliliters two times a day to add 22 grams of protein and 160 kilocalories. The 8/25/15 Nutrition Data Form revealed the resident weighed 144 pounds. The resident has had weight loss and a Stage 3 and unstageable wound. The resident has a swallowing disorder and continues on a regular mechanical soft diet. The resident has had a significant weight loss since admission. The dietician recommended to add a multivitamin with minerals daily and Prostat 30 milliliters two times a day. The physician's orders [REDACTED].

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0325 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 8) The progress note dated 8/26/2015 and timed 7:58 PM revealed the nurse practitioner ordered a protein shake since the resident refused the ordered Prostat. The resident received Glucerna at lunch every day and staff will clarify the order for the protein shake. The clinical record lacked evidence the resident received the protein shake or the Prostat two times a day. The progress note dated 9/10/2015 and timed 5:25 PM revealed the staff fed the resident and the resident was able to feed him/herself finger foods. Observations on 9/15/15 at 4:05 PM, revealed the resident had no teeth noted on the top and missing teeth noted on the bottom. Observations on 9/16/15 at 12:51 PM, revealed the staff served the resident a mechanical soft diet of broccoli, macaroni and cheese, fish, fruit bake, water, tea, and 1 can of Glucerna. The resident did not have built up silverware or a scoop plate. The resident ate without supervision. At 1:26 PM, observations revealed the resident ate 50 percent of the macaroni and cheese and fish, 25 percent of the fruit bake, 100 percent of the Glucerna and tea, and did not drink the water or eat any of the broccoli. Observations revealed the staff did not supervise the resident, did not encourage the resident to eat, or provide a substitute. Observations on 9/17/15 at 8:15 AM, revealed the resident ate breakfast in bed, unsupervised. The staff served the resident scrambled eggs, cube potatoes, hot cereal, 1 piece of toast, milk, water, and juice. The resident did not have a scoop plate or built-up silverware. Interview with Direct Care Staff #10 on 9/16/15 at 4:30 PM, revealed the resident can eat without supervision. The resident usually ate 50 to 75 percent of his/her meal. This staff also stated the resident did not have teeth and he/she did not know if the resident had dentures. Interview with Dietary staff #11 on 9/16/15 at 4:57 PM, revealed the dietician completes the Dietary Data form and within 14 days completes the admission assessment. Dietary staff do not document the resident's likes or dislikes unless they are very distinct and then would document them on the dietary sheet. Interview with Dietary Staff #15 on 9/17/15 at 9:16 AM, revealed the resident received a mechanical soft diet with thin liquids. The resident received Glucerna 1 can a day at lunch since 8/27/15. On 6/9/15 the resident was to receive a frozen treat (magic cup) high calorie supplement, but the clinical record lacked evidence the staff provided it for the resident. Review of the clinical record also lacks evidence the resident received the 2 cal supplement two times a day or the Glucerna 1 can two times a day. The protein shake was the Glucerna 1 can at lunch every day started on 8/27/15. Occupational therapy on 5/24/15 ordered the scoop plate and built-up silverware and those were not restarted when the resident returned from the hospital on [DATE]. Interview with Licensed Nurse #4 and #9 on 9/17/15 at 10:45 AM, revealed the dietician's recommendations go to the Director of Nursing (DON) and the DON contacts the physician. The recommendations from the Change of Condition meetings are followed up on by nursing and dietary. Interview with Therapy Staff #16 on 9/17/15 at 12:08 PM, revealed the resident originally had the order for the scoop plate and the built-up silverware due to [MEDICAL CONDITION] resident had. The facility failed to implement interventions as planned for the prevention of significant weight loss for this cognitively impaired resident, which resulted in actual harm to this resident.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** Based on observation, and interview, it was determined the facility failed to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care which had the potential to impact 76 of 76 residents. Findings include: 1. The survey team made the following random resident observations on 9/14/15 and 9/15/15: -9/14/15 at 10:45 AM, Resident #9 was observed to be unshaven. -9/14/15 at 10:53 AM, Resident #51 (female) was observed to have chin hair. -9/14/15 at 12:45 PM, Resident #79 had fingernails which were long, broken and had brown residue underneath the fingernails. -9/14/15 at 1:05 PM, Resident #156 had facial hair unshaven. -9/14/15 at 4:42 PM, Resident #88 was observed with long, broken nails (fingernails), half painted. -9/14/15 at 5:18 PM, Resident #56 had dirty fingernails. -9/15/15 at 8:34 AM, Resident #1 was observed in a tee shirt and shorts which he/she was wearing the day before. Resident #1's shirt had debris on his/her shirt (resident was NPO, nothing given by mouth). Resident #1 was unshaven. Resident #1 had a rash/skin irritation from his/her left ear to the left half of his/her face with dried skin and debris unwashed. -9/15/15 at 9:50 AM, Resident #85 (male) was unshaven. -9/15/15 at 8:58 AM, Resident #11 ' s (female) hair was unkempt and had long, half-painted fingernails. 