STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **015382**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/15/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANTERBURY HEALTH CARE FACILITY	**1720 KNOWLES ROAD PHENIX CITY, AL 36869**

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 0278

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure each resident receives an accurate assessment by a qualified health professional.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on review of RI #1's medical record and staff interviews, the facility failed to ensure Resident Identifier (RI) #1's pressure ulcer measurement was coded correctly on the resident's Minimum Data Set ((MDS) dated [DATE]. This affected one of 14 sampled residents whose MDS were reviewed.
Findings include:
RI #1 was admitted to the facility on [DATE] from a local hospital with a [DIAGNOSES REDACTED].
RI #1's MDS with an assessment reference date of 6/12/2017 indicated RI #1 had one Stage 4 pressure ulcer that measured 0.3 in length by 0.3 in width and 0.1 in depth.
In a telephone interview on 8/10/2017 at 4:15 p.m., Employee Identifier (EI) #11, the Registered Nurse (RN) MDS Coordinator acknowledged that she completed the skin section of RI #1's MDS dated [DATE]. According to EI #11 she got RI #1's pressure ulcer measurements from the resident's chart (medical record).
In a follow-up interview on 8/11/2017 at 10:00 AM, EI #11, the (RN) MDS Coordinator reviewed RI #1's medical record and stated she didn't see any pressure ulcer measurements. When EI #11 reviewed a local hospital report of RI #1's coccyx bone biopsy, she stated the measurements listed on the MDS dated [DATE] were incorrect. According to EI #11, the measurements of 0.3 by 0.3 by 0.1 came from RI #1's coccyx bone biopsy and not the measurements of the resident's Stage 4 pressure ulcer. When asked when did she notice this error, EI #11 stated just now. When asked how could a Stage 4 pressure ulcer measure 0.3 by 0.3 by 0.1, EI #11 stated it would not. EI #11 was asked, how the incorrect measurements could affect the resident's wound care. EI #11 replied, it could affect coding for insurance purposes and care planning. When asked if she ever got measurements for RI #1's Stage 4 pressure ulcer, EI #11 said she did not.
The SURGICAL PATHOLOGY SERVICE note, located within RI #1's medical record, indicated on 6/2/2017 at 1:10 PM, a specimen that consisted of a 0.3 x (by) 0.3 x 0.1 cm (centimeter) fragment of RI #1's coccyx bone was collected for a biopsy.
This deficiency was cited as a result of the investigation of complaint/report number AL 237.

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

Provide care by qualified persons according to each resident's written plan of care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on a review of Resident Identifier (RI) #1's medial record, interview with the resident and staff interviews, the facility failed to implement the care plan of RI #1, a resident admitted to the facility with a Stage IV pressure ulcer to the sacral region. RI #1's care plan titled I am at risk for impaired skin integrity . had interventions to provide wound care as ordered, offer supplemental nutrition and weekly evaluation of wound healing. These interventions were not implemented as care planned. RI #1 was admitted to the facility on [DATE] and discharged home on[DATE]. During RI #1's entire stay in the nursing facility, the licensed nursing staff failed to conduct weekly wound/skin assessments of RI #'1 Stage IV pressure ulcer to the sacral region. RI #1 was ordered to have the wound vac changed on Mondays and Thursdays. A review of RI #1's electronic Treatment Administration Record (eTAR) and staff interviews revealed, RI #1's wound vac was not consistently changed as ordered and care planned. Also, it was recommended and ordered by the physician on 6/19/2017 for RI #1 to have Juven and a protein supplement to aid in wound healing. This intervention was not implemented and RI #1 never received the recommended and ordered Juven and protein supplement. These deficient practices placed RI #1, one of nine sampled residents reviewed for pressure ulcer care, in immediate jeopardy as these failures could have caused serious harm, injury or death.
On 8/17/2017 at 4:25 p.m., EI #1, the Administrator was informed the scope and severity of F 282, Comprehensive Care Plan was increased to an immediate jeopardy level J.
Findings include:
RI #1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED].
RI #1's care plan titled I am at risk for impaired skin integrity and I have a Stage 4 pressure ulcer to sacrum . with a problem onset date of 6/5/2017 had the following approaches . * I need a wound care as ordered by <my> physician . * Offer me supplemental nutritional support as needed . * I need a weekly evaluation of wound healing . * I need a full skin evaluation weekly .
1) RI #1's PHYSICIAN ORDERS [REDACTED]. with a start date of 6/12/2017.
In a telephone interview on 8/12/2017 at 5:20 p.m., Employee Identifier (EI) #9, the Licensed Practical Nurse (LPN) who was responsible for admitting RI #1 into the facility on [DATE], was asked why RI #1's order to change the wound vac was dated 6/8/2017 and not 6/5/2017. EI #9 stated she forgot to put the order in the computer. When asked to explain why the order was dated 6/8/2017 with a start date of 6/12/2017, EI #9 stated she did not know. EI #9 explained the order should have been dated 6/5/2017 with a start date of 6/8/2017.
A review of RI #1's electronic Treatment Administration Record (eTAR) for June 2017 revealed, RI #1's wound vac was not changed on 6/8/2017 and 6/29/2017.
During an interview on 8/10/2017 at 12:05 p.m., EI #13, a LPN acknowledged she was assigned to care for RI #1 on 6/29/2017. EI #13 reviewed RI #1's eTAR and acknowledged that she did not sign the eTAR as changing RI #1's wound vac on 6/29/2017 (a Thursday).
A review of RI #1's eTAR for July 2017 revealed, RI #1's wound vac was not changed on 7/6/2017.
In an interview on 8/10/2017 at 11:30 a.m., EI #12, a Registered Nurse (RN) was asked if she ever worked the medication (med) cart. EI #12 said yes. When asked if a resident has a wound vac and she was on the med cart, whose responsibility was it to change the wound vac, EI #12 stated it was her responsibility. According to EI #12 she worked the med cart on Thursday, 7/6/2017. When asked if she changed RI #1's wound vac on 7/6/2017, EI #12 reviewed the eTAR and stated it didn't look like she did. EI #12 was asked why she did not change RI #1's wound vac. EI #12 answered that she truly couldn't say why but perhaps she did not look at the eTAR. EI #12 further explained that she worked all day, there was no excuse that she didn't do it.
During a telephone interview on 8/13/2017 at 5:45 p.m., RI #1 was asked how often did the facility change the wound vac. RI #1 stated the facility didn't change the wound vac often.
2) RI #1's Departmental Notes dated 6/13/2017 9:40 a.m., written by EI #8, the Registered Dietician (RD) documented . Resident was admitted to facility with DX (diagnosis): . Stage IV to sacrum . Resident has increased cal (calorie) and protein needs to aid healing . PLAN: add juven BID (twice a day) and 30cc (cubic centimeter) protein supp (supplement) BID.
RI #1's physician's orders [REDACTED]. 2) Juven BID to aid in healing 3) 30cc protein supp BID to aid healing.

