

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2022
NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 131 Meadowlark Drive Richmond, KY 40475	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22976</p> <p>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to notify the physician for one (1) of thirty-three (33) sampled residents (Resident #428) when the resident experienced a change of condition and there was a need to alter treatment.</p> <p>Resident #428 had experienced a decrease in food and fluid intake since [DATE], which continued after the resident was diagnosed with COVID-19 on [DATE] and moved to the facility's COVID unit. However, there was no evidence the resident's physician was notified of the resident's decrease in food/fluid intake. In addition, although the resident's physician was notified in a telehealth visit on [DATE], that the resident's fingers and toes were discolored, there was no evidence the physician was notified the resident's extremities remained discolored until [DATE], when the resident was transferred to the hospital and admitted with diagnoses to include Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection. Resident #428 expired at the hospital on [DATE].</p> <p>The facility's failure to ensure the resident's physician(s) were notified when the resident experienced a change in condition and/or need to alter treatment has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on [DATE].</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on [DATE], which alleged removal of the Immediate Jeopardy effective [DATE]. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on [DATE]. The Immediate Jeopardy is ongoing.</p> <p>Refer to F657 and F692</p> <p>The findings include:</p> <p>A review of the facility's policy, Change of Condition Standard of Practice, dated [DATE], revealed the facility would immediately (as soon as possible/no longer than 24 hours) inform/consult with the resident's physician when there was any significant change in the resident's status.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 185262
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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #428's closed medical record revealed the facility admitted the resident on [DATE], with diagnoses that included Dementia, Delirium, Delusional Disorder, and Encephalopathy.</p> <p>Review of Resident #428's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident was cognitively severely impaired.</p> <p>Review of Resident #428's nutritional assessment completed by the Dietitian dated [DATE], revealed the facility assessed the resident to require between 1475 milliliters (ml) to 1770 (ml) of fluid daily.</p> <p>Further review of Resident #428's average daily food and fluid intake report, dated [DATE], revealed the resident consumed an average of 240 ml daily, which was less than the fluid needs the resident was assessed to have, between 1475 to 1770 ml. However, there was no evidence the facility staff contacted the resident's physician when he/she decreased his/her fluid intake.</p> <p>Review of Resident #428's meal intake documentation from [DATE] through [DATE], revealed on [DATE]; the resident refused all meals and ate less than twenty five (25%) percent; on [DATE], the resident had no food intake documented; on [DATE], the resident ate seventy-five to one-hundred (,d+[DATE]%) percent of breakfast, but refused lunch and dinner; on [DATE], the resident had no documented intake at breakfast and refused lunch and dinner eating less than twenty-five (25%) percent; on [DATE], the resident refused breakfast, ate lunch at fifty to seventy-five (,d+[DATE]%) percent and refused dinner; on [DATE], the resident had no breakfast intake documented, refused lunch, ate less than twenty-five (25%) percent and ate twenty-five to fifty(,d+[DATE]%) percent for dinner; on [DATE], the resident ate fair with fifty to seventy-five (, d+[DATE]%) percent for breakfast; no documented intake for lunch, and ate poor for dinner, eating twenty-five to fifty (,d+[DATE]%) percent; on [DATE] and [DATE], the resident had no documented intake. However, there was no evidence found in the resident's medical record to indicate staff notified the resident's physician when he/she refused his/her meals and when the resident was documented to have eaten fair topoor for most of his/her meals, during the period of [DATE] through [DATE].</p> <p>Continued review of Resident #428's closed medical record revealed on [DATE], Resident #428 tested positive for COVID-19 and was transferred to the facility's designated COVID unit. Further review of the resident's medical record revealed on [DATE], the resident had no food intake.</p> <p>Review of the Nursing Progress Notes, dated [DATE] at 10:25 AM, completed by, Registered Nurse (RN) #2 revealed the resident appeared lethargic and the resident's fingers and toes on the right side and three (3) fingers on the left hand were purple in color. However, there was no documented evidence the resident's physician was notified that the resident had not met his/her fluid needs or had consumed less than twenty-five (25%) percent of his/her average food intake since [DATE].</p> <p>Further review of Resident #428's medical record revealed, on [DATE] at 2:33 PM, Resident #428's physician conducted a telehealth visit with the resident. Review of the Physician's Orders, dated [DATE], revealed orders for support medication (Vitamin C and Aspirin). Staff were advised to offer the resident fluids to maintain adequate hydration. However, there was no evidence that the physician was notified that the resident failed to meet his/her fluid needs and had only consumed twenty-five (25%) percent of meals since [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Physician Progress Notes, completed by Physician #1 for the [DATE] telehealth visit, revealed the resident's fingers were discolored; staff were unable to obtain the resident's blood oxygenation level; and, the resident was not on oxygen. Continued review of the Physician Progress Note revealed the physician's plan was for the resident to receive Dexamethasone (steroid medication used to decrease inflammation), Tessalon (a cough medicine) and administer the resident oxygen if his/her blood oxygen saturation was lower than ninety (90%) percent on room air.</p> <p>A continued review of Resident #428's medical record revealed Nurses' Progress Notes dated [DATE] at 08:59 AM, completed by RN #2, revealed the Resident #428 continued to have purple fingers and toes. However, there was no documentation that the resident's physician was notified that the resident's fingers and toes remained discolored, and the resident continued to not eat or drink adequately.</p> <p>An interview with State Registered Nurse Aide (SRNA) #4, on [DATE] at 2:14 PM, revealed he cared for Resident #428 the night before the resident was sent to the hospital on [DATE]. SRNA #4 stated at approximately 5:00 AM on [DATE], he could not obtain an oxygen saturation on the resident and could not get the resident to take in any fluids. The SRNA stated the resident's breathing was labored and he/she was drenched in sweat. SRNA #4 stated, I thought (the resident) was going to die. Further interview revealed he notified Licensed Practical Nurse (LPN) #6 of the resident's condition multiple times during the night; however, LPN #6 did not notify the resident's physician. SRNA #4 stated LPN #6 revealed, day shift would take care of the resident when they came on shift. The SRNA #4 stated LPN #6 did not do anything to assist the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on [DATE] at 2:58 PM, revealed she provided care to Resident #428, located on the COVID unit, during the night shift from [DATE] through [DATE], 7 PM to 7 AM. LPN #6 revealed that when she last checked on the resident, the resident was in no distress, which she could recall. Further interview revealed staff had not notified her of the resident's change in condition. She further stated that if staff had, she would have notified the resident's physician.