STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115291	A. BUILDING _____ B. WING _____	**08/05/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - WINDERMERE	**3618 J DEWEY GRAY CIRCLE AUGUSTA, GA 30909**

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined that the facility failed to notify the physician as the resident's status changed as evidenced by failure to obtain physician's orders [REDACTED].#84) and failed to notify the physican of pain for resident T, and the facility failed to notify the Physician that an ordered antibiotic was not administered until two days after it was ordered for one (1) resident (R#28) of the sampled fifty-one (51) residents, the census was one-hundred and one (101). A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On [DATE] at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on [DATE] related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was found unresponsive on [DATE] and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on [DATE] revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on [DATE] at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on [DATE] and remains on-going. Findings include: 1. Resident N (a closed record review) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Clinical Health Status Admission assessment dated [DATE] revealed a late entry note dated [DATE] on the [DATE] Clinical Health Status Admission Assessment that the resident was admitted with redness on his sacrum and bilateral fluid filled blisters on his bilateral heels. Although staff indicated that the resident actually had blisters on his heels and redness on his sacrum on [DATE], there was no indication that staff notified the physician about the resident's pressure sores or obtained treatment orders on [DATE]. Review of the General Note dated [DATE] revealed that the resident was again assessed on [DATE] with intact bilateral heel blisters and a red sacrum without any open areas. Review of the ,[DATE] Treatment Administration Record (TAR) revealed that staff eventually obtained a treatment order for the bilateral heel wounds on [DATE], six (6) days after admission. However, there was no indication that staff notified the physician about the red sacral area from [DATE] to [DATE] when the resident went to the hospital. Review of the ,[DATE] Treatment Administration Record (TAR) for resident N revealed that although the resident was assessed on admission with pressure sores on the bilateral heels, there was no indication that staff had notified the physician and obtained treatment for [REDACTED]. Furthermore there was no indication that staff notified the physician about the red sacral area in order to obtain and initiate treatment to prevent the red area on the sacrum from deteriorating for ,[DATE]. Review of the SBAR/Change of Condition Note dated [DATE] revealed that resident N was sent to the hospital for chest pain and was diagnosed with [REDACTED]. However, there was no indication that staff notified the physician about the sacral area until [DATE]. Review of the General Note/Wound Care Note dated [DATE] revealed that resident N sacral pressure sore had increased in size and measured 8.0 x 4.5 centimeters (cms.) and had deteriorated as evidenced by necrotic tissue in the wound bed and greenish tissue on the edges of the wound. Review of the General Note dated [DATE] at 1:45 p.m. revealed that the resident was lethargic, had periods of apnea and had a low blood pressure. The resident was transferred to the hospital. Review of the Hospital Discharge Summary dated [DATE] revealed that resident N was admitted with a Stage IV sacral pressure sore that was malodorous and septic shock with blood cultures positive for Corynebacterium and Bacteroides fragilis. Continued review of the Discharge Summary revealed that the resident was not a surgical candidate for debridement of the sacral wound because of the septic shock. Further review revealed that the resident did not respond to treatment and the family placed the resident on Hospice services for comfort measures. Continued review revealed that the final hospital [DIAGNOSES REDACTED]. The resident expired on [DATE]. The resident's Certificate of Death indicated that the immediate cause of death was septic shock and sacral decubitus. Interview with Treatment Nurse UU on [DATE] at 9:55 a.m. revealed that when a resident was admitted or readmitted from the hospital, the treatment nurse assessed the resident and reviewed the Hospital Discharge Summary for treatment orders. If there were no orders, then the treatment nurse notified the physician to obtain treatment orders. Interview with the Assistant Director of Nursing Service (ADNS) on [DATE] at 2:37 p.m. revealed that the physician was not notified of the sacral pressure sore or of changes in conditions related to the pressure ulcers. Staff failed to notify the physician about the sacral redness for resident N on his [DATE] admission and [DATE] readmission in order to obtain and initiate treatment timely to prevent deterioration of the sacral redness. This failure resulted in the resident's hospitalization on [DATE] for septic shock secondary to a Stage IV sacral decubitus and eventual death. Cross-refer to F 314 2. Review of the clinical record for resident T' revealed they were admitted to the facility on [DATE] with a Stage II pressure ulcer to the sacrum and non-blanchable pressure ulcers to both heels. Further review revealed physician orders [REDACTED]. The sacral wound healed on [DATE]. The sacral wound reopened on [DATE] as a Stage II pressure ulcer; however there was no evidence that an order was obtained to treat this Stage II sacral wound until [DATE]. Review of the the care plan for Resident T dated [DATE] revealed that the resident required pain management and monitoring related to his wounds with an intervention to evaluate the characteristics and frequency/pattern of pain and to evaluate the need for routinely scheduled medications rather than as needed (PRN) pain medications. Although resident T was admitted on [DATE] with a Stage II sacral pressure sore, there was no indication that staff obtained and provided treatment for [REDACTED]. Although the sacral pressure sore healed on [DATE] for resident T, on [DATE] the staff identified an open area on the sacrum with a yellow-green wound bed on resident T. There was no indication that the physician was notified of the open area until [DATE] when he ordered [MEDICATION NAME] to be applied every day and to obtain a Wound Care consult. On [DATE], staff assessed the 4.0 x 3.0 x 0 cm. pressure sore with 75% necrotic tissue. Review of the vascular Physicians note dated [DATE] revealed that the resident had peripheral arterial occlusive disease with pressure and ischemic ulcerations of both feet. Continued review revealed that the left foot had dry gangrene. On [DATE] at 2:12 p.m. Licensed Practical Nurse (LPN) Treatment Nurse CC and Treatment Nurse UU he resident yelled when staff approached him to assist him with turning and repositioning in the bed. The resident yelled out whenever staff touched his legs and when staff removed his pravalon boots. During the treatments to the sacrum and right foot the resident

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) yelled Don 't hurt me Oh, Lord Jesus, help me. The resident would continue to watch Treatment Nurse CC provide treatment to his right foot and begin yelling again. As soon as the treatment was completed, the resident stopped yelling. Review of the medical record for the resident revealed a Physicians order dated [DATE] for [MEDICATION NAME] 200 milligrams (mgs.) every day for pain that was scheduled for 9:00 a.m. and an order dated [DATE] for [MEDICATION NAME] 50 mgs. every six (6) hours as needed (PRN) for pain. Interview with LPN Treatment Nurse CC on [DATE] at 12:05 p.m. revealed she had not notified the physician that the [MEDICATION NAME] was not managing the resident's pain during treatment and that his pain management may need to be reevaluated. Cross-refer to F 314 and F 309 3. Review of the clinical record for R#84 revealed that they were admitted to the facility on [DATE] with a Stage IV sacral decubitus. Review of the pressure ulcer documentation from [DATE] to [DATE] revealed that there was increased signs and symptoms of infection, such as increased odor, but the physician was not notified until [DATE]. 4. Interview on [DATE] at 11:55 a.m. with the Director of Nursing Services (DNS) revealed that the physician was never notified that the antibiotic for R #28 was not administered until two days after it was prescribed. Cross-refer to F 314
F 0170 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Send and promptly deliver unopened mail to residents.** Based on review of the facility Mail Service policy, resident and staff interviews, it was determined that the facility failed to distribute mail to residents on the weekends. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: During an interview with resident Q on 07/26/16 at 12:30 p.m., Q stated that the mail was not delivered on Saturdays. During continued interview Q stated that there was no one in the facility on the weekend to pass the mail, and that the mail was delivered Monday through Friday by the activity staff. During further interview, resident Q stated that to their knowledge, the Resident Council had not voted to stop delivering the mail on the weekends. During an interview with the Activities Director (AD) on 07/26/16 at 2:10 p.m., she stated that the mail was delivered to the facility Monday through Friday, and after 4:00 p.m. on Saturday. Continued interview revealed that either the AD, or her assistant, worked every weekend from 9:00 a.m. to 4:00 p.m., but that the facility had asked the post office to stop delivering mail on the weekend due to a concern with the security of the mail. Interview with the Business Office Manager on 07/27/16 at 10:53 a.m. revealed that the mail was delivered weekdays between 8:00 a.m. and 4:30 p.m. Review of the facility policy titled Mail Service revealed that the Living Center will provide a mail delivery service and mail sending service within twenty-four (24) hours of receipt of mail or residents' request to send mail. This includes Saturday delivery.
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's policies entitled, Preventing, Investigating, Reporting Alleged Sexual Assault and Abuse Violation policy (the policy of this center to take appropriate steps to prevent the occurrence of neglect (neglect means the failure to provide goods and services necessary), the Skin Integrity Guidelines policy and procedure, and staff interviews, the facility failed to ensure that residents with pressure ulcers and/or other skin conditions received the services necessary to identify, report, obtain physician orders [REDACTED].#84, R #24, R #50, R #64, R #120, R #180). In addition, the facility failed to ensure that one (1) resident (R #170) identified as an elopement risk on admission received the services necessary to prevent an elopement, the resident eloped from the facility four (4) days after admission. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On [DATE] at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on [DATE] related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on [DATE] and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on [DATE] revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on [DATE] at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on [DATE] and remains on-going. Findings include: Review of the facility's Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy and procedure revealed that it was the policy of this center to take appropriate steps to prevent the occurrence of neglect. Neglect means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The executive director (ED) and director of nursing services (DNS) identify, intervene and correct in situations in which neglect is more likely to occur. Review of the facility's Skin Integrity Guideline noted that a routine schedule to review residents with wounds or at risk on a weekly basis and will document findings, and the DNS or designee will be responsible to implement and monitor the skin integrity program. The licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review UDA (user defined assessment). Licensed nurse to document weekly on identified wounds using the Wound Evaluation Flow Sheet (WEFS) UDA. A manual tracking system to monitor completion of weekly WEFS must be created. Monitoring Compliance includes the WEFS UDA is accurately and thoroughly completed for wounds. 1. Record review revealed that resident N was admitted to the facility on [DATE] with fluid-filled blisters on their bilateral heels and a reddened sacral area, with wound care orders from the hospital. However, review of the facility's physician's orders [REDACTED]. Resident N returned to the facility on [DATE] after a hospitalization , and hospital Instructions included Stage I right heel wound, Stage I sacral wound, and unstageable left heel wound. However, there was no evidence that the physician was notified of the readmission and/or no evidence that there were any new physician's orders [REDACTED]. The previous three (3) pressure ulcers the resident was admitted with had become unstageable, and two new pressure ulcers had developed that were also unstageable. Review of the clinical record revealed that resident N was hospitalized on [DATE]. Review of a hospital Discharge Summary revealed that the resident expired on [DATE], and final [DIAGNOSES REDACTED]. 2. Review of the clinical record for resident T' revealed they were admitted to the facility on [DATE] with a Stage II pressure ulcer to the sacrum and non-blanchable pressure ulcers to both heels. Further review revealed physician orders [REDACTED]. The sacral wound healed on [DATE], but there was no evidence that preventive measures were put in place to protect the area, and the sacral wound reopened on [DATE] as a Stage II pressure ulcer. During further record review there was no evidence that an order was obtained to treat this Stage II sacral wound until [DATE]. Review of a General Note dated [DATE] revealed that the pressure sore on the sacrum had deteriorated, had 75% necrotic tissue in the wound bed and measured 4.0 x 3.0 x 0 centimeters (cm). Review of the Treatment Administration Records (TARs) revealed that there was no evidence that treatments were completed as ordered to the heels on [DATE], [DATE], [DATE], and in [DATE] there was no evidence that the every three days heel treatments were completed between [DATE] and [DATE] (8 days between treatments). Review of the TAR for the sacral wound treatments revealed that there was no evidence that the

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) treatments were completed on [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of the April and May TARs revealed that there was no evidence that staff performed treatments twice a day for the sacral pressure sore as ordered from [DATE] to [DATE] (6 consecutive days), on [DATE], from [DATE] to [DATE] (3 consecutive days), from [DATE] to [DATE] (6 consecutive days), from [DATE] to [DATE] (4 consecutive days), and on [DATE]. Review of the May TAR revealed that there was no evidence that treatment to the heels was completed on [DATE]. Continued review revealed no evidence that staff performed any treatments to the resident's sacral pressure sore on [DATE] and [DATE]. Review of weekly assessments of the sacral pressure sore and the bilateral heel pressure sores revealed the staff failed to do the assessments as scheduled on [DATE] and [DATE], almost three weeks between assessments. Review of the July TAR revealed no evidence that staff provided treatment as ordered for the sacral wound on [DATE] and [DATE] which resulted in the resident not receiving needed treatment for [REDACTED]. Continued review of the July TAR revealed no documentation that treatments were completed as ordered for the bilateral feet on [DATE] and [DATE], which resulted in the resident not receiving the needed treatment for [REDACTED]. 3. Review of a General Note dated [DATE] revealed that a blister was identified on resident R's right heel. Review of the wound care clinic's Nursing Wound/Ulcer assessment dated [DATE] revealed that resident R had a large callous over the right malleolus (ankle bone) from a previous ulcer which the physician debrided that day but, there was no indication that the right ankle was treated until [DATE], and no indication that staff assessed the right ankle wound until [DATE]. Review of a care plan note dated [DATE] revealed that the Stage II pressure sore on the right ankle measured 1.0 x 1.0 x 0 centimeters (cm), but there was no indication that assessments of the right ankle wound were completed after [DATE] until [DATE], when staff documented that the right ankle wound was now a Stage III pressure sore that measured 1.7 x 0.5 x 0.2 cm. Review of wound care physician's orders [REDACTED]. Review of the May TAR revealed that there was no indication that the right heel pressure sore was treated from [DATE] until [DATE]. Observation of resident R's bilateral foot dressings on [DATE] at 2:40 p.m. revealed that they were dated [DATE], despite orders for daily dressing changes. Review of the resident's TARs revealed that there was no evidence that treatments were done as ordered to one or more wounds on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] through [DATE], [DATE] through [DATE], and [DATE] through [DATE]. 4. Review of R #84's clinical record revealed that they were admitted to the facility on [DATE] with a Stage IV sacral decubitus. Review of the pressure ulcer documentation from [DATE] to [DATE] revealed that there was increased signs and symptoms of infection, such as increased odor, but the physician was not notified until [DATE]. Further review of the clinical record revealed that the resident was admitted to the hospital on this date, with a temperature of 103.7 degrees. Review of a hospital supervising physician's note dated [DATE] revealed that the resident had multiple infections, including pressure ulcer. Review of a Discharge Summary note dated [DATE] from a local specialty hospital, where the resident had been sent to for long-term intravenous antibiotic therapy, revealed that the reason for admission was an infected decubitus wound. Resident #84 was discharged from the specialty hospital and readmitted to the long-term care (LTC) facility on [DATE], and no wound assessment was completed on readmission, and no reassessments or measurements were completed for the wound from [DATE] until [DATE]. Review of resident #84's TARs from January through [DATE] revealed that there was no evidence that wound care was provided for the sacral wound for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] through [DATE], [DATE], [DATE]. Further review of the July TAR revealed that there was no evidence that the sacral wound care was completed except twice the entire month on [DATE] and [DATE], exactly two (2) weeks apart. After an observation of R #84's wound care on [DATE] at 2:51 p.m., a full skin assessment was done by Licensed Practical Nurse (LPN) Treatment Nurses CC and UU. The resident's bilateral heels were noted to be soft and boggy, and were non-blanchable. An excoriated area was noted to resident's left buttock down the residents left thigh that measured 31.3 cm long and 23.4 cm wide. The skin on both inner thighs were excoriated and measured approximately 4 inches long by 4 inches wide each. The right breast was observed to have a large red excoriated area under the breast. Further observation revealed that under the resident's left arm was a very large red excoriated area that measured 19.7 cm long by 12.9 cm wide. A red excoriated rash was noted from the resident's mid-abdomen around to their right hip. Further observation revealed that under her right arm around to the right shoulder was a red excoriated area as well as an open area of skin, and this open area measured 0.9 cm by 0.7 cm. During interview with the treatment nurses at this time, they stated that they were not aware of these excoriated areas of skin. Continued observation revealed that R #84's scalp was noted to have a thick layer of oily scales which covered the resident's scalp, behind and in the resident's ears, as well as red flaky skin on several areas of the resident's face. 5. During interview and record review with the Director of Nursing Services (DNS) on [DATE] at 3:41 p.m., she verified that there was no evidence that treatments were completed as ordered for R #24's left foot wounds on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. 6. Review of R #50's computerized Weekly Skin Reviews revealed that the skin assessments were not completed on [DATE]; [DATE]; and none between [DATE] and [DATE] (a total of twelve missed assessments since admission). This was verified during interview with Registered Nurse (RN) Field Services Clinical Director PPP on [DATE] at 10:24 a.m. Review of the TARs from admission through July revealed no evidence that wound care was completed on [DATE]; and [DATE]. This was verified during interview with the DNS on [DATE] at 11:09 a.m. 7. Review of the clinical record for R #64 revealed that they had a history of [REDACTED]. Review of physician's orders [REDACTED]. Observation of R #64 on [DATE] at 9:50 a.m. revealed that they were positioned on the right side with no visible wedges or pillows, and the heels were not floated and the ankles were on top of each other. Continued observation of R #64 on [DATE] at 10:44 a.m. revealed they were sleeping on the right side, and no pillows, wedges or other positioning devices were visible. Observation on [DATE] at 11:14 a.m. revealed the resident was sleeping on the right side, no positioning devices were visible, and the heels were not floated. Observation on [DATE] at 2:15 p.m. revealed that R #64 was resting on their right side in a fetal position with their full weight on the right trochanter. No positioning devices were visible, and their knees and ankles were resting on top of each other. Observation of R #64 on [DATE] at 5:55 p.m. revealed that their heels were not floated. 8. Review of a General Note dated [DATE] for R #120 revealed that the resident was admitted on [DATE] with an unstageable pressure sore on his/her right heel that measured 6.5 x 4.5 x 0 cm, a Stage IV pressure sore on his/her left trochanter that measured 4.2 x 4.0 x 0.4 cm with tunneling, a Stage IV pressure sore on the left ischium that measured 4.4 x 4.0 x 0.4 cm with tunneling, and a Stage III pressure sore on the sacrum that measured 3.0 x 6.0 x 3.0 cm. Review of the General Note dated [DATE] revealed that the sacral pressure sore had resolved. Review of R #120's Treatment Administration Records (TAR) revealed that there was no evidence that treatments were completed as ordered to the left ischium and left trochanter wounds on [DATE] (Sunday). Further review of the TARs revealed that there was no evidence of treatment provided for the left ischial pressure sore as scheduled on [DATE] (Saturday), [DATE], [DATE], [DATE] and [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of R #120's clinical record revealed that he was hospitalized from [DATE] to [DATE] for urosepsis, and a readmission General Note dated [DATE] revealed that the resident had a sacral wound that measured 13.4 x 12.3 x 0 cm; a left gluteal fold (ischial) wound that measured 4.1 x 5.3 x 2.6 cm; and an unstageable wound on the right heel. Review of the TARs revealed no evidence that treatment was provided to these wounds on [DATE], [DATE], [DATE], or [DATE]. Interview with the DNS on [DATE] at 11:10 a.m. revealed the facility had a full time treatment nurse and a part time treatment nurse from [DATE] to [DATE], at which time the part time nurse resigned. Continued interview revealed that the full time treatment nurse provided treatments by herself from [DATE] until LPN Treatment Nurse UU was hired to assist with treatments a couple of days a week. Further interview with the DNS revealed that the full time treatment nurse became a part time employee on [DATE], at which time Treatment Nurse UU had the responsibility of providing treatments on her own most days. Further interview revealed that UU stated that she was drowning during that time, and the facility hired Treatment Nurse CC on [DATE]. 9. Review of a nursing Progress Note dated [DATE] at 8:40 a.m. (late entry for [DATE]), and in the Additional Notes section of the admission Clinical Health Status form dated [DATE], noted that there was discoloration to the bottom of both of R #180's feet, and pink areas to right and left buttocks without open areas at this time. Review of a Weekly Skin Review dated [DATE] noted that the skin was thin and fragile, and there were open areas to sacrum that looked like burst blisters. Further review of this Skin Review noted blisters to the right buttock, and burst blister to the left buttock. Review of

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) the Treatment Administration Record (TAR) revealed that no measures were documented to prevent skin breakdown to these areas on admission, nor any treatments initiated once the blisters and open area to the buttocks were identified on [DATE]. During interview and record review with Treatment LPN UU on [DATE] at 1:28 p.m., she verified that there was no evidence on R #180's Treatment Administration Records (TAR) that the following treatments were ever completed: May TAR: 5:00 p.m. no evidence that treatments were completed on [DATE]; [DATE]; and [DATE] (the TAR did not specify what wound was being treated). 5:00 p.m. no evidence that treatments were completed to left buttock on [DATE], and to the left buttock, right buttock, and sacrum at 5:00 p.m. from [DATE] to [DATE]. In addition, there was no evidence that the treatment was completed at 9:00 a.m. for any of these three areas on [DATE]. June TAR: The 5:00 p.m. there was no evidence that the treatment to the right and left buttocks and sacrum were completed on [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. There was no evidence that the daily treatment to the sacrum was completed on [DATE]; [DATE]; and [DATE]. July TAR: There was no evidence that the daily treatments to the sacrum and right buttock were completed on [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. During interview with LPN Treatment Nurse UU on [DATE] at 1:28 p.m., she verified that the [DATE] Weekly Skin Review for R #180 noted open and closed blisters to the right and left buttocks and sacrum, and that the charge nurse that discovered them should have told the treatment nurse, but that she (LPN UU) was unaware of them. She added that she saw no documentation that these wounds were ever treated before the resident's hospitalization on [DATE]. During further interview, Treatment Nurse UU stated that this was a transition period where she was the only treatment nurse in the facility for about six weeks. During further interview, she stated that she was doing the best that she could to manage the wounds, but that she was the only one and some things may have fallen between the cracks. During interview with Licensed Practical Nurse (LPN) SSS on [DATE] at 5:15 p.m., she stated that about twice a week one of the treatment nurses would come up to her and say that they didn't get a chance to do a treatment on a resident, and ask her to do it. During further interview, she stated that if the resident's treatment was ordered to be done twice a day and the treatment nurse told her that they didn't get to it, that she would change the dressing only once on her shift. Cross-refer to F 157, F 281, F 282, F 314, F 353, F 490, F 520. 10. Review of R #170's clinical record revealed that they were admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] noted that the resident had severe cognitive impairment, wandering occurred one to three days which placed the resident at significant risk of getting to a potentially dangerous place, and significantly intruded on the privacy of activities of others. Review of a Clinical Health Status assessment dated [DATE] noted that R #170 had short- and long-term memory problems, had a history of [REDACTED]. Review of the Risk for Elopement section of this form revealed that the resident had a history of [REDACTED]. Review of R #170's Immediate Plans of Care dated [DATE] revealed that one had not been developed for Elopement. Review of computerized Progress notes revealed a SBAR (Situation-Background-Assessment-Response) Change of Condition entry dated [DATE] at 12:02 a.m. that noted that R #170 was seen ambulating in the road off facility premises and was not injured upon assessment. Review of a Verification of Investigation report with a Date/Time of Occurrence of [DATE] at 6:30 p.m., noted that R #170 was found ambulating outside in the parking lot near the road. Review of the Provide Summary and Outcome Of Investigative Findings section of the form simply noted that the resident had a history of [REDACTED]. During interview with Certified Nursing Assistant (CNA) II on [DATE] at 9:07 a.m., she stated that R #170 could walk and/or propel his wheelchair without assistance, and that they didn't have to do any special monitoring for him. During interview with LPN AA on [DATE] at 9:14 a.m., she stated that she did not do any special monitoring for him, and that he would be allowed to go outside with staff or family supervision only. During interview with LPN Unit Manager HH on [DATE] at 2:28 p.m., she stated that she was not there when R #170 eloped, but it was her understanding that he went out the back door at the end of the 200-hall. During further interview she stated that the wanderguard bracelet was not placed on him until after he exited the building. During interview with the DNS on [DATE] at 3:10 p.m., she stated that she did not know how the resident got out unwitnessed, and it was possibly through a side door in the resident lounge by the west wing nursing station. During interview with LPN QQQ on [DATE] at 8:22 a.m., she stated that she was working evenings the day that R #170 left the building, but that she did not see how he got out, and assumed it was through the exit door at the end of the 200-hall as that was close to his room. She further stated that she never heard an alarm go off, and thought that it was another resident who had told her that there was a resident outside, so she went to investigate. LPN QQQ further stated that she found R #170 by a tree on the hospital campus across the road from the facility, and that he would have had to gone down the steep hill in front of the facility and crossed the two roads and median to get to where he was. During interview with CNA RRR on [DATE] at 9:03 a.m., she stated that the evening that R #170 got outside was the first time she had ever worked with him, and she was not told to do any special monitoring for him. She further stated that the resident must have gone out at the end of the 200-hall door, as that was the last area she saw him right before he was found outside, but that she did not hear an alarm go off. During further interview, she stated that a family member, whose room looked outside to the parking lot, told her that she saw a resident in pajamas outside in the parking lot. Cross-refer to F 323.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Prohibition, Safety and Loss Control Policies and Procedures, review of newly-hired staff employment information, review of facility self-reported incidents, and staff interview, the facility failed to conduct pre-employment reference checks for one (1) of nine (9) employee files reviewed; failed to thoroughly investigate and report an allegation of misappropriation of property for one (1) resident (M) and for an allegation of staff to resident physical abuse for one (1) resident (R #35); and failed to report to the state survey agency (SSA) two allegations of resident to resident sexual abuse for four (4) residents (one unsampled, R #170, R #130 and R #104) and a visitor to resident verbal abuse for one (1) resident (R #4) in the required timeframe's. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: 1. Review of the facility self-reported incident GA 441 revealed an allegation of verbal abuse by a family member to R #4 on 07/06/16. Review of the final investigation labeled 5-day follow up revealed that it was dated 07/18/16. Review of facility self-reported incident GA 180 revealed that R #170 was found lying naked in a female resident's bed on 03/27/16. Review of the facility's initial investigation of the incident revealed that it was faxed to the SSA on 03/30/16, and the five-day follow-up complete investigation was faxed to the SSA on 04/08/16. During interview with the Director of Nursing Services (DNS) on 07/28/16 at 3:10 p.m., she stated that all investigations had to be sent first to the corporate office to be reviewed and approved, which took three days, and that she had several self-reports that were late because of this. During further interview, the DNS verified that both the initial and final investigations for GA 180 were late in being sent to the state's complaint intake unit. During interview with the DNS on 07/31/16 at 1:27 p.m., she stated that the facility's procedure for reporting incidents to the state was that the initial investigation should be sent within twenty-four hours, and the final investigation sent within five days. Review of the facility's Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy noted the results of all investigations are reported to the Executive Director (ED) or designee and to the appropriate state agency, as required by state law, within five working days of the alleged violation. 2. Review of facility employee files revealed that Licensed Practical Nurse (LPN) CC was hired on 06/07/16. Further review of this employee's file revealed that there was no evidence that references had been checked prior to hire.