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 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
During an interview on 8/9/2017 at 12:43 p.m., EI #6, the RN Unit Manager was asked about RI #1's physician order [REDACTED].
In an interview on 8/10/2017 at 10:25 a.m., EI #8, the RD, was asked what should have occurred after the physician order [REDACTED].#1 to have Juven and protein supplement. EI #8 stated the Juven and protein supplement should have been implemented. When asked why the Juven and the protein supplement was recommended for RI #1, EI #8 stated she recommended the Juven and the protein supplement to aid in wound healing because the resident had a Stage IV pressure ulcer.
On 8/10/2017 at 5:15 p.m., a telephone interview was conducted with EI #7, the former RN Unit Manager, was asked about RI #1's physician order [REDACTED]. EI #7 stated she couldn't recall what happened with the order as the why the resident never received Juven and the protein supplement. When asked what type of review did she do to ensure the physician's orders [REDACTED].#7 stated she didn't remember and explained that was a reason she was no longer employed at the facility because she didn't have time to document.
3) A review of RI #1's medical record revealed no weekly wound/skin assessments during the time RI #1 resided at the facility.
During an interview on 8/9/2017 at 12:43 p.m., EI #6, the RN Unit Manager was asked where were RI #1's weekly skin evaluations (assessments). EI #6 stated there were none. According to EI #6, an initial Braden scale was done but there no weekly wound/skin assessments. When asked when should the wound assessments be done, EI #6 stated upon admission, weekly and if there were any changes in the resident's skin condition. EI #6 was asked who was responsible for conducting weekly wound/skin assessments. EI #6 replied, when the Treatment Nurse, EI #3, left the facility, the person responsible was EI #7, the RN Unit Manager, who recently quit working at the facility. EI #6 stated she was now responsible.
In a follow-up interview with EI #6, the RN Unit Manager on 8/13/2017 at 12:25 p.m., she stated there were no wound care assessments done for RI #1 during the resident's admission/stay here at the facility.
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On 8/15/2017 at 8:00 p.m., the facility submitted an acceptable Allegation of Credible Compliance which documented:
1. RI #1 was discharged from the facility on 7/6/17. RI #2 wound assessment was completed on 7/18/17 with weekly documentation to 8/14/17 by the Registered Nurse Unit Manager. Pressure ulcer care plan for RI #2 have been reviewed and revised by the Minimum Data Set (MDS) Coordinator on 8/15/17 to assure implementation of weekly wound/skin assessments were completed and documented and observation of interventions are in place.
2. Canterbury Health and Rehabilitation Center does not have any residents that are utilizing a wound vac for Pressure Ulcer treatment as of 8/14/17. As of 8/15/17 all current residents with identified pressure ulcers have a wound assessment completed and documented in the electronic health record by the Licensed Practical Nurse UM and Registered Nurse UM. On 8/15/17, the Registered Dietician Consultant reviewed 11 residents with pressure sores for completion of Registered Dietician recommendations for Protein supplements with all completed. On 8/15/17, the Dietary Manager completed an audit of Registered Dietician recommendations over the past 30 days to assure Registered Dietician recommendations were implemented.
3. On 8/14/17, the Director of Clinical Education, Director of Nursing, Registered Nurse Supervisor and Director of Clinical Operations provided an in-service education for the Licensed Nurses on completion and documentation of the center's weekly wound assessments. No Licensed Nurse will work after 8/15/17 until education has been completed. On 8/15/17, an in-service education provided to the facility Director of Nursing Services and Administrator by the Senior Director of Clinical Operations on the facility guidelines for Skin Care and Registered Dietician recommendations for residents with pressure ulcers.
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After reviewing the facility's information provided in their acceptable Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 282 was lowered to a D level on 8/15/2017, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.
This deficiency was cited as a result of the investigation of complaint/report number AL 237.

F 0314

Level of harm - Immediate jeopardy

Residents Affected - Few

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on a review of Resident Identifier (RI) #1's medical record, review of www.webmd.com, the facility's policies titled Care System Guideline Skin Care, Medication Policies Prescriber Medication Orders and Supplements and resident and staff interviews, the facility failed to:
1) complete an initial wound assessment of RI #1's infected Stage IV sacral pressure ulcer. RI #1 was admitted to the facility on [DATE] with an infected Stage IV pressure ulcer to the sacral region. The admission nurse failed to conduct an initial wound assessment of the resident's pressure ulcer. The only wound/skin assessment found within RI #1's medical record was a Skin Inspection Report dated 6/6/2017 that documented Skin Not Intact - Existing;
2) transcribe the admission wound care orders to change the wound vac on Mondays and Thursdays. RI #1's wound care orders were not transcribed until 6/8/2017 with a start date of 6/12/2017. When questioned why the delay in wound care orders, the admission nurse, Employee Identifier (EI) #9 stated she forgot;
3) consistently change the wound vac as ordered. A review of the electronic Treatment Administration Record (eTAR) and staff interviews revealed, the resident's wound vac was not changed as ordered by the physician;
4) conduct subsequent wound/skin assessments of RI #1's infected Stage IV sacral pressure ulcer. During the course of RI #1's stay at the nursing facility, from 6/5/2017 until 7/6/2017, there was no evidence the licensed nursing staff conducted weekly wound/skin assessments as listed in the facility's policy and RI #1's care plan. The weekly wound assessments, that was the responsibility of the Treatment Nurse, were not done. The facility's Treatment Nurse left the faciity on [DATE] and the administrative staff had no system in place to ensure wound/skin assessments were completed weekly; and
5) follow the Registered Dietician's (RD) recommendation and physician's orders [REDACTED].#1, to aid in the healing of the resident's sacral pressure ulcer. The licensed nurse overlooked the order dated 6/19/2017, thus the resident never received the Juven and protein supplement that was recommended by the RD and ordered by the physician to aid in wound healing.
The facility further failed to ensure RI #1's at risk for skin integrity care plan accurately reflected the resident's status. RI #1's care plan with a problem onset date of 6/5/2017 indicated the resident refused at times to be repositioned. Staff interviews revealed this was inaccurate. The facility also failed to ensure documentation contained within RI #1's medical record was correct. The licensed nurse documented on 6/5/2017 that RI #1's wound vac in progress; however, during interview she revealed the wound vac was not attached to the resident.
These failures placed RI #1, one of nine sampled residents reviewed for pressure ulcer care in immediate jeopardy as it was likely to cause serious harm, injury or death.
Furthermore, the facility failed to conduct weekly wound/skin assessments of RI #2, a resident admitted to the facility with an unstageable sacral pressure ulcer from 5/1/2017 until 7/18/2017. This deficient practice affected RI #2, one of nine residents reviewed for pressure ulcer care.
On 8/14/2017 at 1:28 p.m., Employee Identifier (EI) #1, the Administrator and EI #2, the Director of Nursing (DON) were notified of the findings of substandard quality of care at the immediate jeopardy level of J in the area of Quality of Care, F 314.
Findings include:
1) The facility's policy titled Medication Policies Prescriber Medication Orders dated March 2011, documented . Procedures . 4. Written transfer orders/readmission orders [REDACTED]. Unless the order is unclear or incomplete, implement a transfer order without further validation if it is signed and dated by the resident's current attending physician. If the order is unclear, incomplete, or a discrepancy is noted, the order should be clarified with the physician and a new order obtained. B. If the order is unsigned or signed by another prescriber, the receiving nurse verifies the order with the current attending physician .
RI #1 was admitted to the facility on [DATE] from a local hospital with a [DIAGNOSES REDACTED]. According to www.webmd.com,
[DIAGNOSES REDACTED] is an infection of the bone.
The PHYSICIAN ORDERS [REDACTED].#1 documented Transfer to SNF (skilled nursing facility) . Change (wound) Vac Monday &