</p> <p>Review of the Nurses' Progress Notes signed by Licensed Practical Nurse (LPN) #5, on [DATE] at 11:00 AM, revealed Resident #428 had vomited a large amount of dark black colored emesis, and the resident's oxygen saturation were not able to be obtained. The staff notified the resident's physician, who instructed staff to transfer the resident to the hospital for further evaluation and treatment.</p> <p>Review of Resident #428's hospital record dated [DATE], revealed the hospital admitted the resident with the diagnoses of Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection. Further review of the medical record revealed Resident #428's condition declined, he/she was placed on comfort measures and expired at the hospital on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with Physician #1, on [DATE] at 2:25 PM, revealed he was made aware of Resident #428's discolored fingers and toes during the telehealth visit on [DATE]. However, further interview revealed he was unaware of the resident's change in condition in which staff were unable to obtain the resident's oxygen saturation and of the resident's decreased food/fluids intake. Continued interview revealed he expected to be notified when a resident's condition worsened, as it would indicate further oxygenation problems. According to the physician, he was never made aware of Resident #428's refusal of meals/fluids nor was he aware the resident was not meeting his/her estimated fluid needs. Further interview revealed he had visited Resident #428 in the hospital and the resident's condition had declined since the telehealth visit on [DATE]. Physician #1 stated he had not been notified of Resident #428's decline prior to the resident's hospitalization . Further interview with the physician revealed if he had been made aware that the resident was not eating or drinking, he would have ordered labs, intravenous (IV) fluids, and would have sent the resident to the hospital sooner.</p> <p>Interview with the Former Director of Nursing (DON), on [DATE] at 12:29 PM, revealed she was not aware of any concern with Resident #428 not eating or meeting his/her estimated fluid needs. The DON stated she did not recall any concerns with the resident having discolored fingers, but she would have expected staff to report such concerns to the resident's physician, as a change of condition and for staff to provide increased monitoring of the resident. Further interview revealed if the Interdisciplinary Team (IDT) had been aware of the resident's decline, the physician would have been notified and orders would have been obtained from the physician for intravenous (IV) fluids, or the resident would have been sent to the hospital.</p> <p>Interview on [DATE] at 1:05 PM, with the Former Administrator, who was the Administrator in September of 2021, revealed she was not aware of any concerns with Resident #428. She stated she was not aware that State Registered Nurse Aide (SRNA) #4 reported Resident #428's concerns to Licensed Practical Nurse (LPN) #6, which were not addressed. The former Administrator stated daily conference calls were made during the morning meetings by the Administrator or the DON to the nursing staff working on the COVID unit. Per the interview, this call was made to discuss any concerns the floor nurse might have had while working the unit; however, there were no concerns identified related to Resident #428.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>22976</p> <p>Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI), Version 3.0, dated 10/2019, it was determined the facility failed to implement the Comprehensive Plan of Care related to pressure ulcers for four (4) of thirty-three (33) sampled residents (Residents #19, #39, #47, #63).</p> <p>Review of the Comprehensive Care Plan for Resident #47 revealed the Comprehensive Care Plan (CCP) interventions included: assess the skin and report skin breakdown; treatments as ordered; treatment to the Deep Tissue Injury (DTI) to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered. However, there was no documented evidence the facility was monitoring the resident's wounds, as there was no Wound Assessment completed from 01/13/2020 until 02/16/2022, after Surveyor intervention. Further, there was no documented evidence treatments were performed as ordered. The resident's pressure ulcers deteriorated and he/she developed Osteomyelitis (a bone Infection).</p> <p>Review of the Comprehensive Care Plan for Resident #19 revealed the Comprehensive Care Plan (CCP) interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; provide wound care as ordered by the physician; and provide medications and treatments as per orders. However, there was no documented evidence the facility was monitoring the resident's wounds nor was there documented evidence Physician's orders were implemented related to wound care. There was no initial Wound Assessment until until 12/07/2021, twenty-eight (28) days after admission. Additionally, there was no documented evidence of a Wound Assessment from 12/07/2021, until the surveyor requested to observe a skin assessment on 02/16/2022, seventy-one (71) days later, when the resident's wounds were noted to be larger and unidentified wounds were noted.</p> <p>Review of the Comprehensive Care Plan for Resident #39 revealed the Comprehensive Care Plan (CCP) interventions included: Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction mattress; provide incontinent care as needed; provide wound care as ordered by the MD. However, there was no documented evidence the facility was monitoring the resident's wounds nor was there documented evidence Physician's orders were implemented related to wound care. No documented evidence of a wound assessment from 01/11/2022 until the surveyor requested to observe skin assessment on to 02/16/2022, thirty-six (36) days later, the wound has worsened with a tunneling noted at 6.5 cm.</p> <p>Review of the Comprehensive Care Plan for Resident #63 revealed the Comprehensive Care Plan (CCP) interventions included: Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction mattress; provide incontinent care as needed; provide wound care as ordered by the MD; treatment to stump per order. Review of Care Plan dated 02/04/2022 revealed new treatments for Resident #63's stage II coccyx and Left AKA was not updated on the care plan until 02/07/2022. No documented evidence of wound assessment for residents left AKA until the surveyor requested to observe skin assessment on to 02/16/2022.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's failure to ensure Resident's Comprehensive care plans were implemented has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022.</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing.</p> <p>The findings include:</p> <p>Interview with the Administrator on 02/21/2022 at 3:12 PM revealed the facility did not have a policy related to implementation of the Comprehensive Care Plan. According to the Administrator, the facility followed the Resident Assessment Instrument (RAI) process for developing, and implementing the plan of care.</p> <p>Review of the facility's copy of the RAI, Version 3.0, dated 10/2019, revealed the Minimum Data Set (MDS) views the resident in distinct functional areas to gain knowledge of the resident's functional status. Per the RAI, the facility should develop and implement an interdisciplinary care plan based on assessment information gathered throughout the RAI process. Further RAI review revealed, facility should re-evaluate the resident's status at prescribed intervals and modify the individualized care plan as appropriate.</p> <p>Review of the facility's Skin Care Standard of Practice Policy, dated 07/2020, revealed the facility would assess all residents on admission, readmission, and quarterly and with each change in condition that would compromise the skin. Per policy, the baseline skin assessment would be completed within twenty-four (24) hours of admission and documented in the medical record. Additionally, the Comprehensive Care Plan (CCP) initiated upon admission with the Baseline Care Plan and the development process for the CCP. Continued review revealed the CCP would reflect skin care needs, ADLs, nutrition, and activity level that would impact skin integrity risk. The Braden Risk Assessment would be completed on Admission, weekly for 4 weeks, with changes of condition, and on a quarterly basis. A skin assessment would be completed by a licensed nurse on admission/readmission, and on a minimum of weekly thereafter.