2. Resident, family, and staff interviews conducted on 9/14/15 thru 9/17/15 by the survey team revealed a concern regarding insufficient staffing to meet the daily needs of the residents. The interviews are as follows: -9/14/15 at 11:14 AM, during an interview Resident #159 stated the facility used an agency to staff the night shifts. The resident stated One (1) nurse on nights would not wipe me after I used the bed pan. The Resident indicated he/she didn't think the facility check to see how things are going with the agency staff. Resident #159 stated he/she only get one (bath/shower) when the therapist is here. The Resident stated he/she would prefer to have at least two (2) bath/showers a week. -9/14/15 at 11:13 AM, a family interview for Resident #108 indicated the facility is short staff and indicated staffing issues on the 3rd shift which he/she indicated was 10 PM to 6 AM. The family interview indicated he/she will stay the night if the facility only has three (3) techs (CNAs, certified nursing assistants) working between the 1, 2, 3, and 4 hallways of the facility. The family interview indicated on 7/2/15 he/she left the facility at 10:15 PM and returned to the facility between 5:15-5:30 AM and observed Resident #108 in the same position and had BM (bowel movement) and urine in the diaper and his/her skin was wet . The family member indicated he/she maintains documentation of the short staffing on nights. The family member stated he/she has pulled the call light for staff assistance and he/she have sat here at least 30-35 minutes. No one shows, I get up and go and find them (staff). -9/14/15 at 11:47 AM, Resident #26 indicated he/she does not participate in the activities program at the facility because staff do not offer to take him/her. -9/14/15 at 11:56 AM, Resident #164 was interviewed and stated he/she does not participate in the activities program at the facility because no activities were offered. The resident stated no the activities were not offered to his/her preference on weekends and evenings because none offered. - 9/14/15 at 12:42 PM, a family interview indicated Resident #85 received showers 2-3 times weekly but stated the resident would prefer daily showers. The family interview stated staffing was worse on evening shifts and weekends and indicated staffing was much better on days. The interviewee stated I have come in and he/she is very wet and it doesn't look like he/she is turned as often as (he/she) needs. They will bring in his/her snacks and set up on the television where the resident can't reach it. I found mold in a container of juice about a month ago. The family member stated (His/her) clothing is often missing and other peoples clothes are in his/her room. There is a big problem with socks. I try to label everything. The family member stated the building could be much better in regards to cleanliness. The family member indicated Some of the bathrooms may have feces or urine on the floors, sometimes the smell is really bad. -9/14/15 at 12:54 PM, Resident #156 was interviewed and stated he/she has only received one (1) shower and the rest have been with a wash basin at the bedside. -9/14/15 at 3:28 PM, Resident #59 indicated I like to go to the shower but I haven't had a shower in over two (2) months. They wipe me when they clean me but it is not a good bath. Resident #59 indicated he/she had a chipped front tooth and told staff but nothing has been down. Nothing has been done. The resident stated the dentist comes to the building but he hasn't

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) seen me. The resident indicated he/she did not think the facility was staffed adequately to provide the care residents needed without a long wait. The resident stated they are very short staffed with CNAs. -9/14/15 at 3:51 PM, Resident #4 stated no there was not activities provided as often as he/she would prefer. Resident #4 indicated there were no activity services provided on the evening shifts and weekends. -9/14/15 at 4:17 PM, a family interview for Resident #44 stated excellent nurses have recently left the facility. The family interview stated the facility is short staffed during the day and there are a lot of agency staff working here daily. The family interview indicated the agency staff are good. Interview with the Maintenance Director on 9/16/15 at 4:00 PM, he/she stated he/she was unable to perform his/her duties as assigned. The staff member indicated the facility was short staffed and additional duties had been assigned to him/her. The staff indicated he/she was unable to perform all the duties assigned to him/her. Interview with the Activities Director on 9/17/15 at 9:02 AM, the Activities Director stated he/she was unable to perform his/her assigned duties due to lack of sufficient staffing. The Activities Director stated additional duties had been added to his/her responsibilities and he/she was unable to perform all assigned duties sufficiently. Interview with the Social Services Director on 9/17/15 at 10:55 AM , the Social Services Director stated he/she was unable to keep up with his/her department assignments due to other work assignments. The Administrative staff indicated he/she can't get to all of it. The facility failed to provide sufficient staffing to ensure resident dignity and preferences were met, and failed to provide sufficient staffing to implement plans of care to meet resident needs in the care areas of pressure ulcers, range of motion, and activities and to maintain the facility with standards cleanliness to ensure infection control and in the area of maintenance. Cross reference the following: F242, F248, F253, F314, and F441