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F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) During interview with the Executive Director (ED) on 07/29/16 at 1:28 p.m., she confirmed that the references were not checked prior to employment for LPN Treatment Nurse CC. During further interview, she stated that the corporate office was responsible for contacting and verifying the references. Review of an e-mail dated 07/29/16 from the facility's recruiting services provider revealed that the reference checks were never initiated by the location recruiter for this employee. Review of the facility's policy titled Safety and Loss Control Policies and Procedures: Background Investigations, revised on 09/30/15, revealed: All prospective new hires and rehires will have background investigations conducted at the time of employment. Background investigations will include a review of prior employment and a criminal conviction review. Review of the Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Prohibition, with a review date of 02/12/16, included staff screening which noted that all applicants for employment in the center shall, at a minimum, have the following screening checks conducted: Reference checks with the current and/or past employer. 3. Review of the facility's grievance log revealed that R #35 reported that a male staff member on the second shift on 05/15/16 was rough with him when giving care, and that he was hit in the stomach by a male Certified Nursing Assistant (CNA). During interview with the Executive Director (ED) on 07/28/16 at 2:24 p.m., she stated that no documentation of an investigation for this allegation could be found found. Upon further interview, the ED stated that the person who took the grievance, and the Social Services Director, both reported that they remembered the incident, and that the documentation had been given to the previous ED. During further interview with the current ED, she stated that the previous ED was contacted, but denied knowledge of an incident involving R #35. She added that R #35 was no longer in the facility. During interview with the ED on 07/28/16 at 3:00 p.m., she stated that the Social Service Assistant (SSA) was the one who took the allegation of abuse by R #35 and gave it to the former ED, but on follow-up this ED told her that the form had been misplaced. During interview with the ED on 07/29/16 at 8:21 a.m., she stated that upon their preliminary investigation, there were no male CNAs working on the day in which R #35 stated the incident took place. The ED stated that when a resident or family reported an incident, the report should be given to Social Services or to the ED. Upon further interview she stated that if the incident needed to be reported to the State Survey Agency (SSA), then the preliminary report was sent within twenty-four hours and the final investigation to the state agency within five days. 4. Review of the facility's Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy noted the results of all investigations are reported to the Executive Director (ED) or designee and to the appropriate state agency, as required by state law, within five working days of the alleged violation. Review of the facility's self-reported incident (intake number GA 529) regarding an allegation of sexual abuse involving R #130 and R #104 revealed that the allegation occurred on 07/11/16. Further review of the facility's investigative documents revealed that the initial report of the allegation was sent to the SSA on 07/12/16; however, the final investigation was not sent to the SSA until 07/27/16. Interview with the Director of Nursing Services (DNS) on 07/27/16 at 12:10 p.m. revealed that she had to wait until the corporate office attorneys gave the approval to send the five-day documentation in to the SSA. During further interview, the DNS stated that she faxed the final report in that morning, and confirmed that the final report was sent in late. 5. Review of the clinical record for resident M revealed that they were admitted to the facility 09/26/13. Review of their Quarterly Minimum Data Set ((MDS) dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. During interview with resident M on 07/26/16 at 9:25 a.m., they stated that they discovered that a birthstone ring given to them by a family member in the early 1960's had been taken from their bedside table after returning from a doctor's appointment. Continued interview revealed that this ring was special to him/her, and that he/she had reported it to the facility several months ago, and was told that they would replace the ring but still had not. Interview with the Director of Nursing Services (DNS) and the Social Services Director (SSD) on 07/26/16 at 1:30 p.m. revealed that they were not aware of the resident's missing ring, and the SSD stated that she would call the resident's family member and begin an investigation. Upon further interview with the DNS on 07/26/16 at 3:08 p.m., she stated that the resident's missing ring had been reported to the SSD back in February of 2016, however, there had not been any report sent to her or the SSA, and verified that the SSD should have reported this allegation. During interview with the SSD on 07/26/16 at 4:20 p.m., she stated that back in February resident M had mentioned that their ring was missing, and was told they would need to get a receipt for it to send to the insurance company. During interview with the SSD on 07/29/16 at 8:40 a.m., she stated that when a personal item was reported missing, that it was recorded as a grievance, and if the item was not found the grievance would be given to the appropriate discipline to investigate. She further stated that all grievances were discussed in morning meetings to ensure a resolution had been reached, and the Executive Director (ED) made the final decision whether or not to report the incident to the State Survey Agency (SSA). During interview with the ED on 07/29/16 at 9:13 a.m., she stated that any missing item was supposed to be reported to the SSA. Review of the facility's Grievances log and Social Services Notes from January to July of 2016 revealed no evidence that resident M's missing ring had been documented. Review of the facility's Abuse Policy and Procedure revealed to contact the local police department if there was a reasonable cause to believe and/or suspicion of a crime has occurred. Continued review revealed a written report of the investigation will be submitted to the Long Term Care Section Complaint Coordinator within five (5) working days of the incident.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the facility Call Light policy, resident and staff interview, the facility failed to knock before entering a resident's room for three (3) residents (R #8, R #87, R #104). In addition, the facility failed to respond to call lights in a timely and/or courteous manner for one (1) resident (P). In addition, the facility failed to maintain an environment in which there were no signs posted in the resident room that contained clinical information that could be seen by other residents and/or visitors for one (1) resident (R #104). The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: 1. During interview with resident P on 08/03/16 at 8:58 a.m., he/she stated that on the night shift he/she will press their call light, and staff will say that they will be right back, but that it takes about 45 minutes for them to return. The resident stated that morning at 5:00 a.m. he/she woke up and realized they were wet, and pressed their call light, but that he/she was not assisted until 6:30 a.m. The resident further stated that he/she would see staff in the hallway joking and laughing after he/she had called for assistance, and he/she would be told they had other residents to take care of. The resident added that he/she has to wait thirty or more minutes for assistance to be changed several nights a week, and was aware of the length of time it took as he/she watched the clock on the wall. Review of the resident's Admission Minimum Data Set assessment dated [DATE] revealed that the resident had a Brief Interview had moderately-impaired cognition, needed extensive assist for toilet use, and was always incontinent of bladder and bowel. Review of the physical functioning deficit related to mobility impairment care plan revealed an intervention for toileting assistance by staff. Review of physician's orders [REDACTED].>During interview with resident P on 08/04/16 at 3:26 p.m., he/she stated that they awoke at 4:00 a.m. that day, and realized they were wet and pressed the call light for assistance. The resident further stated he/she was told by staff that we already changed you, and there are three other residents ahead of you. The resident stated that it was an hour before staff came back to assist him/her, and that they were soaking wet. The resident stated that he/she couldn't help wetting his/her brief, because his/her bladder had a mind of it's own, and that they could not get up on their own because they would fall.

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) During interview with the Corporate Registered Nurse Field Services Clinical Director on 08/05/16 at 9:26 a.m., he stated that call lights should be answered as soon as possible. Review of the facility's Call Light, Use Of policy and procedure noted to answer ALL call lights promptly, whether or not you are assigned to the resident. Answer call lights in a prompt, calm, courteous manner. Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room. Review of facility Grievances for May through July related to call light response and staff attitude when answering call lights revealed the following: 07/20/16: One (unsampled) resident voiced that he needed to be changed and was told by one Certified Nursing Assistant (CNA) on the 3:00 p.m. to 11:00 p.m. shift that they didn't change residents when they were passing out trays, and gave the resident wipes for him to change himself, and that he had to wait for the 11:00 p.m. to 7:00 a.m. shift to clean him up. 07/01/16: One (unsampled) resident said that some of the 11:00 p.m. to 7:00 a.m. nurses and CNAs were rude when he asked for a cup of ice. 07/04/16: Family of resident #138 said there was no response to their call light for 36 minutes on more than one occasion. 05/12/16: Resident #172 said she is made to wait or told staff will come back to change her, but they won't come back. 05/03/16: The Resident Council voiced that call lights were not being answered in a timely manner, and the staff continued to turn the call light off before they provided the care. 2. Observation on 07/26/16 at 11:31 a.m. revealed that Licensed Practical Nurse (LPN) CC entered resident R #87's room to answer the call light, but did not knock prior to entering the room. Further observation on 07/26/16 at 11:46 a.m. revealed that Certified Nursing Assistant (CNA) TTT entered resident R's room to answer the call light, but did not knock prior to entering the room. Observation on 07/28/16 at 1:25 p.m. revealed CNA NNN entered R #104's room, but did not knock or announce herself prior to entering the room. Interview on 07/28/16 at 2:59 p.m. with CNA NNN revealed that expectations are for staff to knock and announce themselves prior to entering a resident's room. Interview on 05/28/16 at 5:10 p.m. with the Director of Nursing Services (DNS) revealed that her expectations were for staff to always knock before entering the room. Upon further interview, the DNS stated that if the resident was nonverbal, staff should still knock and enter in this instance. 3. On 07/26/16 at 9:05 a.m., Licensed Practical Nurse (LPN) CC was observed to enter R #8's room without first knocking on the door or announcing herself.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide housekeeping and maintenance services.** Based on observations, staff interview, and review of the facility's policy, the facility failed to maintain a clean comfortable environment as evidenced by: heavy buildup of dust/debris on the floors, stained torn privacy curtains, dusty filters, chipped/missing pieces to bathroom doors and closets, rusty personal care items, and missing baseboards, debris noted in the air conditioning units . This failure affected nine (9) rooms on two (2) of five (5) hallways. 1. Observations on 07/26/2016 11:23 a.m. and at 12:12 p.m., 07/27/2016 at 2:06 p.m., 7/28/16 at 8:21 a.m. In room 109 the privacy curtain for bed A was observed to have dark brown and red smears. Also observed missing paint from the wall under the window, and the wall over the toilet seat had missing paint with some brown rusty area noted. In addition to this debris was noted in the air conditioning (a/c) vent. 2. Observations on 7/27/16 at 1:39 p.m. and on 7/28/16 at 8:37 a.m. in room 107 black scuff marks were observed on the wall near bed A, black build up was noted on the floor throughout the room, the privacy curtain was noted to be stained, and spider webs were noted in the corner near the bathroom. 3. Observations on 07/26/2016 at 09:25 a.m., 07/27/2016 at 2 p.m., 07/28/2016 at 8:41 a.m., and 7/29/16 9:50 a.m. in room 112 revealed missing wood panel from the bathroom door, one loose base board in the bathroom, black stains on the floor near the toilet, and a dark brown smear on the grab bar. 4. Observation on 07/26/2016 11:58 a.m. In room 203 revealed the privacy curtain for the A bed was stained, a baseboard by the bathroom door was noted to be loose, and a black stain was noted under the air conditioning unit. 5. Observations on 7/26/16 at 10:50 a.m., 7/27/16 at 2:03 p.m., and 7/28/16 at 8:30 a.m. in room 204 revealed the privacy curtains for the B bed was stained and the privacy curtain for the A bed was ripped at the hem, black stains were noted on the floor near the bathroom, dust buildup was noted in the vent in the bathroom, and the ceiling was noted to be peeling near the window. 6. Observations on 07/26/16 at 10:19 a.m., 7/27/16 at 2:06 p.m., and 7/28/16 at 8:23 a.m. In room 205 revealed the privacy curtain for the A bed was stained. Observation also revealed that there was no handle for closet door, and the closet and bathroom doors were missing wood pieces. 7. Observations on 07/26/16 11:13 a.m., 7/27/16 at 2:15 p.m., and 7/28/16 at 8:30 a.m. and 4:50 p.m., in room 206 the filter to the concentrator had dust build up, debris was noted in the a/c vent, and loose baseboards were noted near the window. 8. Observations on 07/26/16 at 09:18 a.m., 7/27/16 2:09 p.m., and 7/29/16 10:06 a.m. in room 207 revealed the ceiling vent in the bathroom was dusty and the bathroom door had missing pieces and was scratched/scuffed. 9. Observations on 7/27/16 at 2:12 p.m. and 7/28/16 at 8:35 a.m. in room 215 revealed wood paneling missing from the bathroom door. An initial tour began on 7/29/16 at 9:32 a.m. with the Maintenance Director and the Housekeeping Supervisor (HSK). The HSK confirmed all of the observations mentioned above. Interview on 7/29/16 at 9:37 a.m. with the Housekeeping Supervisor (HSK) regarding black stains on floor and spider webs. HSK reported that corners and edges should be of focus every other day in each room and floors should be mopped daily. HSK also expressed that housekeeping staff should be dusting resident's rooms on a regular basis. HSK further reported that a privacy curtain list was received yesterday (7/28/16) identifying curtains that need to be replaced. HSK reported that Housekeeping staff cleans daily and if problems are identified then the staff should report the problems so that maintenance can be notified. Interview on 7/29/16 at 9:41 a.m. with the Maintenance Director who reported that a/c filters are changed monthly and if powder is being used it is difficult to keep the air conditioner vents free from buildup. Interview on 7/29/16 at 9:57 a.m. with Maintenance Director reported that the filters should be changed monthly but acknowledged that some had been missed. The Maintenance Director was unable to provide any documentation that tracks when the vent filter changes are done each month. Interview on 7/29/16 at 10:10 a.m. with the Maintenance Director and the HSK. Maintenance Director reported that vents in bathrooms are supposed to be done monthly. Further reporting that they are done as needed with no specific times for completion. HSK reported that the deep cleaning of rooms is scheduled every month and changing privacy curtains is a part of that task. Daily rounds are done by management and reported to Maintenance during the morning meetings. Both the Maintenance Director and HSK deny being aware of any of the room concerns identified during the tour. Review of the Clinical Rounds Guidelines revealed that staff should be checking to ensure furniture in the residents rooms are clean in good repair, that the floors and walls are in the residents rooms are clean and are in good repair, and that resident's privacy is maintained.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to develop a comprehensive care plan related to one (1) resident (R #32) who has a history of damaging their skin from scratching, and for severe contractures. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include:

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Review of the clinical record for R #32 revealed that she was admitted to the facility on [DATE]. Observation on 08/02/16 at 2:05 p.m. revealed that R #32 had bilateral shoulder, arm, hand and knee contractures, and she was tilted to left side with her legs contracted to the right. During further observation, her fingernails were observed to be long and uneven, with jagged edges, and she was observed scratching her skin. Further observation at this time revealed that she had multiple shallow linear-shaped open areas of skin on her right thigh. During interview with Licensed Practical Nurse (LPN) EE at this time, she stated that the resident had always scratched herself since admission more than ten years ago. LPN EE further stated that when the scratching got bad, the resident was administered anti-[MEDICATION NAME] medications. Review of care plans for R #32 dated 04/21/16 revealed they had not care planned the resident for allergies [REDACTED]. Cross-refer to F 309.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to update the care plan with an intervention for a wanderguard bracelet for a resident at risk of elopement (R #201). The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R #201 revealed she wandered one to three days during the assessment period. Review of their risk for elopement care plan initiated 07/23/13 revealed that there was no intervention listed for a wanderguard bracelet. Review of a facility Incident Reporting Form dated 09/01/15 noted that R #201 was noted to be approximately 300 yards off the facility property. Review of the facility's five (5)-day follow up investigation of the elopement dated 09/04/15 noted the resident was assessed on admission and care planned as a risk for elopement and a wanderguard device placed for the resident's protection. Review of the facility's Elopement Guideline noted that documentation should include a care plan that addressed the potential to wander or exit living center and the measures taken to prevent wandering/elopement, and that the bracelet alarm/device was in place and functioning. Review of R #201's August (2015) Medication Administration Record [REDACTED]. During interview with the Director of Nursing Services on 08/04/16 at 11:06 a.m., she verified that a wanderguard was not an intervention on the care plan for R#201.
F 0281 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the Georiga Nurse Practice Act, Chapter ,[DATE], the facility failed to develop an interim care plan on admission to address an assessment for elopement risk, for resident #170 who eloped from the facility four (4) days after admission. In addition, the facility failed ensure that services were provided in accordance with professional standards of quality as evidenced by the failure in multiple areas of skin and wound management for nine (9) residents (N, R, T, R #180, R #50, R #24, R #120, R #84, R #64) and failed to verify correct placement of the gastric tube ([DEVICE]) for one (1) resident (R#172) during medication administration. A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On [DATE] at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of [DATE] related to elopement. The non-compliance was related to R #170, who was assessed during admission on [DATE] to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on [DATE], and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on [DATE] at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On [DATE] at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On [DATE] at 10:46 a.m., the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) related to 42 C.F.R. 483.25 Quality of Care and 42 C.F.R. 483.20 Resident Assessment was received on [DATE] at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on [DATE] that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On [DATE] at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed as of [DATE], when resident T's sacral pressure ulcer had healed, but no preventive measures were put into place to prevent the wound from recurring, which it did on [DATE] as a Stage II pressure ulcer. In addition, no treatment was initiated until [DATE], and the wound had deteriorated to a Stage III. After Supervisory review by the Enforcement Manager it was determined that the IJ was identified to exist on [DATE] related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on [DATE] and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on [DATE] revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on [DATE] at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on [DATE] and remains on-going. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: Review of the Georgia Nurse Practice Act, Chapter ,[DATE] revealed, Practice nursing as a registered professional nurse means to practice nursing by performing for compensation any of the following: Assessing the health status of individuals, groups, or both throughout the life span; Establishing a nursing diagnosis; Establishing nursing goals to meet identified health care needs; Planning, implementing, and evaluating nursing care; Providing for safe and effective nursing care rendered directly or indirectly; Managing and supervising the practice of nursing; Collaborating with other members of the health care team in the management of care, and;Teaching the theory and practice of nursing. 1. Record review for Resident N revealed the resident was admitted to the facility on [DATE]. Review of the hospital discharge records revealed resident N was admitted to the facility with discharge [DIAGNOSES REDACTED]. Review of the facility admission Clinical Health Status assessment dated [DATE] for resident N revealed the resident is alert with memory problems, sometimes understood, able to understand others, skin condition assessment revealed sacral redness and bilateral blisters on heels. Review of the Braden Scale Assessment = 20, indicating resident is at risk for pressure sores. Resident N can ambulate and transfer with assistance, had a fall risk score of 14 indicating the resident is at risk for falls. Additional notes added on [DATE] indicate a late entry: Resident admitted with [DIAGNOSES REDACTED]. Resident noted to have blister filled on bilateral heels intact. Resident sacral ulcer noted to be red with no open areas. Skin warm to touch. Bilateral heels with [MEDICATION NAME] AG applied, wrapped with Kerlix. Dressing will be changed every three (3) days.