</p> <p>1. Review of the medical record for Resident #47, revealed the facility admitted the resident on 03/18/2019 with diagnoses which included Malignant Neoplasm of the Brain and Lung, Diabetes Mellitus Type II, and Dementia with Behavioral Disturbance.</p> <p>Review of Resident #47's Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicating severe cognitive impairment. Additional review revealed the facility assessed the resident as at risk for developing a pressure ulcer and as having one (1) Stage IV pressure ulcer and three (3) suspected Deep Tissue Injuries (DTIs).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #47's Comprehensive Care Plan (CCP), dated 01/04/2022, revealed the resident had a problem with impaired skin integrity including a Deep Tissue Injury (DTI) to the left heel, an unstageable pressure ulcer to the right outer foot, and a DTI to the left outer foot. The goal with a target date of 04/04/2022, revealed the resident would have no unidentified skin issues through the next review. Interventions included: assess the skin and report skin breakdown; perform treatments as ordered; treatment to the DTI to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered.</p> <p>Review of Resident #47's Physician's orders, dated 01/07/2022, revealed orders for Doxycycline 100 mg (antibiotic medication) twice daily for a wound infection.</p> <p>Review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for treatment to clean the wound to the left outer foot with wound cleanser, pat dry, apply Santyl and cover the wound with a foam dressing daily and as needed.</p> <p>Continued review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for the left heel to be cleaned with Dakins solution, pat dry apply, Santyl (a medicated ointment that removes dead tissues from wounds) to the wound bed, cover with petroleum gauze cover with calcium alginate and cover with a foam dressing, change daily and as needed.</p> <p>Review of Resident #47's Wound Evaluation Form, dated 01/13/2022, revealed the resident had a facility acquired pressure ulcer to the left outer foot which measured 2.9 centimeters (cm) long by 2.0 cm wide; and a facility acquired Stage IV pressure ulcer to the left heel classified as a Deep Tissue Injury (DTI) which measured 6.0 cm long by 4.1 cm wide by 1.4 cm deep. Continued review revealed there were no other Wound Evaluations documented in the Electronic Medical Record, indicating the CCP was not implemented related to assessing and monitoring skin.</p> <p>Review of Resident #47's January 2022 Treatment Administration Record (TAR) revealed wound treatments were not documented as being completed on 01/04/2022, 01/16/2022, 01/23/2022, 01/28/2022, and 01/29/2022, indicating the CCP was not implemented related to performing treatments as ordered.</p> <p>Review of Resident #47's Physician's orders, dated 01/31/2022, revealed orders to clean the wound to the right foot with wound cleanser, apply Santyl and cover with a nonstick foam dressing.</p> <p>Review of Resident #47's Physician's orders, dated 02/05/2022, revealed orders for Santyl to be applied daily to pressure ulcer other site stage IV; however, no wound site was identified in the order.</p> <p>Review of Resident #47's Physician's orders, dated 02/08/2022, revealed orders for intravenous Vancomycin (antibiotic) one (1) Gram every eight (8) hours and Zosyn (antibiotic) one (1) Gram every six (6) hours for six (6) weeks for Osteomyelitis (bone infection).</p> <p>Review of Resident #47's Physician's Note, dated 02/11/2022, revealed there were recent skin changes to the left heel, and x-ray imaging was obtained. Imaging concerning for Osteomyelitis and C-reactive protein (a blood test used to check for inflammation) elevated at 120.4 mg/l (milligrams per liter) (normal range is considered less than 10 mg/l). Further, the resident was to continue on antibiotic coverage in the form of Vancomycin and Zosyn (antibiotic medication).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #47's Physician's orders dated 02/14/2022, revealed orders for skin inspection to be completed on Tuesdays on the evening shift.</p> <p>Review of Resident #47's February 2022 TAR, revealed the ordered wound treatments were not documented as being completed on 02/04/2022, 02/06/2022, 02/11/2022, 02/12/2022, 02/13/2022, and 02/15/2022 indicating the CCP was not implemented related to assessing and monitoring skin.</p> <p>Record review revealed there was no documented evidence of monitoring Resident #47's wounds as per the CCP. There was no documented evidence of Wound Evaluations for Resident #47 from 01/13/2022 until 02/16/2022, when the State Survey Agency (SSA) Representative asked to observe a skin assessment.</p> <p>Observation of a skin assessment, performed on 02/16/2022 at 3:07 PM, by Registered Nurse (RN) #1, revealed Resident #47's Deep Tissue Injury to the left outer foot had opened and increased in size to 4.0 cm long by 3.5 cm wide by 0.2 cm deep. The Stage IV pressure ulcer to the resident's left heel had increased in size to 6.0 cm long by 2.0 cm wide by 0.2 cm deep. Additionally, the resident was noted to have an area of brown eschar to the right lateral foot measuring 2.0 cm long by 1.5 cm wide with no depth. Review of the medical record revealed the brown eschar to the right lateral foot was an unidentified area until this skin assessment.</p> <p>Interview with Director of Nursing (DON) #3, on 02/21/2022 at 4:44 PM, revealed he had started at the facility in January 2022, and was unaware Resident #47 had pressure ulcers. Further, he was unaware skin assessments and wound measurements for Resident #47 were not being completed as per the CCP. According to the DON, a resident's pressure ulcers/wound could get worse or become infected if not being monitored and treated. Per interview, it was his expectation Resident #47's CCP would have been implemented related to monitoring skin, completing Wound Assessments and treatments as ordered.</p> <p>Interview with the Medical Director, on 02/24/20 at 1:27 PM, revealed she was the primary care physician for Resident #47. Per interview, the resident was diagnosed with a left heel deep tissue injury and was started on doxycycline for a Stage IV pressure ulcer. She further stated the resident was later diagnosed with Osteomyelitis and a Peripherally Inserted Central Catheter (PICC) line was placed for intravenous antibiotics related to the pressure ulcers. Per interview, two (2) of the resident's wounds had deteriorated. Continued interview revealed it was her expectation treatments were completed as ordered and skin was monitored consistently in order to identify new skin breakdown and to note the progress of pressure ulcers.</p> <p>44371</p> <p>2. Review of Resident #19's medical record revealed the facility admitted the resident on 11/09/2021 with diagnoses including Osteomyelitis, Methicillin Resistant Staphylococcus Aureus (MRSA) infection, unspecified site, Pressure Ulcer, and Paraplegic.</p> <p>Review of Resident #19's Admission Minimum Data Set (MDS) Assessment, with a reference date of 11/15/2021, revealed the facility assessed the resident as at risk for pressure ulcers and as having two (2) Stage III pressure ulcers that were present at admission on 11/09/2021. Further, the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed there was no documented evidence of a Wound Assessment for Resident #19 on admission.</p> <p>Review of Resident #19's Comprehensive Care Plan, dated established 11/09/2021 and implemented 12/08/2021, revealed the resident was assessed to have two (2) Stage III pressure ulcers on the outside of the right foot; a wound to the right outer leg on the side of the knee; a wound to the mid back spine and a wound to the right outer leg. The goal with a target date of 03/08/2022 stated the resident would remain free from any unidentified skin issues through next review. The interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; pressure reduction mattress; provide wound care as ordered by the physician; and provide medications and treatments as per orders.