STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365687	A. BUILDING _____ B. WING _____	05/20/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBORS AT MARIETTA	400 SEVENTH STREET MARIETTA, OH 45750

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 0221 **Level of harm** - Actual harm **Residents Affected** - Few	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of self-reported incident (SRI), SRI investigation, medical record review, staff interview and resident interview, the facility failed to ensure one resident (Resident #26) was not physically restrained during assessment of vital signs. Actual harm occurred when State tested Nurse Aide (STNA) #301 laid across Resident #26 holding down her arms, and STNA #300 held the resident's legs while attempting to obtain a blood pressure and the resident complained of pain from the incident. This affected one of three residents reviewed for abuse (Resident #126). The facility census was 137. Findings included: Review of Resident #126's history and physical dated 03/30/16 revealed [DIAGNOSES REDACTED]. Further review revealed Resident #126 had a Peripherally Inserted Central Catheter (PICC) line in right upper arm. Review of an SRI dated 04/30/16, revealed Resident #126 reported on 04/30/16 to two visitors, that STNAs #300 and #301 held her down and attempted to take her blood pressure after she told them no due to having a PICC line in her arm and a double [PROCEDURE]. Resident #126 reported she yelled out for help and STNA #75 came into the room and they stopped. Further review revealed STNAs #300 and #301 were terminated. Interview with Resident #126 on 05/11/16 at 12:45 P.M, revealed STNA #301 put her body across her (the resident) and held both arms down. STNA #300 stood at the bottom of the bed. STNA #300 asked STNA #301 what was she doing and she responded she was holding her down to put the blood pressure cuff where she wanted it. Resident #126 reported she felt threatened and scared at the time of the incident due to having a PICC line and double [PROCEDURE]. Resident #126 affirmed she was never to have her blood pressure taken in her arms. Resident #126 stated after the incident staff hung a sign above her bed stating only to apply the blood pressure cuff to her ankles. Review of Resident #126 statement dated 04/30/16 corroborated information in the surveyor's interview. Further review revealed Resident #126 was complaining of arm pain and x-ray of the right arm was ordered. Review of STNA #300's statement dated 04/30/16 revealed only that he was in training and he reported he just stood at the foot of the bed and observed his trainer. There were no details regarding the incident except the resident became combative and verbally abusive. Review of STNA #75's statement dated 05/02/16 revealed she heard two STNAs yelling at Resident #126 that they had to get her vitals done. STNA #75 reported STNA #301 was holding the resident's arms down crossed over each other and STNA #300 was holding her legs down. STNA #75 reported she told them that if the resident refused to have her vital signs taken that was her right. STNA's #300 and #301 then left the room. Review of License Practical Nurse (LPN) #45's undated statement revealed staff reported on 04/27/16 not 04/25/16 that Resident #126 had refused vital signs and became combative and verbally abusive. LPN #45 reported Resident #126 required vital signs due to an unwitnessed fall on 04/27/16 at 11:30 P.M. Review of Resident #126's nurse notes dated 04/27/16 revealed no evidence the resident was combative, verbally abusive, or refusing care. Review of x-ray report dated 05/01/16 revealed no acute abnormalities. Interview with the Administrator on 05/11/16 at 10:50 A.M., revealed after the investigation was complete it was determined the incident actually occurred on 04/27/16. The Administrator affirmed STNA's #300 and #301 involved in the incident were terminated for not respecting the resident's request. STNA #75 was verbally disciplined for not reporting the incident. This deficiency substantiates Complaint Number OH 244.
F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, review of wound center notes, review of facility's policy, wound observations, interview with the medical director, resident and staff interviews, and interview with the wound care center staff, the facility failed to provide physician ordered treatments, accurately assess the condition of pressure ulcers, and provide interventions for pressure ulcers for four of four residents reviewed for pressure ulcers (Residents #1, #2, #3, and #4). This resulted in Immediate Jeopardy for four residents (Residents #1, #2, #3 and #4). Actual harm occurred when Resident #2 required a second surgical procedure to the coccyx due to a deterioration of a coccyx wound from treatments and interventions not being provided per physician orders. Resident #1 sustained actual harm when the facility failed to accurately identify and provide ordered treatments resulting in a decline in a coccyx wound with exposure of the resident ' s bone identified as a Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). In addition, Resident #3 experienced actual harm with a decline in a coccyx pressure ulcer from a Stage III (defined as full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling), to a Stage IV pressure ulcer that developed tunneling. Resident #4 sustained actual harm when the facility failed to accurately assess and provide treatments resulting in a deterioration of pressure ulcers on his coccyx and buttocks. The facility identified eight residents with pressure ulcers and four of the residents presented with in-house acquired pressure ulcers. The facility census was 137. On 05/12/16 at 2:40 P.M., the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Director of Operations (RDO) #50, and Corporate Nurse (CN) #151 were notified Immediate Jeopardy began on 04/21/16, when Resident #2 returned from the wound center with new treatment orders to the coccyx, however, the orders were not transcribed on the treatment administration records and treatments were not completed. Resident #2 requires an additional surgical procedure (scheduled 05/26/16) to the coccyx pressure ulcer area. Resident #2 had a decline in pressure ulcers without appropriate interventions to promote healing, multiple missed treatments, and treatments not provided according to physician orders. The Immediate Jeopardy continued for Resident #1 when the facility's failure to provide physician ordered treatments resulted in the deterioration of the resident's coccyx pressure ulcer with deepening of the wound to bone exposure. The Immediate jeopardy continued for Resident #3 who experienced actual harm with a decline in a coccyx wound from a Stage III to Stage IV. Resident #4 sustained actual harm when the facility failed to accurately assess and provide treatments resulting in a deterioration of pressure ulcers on his coccyx and buttocks that required treatment outside the facility. The Immediate Jeopardy was removed on 05/16/16, when the facility implemented the following corrective actions: · On 05/12/16 at 10:00 P.M., Registered Nurse (RN) #152, Licensed Practical Nurse (LPN) #50, RN #144, and LPN #88 reviewed