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	115291	A. BUILDING _____ B. WING _____	**08/05/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - WINDERMERE	**3618 J DEWEY GRAY CIRCLE AUGUSTA, GA 30909**

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 0281

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 7)
An Immediate Plan of Care was completed for Resident N dated [DATE] which included planning for Pain, Falls, Nutrition, and Urinary Incontinence, however there was no evidence of an Immediate Care Plan for Pressure Ulcer Risk. Review of the Care Plan completed on [DATE] included planning for Pressure Ulcer Actual or at Risk with multiple interventions including conduct weekly skin assessments, skin assessment to be completed per Living Center Policy, weekly wound assessments, float heels, turn and reposition schedule per assessment.
Review of the Treatment Administration Record (TAR), Orders, Medication Administration Records (MAR) and general Progress Notes reveals there were no skin assessments or wound assessments performed for this resident in accordance with the facility policies ' Skin Integrity Guidelines ' or ' Pressure Ulcer Risk Identification/Prevention Guidelines. '
There was no evidence to support that resident N received any pressure ulcer wound care after [DATE]. Wound Care orders were received on [DATE] and wound care performed on [DATE], totaling 6 (six) days without wound care.
The Wound Care Orders received [DATE] addressed only the bilateral heels, to wash with soap & H20, pat dry, spray with [MEDICATION NAME] and then apply [MEDICATION NAME] AG to bilateral heels, wrap with Kerlix every (q) three (3) days.
On [DATE] Wound Care and measurements were performed. The [DATE]-Wound Note: Stage I to Right. heel with measurements of 8.0
x 7.3 x 0 (No unit of measurement indicated) with clear fluid blister intact at this time. Current orders to cleanse with warm soap and water, pat dry and apply [MEDICATION NAME] AG every 3 days. Stage 1 to Left. heel with measurements of 5.5 x 5.0 x 0 (No unit of measurement indicated) cleanse wound with warm soap and water, pat dry and apply [MEDICATION NAME] AG
every 3 days. Will continue to monitor patient.
Review of the Treatment Administration Record (TAR) records Wound Care as having been first provided on [DATE] (9 days after admission).
The Care Plan dated [DATE] was not reviewed after the hospital discharge and no new Care Plans or changes to the existing Care Plans were made.
Further review of the Treatment Administration Record (TAR) records Wound Care as having been provided again on [DATE].
No additional wound care is recorded for resident N until after return from the hospital on [DATE] through [DATE].
Medical Record review reveals the resident was re-admitted on [DATE] but no skin assessment was completed on the Clinical Health Status assessment dated [DATE]. Bilateral bruising to the hands, a tattoo on the left arm, and a scar are noted.
Resident N returned with new [DIAGNOSES REDACTED]. Special Instructions include Stage 1 right heel wound, Stage 1 sacral wound, unstageable left heel wound. Patient needs a low flow air mattress, Prevalon boots and [MEDICATION NAME] AG every (q) three (3) days and as needed (PRN). Follow-up Primary Care Physician (PCP) in two (2) weeks.
On [DATE] [MEDICATION NAME] ointment was ordered to be applied to the heels twice daily bilaterally. The ointment was never applied because it was listed on the Medication Administration Record, [REDACTED].
Review of the Treatment Administration Record (TAR) records Wound Care was provided on [DATE].
Review of the Treatment Administration Record (TAR) records Wound Care provided on [DATE], [DATE], [DATE], [DATE], [DATE],
[DATE], [DATE], however there is no evidence of a progress notes substantiating that wound care was provided on these dates.
On [DATE]- (Late Entry on [DATE])-Wound Care Note: Resident right heel noted to have measurements of 3.0 x 4.0. (No unit measurement indicated) Wound cleansed with warm H20, soap, pat dry then apply [MEDICATION NAME] AG then wrap with kerlix
wrap. Left heel noted to have measurements of 5.0 x 2.0. (No unit of measurement indicated). Wound cleansed with warm H20, soap, pat dry then apply [MEDICATION NAME] AG then wrap kerlix wrap. Sacral wound noted to have measurements of 3.0 x 1.5. (No unit of measurement indicated) Cleansed area with warm H20, soap, pat dry then apply Santyl then cover with ABD pad secure with tape every (q) day.
The Santyl was applied to the bilateral heels on [DATE] prior to a physician's orders [REDACTED]. [MEDICATION NAME] spray was not used as directed by the physician's orders [REDACTED].
The physician was not notified of the changes in the wounds, and no new wound care orders were issued until [DATE]. An appointment was not made for the physician to see the resident 2 (two) weeks after hospital discharge as directed in the Discharge Summary dated [DATE]. Interview with the Director of Nursing Services (DNS) on [DATE] at 11:40 a.m. reveals that the resident was never seen by the physician.
On [DATE]: General Note revealed: sacral wound with necrotic tissue to center of wound bed with greenish color to edges. Measurements 8.0 x 4.5. (No unit of measurement indicated) Sacral wound continues to be treated daily. Right heel noted to have deep tissue injury (DTI), measures 5.0 x 6.5 x 0 (No unit of measurement indicated) with black tissue in center of the wound bed with red edges to the wound. Right great toe noted to have DTI with measurements of 1.0 x 0.5 (No unit of measurement indicated). Bottom of right foot DTI present with measurements of 0.5 x 1.0 (No unit of measurement indicated). Left heel DTI noted to have measurements of 4.5 x 5.0 (No unit of measurement indicated) with black tissue to the center of the wound bed. Resident DTI's are cleansed with water, soap, pat dry, [MEDICATION NAME] AG applied then wrap with kerlix every 3 days.
Review of the Treatment Administration Record (TAR) records that Wound Care was performed on [DATE], [DATE], [DATE], [DATE],
[DATE], [DATE], and [DATE].
Review of the medical record for resident N reveals that the resident was discharged to the hospital on [DATE] after being found in his room with lethargy and periods of not breathing. A sternal rub was applied to resident to cause responsiveness. Blood pressure alternated between ,[DATE] and ,[DATE] with heart rate 116 to 123. Resident afebrile. EMS called for hospital transfer. The physician was not notified however, there are no orders for transfer in the medical record.
Review of the Hospital admission notes dated [DATE] reveal that resident N was admitted [MEDICAL CONDITION]. The resident was discharged to Hospice on [DATE] with discharge [DIAGNOSES REDACTED].
Resident N was transferred to another hospital and died on [DATE] under the care of hospice. Final [DIAGNOSES REDACTED].
Interview with the Assistant Director Nursing Services (ADNS) on [DATE] at 11:00 a.m. and review of the medical record for resident N revealed that the resident did not receive weekly skin assessments as ordered or weekly wound assessments as ordered.
Interview with the Wound Care Nurse LPN CC on [DATE] at 9:35 a.m. revealed that Weekly Assessments are done by the primary care nurse, and Weekly Wound Assessments are done by the wound care team.
Interview with the ADNS on [DATE] at 2:37 p.m. who confirms that the interim care plan dated [DATE] developed on Admission was not completed for Pressure Ulcers. The ADNS states that the Wound Care Team was addressing the pressure ulcers; the Care Plan was just not completed. Further interview reveals that the re-admission Assessment for resident N was not completed, and the section for Skin Assessments was not completed to include the existing pressure ulcers. The assessment was not comprehensive. Review of Progress Notes reveals that the physician was not notified of changes in conditions related to the pressure ulcers, interventions were not documented, and staging of the pressure ulcers was not recorded. The ADNS acknowledged that these were not documented.
Interview on [DATE] at 9:55 a.m. with Treatment Nurse LPN CC and review of the wound care record. CC confirmed that wounds were not staged and wound depths were often not recorded. CC further states she was extremely busy and some information may not be recorded properly. CC also reveals treatments may have been given but not recorded. CC confirms that physician's orders [REDACTED]. CC states that treatments were performed based on the guidelines for what was appropriate treatment for [REDACTED]. When asked how Wound Care Nurse's (WCN) were notified of resident's that needed wound care, CC stated that when
new and readmitted residents are entered, Admissions staff are supposed to notify the wound care nurse. The Wound Care Nurse assesses the resident and reviews the Discharge Summary, then calls the physician for orders. When a resident needs wound care and there are no orders, the WCN follows the guidelines for wound care and calls the doctor. When asked about wound care prevention, CC stated that if it was pre-existing but not documented, it might be overlooked. CC did not know how to assess for [MEDICAL CONDITION] and reveals that he/she has not received any training for this.
Interview of the Director of Nursing Service (DNS) on [DATE] at 11:40 a.m. revealed that the wound care orders were put in late for resident N. Resident N was admitted on [DATE] and wound care orders were not entered until [DATE].
Interview with the DNS on [DATE] at 11:45 a.m. who confirms that the pressure ulcers for resident N were not discussed during the Weekly Care Management Meeting. Pressure ulcers were not listed; therefore, they were not discussed. The DNS confirms that the pressure ulcers should have been discussed because this meeting arranges for services and interventions to be added to the resident plan of care related to the issues discussed. Resident N was not discussed in any subsequent Weekly Care Management Meetings. The DNS further reveals that the Care Plan was not updated on re-admission and it should

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) have been for resident N. New and re-admissions are recorded on the 24-hour report and discussed the following morning in the Inter-Disciplinary Team (IDT) Meeting which is attended by Minimum Data Set (MDS), Care Planning, Activities, Dietary, etc. Nursing should have reviewed the current Care Plan and updated it based on the new [DIAGNOSES REDACTED]. Interview on [DATE] at 12:40 p.m. with the Nursing Consultant reveals that Care Plans are updated by Nursing and plan of care should have been updated for resident N. Cross-refer to F 3142. 2. Review of clinical record for Resident #170 revealed that he was admitted to the facility on [DATE]. Review of the admission Clinical Health Status assessment dated [DATE] noted that the resident had a history of [REDACTED]. Review of the Immediate Plans of Care for R #170 revealed that one had not been developed for elopement. Review of the Risk for Falls Immediate Plan of Care dated [DATE] revealed that the risk factor for wandering was not checked, and no interventions were included to address the wandering and elopement risk. Review of the facility's Elopement Guideline noted that documentation should include a care plan that addressed the potential to wander or exit the living center, and measures taken to prevent wandering/elopement. Review of a computerized nursing Situation-Background-Assessment-Recommendation (SBAR) note dated [DATE] at 12:02 a.m. noted that R #170 was noted ambulating in the road off the facility premises. During interview with the DNS on [DATE] at 3:10 p.m., she stated that residents were assessed on admission for elopement risk on the Clinical Health Status form, and if determined to be an elopement risk a wanderguard bracelet was applied and a care plan developed. Cross-refer to F 323. 3. Review of a nursing Progress Note dated [DATE] at 8:40 a.m. (late entry for [DATE]), and in the Additional Notes section of the admission Clinical Health Status form dated [DATE], revealed that there was discoloration to the bottom of both feet of R #180, and pink areas to the right and left buttocks without open areas at this time. Review of a Weekly Skin Review dated [DATE] noted that the skin was thin and fragile, and there were open areas to sacrum that looked like burst blisters. Further review of this Skin Review noted blisters to the right buttock, and burst blister to the left buttock. Review of the Treatment Administration Record (TAR) revealed that no measures were documented to prevent skin breakdown to these areas on admission, nor any treatments completed once the blisters and open area to the buttocks were identified on [DATE]. During interview and record review with Treatment LPN UU on [DATE] at 1:28 p.m., she verified that there was no documentation on TAR that the following treatments were ever completed for R #180: In [DATE] at 5:00 p.m. on [DATE]; [DATE]; and [DATE], in addition the TAR for R#180 did not specify what wound was being treated; at 5:00 p.m. treatments not documented as completed to left buttock on [DATE], and to the left buttock, right buttock, and sacrum at 5:00 p.m. from [DATE] to [DATE]. In addition, the treatment was not documented as completed at 9:00 a.m. for any of these three (3) areas on [DATE]. In [DATE]: The 5:00 p.m. treatment to the right and left buttocks and sacrum were not documented as completed on [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. The daily treatment to the sacrum was not documented as done on [DATE]; [DATE]; and [DATE]. In [DATE]: The daily treatments to the sacrum and right buttock were not documented as completed on [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. During observation of wound care by LPN Treatment Nurse CC on [DATE] at 9:59 a.m., R #180 the buttocks and sacral area revealed that it was dry and flaky, and had what appeared to be previously healed wounds to the area. Observation of the wound to the upper left medial buttock revealed that it was shallow with a clean red and pink wound base, and was measured as 1.4 by 0.6 by 0.2 cm. During the wound care, the treatment nurse noted a previously unidentified circular area of skin breakdown on the right upper medial buttock, approximately 1.0 cm in diameter (not measured). Cross-refer to F 314. 4. Review of the computerized Weekly Skin Reviews for R #50 revealed that the skin assessments were not completed on [DATE]; [DATE]; and no evidence of Weekly Skin Reviews between [DATE] and [DATE] (a total of twelve (12) missed assessments since admission). This was verified during interview with Registered Nurse (RN) Field Services Clinical Director PPP on [DATE] at 10:24 a.m. Review of the TARs from admission through July revealed no documentation that wound care was performed on [DATE]; and [DATE]. This was verified during interview with the DNS on [DATE] at 11:09 a.m. Cross-refer to F 314. 5. Although resident T was admitted on [DATE] with a Stage II sacral pressure sore, there was no indication that staff obtained and provided treatment for [REDACTED]. Although the sacral pressure sore healed on [DATE], there was no indication that staff provided preventive treatment for [REDACTED]. There was no indication that staff assessed the Stage II pressure sore weekly after [DATE] to track the progression or deterioration until [DATE] when staff identified an open area on the sacrum with a yellow-green wound bed. There was no indication that the physician was notified of the open area until [DATE] when the physician ordered [MEDICATION NAME] to be applied every day and to obtain a Wound Care consult. On [DATE], staff assessed the wound as 4.0 x 3.0 x 0 cm. pressure sore with 75% necrotic tissue. Staff failed to provide accurate staging of the pressure sores by assessing necrotic tissue and slough as a Stage II and thick, black eschar as Deep Tissue Injury (DTI). Staff failed to provide consistent weekly assessments of the sacral pressure sore in order to track the progression or deterioration of the wound between [DATE] and [DATE] when the resident was assessed at the Wound Care clinic and a wound VAC was ordered. Staff failed to consistently assess the bilateral heel pressure sores to include staging, measurements and description after [DATE]. Staff failed to provide treatments for the sacral pressure sore every day as ordered on [DATE], [DATE], [DATE] and [DATE] and twice (2) a day as ordered for 21 of 27 days between [DATE] and [DATE]. Staff failed to provide treatments for the bilateral heel pressure sores every three (3) days as ordered between [DATE] and [DATE] (8 days between treatments), between [DATE] and [DATE] (23 days between treatments), between [DATE] and [DATE] (5 days between treatment), between [DATE] and [DATE] (5 days between treatments), between [DATE] and [DATE] (4 days between treatments) and between [DATE] and [DATE] (4 days between treatments) when the resident was admitted to the hospital from the wound care clinic for wound infection and debridement of the right heel pressure sore. Cross-refer to F 314. 6. Staff failed to initiate pressure relieving devices for the feet of resident R from [DATE] when the resident developed a Stage II blister on the right heel until [DATE] after the right heel pressure sore had deteriorated to a Stage III. Staff failed to perform consistent weekly assessments of the pressure sores of the right heel, right ankle and left ankle to include staging, measurements and description of the wounds. Staff failed to accurately stage the pressure sores. Staff failed to provide treatments as ordered by the physician. Staff failed to use the correct product in the treatment of [REDACTED]. Staff failed to discontinue the use of the multipodus boots as ordered by the physician. Interview with the Wound Care Physician AAA on [DATE] at 1:00 p.m. revealed that resident R had maggots in his right heel wound that required debridement on [DATE]. Further interview revealed that AAA believed that staff were not cleaning the wounds as they should which resulted in the presence of the maggots and a decline of the wounds. Cross-refer to F 314. 7. Review of the medical record for R#120 revealed that he was admitted on [DATE] with an Unstageable pressure sore on his right heel, a Stage IV pressure sore on his left trochanter, a Stage IV pressure sore on his left ischium and a Stage II pressure sore on his sacrum. Review of the General Note dated [DATE] revealed that the sacral pressure sore had resolved. Review of the TARs revealed that staff failed to provide treatments as ordered for the left ischium and left trochanter on [DATE] and failed to provide treatments as ordered related to the wound VAC for the left ischium on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. The resident's left trochanter pressure sore healed. Further review of the resident's medical record revealed [REDACTED]. The resident's pressure sores did not deteriorate. Observation for R#120 of pressure sore treatment on [DATE] at 3:40 p.m., Treatment Nurse CC and Treatment Nurse UU provided treatment as ordered to the resident's sacral and left ischium pressure sores. Treatment to the resident's right heel pressure sore was due [DATE]. The resident's left trochanter pressure sore had resolved. The unstageable sacral pressure sore measured 11.5 x 9.6 x 2.9 cm. The center of the wound had an approximately 5.0 x 4.0 cm area with 95% yellow slough. The outer edges of the wound had beefy red tissue. There was a small amount of serosanguinous drainage and no odor. The

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) Stage IV left ischium pressure sore measured 2.3 x 3.0 x 4.2 cm and was without drainage or odor. The resident's unstageable right heel pressure sore had soft black intact tissue that measured approximately 2.0 x 2.0 cm. Cross-refer to F 314. 8. During interview and record review with the Director of Nursing Services on [DATE] at 3:41 p.m., she verified that there was no evidence that treatments were completed as ordered for R #24's left foot wounds on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Cross-refer to F 314. 9. Observation on [DATE] at 2:25 p.m. revealed LPN AA prepared and administered medication, [MEDICATION NAME] 25 milligrams (mg), via gastrostomy tube ([DEVICE]) for R #172 without verifying correct placement of the tube. LPN AA connected the syringe base to the tube port and poured in the medication mixed with water. LPN AA flushed the tube with water and replaced the cap back on the tube. Interview on [DATE] at 3:10 p.m. with LPN AA revealed she checks placement of the [DEVICE] once per shift by injecting air and listening with the stethoscope. Review of the Physician orders [REDACTED]. Interview with LPN AA on [DATE] at 9:20 a.m. revealed that she was mistaken during her previous interview when she said she checked the placement of the [DEVICE] once per shift. LPN AA stated that she aspirates stomach contents to verify [DEVICE] placement. Interview with the DNS on [DATE] at 7:55 a.m. revealed that her expectation is for [DEVICE] placements to be checked prior to the administration of anything including medications and feedings. Review of the Administration of Enteral Feeding Policy last reviewed on [DATE] revealed that verification of feeding tube placement will be done before the administration of feeding formula, medication or free water flushes, and/or at least one time per shift. Policy documented to verify [DEVICE] placement by slowly drawing back gastric contents and evaluating the color and amount of residual- gastric contents (correct placement). 10. Review of the clinical record for R #64 revealed that her had a history of [REDACTED]. Review of physician's orders [REDACTED]. Observation of R #64 on [DATE] at 9:50 a.m., 10:44 a.m., 11:14 a.m., 2:15 p.m. and 5:55 p.m. revealed the resident lying in her bed on her side. However, staff failed to float the resident's heels as ordered by the physician and the resident's ankles were on top of each. review of the resident's medical record revealed [REDACTED]. Observation on [DATE] at 11:14 a.m. revealed the resident was sleeping on the right side, no positioning devices were visible, and the heels were not floated. Observation on [DATE] at 2:15 p.m. revealed that R #64 was resting on his right side in a fetal position with his full weight on his right trochanter. His heels were not floated, no positioning devices were visible, and his knees and ankles were resting on top of each other. Observation of R #64 on [DATE] at 5:45 p.m. revealed that staff had positioned him onto his left side but, his heels were not floated. Cross-refer to F 314. 11. Review of the clinical record for R #84 revealed that they were admitted to the facili
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 observation, record review, and resident and staff interviews, it was determined that the facility failed to ensure that care plans were followed for use of a bed alarm and picture identification (ID) for the elopement book for resident #170; for staff to assist with personal hygiene and bathing for residents R, O and S; for staff to evaluate the need for as needed (PRN) pain medication prior to wound treatment for [REDACTED].N, T, #180, #150, #120, and #84. A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On 07/29/16 at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of 07/15/16 related to elopement. The non-compliance was related to R #170, who was assessed during admission on 07/15/16 to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on 07/19/16, and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on 7/28/16 at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On 7/28/16 at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On 7/30/16 at 10:46 a.m., the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on 08/02/16 at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on 08/05/16 that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On 08/03/16 at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on 4/6/16 related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on 5/27/16 and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on 6/1/16 revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on 08/04/16 at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on 4/6/16 and remains on-going. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: 1.Resident N was admitted from the hospital on [DATE] with [DIAGNOSES REDACTED]. Resident received a Skin Assessment on admission as documented on the Clinical Health Status Admission form. An Immediate Care Plan was developed for the resident on 4/6/2016 that failed to include Care Planning for the intact blisters and reddened sacral area. Review of the Care Plan completed on 4/18/2016 with planning for Pressure Ulcer Actual or at Risk with Interventions including: Conduct Weekly Skin Assessments, Skin Assessment to be completed per Living Center Policy and Weekly Wound Assessment. Review of the Progress Notes and the Treatment Administration Notes (TAR) reveals that resident did not receive weekly skin assessments or weekly wound assessments as specified in the Care Plan, the facility policies Pressure Ulcer Risk Identification/Prevention Program and the Skin Integrity Guidelines, or as ordered by the physician and wound care was not provided as ordered or by policies Pressure Ulcer Risk Identification/Prevention Program and the Skin Integrity Guidelines. Resident discharged from the hospital and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Special Instructions include Stage 1 right heel wound, Stage 1 sacral wound, unstageable left heel wound. Patient needs a low flow air mattress, Prevalon boots and [MEDICATION NAME] AG every three days and PRN. Resident did not receive a Skin Assessment on re-admission as documented on the Clinical Health Status Admission form. The Care Plan was not reviewed and no new [DIAGNOSES REDACTED]. Interview with Wound Care Nurse 'CC' on 7/29/2016 at 9:35 a.m. who reveals that Weekly Assessments are done by the primary care nurse, Weekly Wound Assessments are done by the wound care team. Interview with Assitant Director of Nursing Service (ADNS) on 7/29/16 at 11:00 a.m. and review of resident's medical record reveals that resident did not receive weekly skin assessments as ordered or weekly wound assessments as ordered in the Care Plan.