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F 0314

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 2)
Thursday .
RI #1's PHYSICIAN ORDERS [REDACTED]. with a start date of 6/12/2017.
In an interview on 8/12/2017 at 4:11 p.m., EI #10, a Registered Nurse (RN) Minimum Data Set (MDS) Coordinator acknowledged that RI #1's physician's orders [REDACTED].#9. EI #10 stated the orders should have been entered on 6/5/2017 with a start date of 6/8/2017.
In a telephone interview on 8/12/2017 at 5:20 p.m., EI #9, the Licensed Practical Nurse (LPN) who was responsible for admitting RI #1 into the facility on [DATE], was asked why RI #1's order to change the wound vac was dated 6/8/2017 and not 6/5/2017. EI #9 stated she forgot to put the order in the computer. When asked to explain why the order was dated 6/8/2017 with a start date of 6/12/2017, EI #9 stated she did not know. EI #9 explained the order should have been dated 6/5/2017 with a start date of 6/8/2017.
2) RI #1's care plan titled I am at risk for impaired skin integrity and I have a Stage 4 pressure ulcer to sacrum. I refuse at times to reposition to relieve pressure off my wound with a problem onset date of 6/5/2017 had the following approaches Reposition me every 2 hours or as pt (patient) allows . * I need a wound care as ordered by <my> physician . * Offer me supplemental nutritional support as needed . * I need a weekly evaluation of wound healing . * I need a full skin evaluation weekly . * Adjust my treatment plan if wound no (not) healing within 2-4 weeks.
During an interview on 8/12/2017 at 4:11 p.m., EI #10, a RN MDS Coordinator was asked was there any evidence in RI #1's medical record that the resident refused at times to reposition as listed in the care plan. EI #10 answered, no ma'am. EI #10 explained there was one entry in RI #1's medical record dated 6/17/2017 that the resident refused to be repositioned. When asked if the care plan statement dated 6/5/2017 that the resident refused at times to reposition a correct statement, EI #10 replied, no. EI #10 explained RI #1's care plan was a general care plan that the facility uses for all residents until an issue has been identified.
3) RI #1's care plan titled I am at risk for impaired skin integrity and I have a Stage 4 pressure ulcer to sacrum . with a problem onset date of 6/5/2017 had the following approach . * I need a wound care as ordered by <my> physician .
RI #1's PHYSICIAN ORDERS [REDACTED]. with a start date of 6/12/2017.
A review of RI #1's electronic Treatment Administration Record (eTAR) for June 2017 revealed, RI #1's wound vac was not changed on 6/8/2017 and 6/29/2017.
During an interview on 8/10/2017 at 12:05 p.m., EI #13, a LPN acknowledged she was assigned to care for RI #1 on 6/29/2017. EI #13 reviewed RI #1's eTAR and acknowledged that she did not sign the eTAR as changing RI #1's wound vac on 6/29/2017 (a Thursday).
A review of RI #1's eTAR for July 2017 revealed, RI #1's wound vac was not changed on 7/6/2017.
In an interview on 8/10/2017 at 11:30 a.m., EI #12, a RN was asked if she ever worked the medication (med) cart. EI #12 said yes. When asked if a resident has a wound vac and she was on the med cart, whose responsibility was it to change the wound vac, EI #12 stated it was her responsibility. According to EI #12 she worked the med cart on Thursday, 7/6/2017. When asked if she changed RI #1's wound vac on 7/6/2017, EI #12 reviewed the eTAR and stated it didn't look like she did. EI #12 was asked why she did not change RI #1's wound vac. EI #12 answered that she truly couldn't say why but perhaps she did not look at the eTAR. EI #12 further explained that she worked all day, there was no excuse that she didn't do it.
In a telephone interview on 8/13/2017 at 5:45 p.m., RI #1 stated the facility didn't change the wound vac often when asked how often the wound vac was changed.
4) RI #1's Departmental Notes dated 6/5/2017 9:27 p.m., written by EI #9, a LPN, documented . (RI #1) admitted . via stretcher from . Hospital . Wound vac in progress for Stage IV sacral wounds .
During a telephone interview on 8/12/2017 at 5:20 p.m., EI #9, a LPN acknowledged that RI #1 was admitted to the facility on [DATE] with orders for a wound vac for a Stage IV pressure ulcer. When asked if the wound vac was in place when the resident was admitted , EI #9 said no. According to EI #9, the wound vac arrived in the facility a couple of hours after RI #1 arrived in the facility. EI #9 stated she could not apply the wound vac so she left it for the next shift. EI #9 stated she only worked in the facility as needed on the rehab unit and didn't feel comfortable with the wound vac, so she left it for the next shift's charge nurse. When asked if the Departmental Notes dated 6/5/2017 9:27 p.m., correct when it stated the wound vac was in progress, EI #9 said it was not correct as she left the wound vac for the next shift, 11:00 p.m., to 7:00 a.m., to apply.