</p> <p>Review of Resident #19's Physician's orders, dated 11/10/2021, revealed orders to monitor the wound on the mid back for signs and symptoms of worsening or non healing every shift until resolved.</p> <p>Review of Resident #19's Physician's orders, dated 11/16/2021, revealed orders to monitor wounds on right outer foot for signs and symptoms (s/s) of worsening or non healing every shift until resolved, and monitor wounds on right outer leg for s/s of worsening or non healing every shift until resolved. However, there was no documented evidence of treatment orders for Resident #19's wounds.</p> <p>Review of Resident #19's Initial Wound Assessment, completed 12/07/2021, twenty-eight (28) days after admission revealed the resident had the following wounds:</p> <ol style="list-style-type: none"> 1) Wound to the right gluteal cleft resolved, scar tissue present. 2) Right outer knee wound measured Length-2.0 centimeters (cm) x Width-1.5 cm x Depth-unable to be determined (UTD), no odor, slough covering wound bed, small amount of bloody drainage noted when wound cleaned. However, the description did not indicate the type of wound or stage of wound. 3) Mid back wound measured Length-2.0 cm x Width-1.0 cm with no Depth recorded, no odor but large amount of bloody drainage when cleaned. However, the description did not indicate the type of wound or stage of wound. 4) Right outer calf wound measured Length-15 cm x Width-4.0 cm x Depth-0.2 cm, area of wound close to 12 o'clock position was noted to have a small area of slough noted, bright red epithelization and granulation present. The wound was described as a Stage III pressure ulcer. 5) Right outer foot wound at base of fifth toe measured Length-2.5 cm x Width-2.0 cm x Depth-0.1 cm, small amount of bloody drainage noted when cleaned, granulation and epithelization present, no odor. The description did not indicate the type of wound or stage of wound. 6) Right outer foot measured Length-1.5 cm x Width-1.5 cm x Depth-0.2 cm, small amount of bloody drainage noted when cleaned. The description did not indicate the type of wound or stage of wound. <p>Review of Resident #19's Physician's orders, dated 12/08/2021, revealed orders to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown (daily).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #19's January 2022 Treatment Administration Record (TAR), revealed the intervention to clean the two (2) Stage III Pressure ulcers on the outside of the right foot with wound cleanser, pat dry, and apply Santyl and cover with border gauze daily at 7:00 AM. However, the treatment was not signed to indicate the treatment was completed on 01/01/2022 and 01/02/2022, indicating the CCP was not implemented related to treatments as ordered.</p> <p>Review of Resident #19's Physician orders, dated 01/14/2022, revealed orders for Iodosorb External Gel 0.9% (Cadexomer Iodine), one (1) application to the back daily between 7:00 AM and 6:59 PM. Cleanse wound to back with wound cleanser, pat dry, and apply Iodosorb to wound, and cover with dry dressing. Change dressing daily and PRN (as needed).</p> <p>Review of Resident #19's Physician's orders, dated 02/05/2022, revealed orders for Vaseline gauze to the right leg and foot and wrap with Gauze every three (3) days.</p> <p>Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown, was not signed to indicate the treatments were completed for thirteen (13) days including 02/01/2022,02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, 02/08/2022, 02/09/2022, 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, 02/15/2022, and 02/18/2022, indicating the CCP was not implemented related to treatments as ordered.</p> <p>Review of Resident #19's February 2022 TAR, revealed the intervention to monitor the wound on the resident's mid back was not signed to indicate monitoring at 7:00 AM for seven (7) days including 02/02/2022, 02/04/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, 02/13/2022, and 02/15/2022, indicating the CCP was not implemented related to treatments as ordered.</p> <p>Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment air mattress was not signed at 7:00 AM for six (6) days including 02/02/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, and 02/13/2022, indicating the CCP was not implemented related to treatments as ordered.</p> <p>Observation of Resident #19, on 02/14/2022 at 9:41 AM, revealed the resident was sitting up in bed. Resident #19 reported there was no bandage on his/her back. The resident's right leg was wrapped in gauze, dated 02/10/2022. Per the TAR, Resident #19's bandage to the right leg was to be changed on 02/12/2022, two (2) days prior, indicating the CCP was not implemented related to treatments as ordered.</p> <p>Observation on 02/16/2022 at 9:41 AM, of a skin assessment for Resident #19 performed by the Education Director, revealed the resident's mid back wound measured Length-7.0 cm x Width-7.0 cm with an open area in the center which measured 1.0 cm x 1.0 cm x 0.5 cm with purulent drainage; the resident's right calf wound measured Length-22 cm x Width-7.0 cm x Depth-0.25 cm ; right great toe wound measured Length-2.0 cm x Width-3.5 cm x (no depth) and was scabbed; right inner ankle wound measured 2.5 cm x 4.5 cm x (no depth) and was scabbed. This Wound Assessment was completed seventy-one (71) days after the last wound assessment, after Surveyor intervention, indicating the CCP was not implemented related to assessing the resident's skin.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation and record review revealed from 12/07/2021 until 02/16/2022, the wound to Resident #19's mid back became larger; the area to the right outer calf became larger and increased in depth; and new unidentified areas were found on the resident's right great toe and right inner ankle. The unidentified areas revealed the CCP was not implemented related to assessing skin.</p> <p>Interview, on 02/16/2022 at 1:40 PM, with the Education Director, revealed the nurses were responsible for the skin assessments and wound treatments at this time. She was unaware skin assessments and wound treatments were not being completed as ordered and revealed the CCP was to be implemented related to skin breakdown.</p> <p>Interview with Registered Nurse (RN) #1, on 02/19/2022 at 2:42 PM, revealed she had not been completing Wound Assessments. She further stated the nurses had not been trained to do Wound Assessments and she was not sure which staff member was responsible for completing them.</p> <p>Interview with Resident #19's Physician, on 02/24/2022 at 1:27 PM, revealed she was aware the resident sometimes refused care, especially wound treatments. However, she stated it was her expectation for staff to try to perform wound treatments, and to ensure wound measurements, staging and description of wounds were documented weekly. Further, it was her expectation that all wounds have a treatment in place, and Resident #19 should have had a treatment in place from admission related to pressure ulcers.</p> <p>3. Record review revealed the facility admitted Resident #39 on 12/20/2021 with Essential (primary) Hypertension, other chronic pain, Polyneuropathy, unspecified, Pressure Ulcer of Right Buttock, Stage 3, Adult Failure to Thrive, Hypokalemia, Hyperglycemia, unspecified, Hyperlipidemia, unspecified, Pressure Ulcer of Right Buttock/unstageable and Acute Kidney Failure, unspecified.</p> <p>Review of Resident #39's Admission MDS Assessment, dated 12/24/2021, revealed the facility had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of six (6) out of fifteen (15), indicating cognitive impairment. Continued review revealed Resident #39 was assessed to be at risk for pressure ulcers and had one unstageable deep tissue injury present on admission on 12/21/2021 and a care plan was developed.</p> <p>Review of Braden Scale for Predicting Pressure Sore Risk, dated 01/31/2022, revealed Resident #39 was at high risk with a total score of twelve (12).</p> <p>Review of Resident #39's Comprehensive Care Plan, dated 12/20/2021, revealed the resident had a Stage III Pressure to right buttock. Staff were to assess skin and report redness, rashes, bruises, abrasion or skin breakdown; pressure reduction cushion; provide incontinence care as needed; provide wound care as ordered by the MD; air mattress as ordered; treatment to buttocks per order.