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) Interview with the Director of Nursing Service (DNS) on 8/5/16 at 11:45 who confirms that the resident's pressure ulcers were not discussed during the Weekly Care Management Meeting. Pressure ulcers were not listed; therefore, they were not discussed. DNS confirms that the pressure ulcers should have discussed because this meeting arranges for services and interventions to be added to the resident plan of care related to the issues discussed. Resident was not discussed in any subsequent Weekly Care Management Meetings. The DON further reveals that the resident's Care Plan was not updated on re-admission and it should have been. New and re-admissions are recorded on the 24-hour report and discussed the following morning in the Inter-Disciplinary Team (IDT) Meeting which is attended my MDS, Care Planning, Activities, Dietary, etc. Nursing should have reviewed the resident's current Care Plan and updated it based on the resident's new [DIAGNOSES REDACTED]. Interview on 8/5/2016 at 12:40 p.m. with the Nursing Consultant reveals that Care Plans are updated by Nursing and the resident's plan of care should have been updated. 2. Resident T was admitted [DATE] with a Stage II sacral pressure sore and bilateral heel non-blanchable redness. Review of the 5/31/16 Quarterly MDS revealed that the resident had a Brief Interview for Mental Status (BIMS) score of six (6) indicating that the resident was cognitively impaired, had almost constant moderate pain, did not reject care and had one Stage III pressure sore and two unstageable pressure sores. Review of the care plan dated 12/12/15 revealed that the resident required pain management and monitoring related to his wounds with an intervention to evaluate the characteristics and frequency/pattern of pain and to evaluate the need for routinely scheduled medications rather than as needed (PRN) pain medications. review of the resident's medical record revealed [REDACTED]. Observation of treatment to the sacrum and right heel wounds on 8/2/16 at 2:12 p.m. and observation of treatment to the resident's left foot wounds on 8/3/16 at 6:00 p.m. revealed that the resident exhibited pain during treatments. Although staff had acknowledged that the resident exhibited pain during treatment, review of the 8/2016 Medication Administration Record [REDACTED]. Cross refer to F309. Review of resident medical record for resident T revealed that he was admitted with a Stage II pressure sore on the sacrum and bilateral non-blanchable redness on his/her bilateral heels. Review of the resident's care plan dated 12/3/15 revealed an intervention for staff to provide treatments as ordered. However review of the Treatment Administration Records (TARs) revealed that staff failed to provide treatments as ordered for the sacral wound on 12/5/16, 3/9/16, 3/17/16, 4/9/16, from 4/12/16-4/17/16, 4/19/16, 4/21/16-4/23/16, 4/25/16-4/30/16, 5/3/16-5/6/16, 5/8/16, 714/16 and 7/24/16. Staff failed to provide treatments as ordered to the bilateral heels on 12/30/15, 1/7/16, 3/10/16, 3/13/16, 3/19/16, 3/22/16, 3/25/16, 3/28/16, 4/3/16, 4/6/16, 5/19/16, 7/14/16 and 7/24/16. Interview with Treatment Nurse CC on 7/29/16 at 9:20 a.m., revealed that the facility had two treatment nurses and that they rotated weekends to provide treatments. Continued interview revealed that the charge nurses were responsible for providing treatments in the evenings and if the treatment nurses were not available. Cross refer to F314. 3. Review of the medical record revealed for resident R that he had developed pressure sores on his/her right heel, right ankle and left ankle since admission. Review of the care plan dated 7/23/15 revealed an intervention for staff to provide treatments as ordered. However, review of the TARS revealed that staff failed to provide treatments as ordered for the right heel wound on 10/18/15, 10/21/15, 10/24/15, 11/5/15, 11/14/15, 12/14/15, 12/19/15, 1/2/16, 1/7/16, 2/15/16, 3/17/16, 4/9/16, 4/10/16, 4/12/16, 4/30/16, 5/19/16, 5/31/16, 6/7/16, 7/8/16-7/11/16 and 7/16/16-7/18/16. Staff failed to provide treatments as ordered to the bilateral ankle wounds on 4/30/16, 5/19/16, 5/31/16, 6/7/16, 7/8/16-7/11/16 and 7/16/16-7/18/16. Although staff had documented that treatment was provided to the resident's wounds on 7/23/16, 7/24/16 and 7/25/16, observation of the resident's bilateral feet dressings on 7/26/16 at 2:23 p.m. revealed that staff had dated the dressings as last changed on 7/22/16, four days earlier. Interview with the Wound Care Physician AAA on 8/3/16 at 1:00 p.m. revealed that resident R had maggots in his right heel wound that required debridement on 6/22/16. Further interview revealed that AAA believed that staff were not cleaning the wounds as they should which resulted in the presence of the maggots and a decline of the wounds. Cross refer to F314. Review of the Annual MDS dated [DATE] for resident R' revealed that the resident had a BIMS score of thirteen (13), indicating that he/she was alert and oriented and that he/she was totally dependent on staff for bathing. Review of the care plan dated 7/11/16 revealed that the resident had a physical functioning deficit with an intervention for staff to assist with personal hygiene. Interview with resident R on 7/26/16 at 2:23 p.m. Revealed that staff were supposed to shower him two times a week but, he had not received a shower in three weeks. Continued interview revealed that he/she preferred showers instead of bed baths. Review of the Activities of Daily Living (ADLs) printout revealed that the last time the resident received a shower was on 6/13/16 on the 7:00 a.m. to 3:00 p.m. shift. Staff had documented that the resident was provided partial baths subsequent days. Interview with Treatment Nurse CC on 7/29/16 at 9:25 a.m. revealed that the resident had pressure sores on both feet but, that he could receive showers as scheduled. Continued interview revealed that Treatment Nurse CC was not aware that the resident was not receiving his/her showers. Staff failed to provide showers for resident R. Cross refer to F312. 4. Review of the Quarterly MDS dated [DATE] for resident S revealed that he had carious teeth and required extensive assistance from staff for personal hygiene which included oral care. Review of the current care plan revealed that the resident had a physical functioning deficit with an intervention for staff to assist with oral care every morning and as needed. Interview with resident S on 7/26/2016 at 9:50 a.m. revealed that he had not brushed his/her teeth in over one month because he/she did not have a toothbrush or toothpaste. Continued interview revealed that he had requested a toothbrush and toothpaste but, staff had not provided them yet. Interviews with the resident and observations of the resident's room and bathroom on 7/27/16 at 3:30 p.m. and on 7/29/16 at 5:20 p.m. revealed that staff failed to provide oral care supplies and/or set up oral care supplies for the resident as care planned. Cross refer to F312 5. Review of the medical record for R #120 revealed that he was admitted on [DATE] with pressure sores on his sacrum, left ishium, left trochanter and right heel. Review of the care plan dated 11/7/15 revealed an intervention for staff to provide treatments as ordered. Review of the medical record revealed a physician's orders [REDACTED]. However, staff failed to provide treatment on 11/29/15. Review of the medical record revealed a physician order [REDACTED]. Review of the TARs revealed that staff failed to provide treatment for [REDACTED]. On 3/17/16, treatment was changed to apply Dakin's soaked gauze to the left ischial wound twice a day. However, staff failed to provide treatments twice a day on 3/18/16, 3/20/16, 3/21/16, 3/24/16, 3/26/16 and 3/29/16. Review of the medical record revealed that he was hospitalized [DATE] to 6/23/16 for urosepsis. Review of the General Note dated 6/23/16 revealed that the resident had a sacral wound that measured 13.4 x 12.3 x 0 cms. with tan to blackish wound bed, a left gluteal fold (ischial) wound that measured 4.1 x 5.3 x 2.6 cm with tunneling of 3.9 cms. at 10 o clock, tunneling of 4.3 cms. at 11 o ' clock and 3.7 cms at 12 o ' clock with slough in the wound bed, and an unstageable wound on the right heel that was dark purple to black in color. Although staff documented in the 6/23/16 General note that treatment, Santyl every day, was provided to the sacral wound on 6/23/16, there was no indication that treatment was provided 6/24/16, 6/25/16, 7/9/16 or 7/24/16. Although staff documented that treatment, Dakin's every day, was provided to the left gluteal fold (ischium) on 6/23/16, there was no indication that staff provided treatment on 6/24/16, 6/25/16, 7/9/16 or 7/24/16. Staff failed to provide treatments as ordered as care planned. Cross-refer to F 314. 6. Review of the clinical record for R #180 revealed that they were admitted to the facility on [DATE], hosptalized on [DATE], and readmitted on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] noted the resident had severe cognitive impairment, required extensive assist for bed mobility, was a pressure ulcer risk but had no current pressure ulcers, and had moisture associated skin damage (MASD). Review of the care plan developed 05/26/16 for pressure ulcer actual or at risk due to assistance required for bed mobility and bowel incontinence included interventions for weekly skin inspections, skin assessment to be completed per Living Center policy, and treatments as ordered.

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) During interview with the Licensed Practical Nurse (LPN) Treatment Nurse CC on 07/29/16 at 4:15 p.m., she stated that the primary nurse did the weekly skin assessments. Upon further interview, she stated that the treatment nurse was responsible for doing weekly wound assessments including measurements, staging, and description. Review of weekly skin assessments from the original admitted through 07/22/16 revealed that there was no skin assessment done on 05/29/16. Review of a skin assessment dated [DATE] revealed that R #180 had a Stage II to the sacral area with pink tissue present, and Stage II to the right and left buttocks. Review of Physician order [REDACTED]. Further review of Physician order [REDACTED]. Review of the Treatment Administration Records (TAR) for R #180 revealed the following: In May 2016: at 5:00 p.m. treatments not documented as completed on 05/21/16; 05/22/16; 05/24/16 (the TAR does not specify what is being treated); at 5:00 p.m. treatments not documented as done to left buttock on 05/25/16, and to left buttock, right buttock, and sacrum at 5:00 p.m. from 05/26/16 to 05/31/16. In addition, the treatment was not documented as done at 9:00 a.m. for any of these three areas on 05/27/16. In June 2016: The 5:00 p.m. treatment to the right and left buttocks and sacrum were not documented as done on 06/01/16; 06/03/16; 06/04/16; 06/07/16; 06/08/16; 06/09/16; 06/11/16; 06/12/16; 06/15/16; 06/16/16; and 06/17/16. The daily treatment to the sacrum was not documented as done on 06/21/16; 06/24/16; and 06/27/16. In July 2016: The daily treatments to the sacrum and right buttock were not documented as done on 07/06/16; 07/09/16; 07/10/16; 07/11/16; and 07/18/16. This missing wound care documentation was verified during interview with Treatment LPN UU on 08/01/16 at 1:28 p.m. Cross-refer to F 314. 7. Review of the clinical record for R #150 revealed that she was admitted to the facility on [DATE]. Review of her Admission MDS dated [DATE] revealed that she had one unstageable pressure ulcer with slough or eschar. Review of the Quarterly MDS dated [DATE] noted she had one Stage III pressure ulcer with slough. Review of the pressure ulcer care plan revealed interventions for weekly skin inspections, and to do treatments as ordered. Review of computerized Weekly Skin Reviews revealed that the skin assessments were not completed on 03/26/16; 04/09/16; and none between 05/09/16 and 07/26/16 (a total of twelve missed assessments since admission). This was verified during interview with RN Field Services Clinical Director PPP on 08/04/16 at 10:24 a.m. Review of Physician order [REDACTED]. 06/10/16-present time Cleanse right heel with water, soap, pat dry, and apply Santyl then wrap with kerlix wrap every day. Review of the TARs from admission in January 2016 through July 2016 noted blanks in the wound care documentation as follows, and was verified during interview with the DNS on 08/04/16 at 11:09 a.m.: In January 2016: No documentation that the right heel wound care was done on 01/31/16. In February 2016: No documentation that wound care to the right heel was done on 02/09/16; 02/14/16; 02/23/16; and 02/29/16. In March 2016: No documentation that wound care to the right heel was done on 03/03/16; 03/06/16; 03/09/16; 03/12/16; 03/15/16; and 03/21/16. In April 2016: No documentation that the treatment was done to the right heel on 04/06/16. In May 2016: No documentation that the treatment was done to the right heel on 05/04/16; 05/07/16; and 05/19/16. In June 2016: No documentation that the treatment was done to the right heel on 06/09/16; 06/10/16; and 06/21/16. In July 2016: No documentation that the treatment was done to the right heel on 07/06/16; 07/09/16; 07/10/16; 07/18/16; 07/24/16; and 07/31/16. Cross-refer to F 314. 8. Review of the clinical record for R #170 revealed that he was admitted to the facility on [DATE]. Review of the Admission MDS dated [DATE] noted that he had severe cognitive impairment, and wandered 1-3 days of the assessment period. Review of a care plan for risk for wandering initiated on 07/19/16 included an intervention for a bed alarm. Review of a care plan for risk for elopement related to attempts to leave the Living Center initiated 07/22/16 included an intervention to take a picture of the patient on admission for identification for updating the elopement book. Review of a Verification of Investigation report dated 07/19/16 at 6:30 p.m. revealed that R #170 was noted ambulating outside in the parking lot near the road. During observation and interview with Licensed Practical Nurse (LPN) AA on 07/28/16 at 9:14 a.m., she verified that R #170 did not have an alarm on his bed. During interview with LPN Unit Manager HH on 07/28/16 at 2:28 p.m., she verified that there was no photo of the resident in the elopement book, that there should have been, and that either she or the Assistant Director of Nursing Services (DNS) initiated these forms. During interview with the DNS on 07/28/16 at 3:10 p.m., she verified that there was no picture of R #170 in the elopement book, and that there should have been. During observation and interview with Certified Nursing Assistant (CNA) MM on 07/30/16 at 3:24 p.m., she verified that there was no bed alarm on the bed. During observation on 08/02/16 at 9:01 a.m., no alarm was seen on the bed. Cross-refer to F 323. 9. Review of the MDS assessment dated [DATE] for resident O revealed that they had no cognitive impairment, needed extensive assistance for personal hygiene, and had impairment on one side of the upper and lower extremities. Review of the care plan for impaired neurological status related to [MEDICAL CONDITION] (stroke) and [MEDICAL CONDITION] included interventions to assist with ADLs as needed, and monitor ADLs for assistance and render care as needed. Review of the physical functioning deficit related to self-care and mobility impairment care plan included an intervention for personal hygiene assistance. During interview with resident O on 07/26/16 at 10:01 a.m., 07/27/16 at 9:20 a.m., 07/27/16 at 1:49 p.m., 07/28/16 at 10:28 a.m., 07/29/16 at 4:05 p.m., 07/30/16 at 8:04 a.m., and 07/30/16 at 3:25 p.m., the resident stated they had not received oral care that day and/or since February 2016, and white and/or tannish debris was noted along their bottom teeth at the gum line. During interview and observation with Certified Nursing Assistant (CNA) MM on 07/30/16 at 3:30 p.m., she was not able to find any mouth care supplies in he room of resident O. Cross-refer to F 312 10. Review of the clinical record for R #84 revealed that the resident was admitted to the facility on [DATE] was hosptalized on [DATE] and was readmitted to the Long Term Care facility on 01/27/16. Review of the Admission Minimum Data Set ((MDS) dated [DATE] noted that R# 84 had moderate cognitive impairment, was extensive for bed mobility, was a pressure ulcer risk and was admitted with one stage four (IV) pressure ulcer with measurements noted as 6.5 x 5.0 x 0.8 (noted to be error actual depth on admission 8.0 cm). No moisture associated skin damage noted. Review of the Immediate care plan dated 11/12/15 for Pressure Ulcer Risk documents pressure ulcer present with intervention of implement Tender Loving Care (TLC) program where available, Ulcer care Ma65 (low air mattress). Review of care plan dated 01/27/16 for Pressure ulcer actual or at risk due to stage IV to sacrum included interventions for weekly skin assessments, treatments as ordered, weekly wound assessment, skin assessment to be completed per Living Center Policy. Review of the care plan for R #84 revealed the following: Pressure ulcer actual or at risk due to: Pressure ulcer present, assistance required in bed mobility, bed fast, skin desensitized, bowel incontinence, stage IV wound to sacrum. The following care planned interventions are noted: conduct weekly skin inspection, skin assessment to be completed by policy. After resident was readmitted to the Long Term Care facility on 01/27/16, the first weekly skin assessment after re-admitted d 01/28/16 - documents open area- Pre-existing, signed 02/12/16. No wound care description or wound care measurements noted. Skin assessment: 01/28/16 - wound description and measurements. New wound care order for [MEDICATION NAME] AG to be applied to DTI to 3rd toe and unstageable o 2nd digit. There is no documentation that [MEDICATION NAME] was applied for the following dates: 01/28/16, 01/31/16. 02/06/16, 02/09/16, 02/12/16, 02.15/16, 02/18/16, 02/27/16. Review of Nurses Progress Notes revealed only three Nurses Notes addressing R #84's sacral wound from the date of readmission on 01/27/16 until 02/29/16 and include: Nurses Note dated 01/27/16 Admission note: with admitting [DIAGNOSES REDACTED]. Nurses Note dated 01/28/16 at 4:30 p.m. documents: Admission Skin assessment: Skin warm and dry to touch. Sacrum with Stage IV with red granulating tissue, wound bed without slough or necrotic tissue noted, with measurements 5.0 x 5.0 x 1.5. Right foot 2nd digit with eschar noted with measurements of 0.5 x 0.5 x 0 new order for [MEDICATION NAME] AG every 3 days. 3rd digit with Deep Tissue Injury (DTI) noted with measurements of 0.3 x 0.3 x 0. No additional Nurses note or wound care note documented in the Progress Notes from 01/28/16 until 02/21/16 Nurses Note which documents: Wound Note: Stage IV to sacrum

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 12) with measurements of 6.0 x 4.0 x 1.5 with beefy red granulating tissue noted. Current treatment of [REDACTED]. No odor or signs or symptoms of infection noted. Progress Notes revealed the next wound documentation in the Nurses Note dated 02/29/16 at 10:13 a.m. Wound Note: Stage IV with measurements of 6.0 x 3.0 x 1.5 with beefy red granulating tissue noted with some odor noted, but patient voices no complaint of pain or discomforts at this time. New order for evaluation at JMS wound center on 03/01/16. Review of Weekly Skin Reviews for R #84 revealed a Weekly Skin Review dated 01/27/16 (date R #84 was readmitted to the facility) and documents wound as: Open area, Pre-existing. Site: Sacrum. Description: admitted with open area. (Signed 02/12/16). No other evidence of Weekly Skin Reviews documented from 01/27/16 until 03/03/16. Weekly Skin Review dated 03/03/16 documents Open Area, Site: Sacrum, Description ongoing treatment by wound nurse. No wound description or wound measurements documented. Interview on 08/03/16 at 4:20 p.m. with the Treatment Nurses LPN UU and LPN CC revealed the primary nurse is responsible for doing the weekly skin assessments and if the Primary Nurse finds a problem (like red excoriated skin) then they are supposed to let the treatment nurses know. Interview on 08/05/16 at 8:42 a.m. with the Director of Nursing Services (DNS) revealed that if a resident is experiencing signs and symptoms of wound infection such as nasty drainage, redness, fever, or odor then she expected the nurse to call the Physician and let him know so the Physician can either come in and assess the resident or write an order for [REDACTED]. Wound care nurses are also responsible for changing the first dressing for new residents or readmitted residents. The DNS stated she expects, and it is the policy, for wounds to be assessed and documented at least one (1) time a week and that includes description of the wounds and measurements of the wounds. The DNS stated if an assessment, such as check for pressure relieving measures, are listed on the TAR then she expects each shift to assess for those pressure relieving measures and to document that on the TAR. The DNS went on to say that they were having trouble documenting wounds in the User Defined assessmnet (UDA) from 12/17/15 until 06/13/16 because it was too difficult to use and had a lot of glitches. The DNS stated without the UDA documenting the wound care was not as consistent but even with the UDA the wound care work load was too heavy. The DNS stated she begged the previous Administrator, on at least three different times, to cut back on the wound care admissions but that she never reached out to anyone above the Administrator. The DNS stated that the wound care nurse LPN UU also came in and talked to the previous Administrator about the wound care workload. Review of the TAR for R #84 revealed that wound care orders for sacrum: Dakin's Solution 0.25% Apply to Sacrum topically every day shift for Stage IV cleanse sacrum with warm soap water, pat dry and pack with moistened soaked gauze cover with dry dressing and secure with tape. (Order start date 01/28/16. Order discontinue date 05/16/16). Review of the documented wound care on the TARs for January 2016 through May 2016 revealed no documentation that wound care was provided for the sacral wound for the following dates: 01/31/16, 02/15/16, 03/09/16, 03/15/16, 03/17/16, 04/09/16, 04/10/16, 04/12/16, 04/30/16, 05/04/16. Review of the TAR revealed wound care orders for the right foot, 2nd and 3rd digits as: Cleanse right foot 2nd and 3rd digit with warm soap and water, pat dry and apply Mepiliex AG every 72 hours for Deep Tissue Injury (DTI) to the 3rd toe and unstageable to the 2nd digit. (Order start date: 01/28/16. Order discontinue date: 04/13/16). Review of the documented wound care on the TARs for January through April 2016 revealed no documentation that wound care was provided for the right foot 2nd and 3rd digits for the following dates: 01/31/16, 02/06/16, 02/09/16, 02/12/16, 02/15/16, 02/18/16, 02/27/16, 03/01/16, 03/04/16,03/10/16, 03/13/16, 03/22/16, 03/25/16, 03/28/16, 03/31/16, 04/03/16, 04/06/16, 04/12/16. Further review of the TAR for R #84 revealed an order for [REDACTED]. Discontinued date 05/25/16). There is no documentation of the Pressure Relief Measures being assessed for being in place for the month of April. Review of the TAR for the month of May 2016 revealed no documentation of the Pressure Relief Measures being documented as being assessed to be in place for the following dates: On the Day shift: 05/04/16, 05/19/16; on the Evening shift: 05/03/16, 05/04/16, 05/05/16, 05/06/16, 05/08/16, 05/10/16, 05/11/16, 05/12/16, 05/13/16 05/14/16, 05/17/16, 05/18/16, 05/19/16, 05/21/16, 05/22/16, 05/23/16, and; On the Night: 05/03/16, 05/07/16, 05/12/16, 05/17/16, 05/21/16, and 05/22/16. Review of the TAR revealed Wound Care Order: Sacrum: wash with wound cleanser and dry. Spray barrier to per wound. Place puracyn soaked gauze to wound, cover with ABD. Place [MEDICATION NAME] to per wound and other
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 observation, record review, review of the facility Medication Administration-Preparation and General Guidelines policy and procedure, and staff interviews, the facility failed to administer an antibiotic medication in a timely manner for one (1) resident (#28) with a urinary tract infection [MEDICAL CONDITION]; failed to implement an order for [REDACTED]. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). Although staff identified that resident T exhibited pain during wound care, staff failed to evaluate the need for routinely scheduled pain medication prior to wound treatment. This failure resulted in harm for resident T who exhibited symptoms of pain during wound care on 8/2/16 and 8/3/16 and harm was identified for R #42, who was experiencing shortness of breath and staff had failed to administer an as needed medicine for this. Findings include: 1. Resident T was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the 05/31/16 Quarterly MDS assessment revealed that the resident had a Brief Interview for Mental Status (BIMS) score of six (6) indicating that the resident was cognitively impaired, had almost constant moderate pain, did not reject care and had one Stage III pressure sore and two unstageable pressure sores. Review of the the care plan for Resident T dated 12/12/15 revealed that the resident required pain management and monitoring related to his/her wounds with an intervention to evaluate the characteristics and frequency/pattern of pain and to evaluate the need for routinely scheduled medications rather than as needed (PRN) pain medications. Review of the vascular Physicians note dated 1/20/16 revealed that the resident had peripheral arterial occlusive disease with pressure and ischemic ulcerations of both feet. Continued review revealed that the left foot had dry gangrene. On 08/02/16 at 2:12 p.m. Licensed Practical Nurse (LPN) Treatment Nurse CC and Treatment Nurse UU provided treatments for the residents sacral and right foot wounds. The resident yelled when staff approached him to assist him with turning and repositioning in the bed. The resident refused to allow staff to assist him/her with turning to his/her side but managed to slowly turn himself/herself independently. The resident yelled out whenever staff touched his/her legs and when staff removed his/her pravalon boots. During the treatments to the sacrum and right foot the resident yelled Don 't hurt me Oh, Lord Jesus, help me. During the procedure, LPN Treatment Nurse UU held the hand of the resident and distracted the resident with conversation for brief periods only. However, the resident would continue to watch Treatment Nurse CC provide treatment to his/her right foot and begin yelling again. Treatment Nurse CC stated at that time that the resident had been pre-medicated with pain medication. As soon as the treatment was completed, the resident stopped yelling. Review of the medical record for resident T revealed a Physicians order dated 1/28/16 for [MEDICATION NAME] 200 milligrams (mgs.) every day for pain that was scheduled for 9:00 a.m. and an order dated 3/5/16 for [MEDICATION NAME] 50 mgs. every six (6) hours as needed (PRN) for pain. Review of the 8/2016 Medication Administration Record [REDACTED]. Continued review of the TAR revealed that the as needed (PRN) [MEDICATION NAME] was not administered until 11:17 p.m. that night. There was no indication that staff had pre-medicated the resident with the as needed [MEDICATION NAME] prior to treatment on 8/2/16. Interview with LPN Treatment Nurse CC on 8/3/16 at 12:05 p.m. revealed that resident T yelled out during every treatment, during care and sometimes even when staff just touched him/her. However, continued interview revealed that CC believed the resident felt pain during treatment and that she asked the charge nurse to administer the as needed pain medication to the resident prior to treatment. Further interview revealed that LPN Treatment Nurse UU had informed the charge nurse to pre-medicate the resident with as needed pain medication prior to the treatment performed on 8/2/16. However, interview with LPN Treatment Nurse UU on 8/3/16 at 12:30 p.m. revealed that she thought that LPN Treatment Nurse CC had notified the charge nurse to pre-medicate the resident with pain medication prior to treatment on 8/2/16. Continued interview with UU revealed that she had not notified the physician that the [MEDICATION NAME] was not managing the residents pain during treatment and that his/her pain management may need to be reevaluated. Interview with the Licensed Practical Nurse/Charge Nurse DDD on 8/3/16 at 12:25 p.m. revealed that resident T had pain during any positioning. Continued interview with DDD revealed that she had administered the [MEDICATION NAME] to the