In an interview on 8/10/2017 at 6:25 p.m., EI #21, a RN acknowledged the Departmental Notes written by EI #9, a LPN was incorrect when it documented RI #1's wound vac was in progress. According to EI #21, EI #9 had never done a wound vac before and when she arrived into work the wound vac was still in the box. EI #21 stated she did not remember the exact time, she connected RI #1's wound vac but certain it was not applied by EI #9.
5) RI #1's care plan titled I am at risk for impaired skin integrity and I have a Stage 4 pressure ulcer to sacrum . with a problem onset date of 6/5/2017 had the following approaches . * I need a weekly evaluation of wound healing . * I need a full skin evaluation weekly . * Adjust my treatment plan if wound no (not) healing within 2-4 weeks.
RI #1's Skin Inspection Report indicated on 6/6/2017 EI #9, a LPN assessed RI #1's skin. The report documented Skin Not Intact - Existing.
In an interview on 8/9/2017 at 12:43 p.m., EI #6, the RN Unit Manager was asked where were the wound notes and weekly wound assessments for RI #1. EI #6 reviewed the computer and stated there were none. When asked when should the wound assessments have been done, EI #6 stated upon admission, weekly and if there were any changes in the residents' skin condition. EI #6 stated the only body audit was done on 6/6/2017 and it indicated the resident's skin was not intact - existing. According to EI #6, existing meant present on admission. When asked what was present on admission, EI #6 stated that she would have to review RI #1's medical record. After review of RI #1's medical record, EI #6 stated RI #1 had a sacral pressure ulcer. EI #6 was asked was there a description of the sacral pressure ulcer. EI #6 replied that would have been in the wound assessment and there was none. When asked why not, EI #6 stated they were not done. When asked who was responsible for completing, EI #6 stated the Treatment Nurse, EI #3. EI #6 then explained that EI #3 was not employed in the facility during the time RI #1 was a resident, so the person responsible would have been EI #5. EI #6 was asked what was the facility's policy and procedure for wound assessments. EI #6 replied, that measurements and wound assessments should be completed weekly and documented in the wound assessment manager. When asked if RI #1 had weekly measurements and wound assessments, EI #6 said no.
In a follow-up interview on 8/13/2017 at 12:25 p.m., EI #6, the RN Unit Manager was asked what evidence the facility had to show RI #1's sacral pressure ulcer was assessed weekly/observed for signs of healing. EI #6 stated, there was none. EI #6 explained during the resident's entire stay in the facility there were no wound care assessments done.
6) The facility's policy titled Supplements with an effective date of 1/1/2017, documented POLICY It is the policy of this center to provide supplements to residents/patients in accordance with the current diet order PR(NAME)EDURE . 2. Nutritional supplements are usually given to help resolve an identified nutritional problem. Examples are: . a. to increase calories for residents/patients . who have an increased need for calories due to injury, infection or stress b. to increase protein to facilitate the healing of decubiti; wounds .
RI #1's care plan titled I am at risk for impaired skin integrity and I have a Stage 4 pressure ulcer to sacrum . with a problem onset date of 6/5/2017 had the following approach . * Offer me supplemental nutritional support as needed .
RI #1's Departmental Notes dated 6/13/2017 9:40 a.m., written by EI #8, the Registered Dietician (RD) documented . Resident was admitted to facility with DX (diagnosis): . Stage IV to sacrum . Resident has increased cal (calorie) and protein needs to aid healing . PLAN: add juven BID (twice a day) and 30cc (cubic centimeter) protein supp (supplement) BID.
RI #1's physician's orders [REDACTED]. 2) Juven BID to aid in healing 3) 30cc protein supp BID to aid healing.
During an interview on 8/9/2017 at 12:43 p.m., EI #6, the RN Unit Manager was asked about RI #1's physician order [REDACTED].
In an interview on 8/10/2017 at 10:25 a.m., EI #8, the RD, was asked what should have occurred after the physician order [REDACTED].#1 to have Juven and protein supplement. EI #8 stated the Juven and protein supplement should have been implemented. When asked why the Juven and protein supplement was recommended for RI #1, EI #8 stated she recommended the Juven and the protein supplement to aid in wound healing because the resident had a Stage IV pressure ulcer.
On 8/10/2017 at 5:15 p.m., a telephone interview was conducted with EI #7, the former RN Unit Manager was asked about RI #1's physician order [REDACTED]. EI #7 stated she couldn't recall what happened with the order as to why the resident never received Juven and the protein supplement.