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** Based on policy review, observation, interview, the facility failed to ensure infection control practices were maintained to prevent the potential for infection and cross contamination for 2 of 3 residents with pressure ulcers (Resident #1 and 85), and 1 dining observation. The facility identified a census of 76 residents, sample size included 31 residents The findings included: 1. Review of the facility's Dressing Change, Clean policy dated 3/9/15 revealed hands are to be washed after removing soiled gloves and prior to donning new gloves. 2. A wound care observation was conducted with Nursing Staff #22 and Clinical Staff #21 on 9/17/15 at 1:40 PM for Resident #1. Nursing Staff #22 gathered supplies from the treatment cart and put them on the resident's chest of drawers without a barrier, contaminating the supplies, then proceeded to place a barrier on the bedside table and move the supplies to the table. The Clinical Staff donned gloves at the treatment cart without washing his/her hands and then placed gloved hands on the side of the cart, contaminating the gloves. The Clinical Staff proceeded to pick up a computer and pad of paper with the contaminated, gloved hands, and placed the items on the bedside table. He/she then took the resident's temperature and began writing with a pen on the notepad, contaminating everything he/she touched. Nursing Staff #22 removed the resident's boot from the left foot and removed the old dressing from the wound. The nurse then proceeded to remove his/her soiled gloves and donned new gloves without washing his/her hands and took a hold of the resident's left hand which contained a different wound. Clinical Staff #21 took a hold of the resident's foot with his/her soiled gloved hands and began to examine it. He/she then rubbed her face with her soiled, gloved hand and took a hold of the resident's left hand which contained another wound. He/she then removed the soiled gloves and made a splint out of gauze without washing his/her hands. In the meantime, Nursing Staff #22 was applying skin prep to the resident's left foot. Clinical Staff #21 donned gloves without washing his/her hands and began patting the resident's head, contaminating his/her hands. He/she then moved to the resident's left foot and assisted the nurse with the foot dressing, contaminating the dressing. Without removing soiled gloves, Clinical Staff #21 took her stethoscope from around his/her neck and listened to the resident's chest and then put it back around his/her neck. Without removing her soiled gloves, the nurse began going through the resident's dresser drawer, looking for a sock. The sock and boot were applied to the foot. Clinical Staff #21 moved to the resident's left hand and began assisting the nurse without removing her soiled gloves. Nursing Staff #22 was opening dressing supplies while still wearing his/her soiled gloves. Resident #1's care was completed and all staff left the room. 3. A wound care observation was conducted with Nursing Staff #22 on 9/15/15 at 3:50 PM for Resident #85. While providing wound care, the nurse removed the old dressing and packing from Resident #85's pressure ulcer. The nurse then proceeded to remove her soiled gloves and don new gloves without washing her hands. Measurements of the wound were taken including the inward tunnels and the nurse proceeded to remove her soiled gloves and don new gloves without washing her hands. Interview with Administrative Staff #4 on 9/17/15 at 2:45 PM, revealed staff are to wash their hands prior to a treatment, prior to donning gloves, after removing soiled gloves, and before and after any contact with a resident. He/she stated that hand washing education is mandatory on hire but beyond that he/she isn't sure what the education program entails. Interview with Nursing Staff #22 on 9/17/15 at 5:30 P.M. confirmed that hand washing was lacking during the wound care observations. 4. During the lunch meal observation on 9/14/15 at 12:12 PM, one (1) staff member was observed assisting the residents in the dining room. During the meal service the staff member was observed handing a bowl of salad to a resident by holding the rim of the bowl with his/her bare hands. The staff member failed to wash or sanitize their hands prior to handling the salad bowl. Additional observations revealed the staff member pushing a resident's wheelchair from the dining room. However when the staff member returned to the dining room, the staff member failed to wash his/her hands before further assisting the residents. The staff member then retrieved a warm wash cloth from the cooler (utilized by the residents after dining) and wrung it out without washing and/or sanitizing his/her hands prior. The staff member handed the damp cloth to a resident to wipe his/her hands and face. The facility failed to ensure proper hand washing between assisting the residents in the dining room.