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 13) resident on 8/2/16 at approximately 9:00 a.m. and the resident did not complain of pain after that time. Further interview revealed that she did not administer as needed [MEDICATION NAME] to the resident on 8/2/16. Continued interview with LPN/Charge Nurse DDD revealed that the LPN Treatment Nurse would notify her when a resident needed to be pre-medicated prior to treatment. Although staff stated that resident T yelled out in pain during wound treatments that were provided daily, review of the 7/2016 MAR indicated [REDACTED] On 8/3/16 at 6:00 p.m., LPN Treatment Nurses CC and UU provided treatment for [REDACTED]. Resident T yelled out when the nurses adjusted his/her gown. When the LPN Treatment Nurse CC obtained scissors to cut and remove the Kerlix from the residents left foot, the resident began to yell Don't cut me, don't cut me!. When LPN Treatment Nurse CC removed the gauze that covered the wounds, the resident said it hurts when you pull it. The LPN Treatment Nurse UU held the residents hand during the treatment and distracted the resident with conversation for brief periods only. Review of the 8/2016 MAR for resident T, revealed that staff had administered the [MEDICATION NAME] to the resident at 9:00 a.m. on 8/3/16. However, there was no indication that staff had administered the as needed [MEDICATION NAME] to the resident prior to treatment at 6:00 p.m., nine (9) hours later. Interview with the DNS on 8/5/16 at 8:00 a.m., revealed that the staff believed that routine pain medication would result in over-sedation for the resident. Continued interview revealed that the resident knew when she/he had pain and could request pain medication. Further interview revealed that the resident yelled out when staff got too close to him/her and he/she thought staff would touch him/her. Continued interview revealed that the DNS believed that the resident did have pain during wound treatment and that staff should have administered the as needed pain medication prior to treatment. Interview with Corporate Medical Director III on 8/5/16 at 1:40 p.m. revealed that they assessed the resident on 8/4/16 as having eleven (11) wounds. Continued interview with III revealed that all wounds on the bilateral feet were arterial wounds except for the bilateral heels which were arterial with a pressure sore component. Further interview revealed that arterial wounds were painful. Review of the facility's Pain Assessment and Management Policy revealed that pain was an unpleasant sensory and emotional experience that could be acute, recurrent or persistent. Different types of pain included Incident Pain which was pain that was predictable and related to a precipitating event such as movement or certain actions, i.e., wound care. Continued review of the policy revealed that the facility would promptly assess the pain level and provide relief of symptoms whenever feasible, using a resident-centered and interdisciplinary approach. Residents would be assessed for pain based on their exhibiting symptoms of pain and pharmacological and non-pharmacological interventions would be initiated. Although the staff identified that resident T exhibited pain during wound care, staff failed to evaluate the need for routinely scheduled pain medication prior to wound treatment as care planned. This failure resulted in harm for resident T who experienced pain during wound care on 8/2/16 and 8/3/16. 2. Review of the clinical record for R #28 revealed she was admitted to the facility on [DATE]. Review of the care plan for Infection- Actual or at Risk For Related to: UTI, developed on 07/27/16, revealed that the resident was at risk for UTIs, and included an intervention to administer the antibiotic as ordered. Review of a urinalysis (UA) and Culture and Sensitivity (C&S) report dated 07/17/16 revealed a positive culture for [MEDICATION NAME] Resistant [MEDICATION NAME] (VRE). Review of a Physician order for [REDACTED]. Review of the July 2016 Medication Administration Record [REDACTED]. Further review of the July MAR indicated [REDACTED]. Review of the policy titled Medication Administration-Preparation and General Guidelines dated 06/15 included the following: If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter does of antibiotic is needed), the space provided on the front of the Medication Administration Record [REDACTED]. An explanatory note is entered on the reverse side of the record. If vital medication is withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. Interview on 07/27/16 at 3:10 p.m. with Registered Nurse (RN) WW revealed she was working on the evening of 07/18/16 and noticed a faxed physicians order for [MEDICATION NAME] 50 mg QID for R #28. RN WW further stated that she transcribed the order to the July MAR, and forwarded the order to the pharmacy in the early morning of 07/19/16. RN WW further stated she never looked in the Automatic Dispensing Unit (ADU) for the medication so that she could administer the first dose, and that she was not aware of the facility policy. Interview on 07/28/16 at 1:22 p.m. with the Hospice RN Case Manager XX revealed that R #28 was treated for [REDACTED]. She further stated that the antibiotic medication should have been started as soon as possible. Interview on 07/30/16 at 11:55 a.m. with the Director of Nursing Services (DNS) revealed the nurses were expected to remove the first dose of an antibiotic from the ADU. She further stated that If the antibiotic ordered by the physician was not available, the nurses were expected to call the pharmacy to obtain the first dose. The DNS further stated that the physician was never notified that the antibiotic for R #28 was not administered until two days after it was prescribed. 3. Record review for R #42 revealed a re-admission to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Further clinical record review revealed that they were admitted to hospice services on 04/20/16. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) summary score of three (3), indicating severe cognitive impairment. Observation of R #42 on 08/03/16 at 10:45 a.m. with a Hospice Registered Nurse (RN) revealed that the resident was short of breath and had audible wheezing. Interview with the Hospice RN at this time revealed that R #42 had an order for [REDACTED].#42 continued to appear to be in distress as evidenced by shortness of breath with audible wheezing, and the resident was unable to verbally communicate her needs. Record review for R #42 revealed a Physician Order from the Hospice provider dated 06/01/16 for [MEDICATION NAME] 20 milligram (mg) per 1 milliliter (mL), give 0.5 mL to 1 mL by mouth every one hour for pain and/or dyspnea. Review of the faxed date on the order form revealed that it was sent on 06/02/16, and was located in the Physician Order section of the chart. However, review of the Medication Administration Record [REDACTED]. Interview on 08/03/16 at 12:00 p.m. with the East Wing RN Unit Manager revealed that she was not aware that the pain medication ([MEDICATION NAME]) for R #42 had not been transcribed on the MAR. During further interview, she was not able to explain why the medication was not faxed to the pharmacy so that the medication could be filled, nor why it hadn't been transcribed to the resident MAR. Observation on 08/03/16 at 1:00 p.m. revealed LPN QQQ administering a medication to R #42 with an oral syringe. During interview with LPN QQQ at this time, she stated that she was administering the [MEDICATION NAME]. Observation on 08/03/16 at 3:00 p.m. revealed R #42 sleeping with no shortness of breath noted. 4. Review of the clinical record for R #32 revealed that she was admitted to the facility on [DATE]. During observation on 08/02/16 at 2:05 p.m., R #32 was noted to have bilateral shoulder, arm, hand and knee contractures, and she was tilted to left side with her legs contracted to the right. During further observation, her fingernails were observed to be long and uneven, with jagged edges, and she was observed scratching her skin. Further observation at this time revealed that she had approximately twenty-five to thirty shallow linear-shaped open areas of skin on her right thigh, which extended up to eight inches in length. During interview with Licensed Practical Nurse (LPN) EE at this time, she stated that the resident had always scratched her skin since admission more than ten years ago, and that the areas of skin affected differed according to whatever area the resident was able to access. She further stated that R #32 had scratched their stomach, right thigh, and chest at different times. LPN EE further stated that when the scratching got bad, the resident was administered anti-[MEDICATION NAME] medications. Review of the care plans for R #32 dated 04/21/16 revealed that care plans had not been for scratching and/or allergies [REDACTED]. During interview with the Director of Nursing Services (DNS) on 08/02/16 at 2:45 p.m., she stated that the scratched areas on right thigh of R #32 should have been noted on a weekly skin assessment, and reported on an SBAR (Situation-Background-Assessment-Recommendation). Review of Weekly Skin Assessments from 05/12/16 through 07/27/16 (eleven weeks total), revealed no evidence of any skin problems. During interview with Certified Nursing Assistant (CNA) OO on 08/03/16 at 12:48 p.m., she stated that R #32 would scratch their skin anytime that it was exposed, and that any scratches or skin changes should be reported to the charge nurse. Review of Physician Orders and the Medication Administration Record [REDACTED].

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 14) Review of the facility policy Skin Integrity Guideline revealed that Patient/Resident will be evaluated/observed for risk of skin breakdown and existing areas including but not limited to bruising, skin tears, wounds, abrasions, arterial and venous wounds and pressure ulcers within twenty-four (24) hours of admission, quarterly, and with decline in condition.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interview, the facility failed to provide oral care, showers for three (3) residents (S, O, and R) residentsthe sampled fifty-one (51) residents, the census was one-hundred and one (101). Findings include: 1. Review of the clinical record for resident O revealed that they had [DIAGNOSES REDACTED]. Review of their Annual Minimum Data Set (MDS) assessment dated [DATE] revealed that they had no cognitive impairment, needed extensive assistance for personal hygiene, and had impairment on one side of the upper and lower extremities. Review of the resident's care plan for impaired neurological status related to [MEDICAL CONDITION] (stroke) and [MEDICAL CONDITION] included interventions to assist with activity's of daily living (ADL's) as needed, and monitor ADL's for assistance and render care as needed. Review of the physical functioning deficit related to self-care and mobility impairment care plan included an intervention for personal hygiene assistance. During interview with resident O on 07/26/16 at 10:01 a.m., he stated that staff didn't offer to clean their teeth at all, and that they needed assistance with this. Upon further interview, the resident stated that they would like to have their teeth brushed daily, and the last time they were brushed was months ago. During interview with resident O on 07/27/16 at 9:20 a.m., they stated they had still not received oral care today or yesterday. During interview with resident O on 07/27/16 at 1:49 p.m., the resident stated they had still not received oral care. During observation at this time, the resident was noted to be missing all but one upper tooth, and a small amount of tannish debris was observed on the lower front teeth at the gum line. During further observation and with the resident's permission, his room was checked for mouth care supplies, and an opened package of three toothbrushes was noted in a bag on a countertop, as well as an empty box of toothpaste. During interview with resident O on 07/28/16 at 10:28 a.m., they stated that they still had not received oral care, and whitish debris was observed along their bottom teeth. During further observation at this time the three toothbrushes appeared to be dry and in the same position in the bag, and no toothpaste was seen. During interview with resident O on 07/29/16 at 4:05 p.m., they stated that they had not received oral care since February, including the use of mouthwash, oral swabs, or having their teeth brushed. Observation at this time revealed whitish debris along their lower teeth at the gum line, and the three toothbrushes appeared to be in the same position in the bag. During interview with resident O on 07/30/16 at 8:04 a.m., he stated that they still had not received oral care, and tannish debris was noted along the bottom gum line. During further interview the resident stated that they had not yet eaten anything that day. During observation at this time a few foam swabs were seen in the bottom dresser drawer towards the back, and the resident stated they didn't care if a toothbrush or swab was used, just so long as oral care was done. During interview on 07/30/16 at 3:25 p.m., the resident stated they still had not received oral care, and tannish debris was noted along the bottom teeth at the gum line. During interview with Certified Nursing Assistant (CNA) MM on 07/30/16 at 3:30 p.m., she stated that she often took care of resident O, usually on the day shift, and that she brushed the resident's teeth once on the shift she worked. During observation in resident O's room at this time, CNA MM was not able to find any mouth care supplies in the resident's room. During interview with the Assistant Director of Nursing Services (ADNS) on 07/31/16 at 1:16 p.m., she stated that she was not sure what the facility policy said about mouth care, but thought that oral care should be done in the morning and in the evening, and as needed. During interview with the Director of Nursing Services (DNS) on 07/31/16 at 1:38 p.m., she stated that she would expect oral care be done once a day in the morning, every morning. Review of the facility's Oral Hygiene policy revealed that it did not include how often that oral care should be done. 2. Review of the Quarterly Minimum Data Set (MDS) assessment for resident S dated 4/20/16 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of twelve (12), indicating that he was cognitively intact, that he/she required extensive assistance from staff for personal hygiene which included oral care and that he/she had carious teeth. Review of the current care plan revealed that the resident had a physical functioning deficit with an intervention for staff to assist with oral care every morning and as needed. Interview with resident S on 7/26/2016 at 9:50 a.m. revealed that he had not brushed his/her teeth in over one month because he did not have a toothbrush or toothpaste. Continued interview revealed that he had requested a toothbrush and toothpaste but, staff had not provided them yet. The charge nurse was observed to bring in the resident's medication at that time which included mouthwash. The resident stated at that time that he needed a toothbrush and toothpaste and not this stuff. The charge nurse asked the resident if he wanted a toothbrush and toothpaste and the resident after using the mouthwash, responded I don't need them now. Interview with resident S on 7/27/16 at 3:30 p.m., revealed that staff still had not provided him/her with a toothbrush or toothpaste that morning. S stated at that time that he could brush his/her teeth if staff would provide him the supplies. The resident gave permission to assess his dresser. There was one small travel size toothpaste that was unopened in the drawer. There was no toothbrush. There were no oral care supplies in the bathroom. Interview on 7/29/16 9:10 a.m. with S revealed that staff had provided him/her with oral care supplies. However, observation of the drawer revealed a large tube of unopened toothpaste and a toothbrush in its unopened wrapper. Interview with Licensed Practical Nurse (LPN) CC on 7/29/16 at 9:40 a.m., revealed that she/he assessed residents on his/her rounds to ensure that care had been provided. Interview with the DON on 7/29/16 at 2:30 p.m. revealed that the charge nurses were responsible for ensuring that residents received oral care as care planned. Interview with Certified Nursing Assistant (CNA) EEE on 7/29/16 at 2:45 p.m. revealed that resident S did not refuse care. Continued interview with EEE revealed that she did not set up oral care supplies for the resident or brush his/her teeth. EEE stated that the resident had some food in his/her mouth after lunch and that she/he had swabbed out the food debris from the resident's mouth with a [MEDICATION NAME] swab. Interview with the resident S on 7/29/16 at 5:20 p.m. that staff did not set up supplies for him/her to brush his/her teeth that day. S denied that staff used swabs or anything else to clean his/her mouth. Observation of the resident's drawer at that time revealed the unopened toothpaste and the toothbrush in its unopened wrapper. Interview with Unit Manager HH on 8/5/16 at 10:20 a.m., revealed that there was no reason for staff to use swabs to clean the resident's mouth and that S should be able to brush his/her own teeth. Staff failed to assist resident S with oral care as care planned by setting up oral care supplies for resident S who was capable of brushing his/her own teeth. 3. Review of the Annual MDS assessment for resident R dated 7/7/16 revealed that the resident had a BIMS score of 13, indicating that he was alert and oriented, and cognitively intact and that he was totally dependent on staff for bathing. Review of the resident's care plan dated 7/11/16 revealed that the resident had a physical functioning deficit with an intervention for staff to assist with personal hygiene. Interview with resident R on 7/26/16 at 2:23 p.m. revealed that staff were supposed to shower him/her two times a week but, he had not received a shower in three weeks. Continued interview revealed that he preferred showers instead of bed baths. Review of the Activities of Daily Living (ADLs) printout revealed that the last time the resident received a shower was on 6/13/16 on the 7:00 a.m. to 3:00 p.m. shift. Staff had documented that the resident was provided a full bed bath on 6/16/16, 6/22/16, 7/8/16, 7/18/16 and partial baths the other days.

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 15) Interview with Certified Nursing Assistant (CNA) FFF on 7/28/16 at 1:55 p.m. revealed that the resident did not refuse showers and was supposed to receive showers every Monday and Friday. Interview with Treatment Nurse CC on 7/29/16 at 9:25 a.m. revealed that the resident had pressure sores on both feet but, he could receive showers as scheduled. Continued interview revealed that CC was not aware that the resident was not receiving his/her showers. Interview with Licensed Practical Nurse (LPN) CCC on 7/29/16 at 9:40 a.m. revealed that she/he reviewed the electronic tracker to see if residents were receiving showers/baths. Continued interview revealed that she/he also assessed the residents visually to ensure they were clean and without odors. Interview with Unit Manager HH on 7/29/16 at 10:00 a.m. revealed that the resident's original shower days were on Monday and Thursday on the 7:00 a.m. to 3:00 p.m. shift Continued interview revealed that a CNA notified him/her 2-3 weeks ago that the resident complained he missed his shower on Thursday because of [MEDICAL TREATMENT]. Further interview revealed that the resident's shower days were changed to Monday and Friday at that time. Continued interview revealed that HH was not aware that the resident had not received a shower since 6/13/16. Further interview revealed that the charge nurses were responsible for ensuring that the residents received their showers as scheduled.
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 observation, record review, review of the facility's policy and procedures for pressure sore management, review of the facility's Wound Evaluation Flow Sheet, and resident and staff interview, it was determined that the facility failed to have an effective pressure sore recognition and management program as evidenced by failure to perform consistent weekly skin assessments for residents at risk for skin breakdown (N); failure to identify pressure sores on admission and readmission in order to notify the physician and initiate treatment timely (N); failure to obtain treatment timely for identified pressure sores (T, R); failure to perform treatments as ordered by the physician to facilitate wound healing (N, T, R, R #84, R #24, R #50, R #64, R #120, R #180); failure to provide treatment with the correct wound care supplies as ordered by the physician (R); failure to provide consistent weekly assessment of pressure sores to include accurate staging, measurements and thorough description of the wounds in order to determine progression or deterioration of the pressure sores (T, R, R #84); failure to remove a resident's multipodus boots which were thought to contribute to breakdown (R); and failure to implement interventions to prevent the recurrence of pressure sores (T) and/or deterioration of pressure sores (R) for nine (9) (R, T, N, R #180, R #50, R #24, R #120, R #84 and R #64) of eleven (11) residents reviewed for pressure sores from a sample of fifty-one (51) residents, the census was one-hundred and one (101). A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On [DATE] at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of [DATE] related to R #170, who was assessed during admission on [DATE] to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on [DATE], and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on [DATE] at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On [DATE] at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On [DATE] at 10:46 a.m. the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on [DATE] at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on [DATE] that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On [DATE] at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on [DATE] related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on [DATE] and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on [DATE] revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Resident N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on [DATE] at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on [DATE] and remains on-going. The facility's failure to report and obtain orders for wounds present on admission and readmission to the facility for resident N delayed treatment and the wounds deteriorated, and the resident developed septic shock. In addition, the facility failed to implement interventions to prevent the recurrence of a sacral wound for resident T, and did not implement treatment to the wound in a timely manner for the resident, and the Stage II pressure sore deteriorated to a Stage III pressure sore with yellow-green wound bed. In addition, the facility's failure to provide treatments as ordered possibly contributed to the deterioration of a wound for resident R per wound clinic staff interview. Findings include: Review of the facility's Wound Evaluation Flow Sheet revealed that assessments of pressure sores should include measurements, description of the wound bed and periwound, and presence or absence of exudate. Pressure sores should also be staged according to the following criteria: Suspected Deep Tissue Injury- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlining soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage I- Intact skin with non-blanchable redness to a localized area usually over a bony prominence. Stage II- 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 serum-filled blister. Stage III- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV- 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. Unstageable- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Review of the facility's Skin Integrity Guideline included the following: Purpose: To provide a comprehensive approach for monitoring skin conditions. To decrease pressure ulcer and/or wound formation by identifying those residents who are at risk, and implementing appropriate interventions. To promote healing of wounds of any etiology, whether admitted or acquired. General Guideline: Residents will be assessed or observed for risk of skin breakdown within 24 hours of admission or readmission, quarterly, before transfer or discharge to any setting (unless emergent nature), and as necessitated by change in condition. Living Center develops a routine schedule to review residents with wounds or at risk on a weekly basis and will document findings. DNS or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis. The interdisciplinary plan of care will address problems, goals and interventions

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	115291	A. BUILDING _____ B. WING _____	08/05/2016

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.

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) directed toward prevention of pressure ulcers and/or skin integrity concerns identified. Documentation and Care Interventions for Skin Integrity: 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. Documentation of Weekly Skin Evaluation/Observations: Licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review User Defined Assessment (UDA). Licensed nurse to document weekly on identified wounds using the Wound Evaluation Flow Sheet (WEFS) UDA (one UDA per wound identified). Each LivingCenter must create a manual tracking system to monitor completion of weekly WEFS since this UDA cannot be scheduled. Care plan is to be implemented, evaluated and revised based on the needs of the resident. Monitoring Compliance: Wound Evaluation Flow Sheet UDA is accurately and thoroughly completed for wounds. Visual observation that physical interventions are in place. Weekly Skin Review UDA's are in place. DNS or designee evaluates/observes wounds on a weekly basis. 1. Resident N (a closed record review) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Clinical Health Status Admission assessment dated [DATE] revealed that the resident did not have any skin breakdown. However, staff documented a late entry note dated [DATE] on the [DATE] Clinical Health Status Admission Assessment that the resident was admitted with redness on his/her sacrum and bilateral fluid filled blisters on his/her bilateral heels. However, staff failed to stage and measure the wounds and failed to indicate if the sacral redness was blanchable or non-blanchable. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for resident N revealed that the resident was severely cognitively impaired, had no behaviors, required extensive assistance from staff for activities of daily living (ADLS), was always incontinent of bowel and bladder, had two (2) Stage II pressure sores with [MEDICATION NAME] tissue that were identified on [DATE] and was at high risk for the development of additional pressure sores. Review of the thirty (30) day Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident occasionally rejected care. Although resident N was admitted with redness on his sacrum and bilateral heel blisters, staff failed to develop interventions on the interim care plan to address the actual pressure sores or the prevention of additional pressure sores. Review of the comprehensive care plan dated [DATE] revealed that the resident had actual pressure sores and was at risk for the development of additional pressure sores with interventions for staff to conduct weekly skin inspections, to perform weekly wound assessments and to provide treatments as ordered. However, there was no indication that staff performed weekly skin assessments as care planned from his/her admission on [DATE] to his/her final discharge to the hospital on [DATE]. Review of the General Note dated [DATE] revealed for resident N was again assessed on [DATE] with intact bilateral heel blisters and a red sacrum without any open areas. Staff documented that Prevalon boots had been placed on the bilateral feet. However, there was no indication that the pressure sores on the bilateral heels or sacrum were staged or measured on the [DATE] admission or on the [DATE] assessment. Review of the ,[DATE] Treatment Administration Record (TAR) for resident N revealed that although the resident was assessed on admission with pressure sores on the bilateral heels, there was no indication that staff had notified the physician and obtained treatment for [REDACTED]. On [DATE], staff obtained an order to apply Cavalon spray and then [MEDICATION NAME] AG to the bilateral heel wounds every three days. However, staff failed to provide treatment to the heels on [DATE] for resident N and did not provide treatment until three (3) days later on [DATE], nine (9) days after the resident was admitted . Furthermore there was no indication that staff notified the physician about the red sacral area in order to obtain and initiate treatment to prevent the reddened area on the sacrum from deteriorating. Review of the Skin Integrity Guideline revealed for resident N that Stage I non-blanchable reddened areas that present over a bony prominence (such as the sacrum) may require a thin [MEDICATION NAME] or Foam dressing to be changed per physician order. Review of the [DATE] Registered Dietician (RD) note for resident N revealed that Cal 90 cubic centimeters (ccs) twice a day and large meat portions at meals was initiated to address the underweight status and to promote wound healing. Review of the General Note/Wound Note dated [DATE] revealed that the resident had a Stage II intact fluid filled blister on his/her right heel that measured 8.0 x 7.3 x 0 centimeter (cm), a Stage II pressure sore on his/her left heel that measured 5.5 x 5.0 x 0 cm and a red sacrum with no open areas. However, staff failed to indicate if the Stage II on the left heel was an intact blister or an open wound and staff failed to stage and measure the persistent redness on the sacrum. Review of the Situation Background Assessment Review (SBAR) Change of Condition Note dated [DATE] for resident N revealed that the resident was sent to the hospital for chest pain and was diagnosed with [REDACTED]. Review of the Hospital Discharge Summary dated [DATE] revealed for resident N had a Stage I pressure sore on the right heel, an unstageable pressure sore on the left heel and a Stage I pressure sore on his sacrum at discharge from the hospital. Continued review of the Hospital Discharge Summary for resident N revealed that staff were supposed to apply [MEDICATION NAME] AG every three days and as needed to the wounds. Review of the Readmission Clinical Health Status assessment dated [DATE] for resident N revealed that staff failed to assess the resident with breakdown on his/her feet but, staff identified redness on his sacrum. Although the Hospital Discharge Summary indicated that [MEDICATION NAME] AG was to be applied to the pressure sores every three days, the order was not written. Review of the physician order [REDACTED]. However, there was no indication that staff notified the physician about the sacral wound in order to obtain and initiate treatment to prevent further deterioration of the wound. Review of the ,[DATE] Medication Administration Record [REDACTED]. However, there was no indication that treatment was provided to the sacral wound to prevent deterioration of the wound until [DATE] when the pressure sore had deteriorated and had necrotic tissue in the wound bed. There was no indication that staff had performed weekly pressure sore assessments after readmission as scheduled on [DATE] or [DATE] for resident N . Review of the Nutrition Note by the RD dated [DATE] revealed that the resident had increased needs related to wound healing as evidenced by a Stage II pressure sore on the bilateral heels and an Unstageable pressure sore on the sacrum per wound report. However, there was no indication that staff had staged and assessed the pressure sores prior to the RD's [DATE] note. Review of the General Note/Wound Note dated [DATE] revealed that the right heel wound measured 3.0 x 4.0 cm, the left heel wound measured 5.0 x 2.0 cm and the sacral wound measured 3.0 x 1.5 cm. However, staff failed to stage and describe the pressure sores to include a description of the wound bed, presence/absence of exudate and presence/absence of odor for resident N . Staff failed to perform weekly assessments of the pressure sores as scheduled on [DATE] until [DATE], two (2) weeks later. Review of the General Note/Wound Care Note dated [DATE] for resident N revealed that the sacral pressure sore had increased in size and measured 8.0 x 4.5 cm and had deteriorated as evidenced by necrotic tissue in the wound bed and greenish tissue on the edges of the wound. Continued review of the General Note/Wound Care Note dated [DATE] for resident N revealed that the resident had a Deep Tissue Injury (DTI) on the right heel that measured 5.0 x 6.5 x 0 cm and had black tissue in the wound bed and red wound edges; a DTI on the left heel that measured 4.5 x 5.0 cm and had black tissue in the wound bed; and a new DTI on the right great toe that measured 1.0 x 0.5 cm and a new DTI on the bottom of the right foot that measured 5.0 x 1.0 cm. Review of the ,[DATE] Medication Administration Record [REDACTED]. However, there was no indication that the bilateral heel wounds had healed at that time. Review of the physician orders [REDACTED]. However, review of the ,[DATE] TAR revealed that staff treated the left heel on [DATE]. There was no indication that staff clarified the orders with the physician for resident N . Review of the ,[DATE] TAR revealed that staff failed to obtain and provide treatments to the sacral pressure sore from [DATE] to [DATE]. Review of the ,[DATE] TAR revealed that staff applied a [MEDICATION NAME] dressing on the sacral wound on [DATE]. Review of the General Note dated [DATE] at 1:45 p.m. for resident N revealed that the resident was lethargic, had periods of apnea and had a low blood pressure. The resident was transferred to the hospital. Review of the Hospital Discharge Summary dated [DATE] for resident N revealed that the resident was admitted with a Stage IV sacral pressure sore that was malodorous and septic shock with blood cultures positive for Corynebacterium and bacteroides fragilis. Continued review of the Discharge Summary for resident N revealed that the resident was not a surgical candidate for debridement of the sacral wound because of the septic shock. Further review revealed that the resident did not respond to treatment and family placed the resident on Hospice services for comfort measures. Continued review revealed that the final hospital [DIAGNOSES REDACTED]. The resident expired [DATE]. The resident's Certificate of Death indicated that the immediate cause of death was septic shock and sacral decubitus. Interview with Licensed Practical Nurse (LPN) Treatment Nurse UU on [DATE] at 9:35 a.m. revealed that the charge nurses were