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F 0314

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 3)
7) The facility's undated policy titled Care System Guideline Skin Care documented Purpose: To provide a system for evaluation of skin at risk, identify individual interventions to address risk and process for care of changes/disruption in skin integrity: Process: . * Weekly review of the patient's skin will be completed by the nurse and documented in the electronic medical record . *DNS (Director of Nursing Service) or designee will be responsible to implement and monitor the skin integrity program . When an open area is identified: . * Document evaluation of wound in electronic medical record including: *Location and staging *Size (length x width/depth) presence and location of undermining and tunneling * Exudate/if present: type, color, odor, and appropriate amounts . * Wound bed: color & type of tissue/character including evidence of healing (granulation) or necrosis (slough and eschar). * Reassess, re-evaluate and revise interventions when progress is not noted within 14 days. * Any deterioration of wound status initiate comprehensive re-evaluation, . Key Elements: . Interventions are observed in place . Weekly skin observations are completed .
RI #1's care plan titled I am at risk for impaired skin integrity and I have a Stage 4 pressure ulcer to sacrum . with a problem onset date of 6/5/2017 had the following approaches . * I need a weekly evaluation of wound healing . * I need a full skin evaluation weekly . * Adjust my treatment plan if wound no (not) healing within 2-4 weeks.
During a telephone interview on 8/10/2017 at 4:45 p.m., EI #3, the facility's former Treatment Nurse acknowledged that she was employed in the facility from November 2016 to 5/15/2017. EI #3 stated as the Treatment Nurse she was responsible for conducting wound assessment and following the physician's orders [REDACTED].#3 stated she assessed the wound for changes; conducted weekly measurements; observed for signs/symptoms of infection, drainage, and pain. EI #3 stated all information regarding a resident's wound was documented in the wound assessment section of the computer. When asked if she had an assistant to help perform the duties assigned to her, EI #3 said no. When asked who was responsible for conducting weekly wound assessment/wound care when she left the facility, EI #3 stated she didn't know.
In an interview on 8/11/2017 at 2:00 p.m., EI #6, the RN Unit Manager was asked after the Treatment Nurse, EI #3, left the facility, what system was in place to ensure weekly wound/skin assessments were completed. EI #6 replied there was no system/protocol in place. EI #6 explained the nurses on the floor performed wound care but there was no system or person identified to conduct weekly wound/skin assessments.
During an interview on 8/11/2017 at 4:30 p.m., EI #2, the Director of Nursing (DON) was asked who was responsible after the Treatment Nurse (EI #3) left to ensure wound/skin assessments were completed. EI #2 replied, it was the responsibility of the Unit Manager. When asked if the wound/skin assessment were being done after the Treatment Nurse left in May 2017, EI #2 said no. When asked why not, EI #2 stated she was not sure. EI #2 explained wound care was being done as she reviewed the Treatment Administration Record (TAR) documentation. EI #2 was asked when did she become aware that wound/skin assessment were not being done. EI #2 stated she became aware about one to two weeks prior to last survey (July 2017). EI #2 explained that she conducted an audit and found that assessments were not being documented. When asked what prompted this audit, EI #2 stated nothing prompted the audit she just had gotten around to reviewing that system. EI #2 explained she thought the Treatment Nurse (EI #3) was going to return; however, it was not until the latter part of June that EI #2 became aware that the Treatment Nurse (EI #3) was not coming back.
In an interview on 8/11/2017 at 4:40 p.m., EI #1, the facility's Administrator was asked who was responsible to ensure the system regarding every aspect of wound care to include assessments, nutrition, and prevention was implemented. EI #1 replied, she was. EI #1 explained that is was not until the last survey (July 2017) that she found out that wound/skin assessments were not being done. EI #1 stated she thought it was picked up by the other nurses. When asked how did she ensure that assessments were done after the Treatment Nurse (EI #3) left the facility, EI #1 stated she relied on her DON. EI #1 was asked, as the administrator of the facility, based on the fact wound/skin assessments were not done, has she maintained the residents' highest level of well being. EI #1 answered, No, the system was broke and now it is fixed.
In a follow-up interview with EI #2, the DON on 8/13/2017 at 12:45 p.m., she stated on 7/7/2017 she became aware that wound/skin assessments were not being done. When asked for documentation regarding the audit conducted, EI #2 stated she didn't have any written evidence of an audit or the audit findings. EI #2 again explained the nurses on the hall were doing the wound care; however, there was no one to conduct weekly wound/skin assessments. When asked about RI #1's physician order [REDACTED].#2 stated EI #5, the RN Unit Manager overlooked the order and it didn't get transcribed.
8) RI #2 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED].
RI #2's Annual Minimum Data Set with an assessment reference date of 8/1/17, indicated RI #2 had a pressure ulcer greater than a stage I and to have an unstageable pressure ulcer.
A review of RI #2's medical record revealed no weekly wound assessments from 5/1/17 through 7/18/17. RI #2's Wound Assessment Report dated 5/1/17, documented . Wound Location Sacrum present on admission . Stage Unstageable due to suspected deep tissue injury . Measurements Length - 6.80 cm Width - 9.80 cm Depth - 0.10 cm . RI #2's Wound Assessment Report dated 7/18/17, documented . Wound Type Pressure Ulcer . Wound Location Sacrum . Stage 2 . Measurements Length - 5.00 cm Width - 10.0 cm Depth - 0.00 cm .
On 8/10/17 at 3:30 p.m., the surveyor conducted an interview with EI #2, the Director of Nursing (DON). The surveyor asked EI #2 who was responsible for performing the weekly wound assessments for RI #2. EI #2 stated, (EI #3) the wound nurse up to May 1, 2017, afterwards the unit charge nurse and managers. The surveyor asked EI #2 if the weekly wound assessments were being performed from 5/1/17 through 7/18/17. EI #2 stated, no. The surveyor asked EI #2 if the weekly wound assessments were being conducted by the charge nurses and unit managers. EI #2 stated, No sir it was not.
On 8/10/17 at 4:49 p.m., the surveyor conducted a telephone interview with EI #3, the former Treatment Nurse. The surveyor asked EI #3 who was responsible for RI #2's weekly Wound Assessment Reports from 5/1/17 through 7/18/17. EI #3 said she was the treatment nurse. EI #3 said she left the facility 5/15/17. The surveyor asked EI #3 after she left the facility who was responsible for doing the wound assessment reports for RI #2. EI #3 said she was not sure.
On 8/14/17 at 1:42 p.m., the surveyor conducted an interview with EI #5, the former RN Unit Manager. The surveyor asked EI #5, after the treatment left, when was she made responsible or informed the Registered Nurses were responsible for the weekly wound and skin assessments. EI #5 she was never told this.
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On 8/15/2017 at 8:00 p.m., the facility submitted an acceptable Allegation of Credible Compliance which documented:
1. RI #1 was discharged from the facility on 7/6/17. RI #2 wound assessment was completed on 7/18/17 with weekly documentation to 8/14/17 by the Registered Nurse Unit Manager. Pressure Ulcer care plans for RI #2 have been reviewed and revised by the Minimum Data Set (MDS) Coordinator on 8/15/17 to assure implementation of weekly wound/skin assessments were completed and documented and observation of interventions are in place.
2. Canterbury Health and Rehabilitation Center does not have any residents that are utilizing a wound vac for Pressure Ulcer treatment as of 8/14/17. As of 8/15/17 all current Residents with identified pressure ulcers have a wound assessment completed and documented in the electronic health record by the Licensed Practical Nurse UM and Registered Nurse UM. On 8/15/17 the Registered Dietician Consultant reviewed 11 Residents with Pressure Sores for completion of Registered Dietician recommendations for Protein supplements with all completed, to include a review of RI #2. On 8/15/17 the Dietary Manager completed an audit of Registered Dietician recommendations over the past 30 days to assure Registered Dietician recommendations were implemented for RI #2.
3. On 8/14/17 the Director of Clinical Education, Director of Nursing, Registered Nurse Supervisor and Director of Clinical Operations provided an In-service education for the Licensed Nurses on completion and documentation of the center's weekly wound assessments. No Licensed Nurse will work after 8/15/17 until education has been completed. On 8/15/17 an In-service education provided to the Facility Director of Nursing Services and Administrator by the Senior Director of Clinical Operations on the Facility guideline for Skin Care and Registered Dietician recommendations for residents with Pressure Ulcers.
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After reviewing the facility's information provided in their acceptable Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 314 was lowered to a D level on 8/15/2017, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.
This deficient practice was cited as a result of the investigation of complaint/report AL 237.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **015382**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/15/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANTERBURY HEALTH CARE FACILITY	**1720 KNOWLES ROAD PHENIX CITY, AL 36869**