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

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) and updated the pressure ulcer care plans for Resident#1, Resident #2, Resident #3, and Resident #4. · On 05/12/16 at 11:00 P.M. RN #63, RN #42, RN #73, and CN#151 completed a facility wide skin sweep on 131 residents to identify skin impairments. One resident (Resident #28) of 131 refused the skin sweep. · On 05/13/16 at 12:00 A.M., RN #152, reviewed and updated care plans of all 131 residents as needed for wounds and risk for skin breakdown. · On 05/13/16 at 2:00 A.M., RN #153 and RN #154 reviewed current treatment orders for Resident #1, Resident #2, Resident #3 and Resident #4 to determine effectiveness of treatment and clarified and revised orders. · On 05/13/16 at 12:00 P.M., the DON completed an evaluation of the current pressure reducing devices being utilized on all 131 residents in the facility and care plans were updated if indicated. · On 05/13/16 at 2:00 P.M., CN #151, RN #154, and RN #133 reviewed skin care and wound supplies to ensure all supplies were available and in the cart or storage. · On 05/13/16 at 11:00 P.M., RN #153 and RN #154 provided one on one education with RN #35 with 12 additional return demonstrations. Topics of education included: dressing change procedure and completing the Norton Scale (tool used to establish a resident ' s risk for developing pressure ulcers). · On 05/13/16 at 4:00 P.M., RN #153 audited the agency training book and included a section on wound care protocols, instructions, and location of supplies. Education was provided to the four agency nurses. The four agency nurses were also included in the training plan for the facility. · On 05/13/16, a plan was implemented to observe all licensed staff on wound care by the DON with follow-up one on one education by 06/15/16. · On 05/13/16, a plan was implemented to audit treatment carts to ensure supplies were available and match orders weekly for eight (8) weeks to be completed by RN #43. · On 05/14/16 at 7:35 A.M., RN #135 provided education to 35 nurses on taking orders, noting orders, and transcribing orders as well as writing a nurses note when a new order was obtained. · On 05/14/16 at 7:35 A.M., RN #153 and RN #154 completed education to all 35 nurses (21 LPNs and 14 RNs) on skin process guidelines, wound care, pressure ulcer prevention, push tool, repositioning, and support services. · On 05/14/16 at 5:00 P.M., an audit was completed by RN #135 for 10 residents with IV therapy for accuracy, completion, and documentation. · On 05/14/16 at 9:00 P.M., LPN #114, LPN #50, the DON, RN #133, and RN #152 reviewed all 131 residents' Norton scale to establish the potential risk for skin breakdown. · On 05/15/16 at 12:30 P.M., CN #151, Regional Director of Operations (RDOO) #150, and Office Administrator #27, completed education on turning and repositioning to 55 State tested Nurse Aides (STNA), 19 LPNs, and 13 RNs. Staff not trained were removed from the schedule until training is completed. · On 05/14/16 at 7:05 A.M., interview with LPN #96, LPN #94 on 05/14/16 at 7:35 A.M., STNA #107 on 05/14/16 at 8:00 A.M., LPN #207 on 05/14/16 at 8:15 A.M., LPN #208 on 05/16/16 at 3:05 P.M., and RN #77 on 05/16/16 at 3:10 P.M., confirmed they had been in-serviced on wounds (assessment), turning and positioning, beds, and orders. · As of 05/16/16, one nurse and three STNAs had not been trained and were not on the schedule. Although the Immediate Jeopardy was removed on 05/16/16, the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as all staff had not been in-serviced on skin and wound management, and the facility was in the process of implementing weekly audits to monitor for on-going compliance. Findings include: 1. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review revealed Resident #2 was high risk for developing pressure ulcers. Review of the quarterly Minimum Data Set 3.0 ((MDS) dated [DATE] revealed Resident #2's cognition was moderately impaired. She was at risk for developing pressure ulcers, had a pressure reducing device for the bed, was on a turning and repositioning program, and had an open lesion. Resident #2 was identified to require extensive assist of two or more for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of a telephone order for wound care dated 04/08/16 indicated to change the coccyx wound to one inch plain packing strip twice daily. The wound was to be irrigated with normal saline, pack tunneling at 7:00 and 5:00, not too tightly and cover with ABD and [MEDICATION NAME] twice daily. Review of lab results dated 04/17/16 revealed Resident #2's wound culture to the coccyx grew Escherichia Coli and proteus mirabilis. Review of the facility's wound care notes revealed on 04/19/16 Resident #2's coccyx wound measured 0.5 cm by 0.5 cm by 0.5 cm with depth 0.6 cm at 7:00 with heavy purulent drainage. The wound was irrigated with normal saline, packed with plain packing strip, covered with ABD, and secured with [MEDICATION NAME]. Review of wound center notes dated 04/21/16 revealed orders to cleanse the coccyx wound with saline wound wash, irrigate with Dakin ' s solution, moisten gauze with quarter strength Dakin's solution, pack into any deep areas of the wound, secure with [MEDICATION NAME] tape twice daily. Review of the wound center notes indicated orders for Imipenem-clilastatin (antibiotic) intravenous. Further review revealed an appointment was scheduled on 04/28/16 with an infectious disease doctor regarding a culture report. The wound center note identified the coccyx wound measured 0.5 centimeter (cm) by 0.5 cm by 1.2 cm with a large amount of serous drainage and a small amount of necrotic (dead) tissue. Further review revealed a peripherally inserted central catheter (PICC) line was inserted on 04/21/16. Review of telephone orders dated 04/23/16 revealed Imipenem-cilastatin via PICC line every 8 hours until further notice. Review of the wound center notes dated 04/26/16 revealed additional notes to turn the resident every two hours, physician office will schedule appointment of surgery, and to continue current treatment of [REDACTED]. Review of the April 2016, Medication Administration Record [REDACTED]. There was no documented evidence the medication was administered on 04/28/16 at 4:00 P.M., or 04/29/16 and 04/30/16 at midnight. Review of the May 2016, MAR indicated [REDACTED].M., 05/04/16 at 8:00 A.M. and 05/05/16 at midnight. The medication was discontinued on 05/07/16 at 4:00 P.M. Review of the April 2016, Treatment Administration Records (TAR) revealed new orders were received on 04/09/16 to irrigate the coccyx wound with normal saline, pack tunneling at 7:00 and 5:00 with one inch plain packing strip, do not pack tightly, and cover with ABD and [MEDICATION NAME] twice daily. Further review revealed Resident #2 had 17 treatments not documented as completed from 04/09/16 to 04/30/16. Review of additional pressure interventions listed on the TAR included out of bed to chair for one hour daily, turn and reposition every two hours and as needed, float heels while in bed, may sit up in chair, no pressure to wound limited to one hour at a time, and Dolphin bed (fluid immersion bed used to offload pressure) for