STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035232	A. Building B. Wing	02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	1313 West Magee Road Tucson, AZ 85704

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36759 Based on clinical record reviews, observations, staff and resident interviews and policy review, the facility failed to ensure that two residents (#39 and #245) were treated with dignity and respect. The deficient practice could result in further incidents of residents not being treated in a dignified manner. Findings include: -Resident #39 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, adult failure to thrive and ileostomy status. An observation was conducted on January 27, 2020 at 2:49 p.m. of resident #39 lying in bed with the door open and the bed was closest to the door leading to the hallway. During the observation, the resident's brief and colostomy bag were exposed and visible from the hallway. Stool could be observed in the colostomy bag. At 3:01 p.m., the call light for this room was turned on. A staff member entered the room for a brief moment and then exited the room. The resident was left exposed. From 3:08 p.m. to 3:23 p.m., the resident continued to be exposed and was visible from the hallway, despite multiple staff walking by the resident's room. In an interview with a Certified Nursing Assistant (CNA/staff#68) on February 2, 2020 at 10:03 a.m., she stated that to maintain residents' dignity, she makes sure the door is closed and/or curtain is closed when providing patient care. She stated, if a resident is exposed when she walks by the room, she would go in and correct it. She stated if the resident refuses, she would ask if she could close the resident's door and if the resident refuses, she would report it to management. An interview with a Licensed Practical Nurse (LPN/staff #67) was conducted on February 3, 2020 at 10:29 a.m. She said to treat resident's with dignity, she gives resident's their privacy. She stated if she sees a resident exposed from the hallway, she would go in and inform them they are exposed and cover them. In an interview with the Director of Nursing (DON/staff #132) on February 3, 2020 at 10:49 a.m., she stated that she was unsure why a staff member would enter the resident's room and not at least offer to cover the exposed resident. She stated it is her expectation to keep the resident's covered and that nothing personal should be exposed from the hallway, where passersby's can see it. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	35111 -Resident #245 was admitted to the facility on [DATE], with diagnoses of encephalopathy, muscle weakness and cognitive communication deficit. A review of the inventory of personal effects sheet dated January 11, 2020 revealed no documentation of any personal garments/clothes. The daily skilled note dated January 13, 2020 included the resident was alert and oriented x 2 with confusion, but can make basic needs known. The physician progress note dated January 15, 2020 revealed the resident was alert and oriented x 4. The admission MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 8, indicating the resident had moderately impaired cognition. The physician progress note dated January 25, 2020 revealed the resident was alert and oriented x 4. Multiple observations conducted on January 27, 2020 revealed the following: -At 9:50 a.m. resident #245 was observed sitting up in bed and was wearing a yellow printed hospital gown. -At 11:02 am, the resident was in therapy and was still wearing the yellow printed hospital gown. During an interview with the resident conducted on January 27 at 11:41 a.m., she was still wearing the yellow printed hospital gown which was loosely tied on the neck and the resident had to pull the front collar of the gown occasionally to keep her chest area from becoming exposed. When asked about wearing the hospital gown, the resident did not comment. Another observation of the resident was conducted on January 27, 2020 at 2:16 p.m. The resident was in her room and was still wearing the yellow printed hospital gown. An observation was conducted on January 28, 2020 at 8:15 a.m., of the resident in bed watching television and she was wearing a yellow hospital gown. The neckline of the gown was all the way down her chest exposing her neck/shoulder area and the area just above her breast. In another interview conducted on January 30, 2020 at 9:54 a.m., resident #254 was observed wearing a blue short sleeved dress. The resident stated she did not choose to wear and did not like wearing the gown for the past 2-3 days. She stated that she did not have a choice because the facility could not find her clothes. Resident #254 said she has an appointment to go to and the facility was only able to find her clothes yesterday. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with a licensed practical nurse (LPN/staff #111) was conducted on January 30, 2020 at 10:58 a. m. She stated when a resident is admitted at the facility, an inventory of the resident's personal items are completed by the certified nursing assistant (CNA). She stated if the resident does not have anything to wear, the CNA's check for any donated clothes the resident can wear. Further, she stated that hospital gowns are only used by residents if they want and choose to wear them. In an interview with a CNA (staff #19) conducted on January 31, 2020 at 10:55 a.m., she stated she does not know the resident very well but she knows that the resident is alert and oriented. She stated if a resident is wearing a hospital gown they were admitted with no change of clothes in their personal belongings. She stated if this happens, she will try to find something that would fit the resident from the donated clothes the facility has. During an interview with a LPN (staff #92) conducted on February 3, 2020 at 10:10 a.m., she stated if residents wear a hospital gown it may be because it is their scheduled shower. She stated the resident cannot wear a hospital gown unless the resident chooses to wear one. She stated if the resident prefers to wear a hospital gown, it will be noted in the resident's care plan or the clinical record. Review of a policy titled, Dignity and Respect revealed that all residents will be treated with kindness, dignity and respect. Residents will be appropriately dressed in clean clothes arranged comfortably on their persons and be well groomed. The policy included that residents shall be examined and treated in a manner that maintains the privacy of their bodies and that the privacy of a resident's body shall be maintained during toileting, bathing and other activities of personal hygiene.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36759 Based on clinical record reviews, interviews and policy review, the facility failed to provide oversight of the facility's pressure ulcer program, resulting in a pattern of failures regarding the care and treatment of pressure ulcers for four of five residents (#'s 245, 247, 248 and 89), resulting in neglect. The deficient practice resulted in inadequate care to residents with pressure ulcers. Findings include: -Resident #245 was admitted to the facility on [DATE], with diagnoses that included sepsis, pressure induced deep tissue damage of right heel and pressure ulcer of sacral region-unstageable. Regarding the left heel: According to a care plan dated January 11, 2020, the resident had a fluid filled blister to the left heel. Interventions were to monitor and document the location, size and treatment of skin injuries, and to report abnormalities to the provider (failure to heel, signs and symptoms of infection or maceration). However, review of the clinical record revealed there was no thorough assessment of the left heel that that included any measurements, description of the wound bed and surrounding skin, or if any drainage was present, from January 11 through 19, 2020. There was also no documentation that the physician was notified, nor any evidence that the left heel was provided any treatment from January 11 through 19. An assessment of the left heel was completed on January 20, 2020. The left heel wound was described as having eschar and measured 9.5 cm x 10 cm. Despite the wound being on the heel, it was not identified as a pressure ulcer. In addition, there was no physician's order obtained until January 27, 2020, which stated it was a late entry for January 20, 2020, however, the treatment did not start until January 28. An interview with a Licensed Practical Nurse (LPN/wound nurse/staff #35) was conducted on January 30, 2020 at 10:53 a.m. She stated that she did an assessment upon admission of resident #245 and that the left heel area was identified on January 20, 2020. She said that a treatment would have been started upon finding the area on January 20. She then reviewed the TAR and acknowledged that the treatments were not documented until January 27. She stated she must have forgotten to put the treatment into the electronic charting system. Regarding the buttocks/coccyx: An Initial Admission Record dated January 11, 2020 included the resident had redness on the buttocks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, a care plan dated January 11, 2020 revealed the resident had an unstageable wound to the coccyx. Interventions were to monitor and document the location, size and treatment of skin injuries, and to report abnormalities to the provider (failure to heel, signs and symptoms of infection or maceration). Review of the clinical record revealed there was no thorough assessment of the redness to the buttocks area or a description of the unstageable wound to the buttocks on admission, no documentation that the physician was notified and no treatment that was done on January 11 or 12, 2020. Review of the clinical record revealed the buttocks was assessed on January 13, 2020, two days after admission. The pressure ulcer measured at 4.5 cm x 5.5 cm and was unstageable with slough/eschar. Despite this, there was still no physician's order for any treatment to the buttocks area until January 15. A physician's order was obtained on January 15, 2020 for the coccyx pressure ulcer. The coccyx pressure ulcer was assessed next on January 20, 2020. The pressure ulcer measured 4.5 x 5.8 cm and was unstageable with eschar. There was no documentation that the physician ordered treatment was done on January 20 and 22. Per the wound documentation dated January 24, 2020, the coccyx wound measured 12 x 19 x 2.0 cm with 40% eschar and 30% pink tissue. In an interview with staff #35 on January 30, 2020 at 10:53 a.m., she stated she did an assessment upon admission for resident #245. She stated that she noted the cites that were found including the sacral area. She stated the wound NP was brought in because the wound on the coccyx was not getting better. Regarding the right heel: An Initial Admission Record dated January 11, 2020 revealed the resident had a blister to the right heel. A care plan dated January 11, 2020 revealed, the resident had a deep tissue injury to the right heel. Interventions were to monitor and document the location, size and treatment of skin injuries, and to report abnormalities to the provider (failure to heel, signs and symptoms of infection or maceration). Review of the clinical record revealed there was no thorough assessment of the blister to the right heel, no documentation that the physician was notified and no treatments were documented from January 11 through January 13, 2020. Further review of the clinical record revealed the wound was not assessed until January 13, 2020, two days after admission. The right heel was unstageable and measured 2.0 x 1.0, unstageable with (slough/eschar), blood blister, no exudate, no odor and was present on admission. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, review of the clinical record and the TAR revealed no physician's order for any treatment to the right heel until January 15, 2020. According to the January 2020 TAR, the physician ordered treatment was not completed from January 17 through January 24. A wound note showed that the right heel was assessed on January 20, 2020 and measured 4.5 x 3.0 cm. A wound care consult note dated January 24, 2020 included the right heel had two wounds; one was 4.5 x 3.0 and one was on the right planter which measured 2.5 x 2.5 cm, with 100% eschar. During an interview with staff #35 conducted on January 30, 2020 at 10:53 a.m., she said that she did an assessment upon admission for resident #245. Regarding the days where the treatments were not documented as completed, she stated that sometimes time gets away from her and she may forget to document that the treatment was done. She stated she has a notebook where she jots down treatments that she does for the day and any new orders. However, review of this documentation did not provide what type of treatment was done or what the location of the treatment was. -Resident #89 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia, type 2 diabetes mellitus and dysphagia. A care plan included the resident was at risk for impairment to skin integrity related to a history of moisture associated skin damage, bladder incontinence and limited mobility. The care plan included the resident had a stage 2 pressure ulcer to the right buttock. An intervention was to provide treatment as ordered. A skin pressure ulcer weekly assessment dated [DATE] revealed there was an open area to the right buttock which was identified on October 1, 2019. The assessment included the wound was a stage 2 measuring 4 cm x 2 cm x 0.1 cm. The interventions were to cleanse buttocks and apply barrier cream every shift and as needed until healed, and reposition frequently. A physician's order dated October 2, 2019 included to cleanse buttocks and apply barrier cream every shift and as needed until healed for wound care. Review of the Treatment Assessment Record (TAR) for October 2019 revealed the wound treatment order and been transcribed onto the TAR, however, the treatment was not completed on 8 occasions. Review of the TAR for November 2019 revealed the wound treatment was not completed on 2 occasions. Review of the TAR for December 2019 revealed the wound treatment was not completed on 2 occasions. A physician's order dated January 2, 2020 included for a sponge dressing to bilateral buttocks, cleanse with saline, cover with sponge dressing daily x 10 days in the morning for wound healing, until January 13, 2020. Review of the TAR for January 2020 revealed the wound treatment was not completed on 3 occasions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with a LPN (staff #82) on January 30, 2020 at 10:00 a.m., she stated the floor nurse who admits a new resident to the facility completes the initial skin assessment. She said if something of concern is noted, it is documented and the wound nurse is notified. She stated the wound nurse does a complete assessment of the area of concern. She stated if an area of concerns on the skin is identified by a Certified Nursing Assistant (CNA) during care, they are to report it to the nurse right away and will look at it, then the nurse should contact the doctor to get an order and that the wound nurse should also be notified. In an interview with the wound nurse (staff #35) on January 30, 2020 at 10:24 a.m., she stated that upon admission she does a skin evaluation assessment. She stated she notes everything she sees on the assessment and then opens a more specific pressure ulcer or non-pressure ulcer weekly assessment on a schedule, so it will trigger every week in the system. She stated if a resident has a wound concern, she will put the appropriate treatment in place with the wound NP who comes in weekly. She stated the wound NP rounds with her on residents he is following and sees any new residents who she has concerns about. She stated that she stages the wounds unless she has questions, then she would consult with the wound NP. She stated when she does her initial assessment, she assesses the resident by starting at the heels and works her way up. She stated if something comes up on a resident she is not already seeing, staff members let her know there is an area of concern. An interview was conducted on January 31, 2020 at 12:53 p.m., with the wound NP (staff #141). He stated he does not work specifically for this building, but rounds once a week with the wound nurse (staff #35). He stated they follow her list of residents with wounds and go over any new concerns she has. He also stated that he is not contracted to work with all of the residents in the facility. He stated he typically lets staff #35 measure so the measurements stay consistent, but he is also assessing everything such as, how debilitated they are, preventative measures in place and signs and symptoms of infection. He further stated that he only provides oversight to staff #35 when he is here rounding with her. 35111 -Resident #247 was admitted to the facility on [DATE], with diagnoses of morbid obesity and type II diabetes. Review of the hospital history and physical note dated January 12, 2020 revealed the resident had no rashes or lesions to exposed areas of the skin. Regarding the mid back pressure ulcer: The initial admission record dated January 13, 2020 included the resident was alert and oriented to person, place and time. Per the assessment, there was no documentation of a pressure ulcer to the back. A nursing admission note dated January 13, 2020 included that a head to toe assessment was done and there was no documentation of a pressure ulcer to the back. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, a skin care plan dated January 13, 2020 included the resident had a stage 3 pressure ulcer on the vertebrae. The goal was to have no complications related to skin injury type. Interventions were to monitor/document location, size, treatment of skin injury and report to the physician abnormalities (failure to heal, signs and symptoms of infection, maceration). A skin evaluation was completed on January 14, 2020 and revealed the resident had a pressure ulcer to the mid back. However, the documentation did not include the stage, measurements, a description of the wound bed/edges and surrounding skin, and if any drainage was present. Despite documentation that the resident had a stage 3 pressure ulcer, there was no clinical record documentation that a thorough assessment of the stage 3 pressure ulcer to the mid back was completed on January 13 or 14, 2020, nor any evidence that the physician was notified, or that treatment orders were obtained or that wound treatments were provided on January 13 or 14. The weekly skin pressure ulcer note dated January 15, 2020 which was two days after admission and was not signed by the nurse revealed the resident had a stage 3 pressure ulcer to the mid vertebrae. Per the note, this assessment was the initial evaluation. The assessment included the pressure ulcer was present on admission, with an unknown onset date. The wound measured 1 cm x 2 cm x 1.5 cm, with a pink wound bed and undefined edges, and a small amount of serosanguineous exudate and surrounding skin was normal. However, there were no physician orders for any wound treatment on January 15 or 16. The wound NP note dated January 17, 2020 included a chief complaint of mid-back wound. The history of present illness included the wound nurse reported wound on the back x 1 year. The plan included aggressive wound care and offloading of pressure points, assistance with turning as needed. Goals included offloading of all pressure points by turning, using specialized mattresses, wheelchair cushions and clearing of dead tissue if any. The treatment included to apply Mupirocin (topical antibiotic) to 1/4 inch packing gauze three times a week and as needed. The documentation did not include the type of wound, the stage, any measurements or a description of the wound bed/edges/surrounding skin and if any drainage was present. Despite documentation in the NP note to apply Mupirocin to the back, there was no physician's order for Mupirocin to be applied. In addition, there was no evidence that the Mupirocin was applied to the mid back pressure ulcer from January 17 through 20. The weekly skin pressure ulcer note dated January 21, 2020 revealed the resident had a stage 3 pressure ulcer to the upper mid vertebrae which was present on admission. Per the note, the pressure ulcer measured 1 cm x 2 cm x 1.5 cm, with a pink wound bed, undefined wound edges, had scant serosanguineous exudate, no odor and normal surrounding skin. The treatment included to cleanse the area with Dakin's solution, pat dry, pack with packing strip and cover with dry dressing Monday, Wednesday and Friday and as needed until resolved. However, was there no order for Dakins treatment and there was no documentation that the treatment was done from January 21-23, 2020. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The wound NP note dated January 24, 2020 included a chief complaint of mid back wound. Per the note, the back wound was chronic. The low back open wound measured 1 cm x 2 cm x 2.7 cm, wound bed was 80% pink and 20% yellow slough, with a small amount of serous drainage. The plan was to continue Anasept on 1/4 inch packing gauze 3x/week and as needed and cover. However, there was no physician's order for the use of Anasept and this treatment was not on the MAR/TAR for January 2020. As a result, there was no evidence that this treatment was administered from January 24-27. The weekly skin pressure ulcer note dated January 28, 2020 included a stage 3 pressure ulcer to the upper mid vertebrae which was present on admission. The wound measured 1 cm x 2 cm x 1.7 cm with a pink wound bed, scant serosanguineous exudate with no odor, undefined wound edges and normal surrounding skin. The treatment documented was to cleanse the area with Dakin's solution, pat dry, pack with packing strip and cover with a dry dressing on Monday, Wednesday and Friday and as needed until resolved. On January 28, 2020, a physician's order was obtained to cleanse the wound with Dakin's solution, quarter strength solution, pat dry, apply packing strip soaked in Anasept wound gel and pack Monday, Wednesday and Friday and as needed until resolved for a diagnosis of a stage 3 pressure ulcer to mid back. Regarding the coccyx and right gluteal pressure ulcers: The initial admission record dated January 13, 2020 included the resident was alert and oriented to person, place and time. Per the assessment, the resident had a pressure ulcer on the coccyx and on the right gluteal area. The nursing admission note dated January 13, 2020 included a head to toe assessment was completed and the resident had a pressure ulcer to the coccyx, with a dressing in place and no drainage and had a pressure ulcer to the right gluteal area. The note did not include measurements, a description of the wound bed/edges and surrounding skin of both pressure ulcers. A skin care plan dated January 13, 2020 revealed the resident had potential/actual impairment to skin integrity and had a stage 3 pressure ulcer on the vertebrae. However, the pressure ulcers to the coccyx and the right gluteal area were not included in the care plan. A goal was to have no complications related to skin injury type. Interventions included for monitoring/documenting location, size, treatment of skin injury and report any abnormalities (failure to heal, signs and symptoms of infection and maceration) to the physician. A physician's order dated January 13, 2020 included the following orders: Cleanse pressure ulcer to the coccyx with NS (normal saline), pat dry and cover with 4 x 4 gauze in the mornings; and apply barrier cream to pressure ulcer to right gluteal area every shift until healed. The order also included for the pressure ulcer to the coccyx and right gluteal area to be staged by house wound nurse in the morning (on January 14). A skin evaluation was completed by the wound nurse (staff #35) on January 14, 2020. However, it did not include any documentation regarding a pressure ulcer to the coccyx and right gluteal area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the clinical record revealed there was no documentation that the pressure ulcers to the coccyx and the right gluteal fold were evaluated by the wound nurse on January 14, 2020, as ordered by the physician. The NP progress note dated January 15 and 17, 2020 revealed no documentation of any open areas or pressure ulcers. The January 2020 TAR included the wound treatment orders to cleanse the pressure ulcer to the coccyx with NS, pat dry and cover with 4 x 4 gauze in the mornings; and to apply barrier cream to the pressure ulcer to right gluteal area every shift until healed. However, further review of the TAR revealed the following: -For the pressure ulcer to the coccyx: There was no documentation that the wound treatment was done on January 14, 16, 17, 20, 21, 23, 24 and 27 and -For the pressure ulcer to the right gluteal: There was no documentation that the wound treatment was done on the day and night shift on January 16; the night shift on January 22 and the day shift on January 17, 20, 21, 23, 24 and 27. Further review of the corresponding nurses notes revealed there was no documentation as to why the treatments were not done. There was also no documentation that the physician was notified of the missing treatments. In addition, there was no evidence that the pressure ulcers to the coccyx and the right gluteal area were thoroughly assessed to include the stage, measurements, description of the wound bed/edges and surrounding skin from admission on January 13 through 27, 2020. Per the documentation on the TAR, the treatment for the pressure ulcer to the coccyx and the right gluteal area was discontinued on January 28, 2020. A skin evaluation dated January 28, 2020 revealed the resident reported soreness under the right butt and that treatment was initiated. The weekly non-pressure ulcer note dated January 28, 2020 included a partial thickness wound to the right lower butt which measured 0.5 cm x 0.5 x 0.1 cm, with a pink wound bed and scant serosanguineous exudate, wound edges were undefined and surrounding tissue was normal. Interventions included to cleanse with NS, pat dry, apply barrier cream mixed with petroleum jelly every shift and as needed until resolved. Per the documentation, this wound was a skin abrasion. The weekly wound assessment note dated January 28, 2020 did not include if the right lower butt wound was the same wound as the pressure ulcer to the right gluteal area, which was identified on admission or if this was a new wound. In addition, the note did not include an assessment of the coccyx area which included the stage, measurements, description of the wound bed/edges and the surrounding skin. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated January 28, 2020 included to cleanse with NS, pat dry, apply barrier cream mixed with petroleum jelly every shift and as needed, until resolved for skin abrasion to the right lower buttocks. Regarding the right posterior thigh: According to the clinical record documentation, there was no evidence that the resident had any open areas or a pressure ulcer/injury to the posterior thigh on admission (January 13, 2020). Review of the Daily Skilled Notes dated January 22, 23 and 24 revealed the resident's skin was warm to touch, with no active symptom observed affecting the integumentary system. However, it also stated that the resident's skin condition was not a new onset, but did not include what skin condition the resident had. A wound NP note dated January 24, 2020 included a chief complaint of wound to posterior thighs. The resident complained of open area on posterior thigh (did not specify if on the right or left thigh) that comes and goes as this area rubs on her wheelchair and that the open area was causing her discomfort. Per the note, there were only small scattered open areas noted with no real drainage. Review of systems included chronic wound on posterior thigh. The note did not include the type of wound, any measurements, a description of the wound bed/edges, if any drainage was present and the condition of the surrounding skin. The plan included to try and cover the wound with hydrocolloid to see if dressing stays. The shower skin assessment dated [DATE] revealed that pressure wound was handwritten in and it was marked that the wound was on the left posterior thigh. There was no documentation of a wound to the right posterior thigh. Despite documentation in the NP note regarding the use of a hydrocolloid dressing, there was no physician's order for it's use, and there was no treatment on the January 2020 TAR that a hydrocolloid dressing was applied to either the right or left posterior thigh from January 24 through 27. A skin evaluation dated January 28, 2020 revealed that a dry dressing was placed on the right posterior thigh, due to resident stating it rubs on the wheelchair when she gets up and sits down. Per the documentation, treatment was initiated. The weekly non-pressure ulcer note dated January 28, 2020 included a skin tear to the left posterior thigh, due to dressing removal which was described as a partial thickness wound which measured 0.5 cm x 4 cm x 0.1 cm, with scant serosanguineous exudate with no odor, a pink wound bed, undefined wound edges and normal surrounding skin. Interventions included to cleanse with NS, pat dry, apply triple antibiotic and cover with dry dressing Monday, Wednesday and Friday and as needed until resolved. There was no documentation regarding the right posterior thigh. A physician's order dated January 28, 2020 included the following: -Cleanse with NS, pat dry, apply triple antibiotic and cover with dry dressing Monday, Wednesday and Friday and as needed until resolved for skin tear to the left posterior thigh. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Place padded dry dressing to prevent shearing or tearing of skin while sitting down or getting up from wheelchair every shift and as needed if dressing rolls off, until resolved. These orders were transcribed onto the TAR for the left posterior thigh. However, there was no treatment order for the right posterior thigh. In an interview with a licensed practical nurse (LPN/staff #67) conducted on January 29, 2020 at 3:04 p.m., she stated when a resident is admitted at the facility, she will conduct a head to toe assessment and will document what she sees in the clinical record. She stated she cannot identify or stage a pressure ulcer, but can say that it was an open area and describe the surrounding skin, wound bed/edges and will measure the wound. She said she will then notify the wound nurse who will assess the wound the following day and will identify and stage the pressure ulcer. She said that she would also notify the physician and that treatment would be administered as ordered. An interview with another LPN (staff #17) was conducted on January 29, 2020 at 3:52 p.m. She stated that upon admission, she will do a head to toe assessment of the resident and will describes and document what she sees in the clinical record. She stated she can call the wound an ulcer, but she cannot stage the ulcer. She said she will notify the wound nurse and if there are treatment orders, she will implement them as ordered. She stated the wound nurse assesses the wound immediately or the following day, except on the weekend because the wound nurse is not available. However, she stated if the admission is on the weekends and the wound needs treatment, she will call the physician and implement orders received. An interview was conducted with the wound nurse (staff #35) on January 30, 2020 at 11:50 a.m. and the Clinical Resource (staff #136) was present during the interview. Staff #35 stated she had been the wound nurse for 3 months, and sometimes work as a floor nurse and works Monday through Friday. She stated when she comes on shift on Monday; she checks the 24 hour report, new admissions and the progress notes. She stated she will then conduct assessments of wounds identified or reported and she will identify the type, stage, location, size and will provide a brief description of the surrounding tissue. She stated if she is unsure of the staging of the wound, she will consult with the wound NP (staff #141). She stated her assessment will be documented in the clinical record using the PRN skin non-pressure form or the weekly skin pressure form depending on what her findings are. She stated each wound will be documented separately in the clinical record. She stated that she does the treatment of the wounds, but the nurses can provide treatment on as needed basis and during the weekend. She stated treatment administered is documented in the TAR. However, she stated she has her personal wound notes that she uses when she sees and does treatment and these notes are not part of the clinical record. Regarding resident #247, staff #35 stated the pressure injury to the coccyx and the right gluteal area were identified by the nurse on admission. She said when she assessed the resident on January 15, 2020, she did not find these pressure injuries. However, she did not comment as to the reason why these areas were receiving treatment as documented in the TAR. She stated she provided treatment to the stage 3 pressure injury to the vertebrae as noted in her notes. However, she did not comment on why treatment of the wound was not documented in the clinical record. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON/staff #132) conducted on January 30, 2020 at 12:53 p.m., she stated the wound nurse is supposed to document in the TAR that treatments are provided and she does not know why staff #35 is not documenting in the TAR. Regarding oversight, staff #132 stated if staff #35 has questions about the wound, she comes to her for guidance or the assistant DON (ADON/staff #74) who has been a wound nurse in the past. She stated that every Thursday on a weekly basis, she, the ADON, staff #35 and dietary staff meet for the NAR (Nutrition at Risk) meeting where all residents with wounds are discussed to include interventions that are put in place to address the wound. Further, staff #132 stated the personal notes of staff #35 does not include resident names, treatment provided or assessment of the wound and these notes is a way for staff #35 to organize, but these notes are not part of the clinical record. During another interview with the DON conducted on January 30, 2020 at 2:56 p.m., she stated a head to toe assessment is done by the nurses on admission. She said the nurses will describe what they see, but cannot say what it is or stage the wound. She stated the wound nurse will assess the wound and identify the stage and provide treatment on the wound. She stated the nurses on the floor can provided treatment on as needed basis. She stated all treatment is documented in the TAR. Further, she stated the wound nurse (staff #35) brings a computer with her when she provides treatment to residents, but does not know why the staff #35 documents in her personal notes which is not part of the clinical record and not on the TAR as it should be. An interview with the wound NP (staff #141) was conducted on January 31, 2020 at 12:53 p.m. He stated he does not work for the facility but follows up with the wound nurse (staff #35) and the providers once a week every Friday regarding residents with wounds. He stated he sees new wounds and pressure wounds and when he does the wound rounds with staff #35, they have a list of residents they see weekly on a routine basis. He stated he cannot follow all the residents with wounds because he only comes to the facility on ce a week. However, he stated he can come to the facility for emergency consultation as well. He also stated that he is always available when the facility calls him. He said he gives updates to routine NP/providers regarding the status of the wound because these providers do not turn the patient for skin evaluations. He said he does not provide oversight to staff #35 on a day to day basis, but only when he is at the facility to see the patients. Regarding wound assessments, staff #141 stated the assessment includes documentation of factors that may affect the progress of the wound such as how debilitated the resident is, presence of comorbidities, wound measurements and preventative measures in place. He stated when he sees the wound, he lets staff #35 measure the wound because staff #35 measures the wound on a regular basis. However, he stated if the wound is unclear, or if there is eschar on the wound or if he needed to probe the wound, he will measure the wound himself. Regarding resident #247, staff #141 stated the resident had history of all of the wounds she has. He stated the resident informed him that she had these wounds in the past, however, he could not find any history reference to these wounds. He stated the resident informed him that the wounds to her back rubbed on something in the past and this is a pressure injury. He stated the wound to the right posterior thigh is a shearing wound and a pressure injury because it is not on a bony prominence. 