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 17) responsible for performing weekly skin assessments and that the treatment nurse and Director of Nursing Service (DNS) were responsible for obtaining weekly pressure sore assessments. Interview with the Assistant Director of Nursing Service (ADNS) on [DATE] at 2:37 p.m. revealed that the physician was not notified of the resident's sacral pressure sore so that treatment could be obtained and initiated timely to prevent deterioration of the wound. Interview with Treatment Nurse UU on [DATE] at 9:55 a.m. revealed that the resident's pressure sores were not consistently assessed weekly to include staging, measurements and descriptions because she was extremely busy during that time. Continued interview revealed that treatments may have been provided but, not documented. Further interview with UU revealed that when a resident was admitted or readmitted from the hospital, the treatment nurse assessed the resident and reviewed the Hospital Discharge Summary for orders. If there were no orders, then the treatment nurse notified the physician to obtain treatment orders. Staff failed to notify the physician about the sacral redness on the [DATE] admission for resident N and the [DATE] readmission in order to obtain and initiate treatment timely to prevent deterioration of the wound until [DATE] when the wound measured 8.0 x 4.5 cm and had necrotic tissue in the wound bed and red wound edges. This failure resulted in the resident's hospitalization on [DATE] and eventual death from septic shock secondary to the sacral decubitus on [DATE]. Staff failed to perform weekly skin assessments as care planned after the admission on [DATE] to his final discharge to the hospital on [DATE]. Staff failed to perform consistent weekly pressure sore assessments to include staging, measurements, description of the wound bed, and presence/absence of drainage and odor from admission on [DATE] to the resident's final discharge to the hospital on [DATE]. Staff failed to provide treatment as ordered to the bilateral heel wounds on [DATE] and from [DATE] to [DATE]. 2. Resident T was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the [DATE] Admission Minimum Data Set (MDS) assessment revealed that the resident T was admitted with one (1) Stage II pressure sore, was non-ambulatory, required extensive assistance from staff for bed mobility, was always incontinent of bowel and bladder, had occasional moderate pain and did not reject care. Review of the [DATE] Quarterly MDS assessment revealed that resident T now had one (1) Stage III pressure sore and two (2) unstageable pressure sores. Continued review of the [DATE] Quarterly MDS assessment revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 6 indicating that the resident was cognitively impaired, had almost constant moderate pain and did not reject care. Review of the care plan dated [DATE] for resident T revealed that the resident had an actual Stage II pressure sore on the sacrum and soft bilateral heels with non-blanchable redness on admission with an intervention for staff to provide treatments as ordered. Continued review of the resident's care plan for pressure sores revealed that she was at risk for developing additional pressure sores due to impaired mobility, incontinence and [DIAGNOSES REDACTED]. Review of the Wound Evaluation Flow Sheet dated [DATE] revealed that the resident T was admitted with a Stage II pressure sore on her sacrum that measured 0.5 x 0.5 x 0 cm with 75% epithelization and 25% granulation tissue and red, non-blanchable pressure sores on her bilateral heels. However, staff failed to stage and measure the bilateral heel pressure sores at that time. Review of the [DATE] Treatment Administration Record (TAR) revealed that staff failed to obtain treatment for [REDACTED]. Review of the [DATE] TAR for resident T revealed that staff applied Pravalon boots to the feet of resident T. A pressure reduction mattress was also applied to her bed. Vitamin C, Zinc, a multivitamin with minerals and 2 Cal 120 cubic centimeters (ccs) every day was initiated to promote wound healing. Review of the General Note dated [DATE] for resident T revealed that the right heel pressure sore had deteriorated to a deep tissue injury (DTI) that measured 4.0 x 4.0 x 0 cm. and the left heel pressure sore had deteriorated to a DTI that measured 1.5 x 3.8 x 0 cm. Review of the [DATE] and [DATE] TARs revealed that staff applied Cavalon spray to the pressure sores every day as ordered except for [DATE] and [DATE]. Review of the general Note dated [DATE] revealed that the Stage II sacral pressure sore measured 0.5 x 0.5 x 1 cm. with a dark pink wound bed. Review of the General Notes dated [DATE] to [DATE] for resident T revealed that the bilateral heel pressure sores were assessed weekly and continued to be DTIs. Review of the General Note dated [DATE] revealed that the left heel pressure sore was a Stage II that measured 3.0 x 4.0 x 0 cm. With a pink wound bed. The right heel pressure sore was a Stage II that measured 2.0 x 4.5 x 0 cm with a pink wound bed. The physician was notified of the change in the pressure sores at that time and ordered Silavadene to be applied every day. Review of the February 2016 TAR revealed that staff failed to perform treatment on [DATE]. Review of the General Note dated [DATE] for resident T revealed that the Stage II pressure sore on the sacrum had healed and that treatment was discontinued at that time. However, there was no indication that staff had initiated any other interventions to prevent the recurrence of a pressure sore on the sacrum after treatment was discontinued on [DATE]. Further review of the General Note dated [DATE] for resident T revealed that the pressure sore on the sacrum had reopened and was identified as a Stage II pressure sore that measured 1.0 x 1.0 x 0 cm. However, review of the [DATE] TAR for resident T revealed that staff had failed to obtain treatment for [REDACTED]. Review of the General Note dated [DATE] for resident T revealed that the resident had excoriation on her sacrum but, there was no documentation about the presence or absence of the Stage II pressure sore. Review of the [DATE] and February 2016 TARs for resident T revealed that staff failed to obtain treatment for [REDACTED]. Review of the SBAR note dated [DATE] (Late entry for [DATE]) for resident T revealed that the resident's sacral pressure sore had a yellowish-green wound bed with some pink tissue and had uneven borders. However, there was no staging or measurement of the pressure sore. Review of the February 2016 TAR for resident T revealed that staff failed to obtain treatment timely for the pressure sore on [DATE] when it was first identified until four days later on [DATE], when the physician ordered [MEDICATION NAME] to be applied to the pressure sore every day and to obtain a Wound Care consult. Review of the February 2016 TAR for resident T revealed that staff failed to perform treatment for [REDACTED]. Review of the General Note dated [DATE] revealed that the pressure sore on the sacrum had deteriorated, had 75% necrotic tissue in the wound bed and measured 4.0 x 3.0 x 0 cm. Staff incorrectly staged the pressure sore as a Stage II. Review of the Vascular Center office visit note dated [DATE] revealed that resident T had a Doppler study done which suggested ,[DATE]% stenosis of the distal superficial femoral arteries bilaterally. Continued review revealed that the resident was assessed as having [MEDICAL CONDITION] with pressure and ischemic ulcerations on both feet. Further review of the office note revealed that the resident was at high risk for amputation. Review of the care plan note revealed that staff had documented weekly on the bilateral heel pressure sores from [DATE] to [DATE] for resident T . Review of the care plan note dated [DATE] revealed that the left heel pressure sore was unstageable with eschar and measured 3.0 x 2.0 x 0 cm and the right heel pressure sore was unstageable with eschar and measured 5.0 x 4.0 x 0 cm. Review of the General Note dated [DATE] for resident T revealed that the sacral pressure sore measured 4.0 x 3.0 x 1.0 cm. with 25% necrotic tissue in the wound bed and tunneling noted at 10 o ' clock and 11 o ' clock. Staff incorrectly staged the pressure sore as a Stage II for resident T. Review of the [DATE] TAR revealed that staff continued to apply [MEDICATION NAME] to the wound every day until [DATE]. There was no subsequent documentation regarding tunneling of the pressure sore after [DATE]. Review of the General Notes dated [DATE] and [DATE] for resident T revealed that the sacral pressure sore had necrotic tissue and/or slough in the wound bed and now had odor. Staff incorrectly staged the sacral pressure sore as a Stage II. Staff continued to perform weekly pressure sore assessments for the bilateral heels that included measurements and staging. The bilateral feet pressure sores continued to be assessed as unstageable with hard eschar through [DATE]. Review of the General Note dated [DATE] revealed that resident T was assessed at the Wound Care clinic and returned with orders for staff to apply Santyl and Dakin's soaked gauze to the sacral pressure sore every day and apply Exalt/[MEDICATION NAME] to all wounds on the bilateral feet every three days. Review of the [DATE] and [DATE] TARs revealed that staff failed to provide the treatment every day as ordered for the sacral pressure sore on [DATE], [DATE], [DATE] and [DATE]. Staff failed to provide treatment as ordered every three days for the bilateral heels between [DATE] and [DATE] (8 days between treatments) and between [DATE] and [DATE] (23 days between treatments) for resident T . Review of the General Note dated [DATE] for resident T revealed that the sacral pressure sore measured 6.0 x 6.0 x 3.5 cm, had necrotic tissue, a foul odor and was now a Stage III pressure sore. Review of the General Note dated [DATE] (late entry for [DATE]) revealed that the sacral pressure sore had increased in size to 7.0 x 4.0 x 3.0 cm but, continued to be a Stage

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F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 18) III wound with 25% slough. Review of the General Note dated [DATE] (late entry for [DATE]) for resident T revealed that the pressure sores on the bilateral heels remained unchanged. Review of the General Note dated [DATE] revealed that resident T was assessed at the Wound Care clinic and treatment for [REDACTED]. However, review of the [DATE] and [DATE] TARs for resident T revealed that staff failed to perform treatment twice a day for the sacral pressure sore as ordered from [DATE] through [DATE] (6 consecutive days), on [DATE], from [DATE] through [DATE] (3 consecutive days), from [DATE] through [DATE] (6 consecutive days), from [DATE] through [DATE] (4 consecutive days) and on [DATE]. Continued review revealed that staff failed to perform any treatments at all to the sacral pressure sore on [DATE] and [DATE] for resident T . Review of the [DATE] and [DATE] TARs revealed that staff performed treatment as ordered to the feet wounds. Review of the care plan note dated [DATE] for resident T revealed that the sacral pressure sore was a Stage III and measured 5.5 x 4.5 x 2.5 cm., the left heel unstageable pressure sore measured 4.5 x 4.5 x 0 cm., and the right heel unstageable pressure sore measured 5.0 x 4.0 x 0 cm. However, staff failed to obtain weekly assessments of the sacral pressure sore and the bilateral heel pressure sores as scheduled on [DATE] and [DATE], almost three weeks between assessments. Review of the General Note dated [DATE] for resident T revealed that the resident was assessed at the Wound Care clinic on [DATE] and the Wound Care physician ordered a [DEVICE] assisted closure (VAC) to be applied to the sacral wound at a continuous suction of 125 mmHg to promote healing and for the sponge to be changed every Tuesday and Friday. On [DATE], the treatment order was changed to every Monday and Thursday for resident T . Review of the [DATE] and [DATE] TARs revealed that the t
F 0323 **Level of harm** - Immediate jeopardy **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 observation, record review, review of the facility's Elopement Guideline policy, and staff interview, the facility failed to implement preventive measures on admission and provide supervision to prevent an elopement for one (1) resident (R #170), who was identified on admission to be an elopement risk and eloped from the facility four (4) days after admission. In addition, the facility failed to conduct a thorough investigation to determine how R #170 exited the building. Five (5) residents were reviewed for wandering and/or elopement, and the sample size was fifty-one (51) residents, the census was one-hundred and one (101). A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On 07/29/16 at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of 07/15/16 related to R #170, who was assessed during admission on 07/15/16 to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on 07/19/16, and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on 7/28/16 at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On 7/28/16 at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On 7/30/16 at 10:46 a.m. the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on 08/02/16 at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on 08/05/16 that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. Findings include: 1. Review of the clinical record for R#170 revealed that they were admitted to the facility on [DATE]. Review of a General Note dated 07/22/16 at 2:33 p.m. indicated that the resident was admitted for rehab in order to progress back home, and that he had some cognitive loss problems and had a potential to wander. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed that the resident had severe cognitive impairment, wandering occurred one to three days which placed the resident at significant risk of getting to a potentially dangerous place, and significantly intruded on the privacy of activities of others. Review of a Clinical Health Status assessment dated [DATE] revealed that R #170 had short- and long-term memory problems, had a history of [REDACTED]. At the bottom of this Risk for Elopement section was that if Yes was marked for the first two items and any of the other items, to consider a prevention plan of care for elopement. Review of Immediate Plan of Care dated 07/15/16 for R#170 revealed that one had not been developed for Elopement as directed in the Risk for Elopement section of the Clinical Health Status form. An Immediate Plan of Care for At Risk for Falls dated 07/15/16 noted that the risk factor of Wandering was not selected. Review of computerized Progress notes revealed a SBAR (Situation-Background-Assessment-Response) Change of Condition entry completed by Licensed Practical Nurse (LPN) QQQ dated 07/20/16 at 12:02 a.m. that noted that R #170 was seen ambulating in the road off facility premises and was not injured upon assessment. Review of a Verification of Investigation report with a Date/Time of Occurrence of 07/19/16 at 6:30 p.m. that was completed by LPN QQQ noted that R #170 was found ambulating outside in the parking lot near the road. Further review of this form revealed that the resident had a history of [REDACTED]. Review of the Provide Summary and Outcome of Investigative Findings section of the form simply noted that the resident had a history of [REDACTED]. Further review of this form revealed that the section of Witnesses: Identify All That May Have Knowledge of Event Prior To, during or after Alleged Event, was left blank. Review of the comprehensive at risk for wandering care plan dated 07/19/16 revealed an intervention for a bed alarm. Review of a comprehensive care plan for risk for elopement related to attempts to leave Living Center and cognitive impairment dated 07/22/16 revealed an intervention to take picture of patient upon admission for identification for updating elopement book. Review of Physician order [REDACTED]. During interview with Certified Nursing Assistant II on 07/28/16 at 9:07 a.m., she stated that R #170 could walk and/or propel his wheelchair without assistance, and that they didn't have to do any special monitoring for him. During interview with LPN AA on 07/28/16 at 9:14 a.m., she stated that she had never known the resident to elope from the building before, but thought she heard that he tried to a while back. Upon further interview, she stated that she did not do any special monitoring for him, and that he would be allowed to go outside with staff or family supervision only. During observation and interview at this time, LPN AA verified that there was no bed alarm on his bed. During an observation on 07/28/16 at 9:03 a.m., no bed alarm was seen on the bed. During interview with LPN Unit Manager HH on 07/28/16 at 2:28 p.m., she stated that she was not there when R #170 eloped, but it was her understanding that he went out the back door at the end of the 200-hall. During further interview, she stated that if you pushed on the door long enough it would open, but then it would alarm. LPN HH further stated that is how the staff knew the resident got out, because the alarm was sounding, and that he was still in the parking lot when he was brought back in. During further interview she stated that the wanderguard bracelet was not placed on him until after he exited the building. LPN Unit Manager HH further stated that when a resident was identified as an elopement risk, they filled out the Elopement Risk Assessment Tool which was kept in a notebook at the nurse's station. Review of this form for R #170 dated 07/22/16 noted the following: He had not been identified as elopement risk on admission. Exhibited wandering in past 90 days. Wandered aimlessly about the facility, exhibited night wandering, increased confusion. Walks alone. The Space for resident's photo section on the Missing Person Report page of the Elopement Risk Assessment Tool was blank. This was verified by LPN HH, who stated that either she or the Assistant Director of Nursing Services (ADNS) initiated completion of these forms, and that there should have been a picture included for R #170. During interview with the DNS on 07/28/16 at 3:10 p.m., she stated that she thought she interviewed CNA RRR after the elopement of R#170, and was told the CNA saw the resident still in the facility parking lot as the CNA drove into the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 19) parking lot after a supper break. The DNS further stated that she did not know how the resident got out unwitnessed, and it was possibly through a side door in the resident lounge by the west wing nursing station. During further interview, the DNS stated that she also interviewed the nurse that was on duty the night the resident eloped (LPN QQQ). The DNS further stated that residents were assessed on admission for elopement risk on their Clinical Health Status form, and if found to be an elopement risk a wanderguard was placed at that time, the resident was care planned for elopement, and the resident's information was put in the elopement book. During further interview, the DNS verified that R #170 was assessed as having several factors putting him at risk for elopement, but that a wanderguard was not placed until after he eloped, and stated that it should have been applied once he was assessed as being high risk for elopement on admission. The DNS verified that there was no picture in the elopement book for R #170, and that there should have been. During further interview, the DNS stated that she was unaware of the documentation in the SBAR of R #170 being in the road off facility premises, and thought it may have been documented that way in error as the CNA told her she witnessed him in the facility's parking lot. During interview with the Maintenance Director on 07/28/16 beginning at 4:37 p.m., he stated the only exit doors not locked at all times were the Cafe door, the front entrance door; and the ambulance entrance/resident lounge door that was close to the west wing nurse's station. He further stated that these three doors locked down if a resident with a wanderguard approached one of them. During observation at this time, all exit doors were checked and functioned properly except the exit door at the end of the 100-hall, which opened when pushed on and did not alarm. This was verified during interview with the Maintenance Director, who stated that they checked the exit doors daily, and that it functioned properly yesterday. Review of Door Alarm Daily Logs for March 2016 through July 2016 revealed that the door alarms were checked daily except for Sundays, and the 100-hall exit door was initialed as checked on 07/28/16. During interview on 07/28/16 at 7:29 p.m., the Executive Director (ED), DNS, and Registered Nurse (RN) Field Services Clinical Director PPP were asked to provide documentation of how they would ensure that the exit door at the end of the 100-hall would be monitored to prevent an elopement until such time as it could be fixed, and the facility implemented continuous monitoring at this door and in services for staff about monitoring the 100-hall exit door, this was done until the door was fixed on 07/30/16 at 10:46 a.m. Review of the Door Alarm Daily Log noted that the exit doors were checked on 07/19/16 (the date of the elopement), with no concerns documented. During interview with the DNS on 07/28/16 at 3:10 p.m., she verified that there was no picture of R #170 in the elopement book, and that there should have been. During observation and interview with Certified Nursing Assistant (CNA) MM on 07/30/16 at 3:24 p.m., she verified that there was no bed alarm on the bed. During observation on 08/02/16 at 9:01 a.m., no alarm was seen on the bed. During interview on 07/28/16 at 7:03 p.m., the DNS stated that the nurse that did the admission assessment would be the one to apply a wanderguard for a resident assessed as an elopement risk, and she did not know why this was not done for R #170. During interview with LPN QQQ on 07/29/16 at 8:22 a.m., she stated that she was working evenings the day that R #170 left the building, but that she did not see how he got out, and assumed it was through the exit door at the end of the 200-hall as that was close to his room. She further stated that she never heard an alarm go off, and thought that it was another resident who had told her that there was a resident outside, so she went to investigate. LPN QQQ further stated that she found R #170 by a tree on the hospital campus across the road from the facility, and that he would have had to gone down the steep hill in front of the facility and crossed the two roads and median to get to where he was. She further stated that she and a CNA brought him back to the facility, that he was not injured, and that she applied a wanderguard as soon as she brought him back in. During further interview, LPN QQQ stated that whenever she did a new admission's assessment, if she noted that they were at risk for elopement, she would apply a wanderguard bracelet right away. During interview with CNA RRR on 07/29/16 at 9:03 a.m., she stated that the evening that R #170 got outside was the first time she had ever worked with him, and she was not told to do any special monitoring for him. She further stated that the resident must have gone out at the end of the 200-hall door, as that was the last area she saw him right before he was found outside, but that she did not hear an alarm go off. During further interview, she stated that a family member, whose room looked outside to the parking lot, told her that she saw a resident in pajamas outside in the parking lot. The CNA further stated that when she went outside, she found R #170 in the facility's parking lot, and pointed to a cluster of bushes at the end of an intersection of sidewalks coming both from the 200-hall exit door and the ambulance exit door. During interview with LPN QQQ on 07/29/16 at 9:37 a.m., she stated that she had no doubt where she found R #170, and that he was across the street on the hospital grounds, and that it was CNA RRR who helped her bring the resident back. During interview with RN Clinical Director PPP on 07/29/16 at 9:56 a.m., he stated that they were unable to determine which nurse admitted R #170, as more than one nurse documented on him that day and the Clinical Health Status form was not signed. Upon further interview, he stated that the Unit Manager reviewed the Clinical Health Assessments, and would have also been responsible for ensuring that a wanderguard bracelet been placed on R #170 when he was identified as an elopement risk. During interview and record review with LPN Unit Manager HH on 07/29/16 at 10:04 a.m., she stated that it was the facility's process for the unit manager to review the admission assessment to ensure that everything was completed, and verified her signature was on R #170's Clinical Health Status form. Upon further interview, she stated that she did not recall if she reviewed and/or completed any of the Risk for Elopement section on this form, and that because the resident was assessed as an elopement risk on this form, they should have immediately put a wanderguard bracelet on him. She further stated that she didn't know why this was not done, and that it would have been the responsibility of the admitting nurse or herself. During interview with the DNS on 07/29/16 at 11:02 a.m., she stated that the only investigation documented for R #170's elopement was on the Verification of Investigation form, which she said the nurse on duty completed at the time of the incident and that she then reviewed. The DNS verified that she had no documentation that she reviewed and/or conducted an investigation as to how R #170 eloped. During interview on 07/29/16 at 11:16 a.m., LPN QQQ verified that the documentation on the Verification of Investigation form was hers. During further interview she was asked to clarify her notation on this form of the resident ambulating outside in the parking lot near the road, and stated that he was across the road on the hospital grounds. She verified that the wanderguard was NOT in place until after the elopement. During interview with the RN Clinical Director PPP on 07/29/16 at 11:40 a.m., he stated that staff in services related to the elopement procedure were currently being conducted, and included in the in-service was that whoever identified a resident as being an elopement risk would be responsible for putting a wanderguard bracelet on him/her, and that this was where they went wrong with R #170. On 07/30/16 at 12:44 p.m., R #170 was asked if he could move his wheelchair by himself, and he demonstrated that he could easily self-propel the chair with his feet and without assistance. During observation on 07/30/16 at 3:24 p.m., no alarm was seen on R #170's bed. This was verified during interview with CNA MM at 3:30 p.m., who stated that she knew what a resident's care needs were by looking on the CNA Kardex. Review of R #170's CNA Kardex updated 07/30/16 revealed that he had a wanderguard and was an elopement risk, but did not reflect the comprehensive care plan intervention for a bed alarm. During observation on 08/02/16 at 9:01 a.m., no bed alarm was seen on the bed of R#170. During interview with RN Clinical Director PPP on 08/04/16 at 10:28 a.m., he stated that the DNS and/or charge nurse were supposed to update the CNA's Kardex with any changes. Review of facility's Elopement Guideline included the following: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision. Upon admission, each resident is reviewed to establish elopement risk using the Clinical Health Status form, and are assessed quarterly and as needed. A specific system has been developed to notify staff that an external door has been opened in an area accessible to residents. Door alarms are tested daily, results are recorded on designated log. The charge nurse or designee shall test resident personal alarms/devices according to the manufacturer's recommendation. Documentation should include: Admission assessment, which may indicate potential to wander or exit living center. Care plan that addresses potential to wander or exit living center and measures taken to prevent wandering/elopement. All attempts to elope, efforts to locate, notification and results of efforts. Bracelet alarm/device is in place and functioning. The ED (Executive Director) shall notify the State agency as necessary by state requirement, family and responsible party. All elopement events will be reviewed, analyzed and summarized by the QAPI (Quality Assurance Performance Improvement) Committee to ensure the appropriate process improvement actions have been taken.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 20) All residents identified at risk have a picture in the elopement book. Care plan for elopement in place and interventions individualized and implemented per physical observation. Staff able to verbalize knowledge of elopement procedure. Door alarms are checked and documented in Building Engines. Alarm bracelet function is checked daily and documented.
F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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 record review and staff interviews, the facility failed to provide sufficient nursing staff to provide the services necessary to ensure that residents with pressure ulcers received timely treatments and/or treatments as per physician orders [REDACTED].#84, R #24, R #50, R #64, R #120, R #180); failed to provide sufficient staff to supervise one (1) resident (R#170) that the facility identified as at risk for elopement, and who eloped four (4) days after admission. In addition, the facility failed to provide sufficient nursing staff to ensure that residents received timely assistance with activities of daily living (ADL) care for ten unstamped residents, and for nine (9) residents (R#73, R#89, R#93, R#35, R#38, R#113, R#172, R#199, R#50) who voiced grievances about care and services. The sample size was fifty-one (51) residents, and the census was one-hundred and one (101). A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On 07/29/16 at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of 07/15/16 was related to R #170, who was assessed during admission on 07/15/16 to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on 07/19/16, and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on 7/28/16 at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On 7/28/16 at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On 7/30/16 at 10:46 a.m. the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on 08/02/16 at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on 08/05/16 that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On 08/03/16 at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on 4/6/16 related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on 5/27/16 and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on 6/1/16 revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on 08/04/16 at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on 4/6/16 and remains on-going. Findings include: 1. During interview with Licensed Practical Nurse (LPN) Treatment Nurse UU on 08/01/16 at 1:28 p.m., she stated that there was a transition period when she was the only treatment nurse in the facility for about six (6) weeks. She stated that she was doing the best that she could to manage the wounds, but that she was the only one and some things may have fallen between the cracks. She stated that the previous Executive Director (ED) was aware that they were down to one treatment nurse, and during this transition time interviews were being conducted for a new treatment nurse to help with treatments. During further interview with Treatment Nurse UU at this time, she stated that she started as a treatment nurse in January of 2016. During interview with the DNS on 07/30/16 at 4:00 p.m., she stated that if a treatment nurse was not available, the charge nurses assigned to that resident were responsible for doing their own dressing changes. During interview with the DNS on 08/04/16 at 10:54 a.m., she stated that a previous treatment nurse told the (previous) ED that she was having a hard time keeping up with all of the treatments, but didn't remember exactly when this was. Upon further interview, the DNS stated that she had told the (previous) ED not to admit so many residents with wounds as there was only one treatment nurse, but she didn't remember the exact date when this was. The DNS further stated that LPN Treatment Nurse UU had expressed her concerns to the previous ED a couple times that she was having trouble keeping up with all of the treatments, too. During interview with LPN Treatment Nurse UU on 08/05/16 at 8:12 a.m., she stated that starting on 05/07/16, she was the only treatment nurse in the facility except for the previous treatment nurse who had begun working prn (as needed), mostly on the weekends. She further stated that the other current LPN Treatment Nurse CC started working at the facility the second week in June, but did not actually start to assist her with treatments until the week after that. LPN UU stated that she did wounds by herself for about six (6) weeks, with only occasional assistance from a nurse, if there was an extra one, who would help turn and position the resident during wound care. LPN UU further stated that she did not know why there was so many blanks on the Treatment Administration Records (TAR) for wound care. During interview with LPN UU on 08/05/16 at 10:54 a.m., she stated that she told the previous ED the second week that she was by herself that she was having a hard time keeping up with the treatments. She added that when she would tell the ED or DNS that she was having a hard time with keeping up, they would say we're working on it. Review of the facility treatment nurses' time-clock records revealed that for the 61 days in May and June, there was only one treatment nurse scheduled for 43 of these days. During interview with the ED on 08/05/16 at 12:04 p.m., she stated that she did not know why there was a lot of problems with pressure ulcers, but in her opinion it was because there had been such a large amount of turnover in clinical staff. Nine residents N, T, R, R #84, R #24, R #50, R #64, R #120, R #180, did not have treatments completed per the physicians order, staged, sized or measure to monitor the progress or lack of progress, preventive pressure devices implemented, care plans initiated, implemented and/or revised. Cross-refer to F 157, F 224, F 281, F 282, F 314, F 490, F 520. 2. Review of the clinical record for R#170 revealed that they were admitted to the facility on [DATE]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] noted that the resident had severe cognitive impairment, wandering occurred one to three days which placed the resident at significant risk of getting to a potentially dangerous place, and significantly intruded on the privacy of activities of others. Review of a Clinical Health Status assessment dated [DATE] noted that the resident had a history of [REDACTED]. Review of R #170's Immediate Plans of Care dated 07/15/16 revealed that one had not been developed for elopement. Review of computerized Progress Notes revealed a Situation-Background-Assessment-Response (SBAR) Change of Condition entry dated 07/20/16 at 12:02 a.m. that noted that R #170 was seen ambulating in the road off facility premises and was not injured upon assessment. During interview with LPN Unit Manager HH on 07/28/16 at 2:28 p.m., she stated that she was not there when R #170 eloped, but it was her understanding that he went out the back door at the end of the 200-hall. During interview with the DNS on 07/28/16 at 3:10 p.m., she stated that she did not know how the resident got out