ulcer care. Review of 05/03/16 facility wound notes revealed the wound was irrigated with prescription concoction, packed with plain packing strip, moistened with same concoction, covered with dry dressing, and secured with [MEDICATION NAME]. The wound dressing was to be changed twice daily. There was no documentation to explain what was in the concoction. Review of the May 2016, TAR revealed treatment to irrigate the coccyx wound with normal saline, pack tunneling at 7:00 and 5:00 with 1 inch plain packing strip, do not pack tightly, and cover with ABD and [MEDICATION NAME] twice daily. Further review revealed Resident #2 had 14 treatments not documented as completed from 05/01/16 to 05/11/16. Review of the care plan conference summary dated 05/02/16, revealed Resident #2 and her family member had reported to RN #73 and Social Service #66 that her wounds were not getting changed, not getting incontinence care frequently, not getting turned every 2 hours, and not getting up for one hour a day. Review of a telephone order dated 05/09/16, revealed Resident #2 was scheduled for surgery of the coccyx on 05/26/16. Nurse's notes revealed on 05/10/16, Resident #2's coccyx wound had a foul odor and moderate amount of sero-sanguanious drainage. There was no evidence the physician was notified. Interview with LPN #202 on 05/10/16 at 3:45 A.M., revealed treatments were not being done after the wound care nurse left the building as the staff did not have access to the treatment cart. The wound nurse was the only one with keys. LPN #202 confirmed she had reported concerns regarding keys not being available and treatments not being done. LPN #202 verified she was unable to provide treatment to Resident #2 and five other residents the previous night because she did not have access to their supplies.

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) On 05/11/16 at 2:15 P.M., observation of Resident #2's dressing change with RN #35 revealed the un-dated dressing was removed and a large amount of thin tan drainage was noted on the old dressing. RN #35 moistened 4 X 4 gauze with Dakin's solution and cleansed the outside of the wound. The wound continued to drain thin tan drainage. RN #35 soaked plain packing with Dakin's solution; balled up packing, placed it in the wound on the coccyx, and covered it with a dressing. There was no evidence the wound was irrigated with Dakin's solution or the wound was packed as ordered. Interview with Resident #2 on 05/11/16 at 2:00 P.M., revealed staff did not change her dressing to the coccyx or turn her every two hours. Resident #2 reported she had gone three days without having the dressing changed to her coccyx and had to lay in urine for hours. Resident #2 reported she had to have another surgery to her coccyx due to staff not turning her every two hours or changing her dressing per orders. Interview with RN #35 on 05/11/16 at 2:30 P.M., verified new treatment orders for Resident #2 for Dakin's solution were received from the wound care center on 04/21/16 and were not transcribed and were not completed. RN #35 verified it was the floor nurse ' s responsibility to take the orders off the wound care center notes and write them on a telephone order and transcribe the new orders on the TAR. RN #35 verified she did not irrigate the coccyx wound or pack the tunneled area during the wound care observation on 05/11/16. RN #35 verified she had observed Resident #2's dressing and there had been times it had not been changed every day. RN #35 verified she did not confirm the treatment orders prior to administering treatment to Resident #2's coccyx; however, she stated she had recalled reading the 04/26/16 orders from the wound care center. Interview with Wound Center RN (WCRN) #201 on 05/12/16 at 9:14 A.M., revealed they recently had concerns with the facility. WCRN #201 reported concerns with treatment orders and turning not being performed. WCRN #201 reported most residents were ordered treatments twice daily and the wound center staff hoped the facility at least provided treatments once daily. WCRN #201 stated she spoke to the wound center physician and he had reported he could not pinpoint Resident #2's decline in the coccyx wound; however, contributing factors for decline would be not providing treatments per orders and not turning the resident every 2 hours. Interview with the facility's Medical Director on 05/13/16 at 9:05 A.M., revealed he was aware of concerns with pressure ulcers and especially with Resident #2's dressing not being performed according to his orders. He stated he was aware of concerns staff were not using the Dolphin bed correctly. Interview with Visitor #200 (Resident #2's family member) on 05/13/16 at 12:40 P.M., revealed she had voiced concerns with the facility regarding Resident #2 not being turned every two hours and the dressing on the coccyx not being changed. Visitor #200 had reported Resident #2's dressing had not been changed for up to two days at a time and her IV antibiotics were not supposed to be stopped until June 4th. Visitor #200 reported the facility was short on staff and it was the worst care she had ever seen. Visitor #200 reported she had called the ombudsman and they had been investigating her concerns. Interview with the DON on 05/13/16 at 1:30 P.M., verified Resident #2 was ordered the Imipenem-cilastatin on 04/23/16 every 8 hours until further notice. The DON verified there was not an order to discontinue the Imipenem-cilastatin and the staff stopped it on 05/06/16. The DON verified according to the MAR, Resident #2 had missed multiple doses of the antibiotic. The DON verified the physician was notified and new orders were received to continue the Imipenem-cilastatin for four more weeks. Interview with RN #205 on 05/16/16 at 12:25 P.M,. revealed the facility called the infectious disease physician office and had progress notes from the 04/28/16 visit faxed to confirm Resident #2 was to continue the IV antibiotics for six more weeks for the infected sacral wound. 2. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was identified as a high risk for developing pressure ulcers. Review of Resident #1's quarterly MDS dated [DATE], revealed the resident was cognitively intact, at risk for developing pressure ulcers, had one Stage II pressure ulcer (defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister), and had pressure relieving devices, turning and repositioning program, pressure ulcer care, and nutrition interventions. Further review revealed Resident #1 required extensive assist of two or more for bed mobility, dressing, toileting, and personal hygiene. Review of wound center notes dated 04/26/16, revealed Resident #1 had a Stage III pressure ulcer on the right lower leg, Stage IV pressure ulcer on the coccyx with bone exposure, and Stage II ulcer on the left gluteal fold. Further review revealed orders to cleanse the coccyx and left gluteal fold with saline, apply solosite gel to the base of the wound, apply saline wet to dry dressing and secure with [MEDICATION NAME] twice daily. Record review revealed orders not to remove the wound vac. The wound vac dressing was changed by wound care center staff only. Review of the facility wound care notes dated 01/20/16 