22366 -Resident #248 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis, pressure ulcers and multiple sclerosis. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Initial Admission Record dated January 1, 2020 documented .see wound care orders. Patient has right gluteal ulcer decubitus. wound vacuum in place . The admission record did not contain a thorough assessment of the right gluteal pressure ulcer to include any measurements, a description of the wound bed, edges and surrounding skin, and if any drainage was present. There was also no documentation that the resident had any additional pressure ulcers on admission. However, a Skin Pressure Ulcer Weekly note dated January 3, 2020 revealed the resident had a stage 3 pressure ulcer on the left trochanter (hip), a stage 3 pressure ulcer to the left buttocks, and a stage 4 pressure ulcer to the right buttocks. This was the first assessment of the three pressure ulcers with measurements and a description of the wound bed. The note also included that all three pressure ulcers were present on admission to the facility. Review of the physician orders revealed that treatment orders for the three pressure ulcers were obtained on January 1, 2020. According to the January 2020 Treatment Administration Record, there were over 12 missed treatments. An interview was conducted with a LPN (staff #111) on January 30, 2020 at 9:00 a.m. Staff #111 stated that when she did the initial skin assessment, the resident was very contracted when she turned her over and that she [TRUNCATED]

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 35111 Based on clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to ensure that a baseline care plan for dialysis was developed for one (#57) of 22 sampled residents. The deficient practice could result in resident's needs not being identified and interventions in place to address those needs. Findings include: Resident #57 was admitted at the facility on December 29, 2019, with diagnoses of ESRD (end stage renal disease) and dependence on renal dialysis. A physician's order dated December 29, 2019 included the following orders: dialysis every Monday, Wednesday and Friday, pre and post dialysis weights and vitals every day shift every Monday, Wednesday and Friday, and to send communication sheet with the resident to dialysis. The initial admission record dated December 29, 2019 included the resident was alert and oriented to time, place and person. Per the documentation, the resident receives hemodialysis and has an AV (arteriovenous) shunt located on the left upper extremity. A nutrition care plan dated December 29, 2019 included the resident had increase protein needs related to dialysis. A goal included that it was expected for resident to have significant weight changes related to dialysis treatment. An intervention included for dialysis three times per week. The care plan did not include interventions for monitoring the AV shunt site for bruits, thrills, bleeding and signs and symptoms of infection. The NP (nurse practitioner) progress note dated December 31, 2019 included the resident was alert and oriented x 4 and had dialysis three times a week. Review of the clinical record revealed no evidence that a baseline care plan had been developed within 48 hours to address the resident's needs related to dialysis treatment. During an interview conducted on January 30, 2020 at 2:49 p.m., resident #57 stated she leaves the facility at 9:00 a.m. for dialysis every Monday, Wednesday and Friday and does not come back until 3:00 p.m. in the afternoon. In an interview with a licensed practical nurse (LPN/staff #79) conducted on January 31, 2020 at 10:00 a.m., he stated that upon admission, he will conduct a head to toe assessment and will document his findings in the initial admission record. He stated that based on his assessment, the areas that need to be addressed will be put in the initial care plan. He stated if the resident is on dialysis, it will be care planned with interventions to monitor shunt sites for infections and for bruit/thrill every shift and as needed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with another LPN (staff #92) conducted on February 3, 2020 at 10:10 a.m., she stated when a resident is admitted an assessment will be completed. She stated after the resident is assessed, she will create a care plan for identified areas for the resident such as dialysis. She also stated that appropriate interventions will be included in the initial care plan such as checking for vitals, weights, dialysis shunt site for bruit/thrill and signs and symptoms of infection. An interview with the MDS (Minimum Data Set) assessment Coordinator (staff #29) was conducted on February 3, 2020 at 10:33 a.m. Staff #29 stated when a resident is admitted , the initial care plan is initiated with appropriate interventions by the admitting nurse. During the interview, a review of the clinical record for resident #57 was conducted with staff #29. She stated the initial care plan includes cognition, pain, fall, skin and ADLs (activities of daily living). She stated the initial care plan did not include the dialysis needs of the resident. Review of a policy regarding Comprehensive Person-Centered Care Planning revealed that the IDT team will develop and implement baseline care plans for each resident, within 48 hours of admission. The baseline care plan includes the minimum healthcare information necessary to properly care for each resident, and instructions to provide effective and person-centered care that meet professional standards of care. The policy also included that the baseline care plan will included minimum healthcare information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders and physician orders.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21946 Based on clinical record reviews, resident and staff interviews and policy review, the facility failed to ensure that a care plan had been developed for one resident (#40) related to urinary incontinence, for one resident (#146) related to skin integrity, and for one resident (#57) related to dialysis. The lack of care plan development has the potential for staff to be unaware of the residents identified problems, how care and services are to be delivered, and the staff who are responsible to provide the necessary care and services. Findings include: -Resident #40 was admitted to the facility on [DATE], with diagnoses that included muscle weakness, heart disease, clostridium difficile (c-diff) infection and major depressive disorder. Review of an admission bladder incontinence evaluation dated December 9, 2019 revealed the resident was incontinent of bladder. Review of the Certified Nursing Assistant (CNA) Activities of Daily Living (ADL) documentation from December 9 through 12, 2019 revealed the resident was incontinent of urine. Review of an admission Minimum Data Set (MDS) dated [DATE] revealed the resident was frequently incontinent of urine. In Section V of the MDS, the area of urinary incontinence triggered and a care plan was to be developed. However, review of the clinical record from December 12, 2019 through January 31, 2020 revealed no evidence that a care plan had been developed regarding urinary incontinence for resident #40. -Resident #146 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome and chronic non pressure ulcers of the right leg. Review of the physician orders dated January 15, 2020 revealed an order to keep bilateral (both) lower extremities dry, apply abdominal pads, wrap with Kerlix gauze, and then apply an ACE bandage wrap. This was to be completed every shift and as necessary. According to the Treatment Administration Record (TAR) for January 2020, the treatment to the bilateral extremities every shift was provided as ordered through January 27. However, review of the clinical record revealed no evidence that a care plan was developed which included the problems and treatments regarding the resident's lower extremities. An interview was conducted with resident #146 on January 27, 2020 at 3:05 p.m. He stated that he has chronic stasis ulcers and edema in both legs. He stated the staff come in and look at both of his legs for edema and then wrap the legs with ace bandages. During the interview, the resident was observed to have both lower extremities wrapped with ace bandages. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the MDS Coordinator (Licensed Practical Nurse LPN/staff #29) on January 31, 2020 at 8:23 a.m. She stated that she and the other facility staff are late with the completion of the MDS assessments. Staff #29 stated that staff are having problems in getting the care plans done on time. Staff #29 stated that resident #40 needed to have a care plan developed regarding urinary incontinence and resident #146 needed one regarding the lower extremity edema and the leg wraps. An interview was conducted with the DON (Director of Nursing/staff #132) on January 31, 2020 at 8:01 a.m. She stated she is aware that the MDS staff are running late and there is a plan in place for extra nurses to help. Staff #132 stated the proper procedure is that the MDS assessments are accurately completed on time and that a care plan is developed for the specific problem. She further stated that for resident #40 a care plan needed to be completed for urinary incontinence and for resident #146 regarding the leg edema and the application of wraps and bandages. She also stated that care plans had not been developed for either resident. 35111 -Resident #57 was admitted at the facility on December 29, 2019, with diagnoses of ESRD (end stage renal disease) and dependence on renal dialysis. The initial admission record dated December 29, 2019 included the resident was alert and oriented to time, place and person and had an AV (arteriovenous) shunt located on the left upper extremity for dialysis use. The physician's order dated December 29, 2019 included for dialysis every Monday, Wednesday and Friday, pre and post-dialysis weights and vitals every day shift every Monday, Wednesday and Friday, and to send communication sheet with the resident to dialysis. The nutrition care plan dated December 29, 2019 included the resident had increase protein needs related to dialysis treatment. A goal included that it is expected for the resident to have significant weight changes related to dialysis treatment. An intervention was for dialysis three times per week. The care plan did not include interventions to monitor the AV shunt site for bruit, thrill, bleeding and signs and symptoms of infection. The NP (nurse practitioner) progress note dated December 31, 2019 included the resident was alert and oriented x 4 and had dialysis three times a week. The admission MDS assessment dated [DATE] included a BIMS score of 15, indicating the resident had intact cognition. Active Diagnoses included renal insufficiency/failure or ESRD and dependence on renal dialysis. The MDS also coded the resident as having dialysis during the last 14 days. However, continued review of the clinical record revealed no evidence that a comprehensive care plan had been developed from December 29, 2019 through January 26, 2020, which included appropriate interventions to address the resident's assessed need and dependence on dialysis treatment. As a result, there was no evidence that the resident's AV shunt was monitored for bruit, thrill, any bleeding and signs and symptoms of infection on those days when the resident did not go to dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the survey on January 27, 2020, a physician's order was written to monitor AV shunt for bruit and thrill daily, monitor the access site for bleeding and signs and symptoms of infection daily, notify the physician if bruit and thrill are not present and if there are signs and symptoms of infection. A care plan was also initiated on January 27, 2020 which included that the resident required dialysis and had a fistula on the arm. Interventions included checking/changing the dressing daily at the access site, documenting dressing changes and checking the AV fistula for bruit and thrill every day. During an interview conducted on January 30, 2020 at 2:49 p.m., resident #57 stated that she leaves the facility at 9:00 a.m. for dialysis every Monday, Wednesday and Friday and does not come back until 3:00 p. m. in the afternoon. In an interview with a licensed practical nurse (LPN/staff #79) conducted on January 31, 2020 at 10:00 a.m., he stated that if a resident is on dialysis, it will be care planned with interventions to monitor shunt sites for infections and bruit/thrill every shift and as needed. An interview with the MDS Coordinator (staff #29) was conducted on February 3, 2020 at 10:33 a.m. Staff #29 stated she creates and develops the comprehensive care plan when the admission/5-day MDS assessment is completed. She stated the following areas or issues identified in the assessment will be included in the comprehensive care plan: medication, diagnoses, ADLs (activity of daily living) and/or any issues such as dialysis. She stated if the resident goes to dialysis, she will put the place and the contact number of the dialysis center on the care plan and that interventions such as monitoring of the AV shunt site are created by the nursing staff. During the interview, a review of the clinical record of resident #57 was conducted with staff #29. Staff #29 stated that based on the clinical record, the resident was care planned for dialysis on January 27, 2020. She said that she does not know why, but could possibly be because the MDS assessment was completed on January 27, 2020. Review of a policy titled, Comprehensive Person-Centered Care Planning revealed that the IDT (interdisciplinary team) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The policy included that the comprehensive care plan will be developed by the IDT within seven (7) days of completions of the resident MDS and will include resident's needs identified in the comprehensive assessment, any specialized services, resident's goals and desired outcomes, and preferences for future discharge and discharge plans. Further, the policy included that the comprehensive care plan will be reviewed and/or revised by the IDT after each assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21946 Based on clinical record review, observations, interviews and policy review, the facility failed to ensure a medication was administered per the manufacturer's instructions for one (#44) of four sampled residents. The deficient practice has the potential for residents to develop adverse reactions. Findings include: Resident #44 was admitted to the facility on [DATE], with diagnoses that included fractures of the left arm and schizophrenia. Review of an admission baseline care plan dated December 9, 2019 revealed a focus area for the use of anti-psychotic medication related to a diagnosis of schizophrenia. The goal was for the resident to remain free of drug related complications. An intervention was for medications to be administered as ordered and to monitor for adverse reactions or side effects. Review of the physician's orders dated January 14, 2020 revealed an order for Risperdal Consta Suspension Reconstituted (antipsychotic) 50 milligrams (mg) intramuscularly one time a day every 14 days. Review of the Treatment Administration Record (TAR) dated January 2020 revealed the next scheduled dose was due on January 29, 2020. A medication administration observation was conducted on January 29, 2020 at 8:19 a.m., with a Licensed Practical Nurse (LPN/staff #82). Staff #82 entered the medication storage room to access the medication refrigerator where the Risperdal Consta was stored for resident #44. Documentation on the outside label of the Risperdal Consta box included the following: Remove the dose pack from the refrigerator and allow to sit at room temperature for at least 30 minutes before reconstituting. Do not warm any other way. At this time, staff #82 then removed the medication from the box and mixed the medication. She then took the ampoule of the reconstituted Risperdal Consta and put it in between the palms of her hands and rubbed the ampoule vigorously for approximately 5 minutes. At 8:25 a.m., staff #82 was observed to administer the Risperdal Consta intramuscularly in the gluteal muscle of resident #44. An interview was conducted with a Registered Nurse (RN) from the Pharmaceutical Company on January 29, 2020 at 12:19 p.m. The RN stated that if the Risperdal Consta had been removed from the refrigerator and not allowed to sit for at least 30 minutes before administration, the resident should be closely monitored for potential adverse effects. The pharmaceutical RN then asked if he could contact the facility and physician and was told the information could not be relayed, however the administrator (staff #133) was made aware of the request of the pharmaceutical RN for additional information. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 29, 2020 at 3:05 p.m., with staff #82. She stated that she did not check the label on the Risperdal Consta box so she did not see the instructions on how the medicine had to be warmed, before she administered the Risperdal Consta to resident #44. She stated that she had heard from other nurses at the facility that the Risperdal Consta had to be warmed up for about 5 minutes, before administering the medication. Staff #82 stated this was a medication error, so the physician had to be notified. Staff #82 stated the physician gave orders to frequently monitor the resident, complete vital signs and initiate neurological checks every 15 minutes. Staff #82 stated the close monitoring had to be done to check for any adverse effects due to the medication error. An interview was conducted with the Director of Nursing (DON/staff #132) on January 31, 2020 at 8:01 a.m. She stated that she identified there was a medication error due to staff #82 not warming the Risperdal Consta for a full 30 minutes per manufacturer's instructions, and that staff #82 was counseled. Staff #132 stated resident #44 is currently being monitored for potential adverse effects and the monitoring will continue for 72 hours. Staff #132 also stated it was a standard of nursing practice to check medication labels and instructions before any medication was administered. According to a facility policy on Medication Administration, the following was included: It is the policy of the facility to accurately prepare and administer medications. Procedures: Read the label as the medication is removed from the medication cart or refrigerator, read the label prior to pouring or preparing the medication and read the label again before returning the medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36759 Based on clinical record review, family and staff interviews, and policy review, the facility failed to ensure consistent skin assessments and treatments were provided for one resident (#74). The deficient practice could result in residents not being provided skin assessments and treatments. Findings include: Resident #74 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus, difficulty in walking and hemiplegia. A care plan initiated June 3, 2019 revealed the resident had potential/actual impairment to skin integrity related to bilateral upper and lower extremity weakness as evidenced by stroke. The care plan also revealed the resident had actual skin impairment as evidenced by a skin tear to the left upper extremity, redness to scapula with blanching, discoloration to sacrum, and redness to inner thighs. Interventions included providing treatment as ordered and a skin assessment weekly and as needed. A physician's order dated June 3, 2019 included for weekly skin evaluations. Regarding abrasions: A weekly skin evaluation completed on June 4, 2019 included the resident had abrasions to the left cheek and right knee. A skin non-pressure ulcer weekly assessment dated [DATE] revealed: 1. Initial review of left cheek abrasion 2 x 1.5, partial thickness, leave open to air and monitor for signs and symptoms of infection 2. Initial review of right knee abrasion 2 x 1.5, partial thickness, leave open to air and monitor for signs and symptoms of infection However, review of the resident's clinical record revealed no further assessments of the abrasions to the left cheek and right knee and no weekly skin evaluations until January 27, 2020, Regarding open areas: A physician's order dated June 29, 2019 included barrier cream to open areas on the scrotum every shift for 10 days for wound healing until July 9, 2019. A nursing note dated June 29, 2019 included the resident was noted with several open areas to the scrotum, barrier cream was applied and the resident was repositioned. However, review of the clinical record revealed no assessment of these open areas. Regarding discharge and maceration: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note dated July 12, 2019 included the resident was noted with discharge coming from his penis during a shower. The penis was assessed to be swollen with yellow slough in the crease of the shaft, the urethra was elongated to approximately 2 inches long, no bleeding present, and the resident complained of pain. Pain medication was given, the wound was cleansed, and a new catheter reinserted. Review of a Nurse Practitioner (NP) note dated July 13, 2019 revealed the NP was there to see the resident after reports of drainage and irritation to the tip of his penis. The note included the resident had a chronic indwelling catheter in place and purulent discharge was noted to the border of the foreskin. A NP note dated July 20, 2019 included the macerated area to the resident's penis was looking better; the resident had moisture related dermatitis, and was mostly bedbound. The note concluded that the penile irritation was resolved. An NP note dated November 18, 2019 included the resident complained of pain in the area of maceration on the penis. A NP note dated November 24, 2019 included, area on side of penis remains macerated with patient complaining of discomfort. He is receiving lidocaine viscous to help the pain. Moisture barrier cream is ordered as well. Will need careful monitoring of the wound for infection. Further review of the clinical record revealed no evidence the wound to the penis was consistently assessed and monitored. Regarding a wound: A physician's order dated December 1, 2019 revealed an order to cleanse the left hand with saline and apply sponge dressing daily for 10 days for wound management until December 11, 2019. Review of the December 2019 Treatment Administration Record (TAR) revealed the treatment was not provided on December 2, 3, 6, 9, 10, and 11. Regarding skin tears: -A nursing progress note dated December 18, 2019 revealed the resident was found on the floor, was responsive with no injuries to his head, with a minor skin tear on his left arm around the elbow. The skin tear was cleaned and dressed. A care plan initiated on December 18, 2019 included the resident had a fall on December 17, 2019 related to poor balance which resulted in a minor injury of a skin tear. Interventions included continuing interventions from at-risk plan. Review of the clinical record revealed no further documentation regarding the skin tear. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A nursing note dated January 12, 2020 revealed the resident's family member was visiting and observed the resident's left hand in the wheel of the wheelchair caught between spokes. The note included the resident's hand was removed with no difficulty and several small skin tears were noted to the left 2nd and 3rd fingers and thumb area. All the areas were cleansed with saline, followed by bacitracin and a dressing was applied. A physician's order dated January 12, 2020 revealed an order to cleanse the skin tears to the left 2nd and 3rd fingers and thumb with saline followed by bacitracin and dressing daily for two weeks for wound care until January 27, 2020. However, review of the January 2020 TAR revealed no evidence the treatment was provided on January 13, 14, 20, 21, 22, 24, and 27. In an interview with the resident's family member on January 27, 2020 at 10:05 a.m., the resident was observed with a bandage on the top of his left hand. The family member stated the resident scratches himself and the bandage is to protect his skin. In an interview with a Licensed Practical Nurse (LPN/staff #79) on January 31, 2020 at 9:46 a.m., he stated a head to toe skin assessment is conducted weekly on all residents. He stated a weekly skin assessment automatically populates in the electronic clinical record. The LPN also stated that they have the capability to initiate a weekly skin assessment if new skin concerns are identified. He stated new skin concerns are documented on the weekly skin assessment and the wound nurse is notified. During an interview conducted with the Director of Nursing (DON/staff #132) on January 31, 2020 at 9:50 a.m., she stated the weekly skin check in the electronic charting system is auto populated to be scheduled once a week when a resident is admitted . She stated the floor nurses are responsible for ensuring a weekly skin check is done. Review of a facility's policy titled, Care and Treatment: Wound Management reviewed October 2019, revealed it is the policy of the facility to evaluate the status of wounds at least weekly and as needed. Each wound will be measured in centimeters weekly and measurements, size and depth, drainage, odor, color and a short statement on progress (or lack of) will be documented and treatments ordered by the physician will be done. The policy included, A weekly skin assessment will be completed on all residents and documented.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36759 Based on observations, clinical record reviews, interviews, review of the National Pressure Ulcer Advisory Panel (NPUAP) guidelines and policies and procedures, the facility failed to ensure that thorough wound assessments were completed, and/or the physician was notified of pressure ulcers when identified, and/or that treatment orders were obtained timely and/or that treatments were provided as ordered for four of five sampled residents (#245, #247, #248 and #89), with pressure ulcers. The deficient practice resulted in residents not receiving adequate care and treatment for pressure ulcers, and at times experienced wound deterioration, resulting in Substandard Quality of Care. Findings include: -Resident #245 was admitted to the facility on [DATE], with diagnoses that included sepsis, pressure induced deep tissue damage of the right heel and pressure ulcer of the sacral region, unstageable. A Braden Scale for Predicting Pressure Sore Risk dated January 11, 2020 included the resident scored a 13, which indicated moderate risk for developing pressure ulcers. Regarding the left heel: A care plan dated January 11, 2020 revealed the resident had actual impairment to skin integrity related to a fluid filled blister to the left heel. Interventions were to float heels, low air loss mattress for skin integrity, monitor and document the location, size and treatment of skin injuries and report abnormalities (failure to heel, signs and symptoms of infection or maceration to the provider). A shower skin assessment sheet dated January 13, 2020 included the resident had scabs to feet. However, there was no indication of a specific location of the scabs on the feet. A skin assessment shower sheet dated January 16, 2020 included [NAME] on the diagram all body marks that are old or new. Include scars, bruises, rash, cuts, pressure ulcers or other open areas. The sheet indicated an x over both heels, with no further description. A Braden Scale for Predicting Pressure Sore Risk dated January 18, 2020 included the resident scored a 15, which indicated low risk for developing pressure ulcers, despite having a blister to the left heel. Despite documentation that the resident had a blister to the left heel, there was no clinical record documentation that the physician was notified of the left heel blister, there was no documentation of any treatment that was provided and no documentation that a thorough assessment of the left heel was completed, which included measurements, a description of the heel/blister, if any drainage was present and the condition of the surrounding skin from admission on January 11 through 19, 2020. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The first thorough assessment of the left heel was completed nine days after admission. According to the skin ulcer non-pressure weekly eva;uation (although the wound was on the heel) dated January 20, 2020, the following was documented: left heel wound measured 9.5 x 10.0 cm and was described as dark serous filled blister, with a scant amount of serous exudate, no odor, wound bed was black/brown (eschar), wound edges were attached and surrounding tissue was normal. The onset date was listed as January 20, 2020 and that this was the initial review (although there was documentation on the care plan that the resident had a fluid filled blister to the left heel on admission). The evaluation also noted that this wound was marked as other for type of skin ulcer/wound. Interventions included to apply betadine and wrap with Kerlix Monday, Wednesday, Friday and as needed until resolved. However, review of the clinical record revealed there was no physician's order to apply betadine and wrap with Kerlix from January 20 through 24, 2020. In addition, there was no clinical record documentation including on the Treatment Administration Record (TAR) of any treatments that were provided to the left heel from admission on January 11 through January 24, 2020. A wound care consult note was completed on January 24, 2020 by the wound care nurse practitioner (NP/staff #141). The skin assessment was as follows: left heel with a dark serous filled blister which measured 9.5 x 10.0 x 0.0 cm. The plan included the floor nurses will collaborate with the wound team for aggressive wound care and offloading of pressure points and assisting with turning as needed. The goal was to offload all pressure points by turning, using specialized mattress (low air loss/LAL), wheelchair cushions and/or foam heel protectors as needed, clearing dead tissue-if any, granulation and epithelialization. The resident's diagnoses were pressure ulcer left heel, unstageable. A physician's note dated January 25, 2020 included the resident had multiple pressure ulcers, however, no locations were documented. Despite the physician's note, there was no treatment order for the left heel pressure ulcer. A Braden Scale for Predicting Pressure Sore Risk dated January 25, 2020 included the resident scored a 15, which indicated low risk for developing pressure ulcers. A skin ulcer non-pressure weekly assessment dated [DATE] revealed the following: left heel measured 9.5 x 10.0 cm; dark fluid filled blister, other type of ulcer/wound; scant amount of serous exudate, no odor, wound bed black/brown (eschar), wound edges undefined, surrounding tissue normal, onset date January 20, 2020. Interventions included apply betadine and wrap with Kerlix Monday, Wednesday and Friday and as needed until resolved. Review of the physician's orders revealed an order date of January 27, 2020. The order included the following: Late entry for 1/20/2020 left heel serous filled blister, apply betadine and wrap with Kerlix Monday, Wednesday, Friday and as needed until resolved for skin maintenance. However, this late entry order was back dated seven days prior. Review of the January 2020 TAR revealed the order dated January 27, 2020 as a late entry for January 20, 2020 to apply betadine to left heel and wrap with Kerlix on Monday, Wednesday and Friday and as needed until resolved. However, there was no documentation that the treatment was done from January 20 through 28. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A wound treatment observation was conducted on January 29, 2020 at 2:57 p.m., with the wound nurse (staff #35). The resident's left heel appeared to be covered with dark colored tissue. Per staff #35, the left heel measured 9.5 cm x 10.5 cm with 90% necrotic tissue, with an area of pink looking skin. The treatment was completed as ordered. In an interview with staff #35 on January 30, 2020 at 10:53 a.m., she stated that she did an assessment upon admission for resident #245, however, she stated the left heel area was identified on January 20, 2020. She said that a treatment would have been started upon finding the area on January 20. She then reviewed the TAR and acknowledged that the treatments were not documented until January 27. She stated she must have forgotten to put the treatment into the electronic charting system. A wound care consult note was completed on January 31, 2020, by the wound care NP (staff #141). The note included this was a follow up on multiple wounds. The note also included the left heel wound has more eschar, is stable and there is no drainage. The left heel measured 9.3 x 11.0 x 0.0 cm, dark serous filled blister with 60% dry eschar along edges and no drainage. An interview was conducted on January 31, 2020 at 12:53 p.m., with staff #141. He stated that the left heel wound was pressure related, based on the location. Regarding the coccyx: An Initial Admission Record dated January 11, 2020 included the resident had redness on the buttocks. The Admission Record did not include any further description of the redness to the buttocks. However, a care plan dated January 11, 2020 included the resident had actual impairment to skin integrity related to an unstageable wound to the coccyx. Interventions were for a low air loss mattress, monitor and document the location, size and treatment of skin injuries and report abnormalities (failure to heel, signs and symptoms of infection, or maceration) to the provider. Review of the clinical record revealed there was no thorough assessment of the buttocks area, which included measurements, a description of the wound bed, any drainage, any signs or symptoms of infection and the condition of the surrounding skin. There was also no documentation that the physician was notified of the redness/unstageable wound to the coccyx, nor was there a physician's order for any treatment on January 11 and 12, 2020. A shower skin assessment sheet dated January 13, 2020 included the resident had a patch over the left buttock. The first thorough assessment of the buttocks area was not conducted until January 13, 2020. Per the skin pressure ulcer weekly assessment dated [DATE], the resident had an unstageable pressure ulcer as follows: coccyx