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F 0353 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 21) unwitnessed, and it was possibly through a side door in the resident lounge by the west wing nursing station. During interview on 07/28/16 at 7:03 p.m., the DNS stated that the nurse that did the admission assessment would be the one to apply a wanderguard for a resident assessed as an elopement risk, and she did not know why this was not done for R #170. During interview with LPN QQQ on 07/29/16 at 8:22 a.m., she stated that she was working evenings the day that R #170 left the building, but that she did not see how he got out, and assumed it was through the exit door at the end of the 200-hall as that was close to his room. She further stated that she never heard an alarm go off. During interview with Certified Nursing Assistant (CNA) RRR on 07/29/16 at 9:03 a.m., she stated that the evening that R #170 got outside was the first time she had ever worked with him, and she was not told to do any special monitoring for him. She further stated that the resident must have gone out at the end of the 200-hall door, as that was the last area she saw him right before he was found outside, but that she did not hear an alarm go off. Further interview with both LPN QQQ and CNA RRR revealed that it was a visitor who told them that a resident had gotten outside. Cross-refer to F 323. 3. Review of the facility Grievance Tracking Log from February 2016 through July of 2016 revealed the following concerns related to assistance with Activities of Daily Living (ADL) care: On 02/02/16: R #73 stated that an unsampled resident was not being assisted to eat as the resident was blind, and R #73 had to feed him. On 03/13/16: A family member notified a nurse that an unsampled resident needed to go to the restroom, the nurse went to tell a CNA, the family waited over ten (10) minutes and took the resident to the restroom herself, and the resident urinated all over the bathroom. On 03/13/16: R #89 stated she was told she wouldn't be getting up that day because they were short-staffed that evening and it would be hard to put her back to bed. On 03/14/16: Family member of an unsampled resident voiced the resident had on the same clothes for six (6) days, and had not had a bath. On 03/22/16: A family member of an unsampled resident stated she asked a CNA how often they changed the resident, and was told when I have time, whenever we have time, but the CNA was seen sitting down eating popcorn. On 03/25/16: A family member of R #93 voiced that when she visited on the 3:00 p.m. to 11:00 p.m. shift, the resident was not clean and she had to shower her herself. On 03/26/16: An unsampled resident stated he had requested assistance with care over one (1) hour ago, staff informed him she would return but never did. On 04/02/16: An unsampled resident stated that she put her call light on around 3:30 a.m. on Saturday to request a pain pill, but did not get it until 6:00 a.m. She stated that she had told two (2) CNAs. Review of the facility response was that the CNA was unaware that she had been assigned to this resident, as no assignment had been made. On 04/04/16: An unsampled resident voiced she had to wait a long time for assistance on the 11:00 p.m. to 7:00 a.m. shift, and that on 04/03/16 a CNA had left her wet and never came in to change her. On 04/07/16: An unsampled resident said that a CNA on 04/06/16 told him to get up and get water himself, and didn't want to assist him with his bath. On 04/07/16: An unsampled resident said she had her call light on last evening for over two (2) hours, and when the CNA came they told her that they had other residents to help too and that's what took them so long. On 04/13/16: A family member of an unsampled resident stated that every Sunday afternoon when they visited, the resident was very wet and needed changing. On 04/16/16: A family member of R #35 stated the resident was not getting his showers twice a week, and his scalp had dried dandruff and she had to wash his face when she visited. On 04/21/16: R #50 stated that she had to wait hours for assistance, and could not get taken care of. On 04/22/16: A family member of R #138 stated that the resident was soaked with urine as well as the bed sheets, and that the resident's breakfast tray was left unattended so the family member had to feed them. On 04/28/16: A family member of R #113 stated that the resident was not getting her showers, call light was on for ten (10) minutes and staff never answered the call light. 05/03/16: An unsampled resident said the second shift was leaving her wet; R #73 stated that he was left wet during breakfast until after 9:00 a.m., and; An unsampled resident said he hadn't received a shower. On 05/09/16: A family member of an unsampled resident said the resident was not getting changed properly, being left wet, their clothing was not getting changed, and they were not being turned. On 05/12/16: R #172 stated when they asked to be changed they indicated that they were a Physical Therapist so they could get a quicker response, otherwise if the resident identified that it was him requesting assistance he to wait or would be told they would come back then they won't come back. On 05/12/16: An unsampled resident said a nurse was supposed to change his dressing, but didn't return for four to five hours. On 05/23/16: An unsampled resident voiced concerns of another unsampled resident not being assisted by staff in feeding him his meals. On 06/06/16: A family member of R #93 voiced concerns that the resident wasn't being fed in a timely manner, that the food was being left on the cart. They stated that on the second shift that day (a Sunday) around 7:00 p.m. that the resident's tray was still on the cart and the CNAs were picking up trays from down the hall, and the CNAs told the visitor that they were real busy and short-staffed. The visitor stated this was not the first time this had happened. On 06/15/16: A family member of R #138 stated that the resident was left in urine from 7:00 p.m. until 4:30 a.m. On 06/15/16: An unsampled resident stated he was not being gotten ready for [MEDICAL TREATMENT], had not gotten a bath and no snack to go with him, and transportation had to wait for him to get dressed. On 07/04/16: A family member of R #138 stated that the resident's feeding tube was never hooked up from 1:20 to 4:10, and when they pressed the call light for assistance to go to the restroom it was 36 minutes before anyone came to help. They stated the same thing happened over the weekend, and; A family member of an unsampled resident said the resident was soaked and covered in food on the 3:00 to 11:00 p.m. shift. On 07/11/16: An unsampled resident said it took some time for a staff member to come and help her. On 07/16/16: A family member of resident #199 said that the resident was not getting up to the wheelchair. On 07/20/16: An unsampled resident stated that they needed to be changed and was told from a 3:00 p.m. to 11:00 p.m. CNA that they didn't change residents when they were passing out trays, and gave them the wipes so they could change themselves, and the 11:00 p.m. to 7:00 a.m. shift had to clean them up. Review of Resident Council Department Response Forms for concerns related to ADL assistance from November of 2015 to July of 2016 included the following: On 11/03/15: The 3:00 p.m. to 11:00 p.m. CNAs are leaving residents wet too long. On 01/05/16: Not enough CNAs for all the building on all three shifts. Over-working the ones here, CNAs leaving, only three CNAs on the second shift on 01/04/16. The facility's response was that they were constantly taking actions to ensure the 3:00 p.m. to 11:00 p.m. shift was fully staffed. We are asking the 7:00 a.m. to 3:00 p.m. CNAs to stay over and work. We are planning a job fair on 02/04/16. On 03/01/16: Call lights not being answered in a timely manner. Cross-refer to F 312. 4. Review of the Punch Detail History staffing sheet from December 2015 and January 2016 revealed there was no evidence of Registered Nurse (RN) coverage on 12/19/15, 12/31/15, and 01/3/16. This was verified during interview with the Business Office Manager on 07/29/16 at 9:20 a.m.
F 0354 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Use a registered nurse at least 8 hours a day, 7 days a week.** Based on record review and staff interview the facility failed to ensure Registered Nurse (RN) coverage at least eight (8) hours per day for three (3) days as required. The facility census was one hundred and one (101), the sample was fifty-one

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F 0354 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 22) (51). Findings include: Review of the Punch Detail History for the month of December 2015 and January 2016 revealed the facility failed to provide evidence that they had RN coverage for a minimum of eight (8) hours for a twenty four (24) hour time frame for 12/19/15, 12/31/15, and for 01/03/16 as required. Interview on 8/2/16 at 9:00 a.m. with the Administrator confirmed the facility does not have a waiver for this requirement. Interview on 8/2/16 at 9:10 a.m. with the Director of Nursing Services (DNS) revealed that the DNS did not realize the facility did not have RN coverage on 12/19/15, 12/31/15 and 1/3/16. The DNS confirmed that the facility did not have RN coverage for the dates of 12/19/15, 12/31/15 and 01/03/16 as required. The DNS further revealed that the DNS is responsible for ensuring the facility has RN coverage.
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 and staff interviews the facility failed to label one vial of Tuberculin Purified Protein Derivative with the correct expiration date in one (1) of two (2) medication rooms and the facility failed to discard three (3) bottles of expired medications in one (1) of one (1) central supply rooms. The facility census was one hundred and one (101) residents, the sample was fifty-one (51). Findings include: Observation of the Medication room refrigerator 08/03/16 at 12:50 p.m. with Licensed Practical Nurse (LPN) QQQ revealed one vial of Tuberculin Purified Protein Derivative Diluted/Apisol 5 TU/ 0.1 milliliters (mL) opened with a hand written date of 09/29/16. LPN QQQ stated she wasn't sure but she thought that once Tuberculin was opened that it expired in twenty-eight (28) days and LPN QQQ confirmed the handwritten expiration on the vial of Tuberculin was incorrect. Further observation with LPN QQQ of the Central Supply room revealed one (1) eight fluid ounce bottle of Senna Syrup Natural Vegetable laxative with a manufacturer' s expiration date of 06/2016, and two bottles of one hundred (100) tablet count Zinc 50 milligrams (mg) with a manufacturer's expiration date of 06/2016. LPN QQQ confirmed the expiration dates for the Senna Syrup and the two (2) bottles of Zinc 50 mg expired on 06/16. Interview on 08/03/16 at 1:19 p.m. with the Director of Nursing Services (DNS) revealed that the facility's policy is once Tuberculin is opened then it expires in twenty-eight days. The DNS confirmed that the expiration date handwritten on the vial of Tuberculin was incorrect and that there was no way to determine what date the vial of Tuberculin was opened and that the vial of Tuberculin should be thrown away. Review of the facility' s policy titled Medication Storage storage of medications reads: E. When the original seal of a manufacturer ' s container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. Note: the best stickers to affix contain both a date opened and expiration notation line. The expiration date of the vial or container will be thirty (30) days unless the manufacturer recommends another date or regulation / guidelines require different dating. H. All expired medications will be removed from the active supply and destroyed in the facility. Regardless of amount remaining.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the facility's Handwashing/Hand Hygiene, Isolation- Category of Transmission- Based Precaution and staff interview, the facility failed to place one (1) resident (R #28) on contact isolation for a [MEDICATION NAME]-Resistant [MEDICATION NAME] (VRE) infection, and failed to wash or sanitize hands after performing incontinent care for one (1) resident (R #180). The sample size was fifty-one (51), the census was one-hundred and one (101). Findings include: 1. During observation of pressure ulcer wound care by Licensed Practical Nurse (LPN) Treatment Nurse CC on 07/30/16 at 9:59 a.m., R #180 was observed to have been incontinent of stool when the incontinent brief was removed. During further observation, LPN Treatment Nurse CC completed incontinent care, including cleaning up the feces, prior to beginning the treatment. Further observation revealed that after the incontinent care was completed, the treatment nurse removed her gloves, however she did not wash or sanitize her hands, applied a new pair of gloves, and performed the wound care. During an interview, after the wound care was completed, LPN CC verified that she had not washed or sanitized her hands after performing the incontinent care. During an interview with the Director of Nursing Services (DNS) on 07/30/16 at 11:15 a.m., she stated that her expectation was for staff to use hand sanitizer and/or wash their hands and put on clean gloves after cleaning up a resident that had been incontinent of feces. Review of the facility's Handwashing/Hand Hygiene policy noted the following: Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap and water for the following situations: Before handling clean or soiled dressings; before moving from a contaminated body site to a clean body site during resident care; after removing gloves; after contact with blood or bodily fluids. The use of gloves does not replace handwashing/hand hygiene. 2. Review of the policy titled Isolation- Category of Transmission- Based Precaution with a revision date of 11/14/15 documented: In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environment surfaces or resident care items in the resident environment. Examples of infections requiring contact precautions include, but are not limited to, infections with multi-drug resistant organism (determined on a case by case basis). Record review for R #28 revealed a Urine Analysis (UA) and Culture and Sensitivity (C&S) report dated 07/17/16 documenting that R #28's urine culture was positive for [MEDICATION NAME] Resistant [MEDICATION NAME] (VRE), a multi-drug resistant organism. Review of the Physician order [REDACTED]. There was no evidence of a Physician order [REDACTED]. Observation on 07/27/16 at 10:00 a.m. revealed a Certified Nursing Assistant (CNA) VV entering the room of R #28 had began to provide care for R #28 without gloves or gown. The entrance to the room did not have any signs on the door and there was no Personal Protective Equipment (PPE) cart outside of the resident's room. At 1:00 p.m. CNA VV was observed in the resident's room, working with the resident's roommate. The CNA was observed not wearing a gown, was unable to be determine if the CNA was wearing gloves at this time. Interview on 07/27/16 at 3:17 p.m. with the Director of Nursing Services (DNS) revealed she was aware that R #28 had a positive urine culture for VRE. The DNS stated that she asked the Physician about the appropriate isolation precautions for this resident and was told to use gloves for standard care; however, the Physician'ts verbal order, to wear gloves for standard care, was not documented in the resident's chart. The DNS further stated that typically when a resident has tested positive for VRE infection the resident would be placed on Contact Precautions. The DNS confirmed that R #28 was incontinent of urine. Interview on 07/27/2016 at 4:00 p.m. with CNA VV revealed she has worked with R #28 since April 2016, and the resident is incontinent of urine and bowel. CNA VV revealed the resident has had a urinary tract infection in the past but that she was not aware that R #28 had an infection at this time. On 8/5/16 at 9:19 a.m. an attempt was made to contact the physician but he was not available.
F 0460 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide bedrooms that don't allow residents to see each other when privacy is needed.**

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F 0460 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 23) Based on observation and staff interview the facility failed to assure privacy for two (2) residents by failing to assure that the privacy curtain ensured privacy for each resident. The sample was fifty-one (51) residents, the census was one-hundred and one (101). Findings include: Observations on 07/26/16 at 10:50 a.m., 7/27/16 at 2:03 p.m., 7/28/16 at 8:30 a.m. in room 204 revealed the privacy curtain in the room does not assure full privacy for R #21 in the A bed, and there was no privacy curtain for R #142 in the B bed. Observation of room 204 on 7/29/16 at 9:57 a.m. and interview with Housekeeping Supervisor (HSK) and Maintenance Director. HSK stated that they were not aware that privacy curtain was not adequate to ensure privacy for the two residents. HSK stated that he/she does not have a log to show the last time the privacy curtain was changed. The HSK stated that each manager is assigned a zone and tours the zone each morning and reports the findings during the morning meeting. Observation on 7/29/16 at 10:49 a.m. and interview with the Director of Nursing Services (DNS) regarding room 204. The DNS confirmed that the privacy curtain for bed A did not ensure privacy for the resident. The DNS reported that staff may feel that a curtain was not needed for bed B because a barrier was in place for bed A. However, it was noted that if someone entered the room that the resident in the B bed would be compromised and privacy would not be guaranteed. Review of the Minimum Data Set (MDS) assessment section G revealed that R #142 and R #21 both required extensive assistance of one person support for dressing and toilet use. Review of the facility's policy titled Clinical Rounds reads Guideline statement: resident rounds are a critical task in any facility. The DNS is expected to make rounds daily. The Clinical Rounds policy also reads that one area to be reviewed when making rounds is to ensure that when a resident is in bed the resident has privacy.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the facility job descriptions, corporate, wound clinic, and facility staff interviews, the facility failed to be administered in a manner to provide sufficient oversight of the skin and wound program, to ensure that residents with the risk for, or actual pressure ulcers, and other skin concerns received the necessary care and services to prevent and/or promote healing of wounds, and failed to provide adequate training of two (2) newly-hired treatment nurses. Concerns were identified with pressure ulcer care for nine (9) residents (N, T, R, R #84, R #24, R #50, R #64, R #120, R #180) of the eleven (11) residents reviewed for pressure ulcers. The sample size was fifty-one (51) residents, the census was one-hundred and one (101). The non-compliance included the failure to report and obtain orders for wounds present on admission and readmission to the facility for resident N, which delayed treatment, the wounds deteriorated, and the resident developed septic shock and expired on [DATE]. The non-compliance also included failure to implement interventions in place to prevent the recurrence of a sacral wound for one (1) resident T, and also failed to implement treatment to the wound in a timely manner for this resident, whose Stage II pressure sore deteriorated to a Stage III pressure sore with a yellow-green wound bed. In addition, the facility's failure to provide treatments as ordered contributed to the deterioration of a wound for resident R per wound clinic staff interview. A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On [DATE] at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of [DATE] was related to R #170, who was assessed during admission on [DATE] to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on [DATE], and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on [DATE] at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On [DATE] at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On [DATE] at 10:46 a.m. the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on [DATE] at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on [DATE] that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On [DATE] at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on [DATE] related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on [DATE] and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on [DATE] revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on [DATE] at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on [DATE] and remains on-going. Findings include: Interview with LPN Treatment Nurse UU on [DATE] at 1:28 p.m., she stated that this was a transition period where she was the only treatment nurse in the facility for about six weeks. During further interview, she stated that she was doing the best that she could to manage the wounds, but that she was the only one and some things may have fallen between the cracks. Interview with Licensed Practical Nurse (LPN) Treatment Nurse UU on [DATE] at 8:12 a.m., she stated that she did not know why there was so many blanks on the Treatment Administration Records (TAR) for wound care. Interview with the DNS on [DATE] at 8:00 a.m. revealed that she was not aware that resident R had maggots in his wound on [DATE]. Interview with the Director of Nursing Services (DNS) on [DATE] at 10:54 a.m., she stated that they had not identified an issue with missing skin/wound care treatments. The DNS stated that the tool that they used to detect blanks in the documentation on the TARs stopped working about six or seven months ago, and so for the past three months she has had the ADNS check each residents TAR for incomplete documentation, but that they had not identified an issue with the missing treatments. During further interview she stated that a previous treatment nurse, who resigned on [DATE], had told the previous Executive Director (ED) that she was having a hard time keeping up with all of the treatments, and the DNS said she had asked the (previous) ED not to admit so many residents with wounds as they had only one treatment nurse. The DNS added that she was aware that LPN Treatment Nurse UU had expressed her concerns to the ED a couple of times about having trouble keeping up with all of the treatments, too. During interview with LPN UU on [DATE] at 10:54 a.m., she stated that she told the previous ED the second week that she was by herself as the only treatment nurse that she was having a hard time keeping up with the treatments. Interview with the DNS on [DATE] at 11:10 a.m. revealed the facility had a full time treatment nurse and a part time treatment nurse from [DATE] to [DATE], at which time the part time nurse resigned. Continued interview revealed that the full time treatment nurse provided treatments by herself from [DATE] until LPN Treatment Nurse UU was hired to assist with treatments a couple of days a week. Further interview with the DNS revealed that the full time treatment nurse became a part time employee on [DATE], at which time Treatment Nurse UU had the responsibility of providing treatments on her own most days. Further interview revealed that UU stated that she was drowning during that time, and the facility hired Treatment Nurse CC on [DATE]. Interview with Corporate Medical Director III on [DATE] at 1:20 p.m., she stated that two (2) of the corporate staff working