to 05/06/16 revealed Resident #1 had a Stage II pressure ulcer to the coccyx and no evidence of pressure areas on the right leg or left gluteal fold. Review of the April 2016, TAR indicated to cleanse the coccyx and left gluteal wounds with soap and water, apply solosite gel and gauze moistened with normal saline, cover with dry gauze, and border foam twice a day. Further review revealed 10 treatments to the coccyx and nine treatments to the left gluteal fold were not documented as completed in April, 2016. Review of the May 2016, TAR revealed Resident #1 had five treatments to the coccyx, and four treatments on the left gluteal fold not documented as completed. Review of Resident #1's laboratory results dated [DATE], revealed the coccyx wound culture grew pseudomonas aeruginosa and Escherichia coli. Review of orders dated 05/04/16, revealed to administer [MEDICATION NAME] (antibiotic) IV 3.375 gram every six hours for seven days via PICC line. Review of Resident #1's May 2016, MAR indicated [REDACTED]. Interview with RN #35 on 05/11/16 at 1:00 P.M., verified she was responsible for measuring and staging pressure ulcers in the facility. She verified she had the coccyx pressure ulcer for Resident #1 staged as a Stage II pressure and bone exposure was noted. RN #35 verified she did not have the area on the right leg or left gluteal fold identified as pressure ulcers. RN #35 confirmed Resident #1 had several missed treatments to the coccyx and left gluteal fold for both April and May 2016. RN #35 verified the wound center did not permit the facility to change the wound vac on Resident #1's right leg. RN #35 verified the wounds were acquired in the facility. Observation of wound care for Resident #1 with LPN #20 on 05/12/16 at 8:10 A.M. revealed LPN #20 was unable to find Resident #1's solosite gel and she was going to use a solosite dressing instead on the pressure ulcers on the coccyx and left gluteal fold. LPN #20 verified the treatment cart was locked and she did not have keys to access the cart. LPN #20 verified the resident ' s bone was exposed on the coccyx pressure ulcer and there was a scant amount of thick purulent drainage noted on the old dressing. The wound on the left gluteal fold had 90% slough noted to the wound bed. The wound had an odor and blood was noted on the old dressing. Resident #1 reported staff took all his supplies out of his room that morning due to State was in. LPN #20 spoke to the unit manager after the dressing was reapplied and they found a large white trash bag filled with treatment supplies in the unit manager's office under the desk. LPN #20 affirmed Resident #1's solosite gel was in the bag. Interview with WCRN #201 on 05/12/16 at 9:14 A.M., verified not turning and repositioning and not providing wound care per orders could have contributed to Resident #1's wound decline. Interview with the DON on 05/13/16 at 1:30 P.M., verified Resident #1's May 2016, MAR indicated [REDACTED]. 3. Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the pressure ulcer risk assessment dated [DATE] revealed Resident #3 was at moderate risk for developing pressure ulcers. Review of Resident #3's comprehensive MDS assessment dated [DATE], revealed the resident was severely cognitively impaired, at risk for developing pressure ulcers, and had a Stage III pressure ulcer measuring 2.0 cm by 2 .8 cm by 0.2 cm with slough. Resident #3 was receiving pressure reducing devices to the bed and chair, turning and repositioning, and pressure ulcer care. Further review revealed Resident #3 required extensive assist of two or more for bed mobility, transfers, dressing, toileting and personal hygiene. Review of Resident #3's wound notes dated 12/15/15 to 05/09/16, revealed Resident #3 had an in-house acquired Stage III pressure area to the coccyx. Further review revealed the area measured 1.0 cm by 1.5 cm by 0.2 cm on 05/09/16. The wound notes revealed the wound was cleansed with saline wound wash, medi-honey to the wound bed, and covered with a bordered foam dressing. Further review of the wound notes revealed medi-honey was applied to the wound from 03/07/16 to 05/09/16. Review of the March 2016, monthly orders revealed an order for [REDACTED]. Review of Resident 3's TARs for April and May

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) 2016, revealed treatments were indicated despite having no physician order. Review of Resident #3's April 2016, TAR revealed to change wound dressing to coccyx daily, cleanse with normal saline apply medi-honey to wound bed and cover with foam dressing. Further review revealed three treatments were not documented as completed in April 2016. The TAR indicated three treatments were not documented as completed between 05/01/16 to 05/09/16. Interview with RN #35 on 05/11/16 at 12:35 P.M., verified Resident #3 had missed treatments to the coccyx in April and May 2016. RN #35 confirmed there was no current order for treatment to Resident #3's coccyx wound since March 2016. Observation and interview with LPN #5 on 05/12/16 at 10:56 A.M,. revealed she was going to perform a treatment to Resident #3's coccyx using medi-honey. LPN #5 verified there was no order for the medi-honey or any evidence of orders for treatment to the coccyx. Observation and interview with RN #35 on 05/12/16 at 11:30 A.M., revealed the wound on the coccyx had declined from the wound measurement notes from 05/09/16. Resident #3's coccyx wound had an open area in the center of the wound measuring 0.2 cm by 0.4 cm by 0.5 cm with tunneling at 6:00. Resident #3 yelled ouch when RN #35 applied pressure on the area. RN #35 verified the area had deteriorated. RN #35 stated she would call the physician to receive new orders. Review of the pressure ulcer tracking form dated 05/13/16, revealed Resident #3's coccyx wound had further declined to a Stage IV with the tissue type identified as slough. Measurements included length 1.5 cm, width 1.8 cm, and depth 1.0 cm. A moderate amount of serous exudate was note. The surrounding skin was intact. 4. Review of Resident #4's medical record revealed the resident was originally admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Further review of Resident #4's pressure ulcer risk assessment dated [DATE] revealed the resident was at moderate risk for development of pressure ulcers. Review of Resident #4's quarterly MDS dated [DATE], revealed the resident was cognitively intact, at risk for developing pressure ulcers, had one Stage III pressure ulcer measuring 16 cm by 52 cm by 0.3 cm with granulation tissue. Resident #4 had pressure reducing devices, turning and repositioning program, pressure ulcer care and nutrition interventions. Resident #4 required extensive assist of two or more with bed mobility, toilet use, and personal hygiene. Review of Resident #4's May 2016, monthly orders revealed to apply medi-honey to coccyx and left buttocks, cover with border foam dressing, change daily and as needed. Further review revealed to apply liberal amount of medi-honey to the left hip crease and back, cover with a dry gauze dressing and change daily as needed. Review of Resident #4's May 2016, TAR revealed treatments for the coccyx, left buttocks, and left hip/lower back were not documented as administered