measured 4.5 x 5.5 cm unstageable (slough/eschar), black/brown eschar wound bed, scant amount of serosanguineous exudate, no odor, wound edges undefined and surrounding tissue was normal. The assessment included the pressure ulcer was present upon admission, with an unknown onset date, and that this was the initial evaluation. Interventions included cleanse coccyx with normal saline, pat dry, apply calcium alginate, cover with dry dressing on Monday, Wednesday and Friday and as needed until resolved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	However, review of the clinical record revealed there was no physician's order to cleanse the coccyx with normal saline, apply calcium alginate and cover with a dry dressing on Monday, Wednesday and Friday. This treatment was also not on the January 2020 TAR, therefore; there was no documentation that this treatment was provided from January 11 through January 14. Another physician's order dated January 15, 2020 included to cleanse the coccyx pressure ulcer with normal saline, pat dry, apply calcium alginate and cover with a dry dressing on Monday, Wednesday and Friday, and as needed until resolved. Review of the January 2020 TAR revealed this order was included however, there was no documentation that this treatment was completed on January 20. A shower skin assessment sheet dated January 20, 2020 revealed there was a marked area to the buttocks which indicated wound bleeding. A skin pressure ulcer weekly assessment dated [DATE] revealed the following: coccyx pressure ulcer measured 4.5 x 5.8 cm, unstageable black/brown eschar to wound bed, scant amount of serosanguineous exudate, no odor, wound edges undefined and surrounding tissue was normal. The assessment included the pressure ulcer was present on admission with an unknown onset date. Interventions included to cleanse the coccyx pressure ulcer with normal saline, pat dry, apply calcium alginate, cover with dry dressing on Monday, Wednesday and Friday and as needed until resolved. Further review of the January 2020 TAR revealed the treatment to the coccyx was not done on January 22. A wound care consult note was completed on January 24, 2020, by the wound care NP (staff #141). The note included that the chief complaint was a sacral wound. The note stated that the resident's entire sacral area was either red or broken down. The skin assessment regarding the sacral wound was as follows: wound measured 12.0 x 19.0 x 2.0 cm, with 40% eschar, 30% pink, 30% intact skin, red-delayed blanching, small amount of serous drainage, no odor, and some purple discoloration surrounding. The plan included floor nurses will collaborate with the wound team for aggressive wound care and offloading of pressure points and assisting with turning as needed. The goal was to offload all pressure points by turning, using specialized mattress, wheelchair cushions and/or foam heel protectors as needed, clearing dead tissue-if any, granulation, and epithelialization. A diagnosis included pressure injury of sacral region, unstageable. Treatment: currently no dressing will stay in place due to incontinence-Zinc barrier cream mixed with petrolatum. A physician's note dated January 25, 2020 included the resident had multiple pressure ulcers. There was no specific mention of the pressure ulcer to the coccyx. A skin pressure ulcer weekly assessment dated [DATE] revealed the coccyx pressure ulcer measured 12.0 x 19.0 x 2.0 cm; was unstageable (slough/eschar), black/brown eschar wound bed, scant amount of serosanguineous exudate, no odor, wound edges undefined, and surrounding tissue was normal. Physician orders dated January 27, 2020 included to cleanse the coccyx pressure ulcer with normal saline, pat dry, apply copious amount of zinc oxide mixed with skin protectant every shift and as needed until resolved, one time a day for wound maintenance. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A wound treatment observation was conducted on January 29, 2020 at 2:57 p.m., with the wound nurse (staff #35). The wound was observed to be irregular in shape with slough covering some of the wound bed, with wound edges appearing macerated. Per staff #35, the sacral wound measured 10.4 cm x 11.5 cm x 1.2 cm with 60% necrotic tissue in the wound bed, 40% slough and that the wound was unstageable. The treatment was completed as ordered. In an interview with staff #35 on January 30, 2020 at 10:53 a.m., she stated that she did an assessment upon admission for resident #245. She stated that she noted the cites that were found including the sacral area. She stated the wound NP follows this resident weekly and was brought in for this resident's treatment, because the wound on the coccyx was not getting better. A wound care consult note was completed on January 31, 2020 by the wound NP (staff #141). The note included this was a follow up on multiple wounds. The note included the resident's sacral area had improved, the moisture associated damaged area surrounding it has almost completely resolved with use of zinc/petroleum, the eschar covering the wound bed was soft, but there was more slough and there were no signs or symptoms of acute infection. Per the assessment, the sacral wound measured 9.0 x 8.0 x 0.8 cm with 20% pink, 80% yellow/slough loosening and separating from wound bed, small amount of serous drainage and no odor. An interview was conducted on January 31, 2020 at 12:53 p.m., with staff #141. He stated that resident #245, came in with the coccyx wound. Regarding the right heel: An Initial Admission Record dated January 11, 2020 included the resident had a blister to the right heel. A care plan dated January 11, 2020 revealed the resident had actual impairment to skin integrity related to deep tissue injury to the right heel. Interventions were to float heels, low air loss mattress, monitor and document the location, size and treatment of skin injuries and report abnormalities (failure to heel, signs and symptoms of infection or maceration) to the provider. However, review of the clinical record revealed no documentation of a thorough assessment of the right heel, which included measurements of the area and a description of the color of the skin to the right heel, nor was there documentation that the physician was notified and that a treatment was put into place on January 11 or 12. A shower skin assessment sheet dated January 13, 2020 included the resident had scabs to feet. However, there was no further indication as to the specific location on the feet. A weekly skin evaluation dated January 13, 2020 revealed blood blister to right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A thorough assessment of the right heel was completed two days after admission. Review of the skin pressure ulcer weekly assessment dated [DATE] revealed the following: right heel measured 2.0 x 1.0, unstageable (slough/eschar) blood blister, no exudate, no odor, wound edges and surrounding tissue were normal. The documentation included that the pressure injury was present on admission with an unknown onset date and that it was the initial evaluation. Interventions included right heel blood blister, apply betadine and wrap with Kerlix on Monday, Wednesday and Friday and as needed until resolved. However, review of the clinical record and TAR revealed no physician's order for the betadine to be applied to the right heel until January 15, 2020. A physician's order dated January 15, 2020 included treatment for the right heel blood blister as follows: apply betadine and wrap with Kerlix on Monday, Wednesday and Friday and as needed until resolved for skin maintenance. Further review of the TAR revealed the above wound treatment was done on January 15, however, there was no documentation that treatments were done from January 16 through 20. A skin pressure ulcer weekly assessment dated [DATE] revealed the right heel measured 2.0 x 1.0 cm; blood blister suspected deep tissue injury (SDTI); no exudate, no odor, wound bed normal, wound edges undefined and surrounding tissue was normal. The assessment included the SDTI was present on admission with an unknown onset date. Interventions were to apply betadine and wrap with Kerlix on Monday, Wednesday and Friday, and as needed until resolved. However, further review of the TAR revealed no documentation that the betadine treatment was completed from January 21 through January 24. A wound care consult note was completed on January 24, 2020 by the wound NP (staff #141). The note included there were two wounds present to the right heel as follows: right heel measured 4.5 x 3.0 x 0.0 cm, with red serous filled and the right heel plantar measured 2.5 x 2.5 x 0.0 cm, with 100% thin eschar-no fluctuance. The plan included floor nurses will collaborate with the wound team for aggressive wound care and offloading of pressure points and assisting with turning as needed. The goal included to offload all pressure points by turning, using specialized mattress, wheelchair cushions and/or foam heel protectors as needed, clearing dead tissue-if any, granulation and epithelialization. A physician's note dated January 25, 2020 included the resident had multiple pressure ulcers. However, there was no indication of where the pressure ulcers were located. A wound treatment observation was conducted on January 29, 2020 at 2:57 p.m., with wound nurse (staff #35). The wound was observed to cover the resident's right heel with dark colored tissue and measured 4 x 3.2. Staff #35 stated the wound had 100% necrotic tissue and started as a fluid filled blister. The treatment was completed as ordered. In an interview with staff #35 on January 30, 2020 at 10:53 a.m., she stated that she did an assessment upon admission for resident #245. She stated that she noted the cites that were found including the right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	An interview was conducted on January 31, 2020 at 12:53 p.m., with the wound NP (staff #141). He stated resident #245 came in with the right heel wound. A wound care consult note was completed on January 31, 2020, by staff #141. The note included this was a follow up on multiple wounds. The note also included the right heel wound was stable. The skin assessment was as follows: right heel: 2.0 x 3.0 x 0.0, red serous filled, less fluid than last week and right heel plantar: 3. 5 x 3.5 x 0.0 cm, 100% thin eschar-no fluctuance. In an interview with a LPN (staff #82) on January 30, 2020 at 10:00 a.m., she stated the floor nurse who admits a new resident to the facility completes the initial skin assessment, and if something of concern is noted, the area is documented and the wound nurse is notified. She stated the wound nurse does a complete assessment of the area of concern. She stated if an area of concern on the skin is identified by a Certified Nursing Assistant (CNA) during care, they are to report it to the nurse right away, who will look at it and then the nurse should contact the doctor to get an order, and that the wound nurse will also be notified. In another interview with staff #35 on January 30, 2020 at 10:53 a.m., she stated the wound NP follows this resident weekly. Regarding the days where the treatment was not documented as completed, she stated sometimes time gets away from her and she may forget to document that the treatment was done. She stated that she has a notebook where she jots down treatments that she does for the day and any new orders. However, review of this documentation did not provide what type of treatment was done or the location of the treatment. An interview was conducted on January 31, 2020 at 12:53 p.m., with staff #141. He stated that he does not work specifically for this building, but rounds once a week with the wound nurse (staff #35). He stated they follow her list of residents with wounds and go over any new concerns she has. He said that he is not contracted to work with all of the residents in the facility. He stated he typically lets staff #35 measure, so the measurements stay consistent, but he is also assessing everything such as, how debilitated they are, preventative measures in place and signs and symptoms of infection. He said that he only provides oversight to staff #35 when he is rounding with her. -Resident #89 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia, type 2 diabetes mellitus and dysphagia. A care plan (initiated September 2018) included the resident was at risk for impairment to skin integrity related to a history of moisture associated skin damage, had a potential for impairment to skin integrity related to incontinence of bladder and limited mobility. The care plan included the resident had a stage 2 pressure ulcer to the right buttock. An intervention was to provide treatment as ordered. Another care plan identified that the resident had a self care performance deficit with activities of daily living (ADLs) related to weakness, dementia, and impaired mobility. An intervention included the resident required staff participation to reposition and turn in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A skin pressure ulcer weekly assessment dated [DATE] included an open area to the right buttock, which was identified on October 1, 2019. The assessment included the wound was a stage 2 and measured 4 cm x 2 cm x 0.1 cm. The interventions were to cleanse buttocks and apply barrier cream every shift and as needed until healed, and reposition frequently. A physician's order dated October 2, 2019 included to cleanse buttocks and apply barrier cream every shift and as needed until healed. Review of the TAR for October 2019 revealed the wound treatment to the buttocks was not completed on eight occasions. Review of the TAR for November 2019 revealed the treatment was not completed on two occasions. Review of the TAR for December 2019 revealed the treatment was not completed on two occasions. A physician's order dated January 2, 2020 included to cleanse buttocks with saline, cover with sponge dressing daily x 10 days in the morning for wound healing until January 13, 2020. Review of the TAR for January 2020 revealed the above treatment was not completed on three occasions. A care plan dated January 6, 2020 included the resident had pressure ulcer development to the right buttocks related to history of ulcers and immobility. Interventions included to administer treatments as ordered, monitor for effectiveness and to follow facility policies and protocols for the prevention and treatment of skin breakdown. A wound treatment observation was conducted on January 29, 2020 at 1:07 p.m., with wound nurse(staff #35). The resident was observed on a low air loss mattress in a low bed position. Staff #35 measured the wound on the right buttocks at 0.9 cm x 1.9 cm with a general depth of 0.1 cm. She stated there was moisture associated skin damage ongoing with a pink wound bed and slight serosanguineous drainage. She stated the wound was a stage 2 and assessments of the wound were completed weekly with measurements. In an interview with the wound nurse (staff #35) on January 30, 2020 at 10:24 a.m., she stated that upon admission she does a skin evaluation assessment. She stated she notes everything she sees on the assessment. She stated that she then opens a more specific pressure ulcer or non-pressure ulcer weekly assessment, so it will trigger every week in the system. She stated if a resident has a wound concern, then she will put the appropriate treatment in place with the wound NP who comes in weekly. She stated the wound NP rounds with her on residents he is following and sees any new residents who she has concerns about. She stated that she stages the wounds unless she has questions, then she would consult with the wound NP. She stated when she does her initial assessment, she assesses the resident by starting at the heels and works her way up. She stated if something comes up on a resident she is not already seeing, staff members let her know there is an area of concern. 35111 -Resident #247 was admitted to the facility on [DATE], with diagnoses of morbid obesity and type II diabetes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the hospital history and physical note dated January 12, 2020 revealed the resident had no rashes or lesions to exposed areas of the skin. Regarding the mid back pressure ulcer: The initial admission record dated January 13, 2020 included the resident was alert and oriented to person, place and time. Per the assessment, the resident had pressure ulcer on the coccyx and right gluteal area, however, there was no documentation of a pressure ulcer to the back. The nursing admission note dated January 13, 2020 included that a head to toe assessment was done and there was no documentation of a pressure ulcer to the back. The skin care plan dated January 13, 2020 included the resident had potential/actual impairment to skin integrity and had a stage 3 pressure ulcer on the vertebrae. The goal was to have no complications related to skin injury type. Interventions included for monitoring/documenting location, size, treatment of skin injury and reporting to the physician abnormalities such as failure to heal, signs and symptoms of infection, maceration etc. A skin evaluation dated January 14, 2020 revealed the resident had a pressure ulcer to the mid back. However, the documentation did not include the stage, measurements, a description of the wound bed/edges and surrounding skin and if any drainage was present. Despite documentation that the resident had a stage 3 pressure ulcer, there was no clinical record documentation that a thorough assessment of the stage 3 pressure ulcer to the mid back was completed on January 13 or 14, 2020, nor any evidence that the physician was notified, or that treatment orders were obtained or wound treatments were provided on January 13 or 14. The weekly skin pressure ulcer note dated January 15, 2020 which was two days after admission and was not signed by the nurse revealed the resident had a stage 3 pressure ulcer to the mid vertebrae. Per the note, this assessment was the initial evaluation. The assessment included the pressure ulcer was present on admission, with an unknown onset date. The wound measured 1 cm x 2 cm x 1.5 cm, with a pink wound bed and undefined edges, and a small amount of serosanguinous exudate and surrounding skin was normal. The treatment documented was to cleanse the area with Dakin's solution, pat dry, pack with packing strip and cover with a dry dressing every Monday, Wednesday and Friday and as needed until resolved. However, there were no physician orders for the Dakins solution treatment and there was no documentation that this treatment was done on January 15 or 16. Review of a NP progress note dated January 15, 2020 revealed there were no open areas or pressure ulcers to the resident's back. According to a daily skilled note dated January 15, 2020, the resident was alert and oriented x 3 and overall skin description was clean and warm to touch, with no active symptoms. The note also included that the skin condition was not a new onset, however, the documentation did not describe what skin condition the resident had. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The wound NP note dated January 17, 2020 included a chief complaint of mid-back wound. The history of present illness included the wound nurse reported wound on the back x 1 year, had received wound care by home health and denies being evaluated at a wound clinic. Assessment included open wound of back. The plan included aggressive wound care and offloading of pressure points, assistance with turning as needed. Goals included offloading of all pressure points by turning, using specialized mattresses, wheelchair cushions and clearing of dead tissue if any. The treatment included to apply Mupirocin (topical antibiotic) to 1/4 inch packing gauze three times a week and as needed. The documentation did not include the type of wound, the stage, any measurements or a description of the wound bed/edges/surrounding skin and if any drainage was present. The admission MDS assessment dated [DATE] revealed a BIMS score of 14, indicating the resident had intact cognition. Per the MDS, the resident required extensive assistance with two persons for bed mobility, transfers and toilet use. The MDS also included the resident was at risk of pressure ulcer development and had one unhealed stage 3 pressure ulcer. Despite documentation in the NP note (from January 17) to apply Mupirocin to the back, there was no physician's order for Mupirocin to be appled. In addition, there was no evidence that the Mupirocin was applied to the mid back pressure ulcer from January 17 through 20. A Braden Scale for Predicting Pressure Ulcer Risk dated January 20, 2020 revealed the resident was at high risk for pressure ulcer development. The weekly skin pressure ulcer note dated January 21, 2020 revealed the resident had a stage 3 pressure ulcer to the upper mid vertebrae which was present on admission, with an unknown onset date. Per the note, the pressure ulcer measured 1 cm x 2 cm x 1.5 cm, with a pink wound bed, undefined wound edges, had scant serosanguinous exudate, no odor and normal surrounding skin. The treatment included to cleanse the area with Dakin's solution, pat dry, pack with packing strip and cover with dry dressing Monday, Wednesday and Friday and as needed until resolved. However, was there no order for Dakins treatment and there was no documentation that the treatment was done from January 21-23, 2020. The nutrition IDT (interdisciplinary team) update note dated January 23, 2020 revealed the resident had increased protein needs related to multiple pressure ulcers. The wound NP note dated January 24, 2020 included a chief complaint of mid back wound. Per the note, the back wound was chronic. The low back open wound measured 1 cm x 2 cm x 2.7 cm, wound bed was 80% pink and 20% yellow slough, with a small amount of serous drainage. The plan was to continue Anasept on 1/4 inch packing gauze 3x/week and as needed and cover. The primary goal was for infection control/prevention and granulation growth. However, there was no physician's order for the use of Anasept and this treatment was not on the MAR/TAR for January 2020. As a result, there was no evidence that this treatment was administered from January 24-27. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	The weekly skin pressure ulcer note dated January 28, 2020 included a stage 3 pressure ulcer to the upper mid vertebrae which was present on admission, with an unknown onset date. The wound measured 1 cm x 2 cm x 1.7 cm with a pink wound bed, scant serosanguinous exudate with no odor, undefined wound edges and normal surrounding skin. The treatment documented was to cleanse the area with Dakin's solution, pat dry, pack with packing strip and cover with a dry dressing on Monday, Wednesday and Friday and as needed until resolved. On January 28, 2020, a physician's order was obtained to cleanse the wound with Dakin's solution, quarter strength solution, pat dry, apply packing strip soaked in Anasept wound gel and pack Monday, Wednesday and Friday and as needed until resolved for a diagnosis of a stage 3 pressure ulcer to mid back. A pressure ulcer

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21946 Based on clinical record review, resident and staff interviews, and review of policy, the facility failed to ensure one sampled resident (#40) was provided timely assessments to determine the potential for bladder retraining. The deficient practice could result in residents not receiving assessments to determine the potential for bladder retraining. Findings include: Resident #40 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, heart disease, clostridium difficule (c-diff) infection and major depressive disorder. An admission bladder incontinence evaluation dated December 9, 2019 revealed the resident was incontinent of bladder, alert and oriented, had a contributing factor of infection (c-diff), and had an indifferent behavior/attitude. The score of the evaluation was 9, which indicated the resident was a possible candidate for bladder re-training. Review of the care plan revealed no care plan regarding bladder incontinence and bladder training. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have a Brief Interview for Mental Status score of 15, which indicated no cognitive impairment. The resident was also assessed to be frequently incontinent of urine. In addition, the MDS assessment included that the resident had not had a program of bladder training since her admission. The Certified Nursing Assistant (CNA) flowsheet for the time frame of December 6 through 31, 2019 revealed staff initials to indicate the resident was incontinent of bladder throughout the day and night. The CNA flowsheet for January 2020 also revealed documentation that the resident had bladder incontinence throughout the day and night. Further review of the clinical record revealed no evidence of an assessment to determine the resident's potential for bladder re-training. During an interview with resident #40 on January 28, 2020, the resident stated she is always incontinent of urine and wears an incontinence brief. An interview was conducted with a CNA (staff #71) on January 29, 2020 at 3:33 p.m. The CNA stated resident #40 was incontinent of urine and wears an incontinence brief. An interview was conducted with resident #40 on January 31, 2020 at 8:23 a.m. She stated she has a decreased sensation when she urinates in the incontinence brief. She stated she was continent of urine before her admission to this facility and has been incontinent since her admission here. She also stated no staff had ever talked with her about a bladder re-training program and that she thought a program like that could be of help to her. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the MDS nurse (Licensed Practical Nurse/staff #29) on January 31, 2020 at 8:37 a.m. Staff #29 stated she reviewed the admission MDS assessment for resident #40 and noted the resident was frequently incontinent of bladder. She further stated a care plan related to bladder incontinence had not been developed for resident #40 due to the staff having problems in completing the MDS assessments in a timely manner. Staff #29 stated the admission bladder assessment for resident #40 indicated the resident was a possible candidate for bladder re-training. In addition, staff #29 stated there was no documentation in the clinical record to indicate the resident had been further assessed or been placed on a plan for bladder re-training. The MDS nurse also stated the lack of the care plan development may have stalled the entire process. An interview was conducted with the Director of Rehabilitation (staff #126) on January 31, 2020 at 8:50 a.m. Staff #126 stated the skilled therapy department has a program to assist nursing with a resident that has been assessed for bladder re-training. Staff #126 further stated some facility staff had previously identified a problem of residents not being assessed for bladder re-training and resident #40 may have been one of the residents that were identified. An interview was conducted with the Director of Nursing (DON/staff #132) on February 3, 2020 at 10:50 a.m. She stated the MDS assessments and the care plans that are triggered from the MDS assessments should be completed when they are due. She stated she had been aware the MDS staff were late with some of the MDS assessments and care plans. She also stated resident #40 needed to be further evaluated and assessed for a potential bladder re-training program. According to the facility's policy regarding bowel and bladder management the following was included: It is the policy of this facility to provide the resident who is incontinent of bladder the appropriate care and treatment and services to prevent urinary tract infections and to restore as much as normal bladder function as possible. Purpose: The purpose of the bladder evaluation is to develop an individualized goal oriented approach to elimination. Procedures: The bowel/bladder evaluation form will be completed on residents upon admission and as needed for changes in condition to determine the appropriate level of bladder program. Bowel and bladder scoring: 9-12 = possible candidate for bladder re-training. Residents identified to have the potential to benefit from a bladder program will be started on a 3 day bladder diary. The interdisciplinary team (IDT) will conduct a follow up evaluation based on the results of the voiding diary and the appropriate toileting program will be established. The resident's plan of care will reflect the bladder program established and will be updated as needed. Residents will be re-evaluated by the IDT as appropriate or indicated by the circumstances.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35111 Based on clinical record review, interviews, and facility policy, the facility failed to ensure one resident (#57) received dialysis services consistent with professional standards of practice. The sample size was one resident. The deficient practice increases the risk for clinical complications or emergent situations that impact residents on dialysis. Findings include: Resident #57 was admitted to the facility on [DATE] with diagnoses of ESRD (End Stage Renal Disease) and dependence on renal dialysis. The initial admission record dated December 29, 2019 included the resident was alert and oriented to time, place, and person. Per the documentation, the resident received hemodialysis using the AV (arteriovenous) shunt located on her left upper extremity. Multiple physician's orders dated December 29, 2019 regarding dialysis were noted. These included: -Dialysis every Monday, Wednesday, and Friday -Pre dialysis weights every day shift on Monday, Wednesday and Friday -Post dialysis weights every evening shift on Monday, Wednesday, and Friday -Send communication sheet with the resident to dialysis. The orders did not include monitoring for the bruit, thrill, bleeding, or signs and symptoms of infection on the AV shunt site. These orders were transcribed onto the MAR (Medication Administration Record) for December 2019 and were completed as ordered. Review of the resident's baseline care plan, dated December 29, 2019, revealed that the resident required dialysis three times per week. The care plan did not include interventions regarding monitor the resident's AV shunt site for bruit, thrill, and/or infection. The admission MDS (Minimum Data Set) assessment dated [DATE] included a BIMS (Brief Interview for Mental Status) score of 15 indicating the resident was cognitively intact. Active diagnoses included ESRD and dependence on renal dialysis. The assessment also indicated that the resident was receiving dialysis while in the facility. The daily skilled notes dated January 1, 7, 14, 21, 23 and 28 revealed documentation that the resident's AV shunt was patent with bruit and thrill. However, the documentation did not include monitoring for signs and symptoms of bleeding and/or infection. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the clinical record revealed no evidence that the resident's AV shunt was monitored for bruit, thrill and signs and symptoms of bleeding and/or infection on the following days: January 2, 4, 5, 9, 11, 12, 16, 18, 19, 25, and 26. Review of the clinical record revealed that the comprehensive care plan with interventions to address the resident's dialysis needs was not initiated until January 27, 2020. Also, physician's orders to monitor the AV shunt for bruit and thrill, and to monitor the AV shunt for bleeding and signs and symptoms of infection were not ordered until January 27, 2020. In an interview with a Licensed Practical Nurse (LPN/staff #67) on January 29, 2020 at 3:04 p.m., she stated before a resident is admitted to the facility, she will be informed that the resident requires dialysis. She stated when a resident is receiving dialysis, the facility has standing orders which include completing pre and post dialysis assessments, monitoring the AV shunt site for bruit and thrill, and monitoring the AV shunt site for signs and symptoms of infection. She stated these standings orders are entered in the electronic record and will be implemented as ordered. She stated monitoring is done daily on every shift and is documented in the MAR and/or TAR (Treatment Administration Record). During an interview with the resident on January 30, 2020 at 2:49 p.m., she stated that she leaves the facility at 9:00 a.m. for dialysis every Monday, Wednesday and Friday and does not come back until 3:00 p.m. in the afternoon. She stated staff assess her and her dialysis site before and after she goes to dialysis. However, she stated that staff does not assess her dialysis site on days that she does not receive dialysis. She stated that she was at dialysis yesterday and she had to remove the dressing to her dialysis site by herself today. An interview with the Director of Nursing (DON/staff #132) was conducted on January 30, 2020 at 2:56 p.m. She stated that pre and post dialysis assessments include vital signs, weights, assessing the AV shunt site for bruit and thrill, and monitoring for signs and symptoms of infection. She stated the pre and post dialysis assessment is written on a separate sheet of paper that is maintained in a binder at the nurse station. She stated on days the resident does not go to dialysis, the resident's AV site is also monitored for bruit, thrill, and signs and symptoms of infection and this will be documented in the TAR. During an interview with a Compliance Resource (staff #138) on January 31, 2020 at 7:43 a.m., she stated there was no documentation found in the clinical record that the resident's AV shunt was monitored on the days in question. An interview was conducted with an LPN (staff #92) on February 3, 2020 at 10:10 a.m. She stated that pre and post dialysis assessments include vital signs, weights, and assessing the dialysis shunt site for bruit and thrill and signs and symptoms of infection. She stated on days the resident does not go to dialysis, the shunt is monitored for the presence or absence of the bruit and thrill and for signs and symptoms of infection every shift. Further she stated all monitoring is documented in the TAR. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's dialysis policy included a policy statement that the facility will assist the resident in maintaining homeostasis pre and post dialysis; assess and maintain patency of renal dialysis access; and assess resident daily for function related to renal dialysis. The policy also included that documentation includes assessment of care given and condition of the renal dialysis access site. Further, the policy included that all assessments are documented in the clinical record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21946 Based on personnel file review, staff interviews, facility documentation, policy review and the facility assessment, the facility failed to ensure one Licensed Practical Nurse (LPN/staff #35) had the competencies and skill sets as a wound nurse to provide the necessary care and treatment for wounds/pressure ulcers. Failure to ensure proper training for wound care may result in worsening of residents' wounds. Findings include: Review of the personnel file for staff #35 revealed she was hired on July 15, 2019 with a LPN license that was active and in good standing. A review of the job description revealed staff #35 was hired to provide primary care with an emphasis on assessment, illness prevention, and health care management. Continued review of the personnel file for staff #35 revealed a form Skills Checklist-Licensed Nurse that was dated October 29, 2019. Although there were multiple nursing areas designated on the form, such as tube feedings, respiratory therapy, infection control, pharmacy, and medication administration, there was no evidence of an evaluation of wound care or the care and treatment of pressure ulcers. The initials of the nurse evaluator indicated staff #35 demonstrated competency for the skills evaluated. Continued review of the personnel file for staff #35 revealed a form Wound Care-Skills Checklist dated November 1, 2019. The job position was Wound Nurse LPN and there was a handwritten note that now changed the original date of hire of staff #35 to November 1, 2019. The skills checklist had a total of 24 areas and included general areas of handwashing, positioning residents, wearing gloves. There were only approximately 3 areas that pertained to actual wound care and included wearing gloves to hold the gauze to catch irrigation solutions, wearing sterile gloves when physically touching the wound, placing gauze to cover broken skin, removing dry gauze, and applying treatments as ordered. Continued review of the wound care skills checklist form for staff #35 revealed no evidence of an evaluation of the care and treatment of pressure ulcers, such as staging and other descriptors of a pressure ulcer to determine healing or deterioration. Subsequently, there was no evidence staff #35 was evaluated to determine she had the required knowledge for the appropriate care and treatment of pressure ulcers, including timely physician notification when a pressure ulcer had worsened. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with staff #35 on February 3, 2020 at 10:29 a.m. Staff #35 stated she was hired in July 2019 as a LPN with basic nursing responsibilities and given a job description for that role. She stated she was asked to be the wound nurse when the previous wound nurse was leaving. Staff #35 stated she had previous wound treatment experience; maybe two years, however she never had a role as the lead wound nurse. Staff #35 stated the previous wound nurse at this facility showed her how to do the physician treatment orders in the computerized clinical record system (Point Click Care-PCC). She also stated the previous wound nurse trained her on admission assessments and how to measure pressure ulcers. Staff #35 stated The previous wound nurse was with me several weeks and showed me the ropes. Staff #35 stated she thought this may be adequate as far as the hands on treatment aspect of the job as a wound nurse. Staff #35 stated the actual paperwork and documentation of the wounds and treatment took her longer to learn and stated the Director of Nursing (DON/staff #132), Assistant Director of Nursing (ADON/staff #74), and the wound consultant showed her how to run the programs in PCC. Staff #35 stated to her knowledge she was not aware she needed to be wound certified to function as the wound nurse in this facility. She stated that when she was asked if she had wound certification, she told the DON she did not. The LPN stated she was then signed up for a program to obtain the specialized wound certification. An interview was conducted with the DON (staff #132) on February 3, 2020 at 11:50 a.m. Staff #132 stated she knew staff #35 had been evaluated and cleared to provide wound treatment because the wound skill checklist had been completed on November 1, 2019. Staff #132 stated she was not aware the wound skills checklist did not contain anything specific to actual wounds or pressure ulcers. Staff #132 stated staff #35 is currently signed up for a specific wound class so she can be better educated. Staff #135 stated that both she and staff #74 provided some oversight and supervision to staff #35. She also stated the wound Nurse Practitioner was available for staff #35. Staff #132 stated she takes full responsibility for the lack of staging of pressure ulcers and the identification of worsening pressure ulcers and the lack of oversight provided to staff #35 regarding pressure ulcers. Staff #132 then stated she was not aware their current facility assessment specified the wound nurse had to be certified. According to the treatment nurse job description the primary purpose is of the job position is to provide primary skin care to residents under the medical direction and supervision of the resident's attending physicians, the DON, or the Medical Director of this facility, with an emphasis on treatment and therapy of skin disorders. The policy revealed duties and responsibilities included examining the resident and the resident's records and charts, and discriminating between normal and abnormal findings in order to recognize when to refer the resident to a physician for evaluation, supervision, or directions. Medical care functions included identifying, managing, and treating specific skin disorders such as decubitus ulcers and skin abrasions. Ensure that residents with decubitus ulcers (pressure ulcers) receive appropriate prophylaxis and treatment. The facility's policy regarding nursing staff competency revised February 2019 revealed It is the policy of this facility to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility assessment dated [DATE] revealed the facility would accept and provide the necessary care to resident with skin ulcers, injuries. The assessment included the facility would offer their resident population skin integrity care and services, such as pressure injury prevention and care, skin care, and wound care. The policy also included the direct care staff would include a LPN certified wound nurse. Staff #35 was listed as the wound nurse.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41020 Based on clinical record review, staff interviews and review of policy and procedures, the facility failed to ensure one resident's (#48) drug regimen was free of unnecessary drugs, by failing to ensure that narcotic pain medication was administered as ordered. The deficient practice may increase the risk for adverse consequences. Findings include: Resident #48 was admitted on [DATE], with diagnoses that included pressure ulcer of sacral region stage 3, cognitive communication deficit and schizophrenia. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating the resident had moderate cognitive impairment. Per the MDS, the resident stated she had occasional pain of 9 out of 10 on the pain scale. A physician's order dated January 10, 2020 revealed for acetaminophen (non-opioid analgesic) 650 milligrams (mg) every 4 hours as needed for pain level of 1-5 and for morphine sulfate (concentrate) solution 20 mg/ml, give 5 mg by mouth every 4 hours as needed for pain of 6-10. This order was discontinued on January 12. Another physician's order dated January 16, 2020 included for morphine sulfate (opioid/narcotic) solution 20 mg/milliliter (ml), give 10 mg sublingually every 4 hours as needed for pain level of 6-10. Review of an opioid pain management care plan dated January 16, 2020 identified the potential for adverse outcomes for opioid use, with a goal to remain free from pain or at a level of discomfort acceptable to the resident. An intervention included to administer opioid as prescribed. Review of the January 2020 Medication Administration Record (MAR) revealed the resident received 5 mg of morphine sulfate (concentrate) solution on January 11 for a pain level of 4 and 5, and received morphine sulfate solution sublingually two times on January 21 for a pain level of 5, one time on January 23 for a pain level of 5, 2 times on January 27 for a pain level of 5 and one time on January 29 for a pain level of 4. Further review of the January 2020 MAR revealed the resident did not receive acetaminophen at any time during the month. An interview was conducted on January 31, 2020 at 7:58 a.m. with a Licensed Practical Nurse (LPN/staff #30). She stated she always does a pain assessment prior to administration of pain medication. Depending upon the resident's pain level, she said she gives the appropriate medication. In regard to resident #48, she stated that she may have given the morphine prior to wound care, because the resident would be in excessive pain otherwise, especially when she was packing the resident's wound. She stated that she probably should have called the physician and explained her rationale and gotten the order changed instead of administering the medication outside of the parameter. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 31, 2020 at 8:14 a.m., an interview was conducted with the Director of Nursing (DON/staff #132). She stated her expectation is for nurses to hold the pain medication if the resident's pain level is outside of the ordered parameters. She said her expectation is to give the appropriate medications as listed. She reviewed the resident's MAR and stated that it did not meet her expectation. The facility policy titled, Documentation and Charting Pain Medication included it is the policy of the facility to provide the elements of quality medical nursing care. Pain medication administration and documentation pertaining to medication administration should include accurate administration of pain medication, as ordered per pain scale for as needed orders.

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22366 Based on observations, clinical record reviews, staff interviews, review of facility documentation and policies and procedures, the facility failed to ensure that multiple medications including medications for three residents (#14, #20 and #46) were stored at the proper temperatures, per manufacturer's recommendations and facility policy. As a result, the Condition of Immediate Jeopardy (IJ) was identified. The facility also failed to ensure that one narcotic box was secured. The deficient practice resulted in medications not being stored at the proper temperatures, resulting in the potential for medications to not be as effective and causing possible adverse consequences for residents. The deficient practice also resulted in medications not being stored in a manner to prevent loss or diversion. Findings include: On January 29, 2020 at 11:33 a.m., the Condition of Immediate Jeopardy (IJ) was identified. The Administrator (staff #133) was informed of the facility's failure to ensure that medications stored in medication room refrigerators were stored per manufacturer's recommendations and per facility policy. The Administrator (staff #133) and Director of Nursing (DON/staff #132) presented a plan of correction on January 29, 2020 at 12:31 p.m. At 1:10 p.m., the Administrator (staff #133), a compliance RN (registered nurse/staff #136), a consultant RN (staff #137) and a consultant Administrator (staff #138) were informed that the plan of correction was unacceptable and needed to include additional information such as: the content and completion of staff inservice's; nurse education regarding medications stored per manufacturer's recommendations; the duration of the temperature checks; interventions to be implemented if temperatures are out of range; time frames for delivering replacement medications; who is responsible for completing the temperature logs and what audits will be done and who is responsible to complete the audits. A revised plan of correction was received on January 29, 2020 at 4:08 p.m. and included the additional components as mentioned above. The revised plan of correction was accepted at 4:21 p.m. on January 29, 2020. Multiple observations were conducted on January 29 and 30, 2020 of the facility implementing their plan of correction. New medication refrigerators were being maintained per manufacturer's recommendations. Staff interviewed were knowledgeable of the new medication refrigerator procedures and what corrective action was to be done if temperatures were found to be out of the recommended parameters. As a result, the Condition of Immediate Jeopardy was abated on January 30, 2020 at 2:17 p.m. -Resident #46 was admitted to the facility on [DATE], with diagnoses that included coccidiomycosis meningitis and major depressive disorder. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A physician's order dated January 29, 2020 included for Ativan solution (antianxiety medication/Lorazepam) 2 milligrams (mg)/milliliters (ml), inject 1 mg intramuscularly every 24 hours as needed for seizures lasting 2 minutes. -Resident #14 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease, unspecified dementia without behavioral disturbance and schizophrenia. A physician's order dated July 3, 2018 included for Lorazepam solution (schedule IV drug) 2 mg/ml, inject 2 mg intramuscularly every two hours as needed for status epilepticus. Give 2 mg intramuscularly for uncontrolled seizure. May repeat once. -Resident #20 was admitted to the facility on [DATE], with a diagnosis of diabetes. A physician's order dated May 1, 2019 included for Liraglutide Solution (Victoza) Pen-Injector 18 mg/3 ml., inject 1.8 milligrams subcutaneously one time a day for diabetes. An observation was conducted of the 400 hall medication room refrigerator on January 29, 2020 at 8:45 a.m. , with the DON (staff #132). A temperature gauge inside of the refrigerator was observed to be 22 degrees Fahrenheit (F.) At this time, the Lorazepam for resident #46 and #14 and a Victoza pen for resident #20 were observed inside the refrigerator. The Lorazepam was also stored inside of the refrigerator in an unlocked plastic box. Review of the Refrigerator/Freezer Temperature Log for January 2020 which was on the door of the refrigerator revealed that temperatures were to be checked once a day. Further review of the Temperature Log revealed the temperatures recorded were below 36 degrees F. on the following days: January 1, 3, 4, 5, 6, 9, 10, 11, 12, 14, 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27. In addition, the temperatures were not checked on January 28 and 29. The Refrigerator/Freezer Temperature Log did not include what the required temperature range should be. During the observation, an interview was conducted with the DON who stated that the temperature of the refrigerator should be at 34-40 ish. An interview was conducted with a LPN (licensed practical nurse/staff #92) on January 29, 2020 at 8:55 a.m. Staff #92 stated that she was not sure what temperature the Lorazepam and the Victoza should be stored at. She also said that the box that the Lorazepam was stored in should have been locked and that she usually ensures the narcotic box is locked when starting her shift, but she forgot to do that today. An interview was conducted with the facility's pharmacy consultant on January 29, 2020 at 9:10 a.m. The pharmacy consultant stated that the Lorazepam and the Victoza pen should be stored at 36-46 degrees F. Review of the manufacturer's instructions for the Victoza pen documented Keep very cool: do not freeze. The manufacturer's instructions for the Lorazepam documented Refrigerate 36 - 46 degrees Fahrenheit. An observation was conducted of the medication room refrigerator on the 200 hall on January 29, 2020 at 10:40 a.m. with a LPN (staff #67). The temperature gauge was at 29 degrees F. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An immediate interview was conducted with staff #67 who stated that the temperature must have went down as it was just at 32 degrees F. Staff #67 stated if she noticed that the refrigerator temperature was too low, she would call the maintenance director and stand by the refrigerator until he came. Staff #67 stated that she would not complete a work order if she observed that a medication refrigerator was out of range. An interview was conducted with the maintenance director (staff #54) on January 29, 2020 at 2:00 p.m. Staff #54 stated that licensed nursing staff were responsible to ensure the temperature was within range in the medication refrigerators. Staff #54 stated that if licensed nursing staff observed that a temperature was not within range, they should let him know and place a maintenance order in TELS (a preventative maintenance program). Staff #54 stated that he did not recall ever being notified that medication refrigerators were not at the proper temperatures. An observation was conducted on January 29, 2020 at 2:55 p.m. of the 400 hall medication room refrigerator, with an LPN (staff #127) which was recently purchased by the facility. Although no medications were stored in this refrigerator, the temperature gauge was 30 degrees F. An immediate interview was conducted with a LPN (staff #127) on January 29, 2020 at 2:55 p.m. Staff #127 stated It's 30, sounds good to me. Staff #127 further stated that she thought the temperature of the medication refrigerator should be between 28 and 30 degrees F. Another interview was conducted with the DON on February 3, 2020 at 10:00 a.m. The DON said that licensed nursing staff should check the temperature of the medication refrigerators at the beginning of their shift and notify maintenance if it was not within the desired range. 21946 -During an observation conducted on January 29, 2020 at 8:19 a.m. with a LPN (staff #82), staff #82 entered the 200 unit medication storage room to obtain a medication (Risperdal), which she stated was stored in the refrigerator. She then stated that the temperature of the interior refrigerator was between 34 and 35 degrees, per the inside thermometer. Staff #82 then checked the Risperdal that she was going to administer and stated that the manufacturer's recommendation was for the Risperdal to be stored between 36 to 46 degrees, and the current temperature did not meet the specific temperature. Staff #82 then removed the refrigerator log which was attached to the outside of the refrigerator. After reviewing the log, staff #82 said the log for January 2020 contained many entries that she thought were not within the required range. She further stated that she was unsure of what the temperature range should be, however; also stated that some of the documented temperatures of 30 or 32 degrees seemed too low. Staff #82 stated the form did not indicate what the required temperature range needed to be for various medications. She also said that there were no guidelines for staff to follow if a temperature seemed too low or was out of range. Review of the Refrigerator/Freezer temperature logs for the 200 unit hallway refrigerator revealed sections to document the date, the refrigerator and freezer temperatures and staff initials. The temperature logs did not list what the proper refrigerator temperature range should be. Further review of the logs revealed the following: -March 2019: There were 13 out of 31 days with temperatures that were out of range as the temperatures were between 30-34 degrees. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-April 2019: There were 20 out of 30 days with temperatures that were out of range as the temperatures were between 30-32 degrees. -May 2019: There were 7 out of 28 days with temperatures that were out of range as the temperatures were between 30-34 degrees. There were 3 days with no documentation of temperatures. -June 2019: There were 18 out of 28 days with temperatures that were out of range as the temperatures were between 30-32 degrees. There were 2 days with no documentation of temperatures. -July 2019: There were 16 out of 29 days with temperatures which were out of range as the temperatures were 32-34 degrees. There were 2 days with no documentation of temperatures. -August 2019: There were 23 of 27 days with temperatures that were out of range as the temperatures were 28-33 degrees. There were 4 days with no documentation of temperatures. -September 2019: There was 1 day with a temperature of 32 degrees. There was also one day with no documentation of a temperature. -October 2019: There were 22 out of 31 days with temperatures that were out of range as the temperatures were between 32-34 degrees. -November 2019: There were 20 out of 30 days with temperatures that were out of range as the temperatures were 32-34 degrees. There was one day with no documentation of a temperature. -December 2019: There were 21 out of 30 days with temperatures that were out of range as the temperatures were 30-32 degrees. There was one day with no documentation of a temperature. -January 2020: There were 19 out of 28 days with temperatures which were out of range as the temperatures were 30-32 degrees. 35111 -An observation of the refrigerator located in the medication room which was behind the nurse's station was conducted with a LPN (staff #67) on January 29, 2020 at 8:49 a.m. Inside of the refrigerator was a thermometer, with a temperature reading of 30 degrees F. The following medications were located inside the refrigerator: 18 vials of influenza vaccine, 4 vials of tuberculin stabilized solution, 5 vials of pneumococcal vaccine, one box of Bisacodyl (laxative) suppositories, 5 bags of IV (intravenous) Vancomycin (antibiotic), 5 bags of IV cefazolin (antibiotic), a box of GRANIX injection (colony stimulating factor), a vial of Novolin N human insulin and a vial of Humalog insulin. Review of the box of tuberculin solution revealed instructions to store the medication between 36 degrees and 46 degrees F. Review of the instruction packet found in the box of Novolin N insulin revealed instructions to keep all unopened Novolin N in the refrigerator between 36 degrees to 46 degrees F. and to not refrigerate an opened vial. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The instruction packet found in the box of Humalog insulin included that unopened Humalog should be stored in a refrigerator between 36 degrees and 46 degrees F. The box of influenza vaccine revealed instructions to refrigerate and store the vaccine between 36 degrees and 46 degrees Fahrenheit. In the box of the Bisacodyl suppositories were instructions to store the medication at temperatures below 30 degrees F. During an interview with staff #67 conducted on January 29, 2020 at 1:28 p.m., she stated the pneumococcal vaccine, influenza vaccine, tuberculin solution and the Bisacodyl suppositories which were found in the refrigerator were all brand new and had never been used. She stated the bags of IV Vancomycin were prescribed for a resident who is admitted at the facility and is currently receiving the antibiotic treatment. She stated the bags of IV cefazolin were prescribed for a resident who was discharged yesterday from the facility. Staff #67 further stated that she does not know when the medications were delivered and stored in the refrigerator. She said the pharmacy delivers medications and treatments at different times of the day. When the pharmacy delivers the medications, she said the delivery is segregated according to the nursing halls and the nurse in charge will be given the delivered medications prescribed for residents in that hall. She stated the nurse is responsible in receiving and storing the medications either in the medication cart/room or in the refrigerator if needed. Staff #67 stated the night shift nurses are responsible for checking the refrigerator temperatures which are done after midnight and should be documented on the temperature log located on the door of the refrigerators. She stated the refrigerator temperature is maintained and kept every month. Review of a policy regarding Medication Storage revealed it is the policy of the facility to store all drugs and biologicals under proper temperature controls. All medications requiring refrigeration or temperatures between 36-46 degrees F. are kept in a refrigerator, with a thermometer to allow temperature monitoring. A policy regarding Drug Storage included the following: It is the policy of this facility to ensure the proper and safe storage of drugs and biologicals. The policy included that proper temperature ranges should be maintained with acceptable guidelines. Review of the facility's policy regarding Medication Access and Storage dated August 2018 revealed . Schedule III and IV controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose .

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 22366 Based on concerns identified during the recertification survey, staff interview and policy review, the facility failed to be administered in a manner that enabled it to use its resources, as the facility was monitoring medication refrigerator temperatures, but failed to identify that the temperatures were below the recommended range and implement corrective action. In addition, the facility had identified concerns related to pressure ulcer documentation, however, they did not identify additional concerns regarding their pressure ulcer program and implement corrective action to correct the deficiencies. The deficient practice could result in a lack of administrative involvement and appropriate action taken to correct identified concerns. Findings include: During the recertification survey, a Condition of Immediate Jeopardy (IJ) was identified, due to the facility's failure to identify concerns with the temperatures in medication refrigerators not being maintained within the range recommended by the medication manufacturer's recommendations and the facility's policy. Observations of the refrigerator temperatures were conducted and were found to be below the medication manufacturer's recommendation and the facility's policy of 36-46 degrees F. The medication refrigerators contained various medications for residents. Multiple refrigerator logs were reviewed and revealed that temperatures were being monitored daily by staff. However, there were multiple temperatures each month from March 2019 through January 2020, which showed that the temperatures were below 36 degrees F. Despite the monitoring of the temperatures in the medication refrigerators, and documentation that there were multiple days each month for several months when the temperatures were below the recommended range, there was no corrective action which was implemented by management to address this concern. Also during the survey, concerns were identified regarding the care and treatment of four residents with pressure ulcers. Concerns identified consisted of a lack of thorough assessments being done when pressure ulcers were identified, a lack of physician notification, a lack of treatment orders being obtained timely and treatment orders not being implemented as ordered. As a result, Substandard Quality of Care was identified. An interview was conducted with the Administrator (staff #133) and DON (Director of Nursing/staff #132) on February 3, 2020 at 12:30 p.m. They stated that the facility identified concerns with pressure ulcer documentation on October 23, 2019, but they did not identify it to the scope that was presented during the survey. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Administrator job description revealed, The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times .Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22366 Based on facility documentation and staff interviews, the facility failed to ensure that staff competency necessary to provide the level and type of care needed for the resident population was in place, per the facility assessment. The deficient practice could result in staff not being fully trained to provide the necessary care and services to residents. Findings include: Review of the Facility assessment dated [DATE] revealed .The facility admits residents who have pressure ulcers, and/or flap repairs. The facility averages daily about four residents with pressure ulcers. On a rare occasion, a resident at high risk, with multiple co-morbidities will develop an unavoidable pressure ulcer. Rarely, a resident will have a chronic, non-healing pressure ulcer . The Facility Assessment also revealed that pressure injury prevention and care, skin care, and wound care would be offered based on resident needs. The Facility Assessment revealed that the facility identified that a LPN certified wound nurse was needed to provide competent support and care for the resident population. An interview was conducted with the wound nurse (licensed practical nurse/staff #35) on February 3, 2020 at 10:29 a.m. Staff #35 stated that she was hired at the facility in July 2019 as a LPN. Staff #35 stated that she was asked to be the facility's wound nurse, as the previous wound nurse was leaving in November 2019. She said that she had maybe two years experience doing wound treatments, but never as a lead wound nurse. Staff #35 stated the previous wound nurse trained her. She said the facility asked her if she was wound certified and she said no, so they signed her up for an online wound certification program, but she has not logged into that program yet. An interview was conducted with the DON (Director of Nursing/staff #132) on February 3, 2020 at 11:50 a.m. Staff #132 stated that staff #35 had previous experience with wound care and was signed up with a wound class that was coming up soon. Staff #132 stated that she and the assistant director of nursing provided oversight and supervision. Staff #132 stated that only a wound certified nurse or registered nurse can provide the oversight and stage pressure ulcers. Staff #132 stated that she took full responsibility for the lack of staging and the identification of the worsening pressure ulcers. An interview was conducted with the Administrator (staff #133) on February 3, 2020 at 12:30 p.m. Staff #133 stated the Facility Assessment was recently reviewed in the quality assurance meeting and it was missed that the licensed practical wound nurse should be a certified wound nurse. Staff #133 stated that when staff #35 was hired as a wound nurse, the expectation was that she would go to a wound certification class with the registered nurses being a back up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035232	A. Building B. Wing	02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Care Center	1313 West Magee Road Tucson, AZ 85704

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 22366 Based on concerns identified during the recertification survey, staff interviews, facility documentation and policies and procedures, the facility's quality assessment and assurance (QAA) committee failed to identify quality concerns and implement plans of action to correct identified quality deficiencies regarding the proper storage of medications, resulting in Immediate Jeopardy and the lack of care and treatment for pressure ulcers, resulting in Substandard Quality of Care. Findings include: During the recertification survey, concerns were identified regarding low temperature ranges in multiple medication room refrigerators. Observations revealed the temperatures ranged from 22 degrees F. to 30 degrees F. The refrigerators contained multiple medications which were not being stored, per the manufacturer's recommendation. In addition, the temperature log for the 400 hall medication refrigerator for January 2020 revealed there were more than twenty days, where the recorded temperature was lower than 36 degrees F. The temperature logs from March 2019 through January 2020 for the 200 hall medication refrigerator showed recorded temperatures that were below 36 degrees F. anywhere from 7 to 23 days each month. The facility's policy on Medication Storage revealed it is their policy to store all drugs and biologicals under proper temperature controls. All medications requiring refrigeration or temperatures between 36-46 degrees F. are kept in a refrigerator, with a thermometer to allow temperature monitoring. As a result, the Condition of Immediate Jeopardy was identified. The facility was unable to provide any documentation that the concern related to medication room refrigerators had been identified and that corrected action had been implemented through their QA process. During the survey, additional concerns were identified regarding four residents with pressure ulcers. Concerns identified consisted of a lack of thorough assessments being done when pressure ulcers were identified, lack of physician notification, lack of treatment orders being obtained timely and treatment orders not being done as ordered. As a result, Substandard Quality of Care was also identified. An interview was conducted with the Administrator (staff #133) and the DON (Director of Nursing/staff #132) on February 3, 2020 at 12:30 p.m. They stated that the QAA committee usually meets monthly, but at a minimum quarterly. They stated that once concerns are identified audits are done more frequently at first and then tapered off as compliance is found. They stated that the facility identified concerns with pressure ulcer documentation on October 23, 2019, but it was not identified to the scope that was presented to the facility during the survey. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided documentation that they had initially identified pressure ulcers to be a concern and that audits were being conducted up to the time of the survey. However, there was no specific interventions to correct the concerns that were identified. Review of the facility's policy regarding Quality Assessment and Performance Improvement (QAPI), dated October 2019 revealed .The purpose of the QAPI plan and processes is to continually assess the facility's performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individual's highest practicable physical, mental, and social well-being . Committee functions include: QAPI plan, identifying and prioritizing PIPs (performance improvement plans), implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented is being sustained .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on observation, clinical record review, staff interviews and policy review, the facility failed to ensure that infection control procedures were followed during medication administration for one resident (#11), as a staff member touched a medication with bare hands. The deficient practice could result in the spread of infection to residents. Findings include: Resident #11 was readmitted to the facility on [DATE], with diagnoses of chronic respiratory failure and coronary artery disease. An annual Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. Review of the June 2020 physician orders revealed to give 18 micrograms of Tiotropium Bromide Monohydrated Capsule (Spiriva/to prevent bronchospasms), via inhalation in the a.m. daily. An observation of the morning medication administration was conducted on June 18, 2020 at 7:53 a.m., with a Licensed Practical Nurse (LPN/staff #75). Staff #75 opened the Spiriva inhaler and removed an old capsule with her bare hands. She did not wash her hands or use hand sanitizer and she did not don gloves. Staff #75 then removed a new Spiriva capsule from the medication package with her bare hand. She then placed the capsule into the inhaler and closed it. Immediately following this, an interview was conducted with staff #75 who stated that she always leaves the old capsule in the inhaler after administration. She also stated that if a medication is touched by a bare hand, it should be disposed of. Staff #75 stated she did not realize that she had touched the capsule with her bare hand. She said that she did place it in the inhaler, without wearing a glove. An interview was conducted with the Director of Nursing (DON/staff #56) on June 18, 2020 at 9:20 a.m. He stated the expectation of all nurses is to administer medications in a safe manner. He stated that medications should never be handled with a bare hand. He said his expectation is that if a medication touches a surface or is handled with a bare hand, that medication should be discarded and a new one obtained. He stated that leaving the old Spiriva capsule in the inhaler after being administered is not the best practice. Review of a policy titled, Medication Administration revealed that it is the policy of this facility to accurately prepare and administer medications. When administering unit doses, the staff must remove the unit dose medication into a souffle cup. Any used medications must be discarded and staff must wash their hands or use hand sanitizer before and after administration. The policy did not instruct staff to not touch medications with bare hands and ensure that gloves are donned, prior to handling medications.