</p> <p>Review of Resident #39's initial Wound Assessment, dated 12/21/2022 revealed the resident had a wound measuring 12.2 cm in length x 7 cm in width x 0 cm depth. The wound was dry; black in color; with macerated tissue; no drainage, odor or pain. There was no documented evidence of the wound Stage or where the wound was located.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident # 39's Physician orders, dated 01/07/2022, revealed Santyl External Ointment 250 unit/gm (collagenase) apply to buttock daily between 7:00 AM and 6:59 PM. Cleanse wound to right buttock with wound cleanser, pat dry and apply silvadene to the outer perimeter of wound. Apply Santyl to eschar on wound, to cover with border gauze and to change daily and PRN.</p> <p>Review of Resident # 39's EMR revealed the next documented Wound Assessment was eighteen (18) days later, on an MD Note, dated 01/07/2022. Per Note the visit was a telehealth wellness visit. The resident had an Unstageable (US) Wound on his/her sacral, which was worse, deeper getting bigger; the wound had no tunneling, no eschar. The wound measurements were 4 cm in length x 2 cm in width. There was no documented evidence of the wound depth or color.</p> <p>Additional review of Resident #39's EMR revealed a Wound Assessment four (4) days later, dated 01/11/2022 at 5:03 PM. Continued review of the Wound Assessment revealed the resident's wound measurements were 11 cm in length x 6.8 cm in width x 0 cm in depth, the wound was black in color, necrotic, with discolored tissue, small/minimal drainage, no odor, no pain. The wound was documented as not worse. There was no documented evidence of the wound location or Stage.</p> <p>However, continued review of Resident #39's EMR, on 01/11/2022 at 5:10 PM, revealed a Wound Assessment where the wound was measured at 12.4 cm in length x 7.4 cm in width x 0 cm in depth. Per this Assessment the tissue was broken, with moderate serosanguineous drainage, an odor was present, there was no pain and the wound was not worse. However, the measurements were greater, and the wound now had drainage and odor. Further, the Assessment did not include the location of the wound or the Stage of the wound.</p> <p>Review of Resident #39's February 2022 MAR revealed inconsistency in documentation for wound treatment Silvadene order. Continued review revealed</p> <p>blanks areas for seven days on 02/02/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, 02/13/2021 and 02/15/2022, indicating the CCP was not implemented.</p> <p>Review of Resident #39's February 2022 TAR revealed no documented evidence that wound care treatments had been completed for a twice per day coccyx treatment to cleans the wound and apply Silvadene and oil emulsion with a wet to dry gauze dressing for the 9:00 AM treatment dates of 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022 and 02/15/2022 and the 9:00 PM treatment dates of 02/09/2022, 02/11/2022, 02/12/2022 and 02/13/2022, indicating the CCP was not implemented.</p> <p>Interview with Resident #39, on 02/16/2022 at 11:25 AM, revealed the resident felt bad. The resident additionally stated he/she had sores on his/her bottom, and they hurt. The resident was unable to state when the wounds were acquired. The resident further stated the nurses looked at the sore but not daily.</p> <p>Observation of Resident #39 during care provided by Agency SRNA #1, on 02/16/2022 at 11: 30 AM, revealed the resident had two (2) dressings on his/her buttock. One dressing (the top one) was dated 02/14/2022; however, orders revealed the dressing would be changed daily, indicating the CCP was not implemented.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with Agency SRNA #1, on 02/16/2022 at 11:30 AM, revealed she had worked at the facility for nine (9) months on day shift. She was assigned to the resident Resident #39 on 02/16/2022. Per interview, the resident was total care for all Activities of Daily Living . Additionally, the resident had a really big bed sore on his/her buttock since the resident was admitted to the facility. Continued interview revealed the resident was incontinent of bowel and bladder and wore briefs. The resident needed to be changed every two (2) hours; however, it was common practice for the aides to not complete the first round (check and change for peri-care) until after breakfast due to their assignments of vitals and passing trays. Per interview the first round could be after 10:00 AM. Further, the resident had a wound infection earlier in the year and the wound looked a better now.</p> <p>Further review of the EMR revealed Resident #39's wound was assessed on 01/11/2022 and not assessed again until 02/16/2022 at 12:12 PM, thirty-six (36) days between assessments. Per the Wound Assessment, dated 02/16/2022, the wound measurement was 12 cm in length x 7 cm in width x 2.5 cm in depth, to the left wound. The wound was moist, with intact tissue, small/minimal sanguineous drainage, no odor, mild pain and undermining to the left of the wound at the 9:00 o'clock position. Per the Assessment the wound was not worse; however, the wound measurements were greater since the 01/11/2022 assessment, the wound now had pain and undermining. Further, the Assessment did not include the wound location or Stage.</p> <p>Interview, on 02/16/2022 at 1:35 PM, with LPN #7 who was agency staff, revealed she had been to the facility eight (8) times and had not received any training from her agency or the facility on wound care, wound assessment, or documentation of wounds. Additionally, she did not know what the order for treatment was for Resident #39. Further, she told the Director of Nursing (DON) who was present with the Education Director Nurse, she did not feel comfortable performing wound care on the resident.</p> <p>Interview, on 02/16/2022 at 1:40 PM, with the Education Director Nurse, revealed she had worked at the facility since May of 2021 however had been in her current role since February 2022. Per interview, Resident #39 was admitted to the facility with the coccyx wound, at that time it was completely covered with eschar and the treatment was to cover with Santyl. She stated when the border came off, there was a huge wound with tunneling under it. Additionally, she had rounded with the Medical Director on 02/09/2022 for the major wounds in the facility because the wound nurse was no longer at the facility at that point. When she rounded with the physician, the physician told her the resident's wound was Unstageable. Continued interview revealed the wound nurse, prior to leaving the facility, was responsible for all skin and wound assessment and documentation as well as rounding with the physician for wounds. Additional interview revealed after completion of treatment or assessment, the primary nurse was now responsible to documented on the TAR/MAR in the EMR.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation of wound care performed for Resident #39, on 02/16/2022 at 1:45 PM with the Education Director Nurse, the DON and the Agency LPN #7, revealed there were two (2) adhesive border dressings intact to the mid buttock. The top dressing was dated 02/16/2022 with initials, there were two dime size bright red blood spots on the top right corner of the dressing. The bottom dressing had two (2) nickel size bright red blood spots on the distal end of the dressing, it was dated 02/16/2022 and initialed. Continued observation revealed the Education Director Nurse removed the dressing revealing a large, irregular shaped wound that was moist with a beefy red wound bed with scattered yellow slough throughout the wound bed. No drainage noted. No odor noted. No eschar. Peri wound skin was pink but blanchable. The edges of the wound were thick and rolled. At the top of the wound a large hole was noted which tunneled upward and slightly towards the right. The wound was cleaned with wound cleanser on a 4x4 gauze and patted dry. The wound measurements were 11 cm length x 5.5 cm width x no depth measured. Tunneling of the wound was measured at 6.5 cm with Q-tip and the nurse stated the tunneling was from 12:00 -1:00 o'clock positions. Two 4x4 gauze pads were saturated with normal saline and laid over the tunneling hole. An oil emulsion was laid over remaining wound bed and Silvadene was thinly applied around the wound edges. No eschar was noted and no Santyl was used. One (1) adhesive border gauze was placed over the treatment, initialed and dated.</p> <p>Interview with the Regional Quality RN, on 02/16/2022 at 3:00 PM, revealed she had completed a wound assessment for the resident on 02/16/2022 because she heard the SSA wanted to watch wound care. She stated she used the National Pressure Injury Advisory Panel (NPIAP) as a resource for wound assessment. She staged the wound as a Stage III because there was no tendon or muscle showing only deep tissue. Continued interview revealed she measured the wound to be 12 cm length x 7 cm width (at widest across) x 2.5 cm with tunneling. She stated she did not measure tunneling because she did not have a Q-TIP and knew someone else was going to be measuring it with the SSA observing. Additionally, she stated the tunnelling appeared to go upward towards the left and that is why she documented it as at the 9:00 o'clock position to show it went towards the left. Further, she stated p [TRUNCATED]</p>		