from 05/06/16 to 05/10/16. Review of Resident #4's facility wound measurements dated 04/18/16 and 04/25/16, revealed Resident #4 had a Stage III pressure ulcer to left buttocks. The width was 52.0 cm. The measurement prior to and after those dates indicated the width of the area was 16-28 cm. Further review revealed from 02/17/16 to 05/09/16, the wounds were cleansed with saline wound cleanser and Xeroform was applied to multiple areas, and then covered with border foam dressing. Observation of Resident #4 on 05/11/16 at 3:00 P.M., revealed the resident had a large open area from the coccyx area to the left hip with bridges of healed areas. The open area on the coccyx had a macerated area/slough. RN #35 cleansed the wounds and applied Xeroform dressing to the areas. There was no evidence medi-honey was applied. RN #35 affirmed she applied Xeroform to all the open areas and covered with a dressing. Interview with RN #205 on 05/16/16 at 1:00 P.M., verified Resident #4 had undated orders for wound care to left buttocks, coccyx, left hip crease, left lower back, and left upper back. RN #205 verified the entire wound was measured as one wound under the left buttocks and the measurements were inaccurate on 04/18/16 and 04/25/16. RN #205 verified Resident #4's treatments were not performed from 05/06/16 to 05/10/16 to the left buttocks, coccyx, left hip crease, left lower back, and left upper back. Review of the pressure ulcer treatment policy dated 03/23/11, revealed the pressure treatment program should focus on assessing the residents pressure ulcer, managing tissue loads, pressure ulcer care, managing bacterial colonization and infections, operative repair of the pressure ulcers, and education and quality improvement. Further review revealed to document in the medical record any changes in the resident ' s condition, all assessment data when inspecting the wound, resident's refusal, and notifying the supervisor of any resident refusals. This deficiency substantiates Complaint Number OH 241.
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, review of the facility's investigation, and review of facility's policy, the facility failed to ensure safe environment and location of one resident (Resident #135) of three residents reviewed for elopement. The facility census was 137. Finding include: Review of Resident #135's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively intact and required assistance device (walker) for ambulation. Review of the Absence (Temporary) Release policy dated 10/07/10, revealed the facility encourages socialization in the community for the residents when appropriate. The facility will provide a release from responsibility for the resident during an absence; inform the resident and any accompanying person regarding release of responsibility; document that the resident was informed about release of responsibility and; provide a process for residents upon absence from the center to relay pertinent information while on leave. The facility will provide the resident with any necessary medications, diet instruction, and address and phone number of the facility for resident use while on leave. The nurse will document in the nursing notes section of the medical record the date and time the resident left, person accompanying the resident, medication provided, instructions, and any other pertinent information. Review of the facility's investigation report for Resident #135 on 05/03/16, revealed on this date the resident had signed out on the absence log at 10:45 A.M. Further review revealed staff reported around 5:00 P.M., Resident #135 briefly stopped at the facility and left again without signing in and back out. On 05/04/16 at 1:40 A.M., staff called the Administrator to report Resident #135 had not returned to the facility. The facility searched the premises and contacted the local police department. The police department searched Resident #135's room and attempted to contact a phone number they found in her room. The police had no further involvement due to resident was alert and oriented and her own responsible party. Resident #135 was unable to be contacted or found. On 05/05/16 at 8:30 A.M., Resident #135 returned to the facility and was met at the door by the Administrator. Resident #135 reported she had gone out of state with a friend and was fine. The physician was notified and Resident #135 was sent to the hospital and returned the same day. Resident #135 was re-educated on the proper procedure for leave of absence. Staff was educated on the leave of absence and elopement policy. Review of Resident #135 nurse's notes dated 05/03/16, revealed no evidence nursing staff had documented leave of absence (LOA). Further review revealed on 05/03/16 at 7:30 P.M., report was given that Resident #135 was out for the evening. On 05/04/16 at 12:13 A.M., the nurse documented she was concerned when the resident had not returned and had not signed out. This nurse documented the facility was searched and was unable to locate Resident #135. On 05/04/16 at 1:00 A.M., the Administrator was notified and at 2:00 A.M. the physician was notified. New orders were received to allow the resident to be away on leave by personal recognizance and to follow facility policy. Further review revealed no evidence of when Resident #135 returned from leave of absence. On 05/05/16 at 5:30 P.M. Resident #135 returned from hospital. Review of the education provided to Resident #135 signed and dated 05/05/16, revealed staff was unaware she had left the faciity on [DATE] and it was unacceptable. The resident would need to notify staff when she was leaving the facility. Review of May 2016, monthly orders dated 04/22/16, revealed the section for leave of absence (LOA) was not checked for the resident to be able to go on LOA independently or with escort. Review of physician orders [REDACTED]. Further review revealed Resident #135 was not permitted to go on leave of absence without a responsible party. If the resident didn't follow policy she would be discharged . Review of the sign out set revealed Resident #135 had signed herself out of the facility at 10:45 A.M. on 05/03/16. Resident

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	365687	A. BUILDING _____ B. WING _____	05/20/2016

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ARBORS AT MARIETTA	400 SEVENTH STREET MARIETTA, OH 45750

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) #135 had never signed back in, nor did staff sign the resident return section. Interview with Registered Nurse (RN) #73 on 05/10/16 at 7:20 A.M., affirmed Resident #135 was gone for two days and the facility did not know her whereabouts. RN #73 reported the resident came and went as she pleased and didn't sign in or out when she left. Interview with Resident #135 on 05/10/16 at 4:30 P.M., affirmed she had signed herself out on 05/03/16 around 11:30-11:45 A.M., then returned around 3:00 P.M. to the front lobby to drop off her walker. Resident #135 reported she did not return until Thursday around 8-8:30 A.M. Resident #135 stated she felt that she did her part by signing out when she left and felt the facility didn't do their part by signing her back in. This deficiency substantiates Complaint Number OH 241.