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 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record review and a review of the facility's policies titled: Handwashing/Hand Hygiene, Peri Care Audit Tool and Hand Hygiene Care Audit, and Fundamentals of Nursing (Potter & Perry), the facility failed to ensure: Employee Identifier (EI) #1, a Certified Nursing Assistant (CNA) did not use contaminated gloves, that were pulled from her pocket, to provide incontinence care for Resident Identifier (RI) #2, as well as wash her hands and changed her gloves after providing incontinence care; EI #2, CNA, washed her hands after removing her gloves after performing incontinence care for RI #2; EI #16, CNA, washed her hands after providing incontinence care to RI #3, a resident who was soiled with stool; and EI #18, CNA, did not pick up contaminated linens off the floor and placed them on RI #3's bed. These deficient practices affected two of two residents, RI #2 and RI #3, who were observed receiving incontinence care. Findings include: A review of the facility's policy titled, Peri Care Audit Tool revealed: . 6. Buttock, washes . 7. STOP! Removes gloves, washes/sanitizes hands and re-gloves. 8. Applies Clean Brief . A review of the facility's policy titled, Hand Hygiene Care Audit revealed: . 9. Washes hands every time gloves are removed. 1) RI #2 was readmitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. During an incontinence care observation on 7/19/17 at 10:20 a.m., the CNA, EI #1 removed gloves from her pocket and provided care for RI #2. EI #1 did not wash her hands and change her gloves after cleaning RI #2's left buttock and before fastening the clean brief. On 7/19/2017 at 10:37 a.m., the CNA, EI #2 was observed not washing her hands after removing her gloves during incontinence care on RI #2. An interview was conducted on 7/20/2017 at 2:25 p.m., EI #1, the CNA was asked if gloves should be stored in her pocket. EI #1 replied, No. EI #1 was asked what should be done after cleaning the buttocks and before applying the clean brief. EI #1 replied, Wash your hands. EI #1 was asked if she washed her hands after cleaning the buttocks and before fastening the clean brief. EI #1 replied, No. EI #1 was asked what was the potential for harm in not washing hands and applying clean gloves after cleaning the buttocks and before applying the clean brief. EI #1 replied, Infection. An interview was conducted on 7/20/2017 at 3:00 p.m. with EI #2, a CNA. EI #2 was asked what must be done after removing gloves during incontinence care. EI #2 replied, Wash your hands. When asked what was the potential harm in not washing hands after removing gloves during incontinence care. EI #2 replied, Spread of germs. 2) A review of Potter and Perry Chapter 28 titled Infection Prevention and Control page 411 with a copyright date of 2013, documented . Cleaning is the removal of all soil . from objects and surfaces . cleaning involves use of water and mechanical action with detergents . When an object comes in contact with an infectious or potentially infectious material, it is contaminated . Reusable objects need to be cleaned thoroughly before reuse . A review of a facility policy titled Handwashing/Hygiene with a revised date of August 2014 documented . This facility considers hand hygiene the primary means to prevent the spread of infections. 7. Use . soap . and water for the following situations: . m. After removing gloves. RI #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. RI #3's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/2016 revealed RI #3's Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition, and required extensive assist with all Activities of Daily Living (ADL). Section H revealed RI #3 was always incontinent of bladder and bowel. On 08/10/2017 at 4:56 p.m., EI #18, a CNA entered RI #3's room and picked the blanket and sheets off the floor and placed on top of the resident. On 08/11/2017 at 2:10 p.m., an interview was conducted with the CNA, EI #18. EI #18 was asked when you went into RI #3's room what did you do with the linen on the floor. EI #18 said she picked the linen up and put over RI #3. EI #18 was asked should you have placed linen on the floor on the resident. EI #18 said no, because it was contaminated. EI #18 was asked what should you have done with the linen. EI #18 said taken the linen to the hamper and gotten clean linen to place over the resident. On 08/13/2017 at 12:30 p.m., an interview was conducted with EI #12, the Registered Nurse (RN) Infection Control Nurse. EI #12 was asked if staff should pick linen off the floor and place on the resident. EI #12 said no because the linen would be dirty. 3) On 08/10/2017 at 5:39 p.m., an observation was made during incontinent care with EI #16, a CNA. EI #16 wiped RI #3 and stool was present removed her gloves. EI #16 did not wash her hands before opening the resident's closet and touching clean clothing. EI #16 then washed her hands and applied gloves and wiped stool off of RI #3. EI #16 removed her gloves, but failed to wash her hands before placing a clean brief . On 08/10/2017 at 6:51 p.m., an interview was conducted with EI #16, a CNA. EI #16 was asked everytime you removed your gloves did you wash your hands. EI #16 said no I did not and I opened the closet door and touched clothing and the clean brief. I should have washed my hands because of spreading infection. On 08/13/2017 at 12:30 p.m., an interview was conducted with EI #12, the RN Infection Control. EI #12 was asked what was the facility's policy on handwashing and gloving. EI #12 said wash hands before gloving and after removing gloves. EI #12 was asked should staff touch clean objects/linen after removing dirty gloves and not washing their hands. EI #12 said no because of contamination. EI #12 was asked which direction should staff be wiping with peri care. This deficiency was cited as a result of the investigation of complaint/report number AL 237.
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 review of Employee Identifier (EI) #1, the Administrator and EI #2, the Director of Nursing's job description and staff interviews, the administrative staff failed to have a system in place to ensure weekly wound assessments were completed after the Treatment Nurse, EI #3, left the faciity on [DATE] The Administrator, EI #1, revealed in an interview, the facility's system was broken. This failure placed RI #1 in immediate jeopardy of serious injury, harm or death and affected RI #2, two of nine sampled residents reviewed for pressure ulcer care. On 8/14/2017 at 1:28 p.m., EI #1, the Administrator and EI #2, the Director of Nursing (DON) were notified of the findings of immediate jeopardy level of K in the area of Administration, F 490. Findings include: Refer to F 282 and F 314 The undated job description of EI #2, the DON, documented . ACCOUNTABILITY OBJECTIVE Manages the Department of Nursing in accordance with policy and procedure, state and federal regulations to promote high quality care and service to the facility and community . KEY RESPONSIBILITIES . 1. Implements policies/procedures with follow-up and supervision of staff to ensure compliance; . 7. responsible to develop systems . 12. Ensures medical services are provided as required by regulation . During an interview on 8/11/2017 at 4:30 p.m., EI #2, the DON was asked who was responsible after the Treatment Nurse (EI #3) left to ensure wound/skin assessments were completed. EI #2 replied, it was the responsibility of the Unit Manager. When asked if wound/skin assessments were being done after the Treatment Nurse left in May 2017, EI #2 said no. When asked why not, EI #2 stated she was not sure. EI #2 explained wound care was being done as she reviewed the Treatment Administration Record (TAR) documentation. EI #2 was asked when did she become aware that wound/skin assessment were not being done. EI #2 stated she became aware about one to two weeks prior to last survey (July 2017). EI #2 explained that she conducted an audit and found that assessments were not being documented. When asked what prompted this audit, EI #2 stated nothing prompted the audit she just had gotten around to reviewing that system. EI #2 explained she thought the Treatment Nurse (EI #3) was going to return; however, it was not until the latter part of June that EI #2 became aware that the Treatment Nurse (EI #3) was not coming back. In a follow-up interview with EI #2, the DON on 8/13/2017 at 12:45 p.m., she stated on 7/7/2017 she became aware that wound/skin assessments were not being done. When asked for documentation regarding the audit conducted, EI #2 stated she didn't have any written evidence of an audit or the audit findings. EI #2 again explained the nurses on the hall were doing the wound care; however, there was no one to conduct weekly wound/skin assessments. When asked about RI #1's physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **015382**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/15/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANTERBURY HEALTH CARE FACILITY	**1720 KNOWLES ROAD PHENIX CITY, AL 36869**