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<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>22976</p> <p>Based on interview, record review, the facility's policy and the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, revised October 2019, it was determined the facility failed to revise the Comprehensive Care Plan with interventions to prevent malnutrition and dehydration for one (1) of thirty-three (33) sampled residents (Resident #428). In September 2021, Resident #248 was not meeting his/her estimated fluid needs and not eating. Resident #428 was later diagnosed with COVID-19. Resident #248 was transferred to the hospital and diagnosed with Severe Dehydration, Malnutrition, and Acute Renal Failure.</p> <p>In addition, the facility failed to revise the Comprehensive Care Plan with interventions to treat pressure ulcers and prevent worsening of the pressure ulcers for three (3) of thirty-three (33) sampled residents (Residents #19, #39 and #63).</p> <p>The facility's failure to ensure resident Comprehensive Care Plans were revised as indicated has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/18/2022 and was determined to exist on 09/12/2021, in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on 02/18/2022.</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. An Acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to remove the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing.</p> <p>The findings include:</p> <p>1. Interview on 02/21/2022 at 3:12 PM, with the Administrator, revealed the facility did not have a policy for revision of residents' care plans. According to the Administrator, the facility followed the Resident Assessment Instrument (RAI) process for developing, revising, and following the plan of care.</p> <p>Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, revised October 2019, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, 4.7 revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Further review revealed facilities were to use the past fifteen (15) months of assessments results to develop, review, and revise the resident's comprehensive plan of care. Further review revealed the resident's care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #428's closed medical record revealed the facility admitted him/her on 05/18/2021, with diagnoses which included Delirium, Dementia, Encephalopathy, and Delusional Disorder.</p> <p>A review of Resident #428's Quarterly Minimum Data Set (MDS) Assessment, dated 08/03/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident was cognitively impaired. The facility assessed the resident to require the extensive assistance of staff for eating and weighed one hundred and thirty (130) pounds. Further review of the assessment revealed the resident had no weight loss or gain in the past month or six (6) months, and had no assessed concerns for nutrition and hydration.</p> <p>Review of Resident #428's Comprehensive Care Plan revealed a nutritional services care plan for the resident dated 06/11/2021. Review of the nutritional services care plan revealed Resident #428 had problems noted of difficulty swallowing/chewing, and weight gain of 6.9% in one (1) month. Continued review revealed goals had been developed for Resident #428 which included the resident to maintain a consistent body weight plus or minus five (5) percent for ninety (90) days, and remain free of signs and symptoms of dehydration for ninety (90) days. Further review revealed the interventions developed included: staff to allow for the resident's likes/dislikes; provide his/her diet, snacks and supplements as ordered; provide follow up diet education/encouragement if preferences were not in compliance with prescribed diet; monitor his/her weight; and provide nutritional counseling as needed. In addition, review of the care plan further revealed no documented evidence of any revisions made to Resident #428's Comprehensive Care Plan after the date of 06/11/2021.</p> <p>Review of a nutrition assessment completed for Resident #428 by the dietitian, dated 07/29/2021, revealed the facility assessed the resident's estimated fluid need was 1475 to 1770 milliliters (ml) per day. In addition, Resident #428's documented food intake from 09/12/2021 until 09/20/21, revealed Resident #428 had only consumed meals five (5) times in the eight (8) day period. Further review revealed no documented evidence of any food intake for Resident #428 for the dates of 09/13/2021, 09/15/2021, and 09/19/2021.</p> <p>Review of Resident #428's closed medical record revealed the resident was diagnosed with the COVID-19 virus on 09/15/2021. Further review revealed five (5) days later, on 09/20/2021, the resident was transferred to the hospital following a change of condition. The resident was noted to vomit a dark black substance.</p> <p>Review of the hospital record for Resident #428 revealed the resident was admitted to the hospital on 09/20/2021, with diagnoses that included severe malnutrition, and dehydration. The resident's BUN (blood urea nitrogen, a test that measures waste product in your blood) was 110 (normal range is 5-20) and his/her creatinine was 3.91 (normal range is 0.74 to 1.35). The Emergency Department Physician documented Resident #428 was thin and cachectic (extreme weight loss and loss of muscle mass).</p> <p>According to the hospital Dietitian's assessment of Resident #428, on 09/21/2021, the resident was severely malnourished with a Body Mass Index (BMI) of 17.52. The Hospital dietetic also documented the resident had severe loss of muscle mass, prominent protrusion of bones, and pronounced hollowness/depression of the eyes. Resident #428 passed away at the hospital on 09/26/2021.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with the MDS Nurse, on 02/24/2022 at 8:56 AM, revealed she did not develop or revise Resident #428's plan of care for nutrition/hydration when the resident had a decline in food/fluid intake. Further interview revealed the Dietitian was responsible for developing and revising the resident's plan of care for nutrition and hydration.</p> <p>Interview with Dietitian #1, on 02/18/2022 at 2:47 PM, revealed she was responsible for revising the nutritional services care plan for Resident #428. According to the Dietitian, she had not been made aware that Resident #428 had not been eating and drinking, and not meeting his/her estimated fluid needs. The Dietitian stated she came to the facility and met with the Interdisciplinary Team (IDT) weekly. She stated during her weekly visit she reviewed any resident identified as having a nutritional concern. The Dietician stated she mainly focused on weight loss or, on residents whom the facility had identified as nutritionally at risk. However, the Dietician stated she was never notified of a concern regarding Resident #428, and she had not assessed the resident. Further the Dietician stated in the previous month (August 2021) Resident #428 had improved as far as his/her weight and nutrition. She stated since the improvement, the IDT had determined Resident #428's weekly weights could be changed to monthly weights. Dietician #1 further stated she could not recall any concerns being discussed in the IDT meetings related to Resident #428's nutrition and hydration.