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents were free of significant medication errors when a blood thinning medication and intravenous antibiotics were not administered per physician orders. This affected two (Residents #1 and #2) of three residents reviewed for medication administration. Findings included: 1. Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1 orders dated 05/03/16 revealed to hold [MEDICATION NAME] (blood thinning medication) today, repeat international normalized ration (INR), (a blood test to measure the effectiveness of the blood thinning medication), in A.M., and continue checking INR on Tuesday and Friday. If INR is less than three (3), restart [MEDICATION NAME] at 3 milligrams (mg). Further review revealed on 05/04/16 orders for intravenous (IV) [MEDICATION NAME] (antibiotic) every six hours for seven (7) days. Review of Resident #1's lab results on 05/15/16, revealed no evidence an INR was performed after 05/04/16. Further review revealed Resident #1's INR goal was between 2.0 and 3.0. Interview with Registered Nurse (RN) #153 on 05/15/16 at 11:20 A.M., verified the last INR that was in Resident #1's medical record was 05/04/16. Review of Resident #1's Medication Administration Record [REDACTED]. [MEDICATION NAME] 3 mg was restarted on 05/14/16. Further review revealed Resident #1 was started on IV [MEDICATION NAME] every six hours on 05/04/16, and was still receiving [MEDICATION NAME] 9 days later on 05/12/16. Further review revealed from 05/04/16 to 05/12/16, Resident #1 had seven (7) missed doses of [MEDICATION NAME]. Interview with RN #205 on 05/16/16 at 12:00 P.M., verified Resident #1 had an INR on 05/07/16 and 05/11/16, which were not in the resident's medical record. RN #205 verified Resident #1 should have had an INR on 05/06/16, 05/10/16, and 05/13/16. RN #205 verified Resident #1 did have an INR on 05/07/16, and the INR was 2.39 and the nurse should have started [MEDICATION NAME] 3 mg per the order written on 05/03/16. RN #205 verified Resident #1 had an INR on 05/11/1,6 and the INR was 1.10. RN #205 verified Resident #1's [MEDICATION NAME] was restarted on 05/14/16 at 3 mg, and the facility did not have a current order. RN #205 verified Resident #1 was on IV antibiotics. 2. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of lab results dated 04/17/16, revealed Resident #2's wound culture of the coccyx was positive for Escherichia coli and Proteus mirabilis. Review of wound center notes dated 04/21/16, revealed orders for Imipenem Dilatation (antibiotic) intravenous, pharmacy to dose and monitor of two weeks. Further review revealed an appointment was scheduled with the infectious disease physician on 04/28/16 regarding the positive culture report. Review of nurse's notes dated 04/21/16, revealed Resident #2 had returned to the facility with a PICC line and orders for Imipenem Dilatation with pharmacy to dose. An order was sent to pharmacy. Pharmacy called the facility to report Resident #2's [MEDICATION NAME] allergy with Imipenem Dilatation. The Nurse Practitioner was notified and a recommendation was made to hold the dose of the antibiotic and contact the wound center in the morning to clarify. On 04/22/16, the wound center was notified and recommendation was made to start the Imipenem Dilatation. The pharmacy was notified and confirmed they would send the medication. On 04/23/16, Resident #2's primary care physician confirmed the order for Imipenem Dilatation. There was no evidence the medication was started until 04/24/16. On 05/10/16 nurses notes revealed Resident #2's coccyx wound had a foul odor and moderate amount of sero sanguineous drainage. There was no evidence the physician was notified. Review of Resident #2's telephone orders dated 04/23/16, revealed Imipenem Dilatation via PICC line every 8 hours until further notice. Review of April 2016, MAR indicated [REDACTED]. There was no evidence the medication was administered on 04/28/16 at 4:00 P.M., 04/29/16 at midnight, and 04/30/16 at midnight. Review of Resident #2's May 2016, MAR indicated [REDACTED].M., 05/04/16 at 8:00 A.M., and 05/05/16 at midnight. According to the MAR indicated [REDACTED].M. Further review revealed Resident #2 had only received Imipenem Dilatation 13 days of treatment. Interview with the Director of Nursing (DON) on 05/13/16 at 1:30 P.M., verified Resident #2 was ordered the Imipenem Dilatation on 04/23/16. It was to be administered every eight (8) hours until further notice. The DON verified there was no order to discontinue the Imipenem Dilatation, and the staff stopped it on 05/06/16. The DON verified that according to the MAR, Resident #2 had missed several doses of the medication. The DON verified the physician was notified on 05/13/16, and new orders were received to continue the Imipenem Dilatation for four more weeks. Interview with RN #205 on 05/16/16 at 12:25 P.M., revealed the facility called the infectious disease physician office and had progress notes faxed from the resident's visit on 04/28/16. The progress notes confirmed Resident #2 was to continue the IV antibiotics for six (6) more weeks for an infected sacral wound. The surveyor reviewed the faxed progress notes and verified the information with RN #205 during the interview. Review of the Medication Administration policy (dated 12/21/10), revealed medication shall be administered in a safe and timely manner, and as prescribed. This deficiency substantiates Complaint Number OH 241.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interviews, staff interviews, and review of resident council minutes, the facility failed to ensure adequate staffing to meet the total care needs of all the residents in the facility. This had the potential to affect 137 of 137 residents residing in the facility. Findings include: 1. On 05/10/16 at 3:20 A.M., observation revealed there was only one State tested Nurses Aide on the floor for 42 residents. 2. On 05/10/16 at 8:30 A.M., during medication administration observation, the surveyor observed Resident #121's call light was activated when the surveyor arrived to the floor. The call light continued to be activated at 8:50 A.M., when State tested Nurses Aide (STNA) #101 answered the call light and then walked out of the resident's room. On 05/10/16 at 8:45 A.M., Licensed Practical Nurse (LPN) #114 was administering medications around Resident #121's room the entire time of observation. During medication administration, the surveyor asked LPN #114 if there was something wrong with Resident #121's call light because it had been going off a long time. LPN #114 responded she was not for sure. LPN #114 did not follow up to see if Resident #121 needed anything or if there was something wrong with the call light. On 05/10/16 at 8:50 A.M. interview with Resident #121 revealed she needed her bed changed because she had been incontinent of urine. Resident #121 reported her call light had been ringing since 8:20 A.M. Resident #121 reported the facility did