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 0490

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 5)
order [REDACTED].#2 stated EI #5, the RN Unit Manager overlooked the order and it didn't get transcribed.
The job description of EI #1, the Administrator, dated 1/4/2017 documented . Accountability Objective Directs, oversees and manages the 24/7 day to day operations of the Diversicare post-acute care center . Key Responsibilities . Ensures compliance with State and Federal Regulations .
On 8/11/2017 at 4:40 p.m., EI #1, the facility's Administrator was asked who was responsible to ensure the system regarding every aspect of wound care to include assessments, nutrition, prevention, etc. was implemented. EI #1 replied, she was. EI #1 explained that is was not until the last survey (July 2017) that she found out that wound/skin assessments were not being done. EI #1 stated she thought it was picked up by the other nurses. When asked how did she ensure that assessments were done after the Treatment Nurse (EI #3) left the facility, EI #1 stated she relied on her DNS. EI #1 was asked, as the administrator of the facility, based on the fact wound/skin assessments were not done, has she maintained the residents' highest level of well being. EI #1 answered, No, the system was broke and now it is fixed.
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On 8/15/2017 at 8:00 p.m., the facility submitted an acceptable Allegation of Credible Compliance which documented:
1. RI #1 was discharged from the facility on 7/6/17. RI #2 wound assessment was completed on 7/18/17 with weekly documentation to 8/14/17 by the Registered Nurse Unit Manager. Pressure Ulcer care plans for RI #2 have been reviewed and revised by the Minimum Data Set (MDS) Coordinator on 8/15/17 to assure implementation of weekly wound/skin assessments were completed and documented and observation of interventions are in place. The Registered Dietician Consultant reviewed the Nutrition assessment for RI #2 on 8/15/17 for accuracy of supplements with no negative findings.
2. Canterbury Health and Rehabilitation Center does not have any residents that are utilizing a wound vac for Pressure Ulcer treatment as of 8/14/17. As of 8/15/17 all current Residents with identified pressure ulcers have a wound assessment completed and documented in the electronic health record by the Licensed Practical Nurse UM and Registered Nurse UM. On 8/15/17 the Registered Dietician Consultant reviewed 11 Residents with Pressure Sores for completion of Registered Dietician recommendations for Protein supplements with all completed, to include a review of RI #2. On 8/15/17 the Dietary Manager completed an audit of Registered Dietician recommendations over the past 30 days to assure Registered Dietician recommendations were implemented for RI #2. On 8/14/17 the Director of Clinical Education, Director of Nursing, Registered Nurse Supervisor and Director of Clinical Operations provided an In-service education for the Licensed Nurses on completion and documentation of the center's weekly wound assessments. No Licensed Nurse will work after 8/15/17 until education has been completed. On 8/15/17 an In-service education provided to the Facility Director of Nursing Services and Administrator by the Senior Director of Clinical Operations on the Facility guideline for Skin Care and Registered Dietician recommendations for residents with Pressure Ulcers. On 8/15/17 the Facility Administrator assured that the facility maintains compliance with state and federal rules and regulations by reviewing the facility's quality indices to include the facility's weekly wound/skin assessments and Registered Dietician recommendations weekly to include follow up in the Quality Assurance Process Improvement (QAPI) Meeting minutes. Non-compliance with state and federal rules and regulations was (has) been addressed with an Allegation of Credible Compliance. On 8/15/17 the Administrator developed a schedule to meet with Department Managers individually to discuss department functions/concerns as it relates to resident care improvement and identify any resources that may be needed. The Administrator will assure that she utilizes the Facility's resources effectively and efficiently to attain or maintain the highest physical, mental, and psychosocial well-being of each resident by utilizing the expertise of the Facility staff as well as the Corporate Office.
****
After reviewing the facility's information provided in their acceptable Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 490 was lowered to a E level on 8/15/2017, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.
This deficiency was cited as a result of the investigation of complaint/report AL 237.