</p> <p>Interview with the former Director of Nursing (DON) #1 on 02/19/2022 at 12:29 PM, revealed the DON had conducted the daily clinical review (DCR) meetings with members of the IDT. She stated in the DCR meetings, she and the IDT members reviewed any concerns that had developed regarding residents. According to former DON #1, if a resident was not eating and drinking and that information had not been noted, she and the other IDT members might not become aware. Former DON #1 stated average daily intake reports for residents were printed by the Unit Manager, or the DON if the Unit Manager was working the floor. She stated the report was reviewed weekly in the facility's IDT meetings. Further interview revealed the former DON had not been made aware of any concern regarding Resident #428 not eating or meeting his/her estimated fluid needs. She further stated if the IDT had been made aware of any concerns regarding Resident #428's nutritional or fluid deficits, the Dietitian would have revised the resident's care plan with interventions to address those issues.</p> <p>2. Review of Resident #19's medical record revealed the facility admitted the resident on 11/09/2021, with diagnoses which included Pressure Ulcer, Osteomyelitis, Methicillin-Resistant Staphylococcus Aureus (MRSA), and Paraplegia.</p> <p>Review of Resident #19's Admission MDS Assessment, dated 11/15/2021, revealed the facility assessed the resident to be at risk for pressure ulcers with two (2) Stage III pressure ulcers present on admission on 11/09/2021. A care plan was developed. Continued review revealed the facility assessed Resident #19 with a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated the resident was cognitively intact.</p> <p>Review of Resident #19's Physician's Orders revealed an order dated 11/09/2021 for an air mattress to be used on his/her bed to promote wound healing. Continued review of the Physician's Orders revealed an order dated 11/11/2021 for a pressure reducing boot to Resident #19's left leg.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #19's Admission Care Plan dated 12/08/2021, revealed the facility had noted and care planned the resident for the following skin issues: two (2) Stage III pressure ulcers on the outside of the right foot; wound to right outer leg on side of knee; wound to mid-back spine; and wound to the right outer leg. Continued review revealed interventions which included: staff to assess Resident #19's skin and report redness, rashes, bruises, abrasion or skin breakdown. Record review revealed additional interventions included: a pressure reduction mattress; provide wound care, treatments and medications as ordered by the Physician.</p> <p>Further review revealed Resident #19's care plan was not revised/updated with the Physician's Order dated 11/09/2021, for the air mattress to bed to promote wound healing for the resident, until 12/08/2021 (twenty-eight [28] days after receiving the order). In addition, further review revealed Resident #19's care plan had not been updated/revised to include the Physician's Order dated 11/11/2021, for the pressure reducing boot to the resident's left leg every shift as tolerated until 12/08/2021 (twenty-six [26] days after the order was received). Continued review of Resident #19's medical record and care plan revealed the resident was noted as a left above the knee amputee (AKA). Further review revealed Resident #19 was a left AKA and the pressure reduction boot was ordered for the wrong leg.</p> <p>Review of the facility's, Initial Wound Assessment note for Resident #19 dated 12/07/2021, which was completed twenty-eight (28) days after admission, documented the following wounds and measurements: wound to right gluteal cleft resolved; wound to right outer knee measured 2 cm (centimeters) x 1.5 cm x UTD (unstageable depth of a wound); wound to mid back measured 2 cm x 1 cm x UTD; wound to the right outer calf measured 15.0 cm x 4 cm x 0.2 cm; wound to right outer foot at base of pinky toe measured 2.5 cm x 2 cm x 0.1 cm; and the wound to his/her right outer foot measured 1.5 cm x 1.5 cm x 0.2 cm. Further review revealed no evidence of other Wound Assessment Notes or wound measurements present in Resident #19's medical record until 02/16/2022. Review of the care plan revealed the facility failed to update the care plan with interventions to treat pressure ulcers and prevent worsening of the pressure ulcers</p> <p>Observation on 02/16/2022 at 9:41 AM with the Education Director revealed measurements were completed of Resident #19's wounds. Observation revealed the right calf wound measured: Length-22 cm x Width-7 cm x Depth-0.25 cm; right great toe wound measured Length-2 cm x Width-3.5 cm x scab (no depth); right inner ankle wound measured Length-2.5 cm x Width-4.5 cm x scab (no depth); and mid back wound measured 7 x 7 cm with open area in the center that was 1 cm x 1 cm, with purulent drainage. Review of Resident #19's skin assessments and Progress Notes revealed it had been seventy-one (71) days since the last assessment was documented. The facility failed to complete skin assessments and revise Resident #19's care plan to ensure appropriate care was provided.</p> <p>3. Review of Resident #39's medical record revealed the facility admitted the resident on 12/20/2021. The resident's diagnoses included Chronic Pain; Polyneuropathy; unspecified, Stage 3 Pressure Ulcer of right buttock; Adult Failure to Thrive; unspecified, unstageable Pressure Ulcer of right buttock; and Acute Kidney Failure, unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #39's Admission MDS Assessment, dated 12/24/2021, revealed the facility assessed the resident as at risk for pressure ulcers. Continued review of the MDS revealed the facility had assessed the resident with one (1) unstageable pressure injury which presented as a deep tissue injury which was present on the resident's admission. Further review revealed the facility assessed Resident #39 with a BIMS' score of six (6), which indicated the resident was moderately cognitively impaired.</p> <p>Review of the facility's IDT Notes dated 12/20/2021, revealed on admission, the facility assessed Resident #39 to have a large unstageable deep tissue injury (DTI) that was covered in black tissue with varying degrees of redness surrounding it.</p> <p>Review of Resident #39's admission Care Plan, dated 12/20/2021, revealed the facility documented and care planned the resident for a Stage 3 pressure ulcer to the right buttock. Continued review of the care plan revealed no interventions were implemented until 01/07/2022, seventeen (17) days later. Interventions noted on 01/07/2022 included for staff to assess the resident's skin and report any redness, rashes, bruises, abrasion or skin breakdown. Further review revealed the 01/07/2022 interventions additionally included a pressure reduction mattress, and staff to provide wound care as ordered by the Physician, and provide incontinent care as needed.</p> <p>Continued review of Resident #39's medical record revealed the resident was sent to a Wound Care Physician on 02/09/2022 for evaluation of his/her right buttock pressure ulcer. The evaluation revealed a note from the Wound Physician dated 02/09/2022, which documented Resident #39's wound as worse with Santyl ointment (debriding agent) currently being used. Continued review of the Progress Note revealed Resident #39 had been documented as bed bound and wound was deep and getting bigger. Further review revealed the Plan for Resident #39's right buttock pressure ulcer was to discontinue the Santyl ointment; start Silvadene to the center of the ulcer with a dressing twice a day. Review of the Plan further revealed avoid direct pressure to the pressure ulcer with an air mattress and side to side position changes for the resident.</p> <p>Further review of Resident #39's care plan revealed no documented evidence of updates/revisions to the care plan regarding the new Physician's Orders received on 02/09/2022.