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) not have much help and it wasn't getting better. The resident revealed the staff did not help her. STNA #101 was observed standing on the other hall (D-Hall) and another STNA was picking up breakfast trays. On 05/10/16 at 9:10 A.M., STNA #101 returned to D-hall and was talking to a resident in the hallway. The other STNA was assisting a resident in a different room. The other aide asked STNA #101 to assist her with the resident. On 05/10/16 at 9:12 A.M., Resident #121 rang her call light again. At 9:15 A.M., STNA #101 left a resident's room and pushed a resident in the wheelchair down the hall. At 9:16 A.M., housekeeping staff entered Resident #121's room and said she would be back to clean the room later. On 05/10/16 at 9:20 A.M., STNA #11 answered Resident #121's call light and told her someone would be back to change her and the bed. On 05/10/16 at 9:20 A.M., interview with Resident #121 revealed she was still wet and her bed was saturated with urine. Resident #121 stated staff had not checked or changed her since 3:00 A.M., and she was frequently incontinent of urine. On 05/10/16 at 9:28 A.M., during interview with LPN #114, she verified Resident #121 had been requesting help since 8:20 A.M. for incontinence care and the care still had not been provided. 3. On 05/10/16 at 11:00 A.M., interview with Resident #135 revealed there was not enough staff and she has had to help her roommate and other residents with care. Resident #135 reported she had helped pass trays and had even helped Resident #72 put her briefs and pants back on after assisting her with her toileting needs. Resident #135 reported this happened a lot and she was lucky to get her medications once a day. 4. On 05/10/16 at 12:35 P.M., interview with Resident #72 revealed staff was unable to shower her last night due to having only one aide for the entire hall. Resident #72 reported she had not had a shower for a week because the staff would either not do it when she was ready or there was only one staff member. Resident #72 reported that Resident #135 had helped her several times with toileting care due to staff not being available. Resident #72 reported she had waited 20 minutes or longer for staff to answer call lights. She reported that on evening shift sometimes its 10:00 P.M. before she got her 8:00 P.M. medications. 5. On 05/13/16 at 7:19 A.M., observation of medication administration with Registered Nurse (RN) #43 verified there were still seven (7) residents who hadn't received their 6:00 A.M. medications. RN #43 verified their medication were not administered within the one hour time frame. RN #43 verified there weren't enough staff to do everything that needed done for the residents and medications were sometimes late. 6. On 05/14/16 at 7:20 A.M., interview with LPN #96 confirmed the residents had to eat in their rooms due to staffing shortage. 7. Review of resident council minutes dated 02/25/16, revealed concerns with not getting help to bed, call lights not being answered, residents had to assist other residents, and meal trays were not being delivered timely. 8. Review of resident council minutes dated 03/15/16, revealed concerns with staff shortage and not getting showers done. 9. Review of resident council minutes dated 03/24/16, revealed concerns with ice not being passed, call lights not being answered timely, resident reported she was sick during the night and had to clean herself up and the floor due to she couldn't find staff, resident reported he was in pain and had to wait 30 minutes for pain medication, resident reported her [MEDICAL CONDITION] medication was to be given before breakfast and she was not getting it until after breakfast. 10. Review of resident council minutes dated 04/28/16, revealed residents were not getting showers and staff tried to get them to sign paper saying they refused. Further review revealed staff were not changing bed sheets. This deficiency substantiates Complaint Number OH 250.
F 0356 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Post nurse staffing information/data on a daily basis.** Based on observation and staff interviews the facility failed to ensure the daily nurse staff posting was updated daily. This had the potential to affect 137 of 137 residents. Findings include: Observation on 05/10/16 at 3:30 A.M., revealed the daily nurse posting was dated 04/28/16. Further review revealed no evidence of the census on 04/28/16. Interview with Registered Nurse (RN) #43 on 05/10/16 at 3:30 A.M., verified the daily nursing posting had not been updated since 04/28/16 and the posting did not include the census. This deficiency is cited as an incidental finding to Complaint Number OH 250.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation, policy review, and staff interview, the facility failed to ensure medication and treatments were secured. This affected one of six medication carts observed, and one of four treatment carts observed. The facility identified two residents (Resident #23 and Resident #93) that were independently mobile and cognitively impaired on the second floor. The census on the second floor was 42. The facility census was 137. Findings include: 1. Observation of medication administration with Registered Nurse (RN) # 56 on 05/12/16 at 7:38 A.M,. revealed she left the medication cart unlocked and unattended. RN #56 was observed in a resident's room behind the privacy curtain and the medication cart was located across the hall. Interview with RN #56 on 05/12/16 at 7:38 A.M., verified she had left the medication cart unlocked and unattended. 2. Observation of the treatment cart on 05/12/16 at 4:25 P.M., revealed the cart was unlocked and unattended on D Hall. This surveyor stayed with unlocked treatment cart until a State tested Nurse's Aide (STNA) arrived. STNA #118 affirmed the cart was unlocked and unattended. Observation of the treatment cart on 05/12/16 at 4:25 P.M., revealed the cart contained dressing supplies and over the counter powders, lotions, and creams. Review of the Medication Storage policy dated 01/01/13, revealed the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cart that is inaccessible by residents and visitors. The facility identified Residents #23 and #93 as independently mobile and cognitively impaired with access to the unlocked medication and treatment carts. This deficiency is cited as an incidental finding to Complaint OH 250.