F 0502

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Give or get quality lab services/tests in a timely manner to meet the needs of residents.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on a review of Resident Identifier (RI) #3's medical record and staff interview, the facility failed to ensure a Basic Metabolic Profile (BMP), a laboratory test, was obtained as ordered for RI #3. This affected one of nine residents whose labs were reviewed.
Findings include:
RI #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
A review of RI #3's February 2017 Physician order [REDACTED].
A review of a facility document titled Clinical Laboratory Services documented . DATE DRAWN 2/27/2017 . TEST NAME . BASIC METABOLIC .
On 08/12/2017 at 5:30 p.m., an interview was conducted with Employee Identifier (EI) #6, the Registered Nurse (RN) Unit Manager. EI #6 was asked what did the physician order [REDACTED]. EI #6 said to collect it every three months. EI #6 was asked when was the last BMP. EI #6 said 02/27/2017. EI #6 was asked why was that the last BMP drawn. EI #6 said because it didn't get drawn. EI #6 was asked who was responsible to ensure the lab orders were obtained. EI #6 stated, she was. EI #6 was asked why was it important to obtain the BMP. EI #6 said to monitor the electrolytes.
This deficiency was cited as a result of the investigation of complaint/report number AL 237.

F 0520

Level of harm - Immediate jeopardy

Residents Affected - Few

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 staff interviews and review of the facility's policy titled Guideline QAPI (Quality Quality Assurance Performance Improvement), the facility failed to implement an action plan when it was determined weekly wound/skin assessments were not being done. Employee Identifier (EI) #2, the Director of Nursing, responsible for leading the QA committee, and EI #1, the Administrator, both were aware weekly wound/skin assessments were not being done since the Treatment Nurse left the facility; however, no action plan had been implemented to correct the identified deficient practice. This failure placed RI #1 in immediate jeopardy of serious injury, harm or death and affected RI #2, two of nine sampled residents reviewed for pressure ulcer care.
On 8/14/2017 at 1:28 p.m., EI #1, the Administrator and EI #2, the Director of Nursing (DON) were notified of the findings of immediate jeopardy level of J in the area of Quality Assessment and Assurance, F 520.
Findings include:
Refer to F 282, F 314 and F 490.
The facility's undated policy titled Guideline QAPI (Quality Quality Assurance Performance Improvement) documented Purpose: QAPI is a data driven, proactive approach to improving the quality of life, care and services in ours centers. The activities of QAPI involve team members at all levels of the organization to identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor the effectiveness of our interventions. QAPI is consistent with our Service Standard: We continually strive to improve personal and company performance Guidelines for completion: QAPI meeting are held monthly . Once the meeting is held with analysis of data and plans of action documented the finished template is posted on the center's shared drive. Five Elements of QAPI: Element 1: Design and Scope . When fully implemented, QAPI program addresses all systems of care and management practices, and includes clinical care, quality of life, and resident choice
Element 4: Performance Improvement Projects (PIPS) A performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the center or center wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The center conducts PIPs to examine and improve care or services in areas identified as needing attention.
Element 5: Systematic Analysis and Systemic Action The center uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. Centers will demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **015382**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/15/2017**
NAME OF PROVIDER OF SUPPLIER **CANTERBURY HEALTH CARE FACILITY**		STREET ADDRESS, CITY, STATE, ZIP **1720 KNOWLES ROAD PHENIX CITY, AL 36869**	

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 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) events and promote sustained improvement . In an interview on 8/9/2017 at 8:30 a.m., Employee Identifier (EI) #1, the Administrator identified EI #2, the Director Of Nursing, as the person responsible for leading the Quality Assurance (QA) committee. During an interview on 8/11/2017 at 4:30 p.m., EI #2, the DON was asked if wound/skin assessments were being done after the Treatment Nurse left in May 2017, EI #2 said no. When asked why not, EI #2 stated she was not sure. EI #2 explained wound care was being done as she reviewed the Treatment Administration Record (TAR) documentation. EI #2 was asked when did she become aware that wound/skin assessment were not being done. EI #2 stated she became aware about one to two weeks prior to last survey (July 2017). EI #2 explained that she conducted an audit and found that assessments were not being documented. When asked what prompted this audit, EI #2 stated nothing prompted the audit she just had gotten around to reviewing that system. EI #2 explained she thought the Treatment Nurse (EI #3) was going to return; however, it was not until the latter part of June that EI #2 became aware that the Treatment Nurse (EI #3) was not coming back. When asked about QA, EI #2 stated the topic of wound/skin assessments was a concern of hers but she was trying to get a Wound Care (Treatment) Nurse. In an interview on 8/12/2017 at 1:05 p.m., EI #1, the Administrator was asked what evidence did the facility have to verify the topic of wound/skin assessments were discussed in QA and an action plan was implemented to address the issue of the licensed nursing staff not performing weekly wound/skin assessments. EI #1 replied she didn't have anything but a plan of correction from when the State Agency left the faciity on [DATE]. ************************* On 8/15/2017 at 8:00 p.m., the facility submitted an acceptable Allegation of Credible Compliance which documented: On 8/15/17 an In-service education was provided to the Administrator and Director of Nursing by the Area Vice President on the Facility guideline for Quality Assurance Process Improvement to assure Quality Assurance Process Improvement is data driven, a proactive approach to improving the quality of life, care and services in our Facility. Quality Assurance Process Improvement involves staff at all levels to identify opportunities for improvement; address gaps in systems or processes and develop and implement an improvement or corrective plan and continuously monitor the effectiveness of our interventions. On 8/15/17 an In-service education was provided to the Facility Director Nursing Service and Administrator by the Senior Director of Clinical Operations to address ongoing completion of Pressure Ulcer/skin assessments as well as review and follow up of Registered Dietician recommendations for residents with Pressure Ulcers, Review/revise and development of care plans for identified concerns; review of Physician orders [REDACTED]. On 8/15/17 a Quality Assurance Process Improvement meeting was held with the Administrator, Director Nursing Service, and Regional Vice President, Director of Clinical Education, Registered Nurse Unit Manager, Licensed Practical Nurse UM, Director of Rehab and Medical Director per phone. This meeting reviewed the Allegation of Credible Compliance that was developed effective 8/15/17. Reviewed Quality of Care and Administration for Wound care assessments and documentation, current status of education, no licensed staff will work after 8.15.17 until training is completed. ************************* After reviewing the facility's information provided in their acceptable Allegation of Credible Compliance and verifying the immediate actions had been implemented, the scope/severity level of F 520 was lowered to a D level on 8/15/2017, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation/report of complaint/report number AL 237.