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 24) with her conducted skin assessments for all the residents not already identified with skin issues by facility staff. They identified eleven (11) additional residents with some type of skin issues, such as dry skin, yeast, unidentified dressings for R #43 (unidentified as the resident was not on the current list of residents with wounds), skin tear, skin damage from scratching, rash, and moisture associated skin damage. She further stated that three (3) of these eleven (11) residents (#3, #55, and an unsampled resident) had possible Stage II pressure ulcers. During interview with Corporate Registered Nurse (RN) LLL at this time, she stated that she showed these skin concerns to the facility's treatment nurse, and the treatment nurse was not aware of and was currently not providing treatment for [REDACTED]. Interview with Corporate Medical Director III on [DATE] at 1:40 p.m. revealed that the right lateral heel wound was a venous stasis ulcer with a pressure component but, the other wounds were venous stasis ulcers. Continued interview revealed that resident R had bilateral [MEDICAL CONDITION]. When asked about the maggots in the wound, III stated that the resident's dressing may have come off for a brief period or loosened which allowed a fly to lay eggs in the wound. Continued interview revealed that it would take 3 to 5 days for the maggots to develop. Further interview revealed that someone from the corporate office had incorrectly told staff that vascular wounds did not need to be measured or assessed. Post survey interview conducted on [DATE] at 2:32 p.m. with the facility ' s previous Administrator revealed that to his knowledge the facility did not have any major issues with wound care. He stated that to his knowledge there no concerns identified through QAPI (Quality Assessment/Performance Improvement) committee related to wound care treatments, sufficient staffing, or documentation. He stated that he was made aware of an increase in the facility-acquired wounds at one time, but that the numbers would fluctuate. He stated that although the rate did increase, it was nothing that alarmed him and the rate of acquired wounds would go up and down. He stated that nothing was brought to his attention by the DNS or the Director of Clinical Consultant of any concerns with wound care and / or documentation of wound care. The previous Administrator went on to say that he was never told that any staff was going to resign because they were having a hard time keeping up with their workload. He stated that the DNS never told him to stop admitting resident with wounds because they were having trouble keeping up. He state that if a resident was to be admitted to the facility that had wounds, the DNS was supposed to look at the wound packet to make sure that they could take care of the resident. He stated that if her recommendation was that they could not take of that resident, then ten out of ten times he would not object. Cross-refer to F 157, F 224, F 281, F 282, F 314, F 353, F 520.
F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to ensure that the medical records were accurate for five (5) residents (R #42, R, R#120, R#180, and R#24) and that the medical records was complete for one (1) resident (R#138). The sample size was fifty-one (51) residents, the census was one-hundred and one (101). A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On 07/29/16 at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of 07/15/16 related to R #170, who was assessed during admission on 07/15/16 to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on 07/19/16, and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on 7/28/16 at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On 7/28/16 at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On 7/30/16 at 10:46 a.m. the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on 08/02/16 at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on 08/05/16 that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On 08/03/16 at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on 4/6/16 related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on 5/27/16 and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on 6/1/16 revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on 08/04/16 at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJ's would be ongoing. Therefore the IJ was identified to exist on 4/6/16 and remains on-going. The facility's failure to report and obtain orders for wounds present on admission and readmission to the facility for resident N delayed treatment and the wounds deteriorated, and the resident developed septic shock. In addition, the facility failed to implement interventions to prevent the recurrence of a sacral wound for resident T, and did not implement treatment to the wound in a timely manner for the resident, and the Stage II pressure sore deteriorated to a Stage III pressure sore with yellow-green wound bed. In addition, the facility's failure to provide treatments as ordered possibly contributed to the deterioration of a wound for resident R per wound clinic staff interview. Findings include: 1. Observation on 8/3/16 at 8:40 a.m. revealed R #42 was observed not to eat her breakfast. Licensed Practical Nurse (LPN) QQQ was informed that the resident refused to eat her breakfast however, record review of the report titled, Resident Meals by Day revealed that the Certified Nursing Assistant (CNA) GGG charted that R #42 had eaten one hundred (100) percent (%) of her breakfast. Interview on 8/3/16 at 10:30 a.m. with CNA GGG revealed they had documented the R #42's percentage of breakfast eaten in error. Observation on 8/3/16 at 10:35 a.m. revealed CNA GGG going to the Kiosk to change the percentage of breakfast eaten by R#42. CNA GGG then learned that she was not able to make a correction to the percentage of food that R #42 had eaten. The Clinical Consultant, revealed that he/she would have to make the change in the percentage eaten on the meal report. 2. Review of the closed record revealed R #138 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the computerized charting program Census in Point Click Care (PCC) revealed that R #138 was transported to a local hospital on [DATE]. However, there was no evidence of a Situation-Background-Assessment-Recommendation (SBAR) noted for this resident prior to the resident being discharged from the facility to the local hospital. Further record review revealed that there were no nursing notes documenting the transfer of the resident to the hospital. Interview on 7/29/16 at 5:00 p.m. with MDS Coordinator OOO revealed that R #138 was admitted to the Long Term Care (LTC) facility on 5/24/16 and then was readmitted to the Long Term Care facility on 6/6/16 confirming that the resident had been transferred from the facility to the hospital. Interview on 7/29/16 at 5:43 p.m. with the Registered Nurse (RN) Assistant Director of Nursing Services (ADNS) confirmed that R #138 was discharged to the hospital but that there was no evidence of documentation that a Situation, Background, Assessment and Response (SBAR) form or any evidence of any nursing notes documenting that the resident had been sent to the hospital. However, according to the facility's census record documented in PCC the residents transferred out of the facility to the hospital on [DATE] at 5:51 p.m. Interview on 07/30/2016 at 12:31 p.m. with the Director of Nursing Services (DNS) stated that her expectation is for the

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F 0514 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 25) nurse to write an SBAR on any change in a resident's condition. The DNS confirmed the nurse did not complete an SBAR prior to the resident being sent to the hospital. 3. Interview with resident R on 7/26/16 at 2:23 p.m. revealed that he was supposed to have daily dressing changes for wounds to his bilateral feet but, the staff had not changed the dressings since Friday, 7/22/16. On 7/26/16 at 2:40 p.m., Unit Manager HH removed the resident's multipodus boots and revealed that the dressings on the resident's bilateral feet were dated 7/22/16. Review of the physician's orders [REDACTED]. Review of the July 2016 Treatment Administration Record (TAR) revealed that staff had inaccurately documented that the treatment had been provided for the resident's wounds on 7/23/16, 7/24/16 and 7/25/16. Review of the 7/2016 TAR with CC on 7/28/16at 3:45 p.m., revealed that she had documented that she had provided treatment to the resident's pressure sores on 7/25/16, Monday. CC stated that the documentation was incorrect and that she should have documented a 5 with her initial indicating that treatment was not provided due to the resident was out of the facility. CC confirmed that two different LPNs had initialed that they provided treatment on 7/23/16 and7/24/16. CC stated that staff should not have documented that treatment was provided on7/23/16 and 7/24/16 if treatment was not performed Interview with the Director of Nursing Services (DNS) on 7/29/16 at 2:30 p.m. revealed that staff should not have documented that treatments were provided 7/23/16 through 7/25/16 if treatments were not done. 4. Review of the medical record for R# 120 revealed that treatments were done as ordered for 10/2016. Review of the medical record revealed a physician order [REDACTED]. However, staff failed to provide treatment on 11/29/15. Review of the medical record revealed a physician order [REDACTED]. Review of the TARs revealed that staff failed to provide treatment for [REDACTED].On 3/17/16, treatment was changed to apply Dakin's soaked gauze to the left ischial wound twice a day. However, staff failed to provide treatments twice a day on 3/18/16, 3/20/16, 3/21/16, 3/24/16, 3/26/16 and 3/29/16. Although staff documented in the 6/23/16 General note that treatment, Santyl every day, was provided to the sacral wound on 6/23/16, there was no indication that treatment was provided 6/24/16, 6/25/16, 7/9/16 or 7/24/16. Although staff documented that treatment, Dakin's every day was provided to the left gluteal fold (ischium) on 6/23/16, there was no indication that staff provided treatment on 6/24/16, 6/25/16, 7/9/16 or 7/24/16. 5. Review of the wound care order for R#180 to the right buttock dated 06/21/16 noted to cleanse the area with soap and water, apply xeroform with [MEDICATION NAME] pad daily. Review of weekly skin assessments from the original admitted through 07/22/16 revealed that there was no skin assessment done on 05/29/16. Medical record review on 05/26/16: Resident is noted to have two Stage II sacral areas with measurements of 1.8x 2.9 and 1.5 x 1.2 with pink wound bed present. However, there was no evidence of the depth of the wound documented. Medical record review on 05/31/16: Resident noted to have three open areas to the sacrum. Resident is noted to have Stage II. There was no evidence of the depth of the wound documented, and no documentation of the left buttock wound noted on 05/26/16. Continued staging the gluteal fold wound as a Stage II despite slough present. No staging of the gluteal fold wound. Medical record review on 06/07/16: Resident is noted have three open areas to the sacrum. Resident is noted to have a Stage II to top right side of the sacrum with slough present to wound bed, Second open area to sacrum is noted and a third open area is noted to the sacral area. Wounds with slough are staged as a Stage II. There was no evidence of the wound depth documented and no staging of two of the three wounds. Medical record review on 06/14/16: R#180 noted to have three areas to sacrum. Top right side of sacrum with Stage II measuring 2.8 cm x 2.4 cm x 0 cm, slough noted to middle of wound bed, no odor noted. Next wound just below top right side of sacrum Third area to sacrum. However, the description of the location of the wound sites changed from week to week, so unable to tell from the documentation of the wounds if these wounds are the same wounds or if they are different wounds. Continued staging wounds as a Stage II despite there being slough in the wound bed. Medical record review on 06/21/16: Resident is noted have three areas to the sacral area. However, two of the wounds do not have depth documented. Medical record review on 06/28/16: R#180 noted to have Stage II to sacral area. Documentation continues to stage wounds with slough as a Stage II. There is no documentation of what happened to the other two sacral wounds, and if the left buttock wound is new or one of the existing wounds. No depth recorded of the left buttock wound. Medical record review on 07/05/16: R#180 noted to have a wound to sacrum However, there is no staging of the wound, and no mention of the other wounds previously treated. Medical record review on 07/12/16: R#180 noted to have Stage II. However, there is no description of the wound bed other than pink. During interview and record review with LPN Treatment Nurse UU on 08/01/16 at 1:28 p.m., she verified she saw no documentation that these wounds were ever treated before the resident ' s hospitalization on [DATE]. During further interview and record review at this time, Treatment Nurse UU verified that there was no documentation for R #180 that the three Stage II to the buttocks and sacrum identified on readmission on 05/17/16 were treated for [REDACTED]. The treatment nurse verified that in the Wound Care Notes on 05/26/16, that the wounds were described in different locations, but that they were actually the same wounds described in the previous assessment, and that she did not document the depth of the wounds, nor stage and describe the wound bed of the left buttock wound. The treatment nurse LPN UU added that this must have been an oversight, but that she was doing the treatments by herself and doing the best she could. During further interview she stated that she just recently learned that you couldn't stage a wound with slough as a Stage II. She verified that left gluteal fold wound on the 05/31/16 Wound Care Notes had no staging or measurements recorded, and that the three wounds in these notes were described as different locations but were actually the same wounds as previously described. Treatment Nurse LPN UU verified that no depth was documented for any of the wounds on 06/07/16, and on 06/07/16 and 06/14/16, there was no staging for two of the three wounds. She verified that there were no depth measurements for two of the three wounds on 06/21/16. She verified that there was no staging or depth measurements of the left buttock wound on06/28/16. During further interview, she verified that she never documented that the right and left buttock pressure sores had healed. She verified that there was no documentation in the clinical record that she staged the sacral wound on 07/05/16. During continued interview and record review with Treatment LPN UU on 08/01/16 at 1:28p.m., she verified that there was no documentation on the TAR for R #180 that the following treatments were ever completed: In May 2016 at 5:00 p.m. No evidence that treatments were completed on 05/21/16; 05/22/16; and 05/24/16 (the TAR did not specify what wound was being treated).5:00 p.m. No evidence that treatments were completed to the left buttock on 05/25/16, and to the left buttock, right buttock, and sacrum at5:00 p.m. from 05/26/16 through 05/31/16. In addition, there was no evidence that treatments were completed at 9:00 a.m. for any of these three areas on 05/27/16. Continued review revealed for the month of June 2016 there was no evidence that the 5:00 p.m. treatments were completed to the right and left buttocks and sacrum on 06/01/16; 06/03/16; 06/04/16; 06/07/16; 06/08/16; 06/09/16; 06/11/16; 06/12/16; 06/15/16; 06/16/16; and 06/17/16. There was no evidence that treatments were completed to the sacrum on 06/21/16; 06/24/16; and 06/27/16.In July 2016 there was no evidence that treatments were completed to the sacrum and right buttock on 07/06/16; 07/09/16; 07/10/16;07/11/16; and 07/18/16. During interview with Corporate Medical Director III on 08/04/16 at 9:09 a.m., she stated that she was asked to help investigate concerns with wounds at the facility, and her team was finding some of the same issues that the state survey team found as far as assessing and documenting wounds, and the training of the treatment nurses, and stated that wound care at the facility was a mess. Upon further interview, she stated that all wounds should be assessed and measured, even if the resident had a [DIAGNOSES REDACTED]. 6. Interview with the DNS on 7/30/16 at 3:41 p.m. revealed the DNS confirmed that no documentation was available indicating treatments were done for 8/4/15, 8/5/15, 8/7/15, 8/14/15, 9/4/15, 9/5/15, 9/11/15, and 9/14/15. The DNS revealed that no explanation was available for the blanks on the treatment record. Cross-refer to F 157, F 281, F 282, F 314, F 353, F 490, F 520.
F 0519 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.**

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F 0519 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 26) Based on staff interviews and record review the facility failed to establish a written agreement with a hospital. The facility census was one hundred and one (101), the sample was fifty-one (51). Findings include: Interview on 07/30/16 at 12:55 p.m. with the Director of Nursing (DNS) revealed that the facility does not have a contract with any hospital for transferring/receiving residents for admission. Interview on 07/30/16 at 2:30 p.m. with the DNS and with the Administrator the DNS again stated, the facility does not have a contract with any hospital. Interview on 07/30/16 at 4:00 p.m. with the Administrator and the Nurse Consultant. The Nurse Consultant stated, I have never known our facility to have a contract with a hospital. That's a foreign thing to me. The Administrator confirmed that the facility does not have a contract with any hospital. Record review revealed that the facility does not have a contract with a hospital.
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that identified, developed, and implemented corrective action plans for residents with pressure ulcers. The QAA committee also failed to identify that their established policy for Skin Integrity Guidelines was not being fully operationalized, and therefore failed to implement corrective actions to address the problems. In addition, the QAA committee failed to ensure that concerns with pressure ulcers identified during the Standard survey on 07/25/13 continued to be effectively monitored to prevent recurrence. The facility census was one hundred and one (101) residents, and the sample size was fifty-one (51) residents. A determination was made that the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. On 07/29/16 at 1:35 p.m., the Executive Director (ED), Director of Nursing Services (DNS), and Corporate Registered Nurse (RN) Field Services Clinical Director were notified that Immediate Jeopardy (IJ) existed as of 07/15/16 related to R #170, who was assessed during admission on 07/15/16 to be an elopement risk. However, the facility failed to implement effective interventions, failed to sufficiently supervise the resident, and failed to develop an immediate care plan to address the risk for elopement. R #170 eloped from the facility four (4) days after admission on 07/19/16, and was found off facility grounds after crossing four (4) lanes of automotive traffic with a median dividing the two (2) lanes of traffic. In addition, the resident crossed through the facility parking lot, onto the road, which led into a Medical Office Complex. Additional IJ noncompliance was identified on 7/28/16 at 4:37 p.m., when during observation of the exit door at the end of the 100 hall, it did not sound an alarm to alert staff that the door was opened. On 7/28/16 at 7:29 p.m., the facility implemented immediate action to ensure that unsupervised exit did not occur with a staff member assigned to sit at the door and provide continuous monitoring of the 100 hall door. The facility also in-serviced staff about monitoring the 100 hall exit door. On 7/30/16 at 10:46 a.m. the SSA validated that the 100 hall exit door was repaired and fully functioning. A Credible Allegation of Compliance (AoC) was received on 08/02/16 at 9:56 a.m. However, the facility failed to complete elopement drills as outlined in their AoC, and the ED was notified at exit on 08/05/16 that the IJ would be on-going until the SSA validated that all interventions were completed in the AoC including the elopement drills as indicated in the facility's AoC. On 08/03/16 at 11:30 a.m., the ED and Corporate Area Vice President (VP) were notified that IJ existed. It was determined that the IJ was identified to exist on 4/6/16 related to resident N who was admitted to the facility on [DATE] after a hospital stay from home for a urinary tract infection, history of falls, who ambulated with a walker, with impaired cognition. The resident was discharged from the hospital to the facility with fluid filled blisters on bilateral heels and a reddened sacral area. The facility failed to develop an interim care plan to address the pressure ulcers. The resident was found unresponsive on 5/27/16 and transferred to the hospital in septic shock. Review of the Hospital Discharge Summary signed on 6/1/16 revealed the Final [DIAGNOSES REDACTED]. Review of the Georgia Death Certificate revealed the immediate cause of death for Res N was Septic shock secondary to decubitus. A Credible Allegation of Compliance was received on 08/04/16 at 5:40 p.m., was not acceptable, the ED was notified during the exit meeting that the IJs would be ongoing. Therefore the IJ was identified to exist on 4/6/16 and remains on-going. Findings include: During an interview with the Director of Nursing Services (DNS) on 08/04/16 at 10:54 a.m., she stated that they had not identified an issue with missing treatments. During an interview with the Licensed Practical Nurse (LPN) Treatment Nurse UU on 08/05/16 at 8:12 a.m., she stated that she did not know why there was so many blanks on the Treatment Administration Records (TAR) for wound care. During an interview with LPN UU on 08/05/16 at 10:54 a.m., she stated that she told the previous ED, the second week that she was by herself as the only treatment nurse, that she was having a hard time keeping up with the treatments. Of the eleven residents reviewed by the survey team for pressure ulcers, nine of these residents (N, T, R, R#84, R#24, R#50, R#64, R#120, R#180) were identified to have concerns related to treatments not consistently documented as completed per Physician order. Review of the federal citation F 314 written during the facility's standard survey on 07/25/13, revealed that the facility failed to consistently document the appearance of a pressure ulcer for one resident, failed to consistently provide wound measurements and a clear description of a heel wound; failed to clarify an order from a Wound Clinic for treatment to heal wounds; and failed to follow the order for treatment to the right heel wound for one resident. During the standard survey with exit date of 08/05/16, the survey team identified concerns in multiple areas of pressure ulcer care for nine (9) residents (N, T, R, R#84, R#24, R#50, R#64, R#120, R#180). This included failure to consistently complete weekly skin and/or wound assessments; failure to report wounds present on admission delaying treatment; failure to perform wound care as ordered; failure to obtain an order for [REDACTED]. During an interview with the ED on 08/05/16 at 12:04 p.m., she stated that pressure ulcers were a standard item that the facility monitored and discussed in QAPI (Quality Assurance Performance Improvement) meetings since at least June of 2015, per her review of the QAPI meeting minutes. Upon further interview, she stated that she saw that a Performance Improvement Plan (PIP) for skin assessments and wounds had been initiated in January 2016 after noting an increase in acquired pressure ulcers. During further interview, she stated that she did not know why there was still a lot of problems with pressure ulcers, but in her opinion it was because there had been such a large amount of turnover in the clinical staff. A post survey telephone interview on 08/22/16 at 2:32 p.m. with the former administrator revealed that, he stated that he left employment at GLC Windermere at the end of July. He stated that to his knowledge the facility did not have any major issues with wound care. He stated that they had two wound care nurses, and that the Director of Clinical Consultant and the Director of Nursing Services (DNS) reviewed all clinical data and focused on wound care, and they did not notify him that they had any concerns with wounds. He stated that under his leadership, they hired two full-time wound care nurses. He stated that to his knowledge, there were no concerns identified through their QAPI (Quality Assessment/Performance Improvement) committee related to wound care treatments, sufficient staffing, or documentation. He stated that he was made aware of a increase in facility-acquired wounds at one time, but that the numbers would fluctuate. He stated that the DNS would develop a PIP (Performance Improvement Plan) as needed to address an increase in wounds, and that they used a company benchmark of 98% for an acceptable rate of acquired pressure ulcers. He stated that although the rate did increase, it was nothing that alarmed him, and the rate of acquired wounds would go up and down. He stated that nothing was brought to his attention by the DNS or Director of Clinical Consultant of any concerns with wound care and/or documentation of wound care. He stated that if an issue was identified, an ad hoc QAPI would be done by the DNS if it was not time for the scheduled QAPI meeting. He stated that he started working at the facility in 2014, and during their standard survey in 2015 they had no

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 27) clinical issues cited. He stated that to his knowledge, the concerns with pressure ulcers cited during the standard survey in 2013 was not kept in QAPI. He stated that acquired wounds were discussed in the monthly QAPI meetings. He stated that PIPs had been developed recently for several months to address acquired pressure ulcers, and to address the weekly skin assessments (that the charge nurses did) not always being done or not done correctly. He stated that their focus for this was for the clinical managers to do random skin assessments to make sure that the charge nurses were identifying wounds. Review of the facility's Skin Integrity Guideline revealed that the DNS or designee will be responsible to implement and monitor the skin integrity program. Tracking and analysis of pressure ulcer trends is completed monthly through the QAPI Committee. Identification of trends and/or opportunities for improvement with skin integrity system reviewed and discussed with action items and/or formal PIP implemented. Cross-refer to F 157, F 224, F 281, F 282, F 314, F 353, F 490.