F 0490 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on medical record reviews, observations, staff and resident interviews, review of resident council minutes, and policy review, the facility failed to provide evidence the facility was being administered in a manner to maintain the highest practicable physical, mental and psychosocial well-being of each resident which resulted in a multi-system breakdown with harm to residents in the areas of pressure ulcers and physical abuse. In addition, residents failed to receive care to maintain their well-being in the areas of elopement, medication administration, medication and biological storage, adequate staffing to meet resident needs, laboratory services, and a functioning quality assessment and assurance committee. This specifically affected Residents #1, #2, #3, #4, #23, #93, #126, and #135 and had the potential to affect all 137 of 137 residents residing in the facility. Findings Include: 1. The facility failed to ensure a resident was not physically restrained during assessment of vital signs. Harm occurred to Resident #126 when a State tested Nurse Aide (STNA) laid across the resident holding her down while another STNA held the resident's legs while they attempted to obtain the resident's blood pressure. Please see Data Tag F221. 2. The facility failed to provide physician ordered treatments, accurately assess the condition of pressure ulcers, and provide interventions for pressure ulcers for four of four residents reviewed for pressure ulcers (Residents #1, #2, #3,

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F 0490 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) and #4). This resulted in Immediate Jeopardy for four residents (Residents #1, #2, #3 and #4). Actual harm occurred when Resident #2 required a second surgical procedure to the coccyx due to a deterioration of a coccyx wound from treatments and interventions not being provided per physician orders. Resident #1 sustained actual harm when the facility failed to accurately identify and provide ordered treatments resulting in a decline in a coccyx wound with exposure of the resident ' s bone identified as a Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). In addition, Resident #3 experienced actual harm with a decline in a coccyx pressure ulcer from a Stage III (defined as full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling), to a Stage IV pressure ulcer that developed tunneling. Resident #4 sustained actual harm when the facility failed to accurately assess and provide treatments resulting in a deterioration of pressure ulcers on his coccyx and buttocks. The facility identified eight residents with pressure ulcers and four of the residents presented with in-house acquired pressure ulcers. Please see Data Tag F314. 3. The facility failed to ensure safe environment and location of one resident (Resident #135) of three residents reviewed for elopement. Please see Data Tag F323. 4. The facility failed to ensure residents were free of significant medication errors when a blood thinning medication and intravenous antibiotics were not administered per physician orders. This affected two (Residents #1 and #2) of three residents reviewed for medication administration. Please see Data Tag F333. 5. The facility failed to ensure adequate staffing to meet the total care needs of all the residents in the facility. This had the potential to affect 137 of 137 residents residing in the facility. Please see Data Tag F353. 6. The facility failed to ensure medication and treatments were secured. This affected one of six medication carts observed, and one of four treatment carts observed. The facility identified two residents (Resident #23 and Resident #93) that were independently mobile and cognitively impaired on the second floor. Please see Data Tag F431. 7. The facility failed to ensure lab results were received and filed in the resident's medical record. This affected one (Resident #1) of three residents reviewed for medication review. Please see Data Tag F507. 8. The facility's quality assurance committee failed to identify areas which required corrective action to ensure all residents received the care and services necessary to attain and/or maintain the highest practicable well-being. This had the potential to affect 137 of 137 residents residing with the facility and specifically affected Resident #2. Please see Data Tag F520. This certification deficiency is cited as an incidental finding to Complaint Numbers OH 250, OH 244, OH 241.
F 0507 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep complete, dated lab records in the resident's file.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to ensure lab results were received and filed in the resident's medical record. This affected one (Resident #1) of three residents reviewed for medication review. The facility census was 137. Findings included: Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of Resident #1's physician orders [REDACTED].M., and continue checking INR on Tuesday and Friday. If INR is less than three (3) restart [MEDICATION NAME] at 3 milligrams (mg). Review of Resident #1's medical record on 05/15/16 revealed no evidence of INR after 05/04/16. Interview with Registered Nurse (RN) #153 on 05/15/16 at 11:20 A.M. verified the last INR in Resident #1's medical record was 05/04/16. Interview with RN #205 on 05/16/16 at 12:00 P.M., revealed Resident #1 had an INR on 05/07/16 and 05/11/16. These lab results were not in Resident #1's medical record. This deficiency is cited as an incidental finding to Complaint Number OH 250.
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on staff interviews, interview with the Medical Director, review of quality assessment minutes, and review of the medical director's agreement, the facility quality assurance committee failed to identify areas which required corrective action to ensure all residents received the care and services necessary to attain and/or maintain the highest practicable well-being. This had the potential to affect 137 of 137 residents residing with the facility and specifically affected Resident #2. Finding included: On 05/13/16 review of the quality assessment minutes dated 04/27/16 revealed no evidence of follow up on previous concerns. Further review revealed no evidence of concerns related to pressure ulcers or specific residents identified with pressure ulcers. Further review revealed staff was re-educated on abuse, staffing recruitment was discussed, and pharmacy services were changed. There was no evidence of medication errors, labs, medication storage, or daily nursing posting were reviewed or discussed. Interview with the Medical Director (MD) on 05/13/16 at 8:50 A.M., revealed he was aware of concerns with pressure ulcers especially with Resident #2 in regard to treatments not being performed and staff not using the specialized bed correctly. Interview with the Administrator on 05/13/16 at 9:40 A.M., revealed he was unaware of concerns with pressure ulcers prior to notification from the surveyor. Review of the medical director's agreement dated 07/17/10 revealed the MD would be responsible for the medical direction and overall coordination of medical care in the facility. An incident of Immediate Jeopardy was identified during a complaint survey regarding the facility's failure to accurately assess, provide interventions and physician prescribed orders of pressure ulcers for Residents #1, #2, #3, and #4. Additional concerns noted during the complaint survey included: staffing shortage, daily staff postings, medication errors, resident abuse, labs results, and medication storage. This deficiency is cited as an incidental finding to Complaint Number OH 250.