</p> <p>Review of the facility's Initial Wound Assessment note for Resident #39 dated 12/21/2021, revealed the resident had been noted to have an unstageable pressure ulcer on his/her right buttock. Continued review of the Wound Assessment note revealed the wound measurements were documented as 12.0 cm length x 7 cm width x depth 0. Further review revealed the unstageable pressure ulcer on Resident #39's right buttock was noted as dark purple/black in color and feels boggy. In addition, further review revealed Resident #39's skin around the unstageable pressure ulcer on the right buttock was macerated (condition occurring when skin remains in contact with moisture for too long) and had moisture-associated skin damage (MASD) noted.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation of wound care and measurements performed on 02/16/2022 at 1:45 PM, by Licensed Practical Nurse (LPN) #4, with the facility's Regional Quality Manager (RQM) and DON also present, during LPN# 4 conducted wound care and measurements. Observation revealed the measurements of Resident #39's right buttock unstageable pressure ulcer revealed LPN #4's measurements were 11 cm length x 5.5 cm width; however, the depth of the wound was not documented. Further observation revealed LPN #4 observed tunneling (occurs when a pressure ulcer progresses causing passageways underneath the surface of the skin) was measured as 6.5 cm with a cotton swab and the RQM stated the tunneling was from 12:00-1:00 o'clock (a clock format used to describe location).</p> <p>4. Review of Resident #63's medical record revealed the facility admitted him/her on 01/14/2022, with Peripheral Vascular Disease, unspecified, Acquired absence of left leg above knee (AKA), Asthma, Chronic Pulmonary Embolism, and Acute Respiratory Failure with Hypoxia.</p> <p>Review of the Admission MDS Assessment, dated 01/19/2022, revealed the facility assessed Resident #63 as at risk for pressure ulcers, with one (1) Stage II Pressure Ulcer and a surgical wound present on admission. Record review revealed a care plan was developed to address Resident #63's skin issues. Further review revealed the facility had assessed Resident #63 with a BIMS' score of fifteen (15), which indicated the resident was cognitively intact.</p> <p>Review of the facility's IDT's notes dated 01/14/2022, revealed the admission orders for Resident #63's Stage II pressure ulcer on the coccyx and left AKA had been received. However, further review revealed no documentation that the IDT addressed the admission orders in Resident #63's care plan.</p> <p>Review of Resident #63's Admission Care Plan, dated 01/14/2022, revealed the resident was noted to have a Stage II Pressure to his/her coccyx and a left AKA which had been care planned. Continued review revealed Resident #63 had new wound orders related to the left AKA dehiscence; however, the facility failed to revise the care plan until 02/07/2022. Continued review revealed interventions included staff to assess skin and report redness, rashes, bruises, or skin breakdown; pressure reduction mattress to bed; provide incontinent care as necessary; and provide wound care and treatment to stump (left AKA wound) as ordered. However, review of Resident #63's Comprehensive Care Plan dated 02/04/2022, revealed new treatments for Resident #63's Stage II coccyx and left AKA were not updated on the care plan until 02/07/2022.</p> <p>Review of the facility's Initial Wound Assessment note for Resident #63, dated 02/16/2022, revealed the resident had a deep wound from dehiscence (partial or total separation of previously approximated surgical wound edges). Continued review revealed the wound measurements were documented as 6 cm in length x 5 cm in width x 1 cm depth. Further review revealed the wound was noted as red flesh, with a small amount of yellow drainage. Review further revealed Resident #63 had complained of pain with the packing of the wound. In addition, record review revealed no documented evidence of the wound tissue or location of the wound.</p> <p>Observation on 02/21/2022 at 1:30 PM, with State Registered Nurse Aide (SRNA) # 17 and Kentucky Medication Aide (KMA) #2 revealed Resident #63 had an open hole on his/her coccyx between the gluteal fold.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation of wound care and interview on 02/21/2022 at 1:50 PM, with LPN #13 revealed the open hole observed on Resident #63's coccyx wound was circular but irregular in shape; the peri skin was blanchable; and there was no drainage or odor. Continued observation revealed LPN #13 measured the coccyx wound and the wound measurements obtained were 1 cm length x 0.9 cm width x 0.4 cm depth, which was the first documented evidence of the coccyx wound assessment since the resident was admitted , thirty-eight days prior. LPN #13 stated she was uncertain of the stage of the coccyx wound, and this had been the first time she had seen the wound or provided care for the resident.</p> <p>Interview with LPN #4 on 02/20/2022 at 4:00 PM, revealed residents' wound changes and treatments were to be updated/revised on their care plans. LPN #4 stated nursing staff used residents' care plans to provide the appropriate care and treatments.</p> <p>Interview with LPN #12 on 02/20/2022 at 4:15 PM, revealed she used MDS residents' care plans to know how to care for the residents. LPN #12 stated she knew residents' care plans needed to be updated or revised when changes occurred with a resident.</p> <p>Interview with the MDS Nurse on 02/24/2022 at 8:55 AM, revealed the facility had no audits in place to ensure residents' care plans were an accurate reflection of the residents. She stated all residents had a baseline care plan when admitted . Interview revealed she relied on the staffs' documentation to know when changes occurred, and she updated/revised the residents' care plans with more specific interventions, after the changes. Continued interview revealed residents' care plans were to be revised and updated to ensure they were accurate. She stated the care should be revised timely to reflect each resident's needs to ensure staff knew how to care for them. The MDS Nurse stated, everyone (all staff) used the residents' care plans as it told them how to take care of each resident. According to the MDS Nurse, the potential problems of residents having an incomplete or inaccurate care plan was that a resident might not receive the care they needed, or the resident might develop a wound which might not be cared for as needed. She stated the floor nurse could tell her or the DON, if the care was not accurate for a resident, and she or the DON would make the necessary changes. Further interview revealed on a resident's admission, the nurses did the face-to-face assessment of the new resident. The MDS Nurse stated she did not normally do a head to toe assessment even on a resident's admission. She further stated she relied on the documentation that was discussed and reviewed in the facility's daily clinical meeting to know when to revise residents' care plans. In addition, she stated all new treatment orders and wound changes should have been placed on the residents' care plans to ensure the care plan was revised timely. The MDS Nurse stated if a resident's care plan was not updated or revised timely it could be harmful for the resident.</p> <p>Interview with the Administrator on 02/24/2022 at 12:58 PM, revealed her expectations were for facility staff to update and revise residents' care plans. Continued interview revealed with any new Physician's Orders the resident's care plan needed to be reviewed and updated, because the care plan showed staff how to care for residents. She stated the residents' care plans were the way staff knew what care the residents needed; therefore, the care plans needed to be updated timely. The Administrator stated she was not aware the residents' care plans were not being updated or revised as required.</p> <p>Interview with the facility's Medical Director on 02/24/2022 at 1:27 PM, revealed residents' care plans were to be revised timely to show changes with residents in order to ensure and maintain the continuity of care for the residents. The Medical Director stated ensuring residents' care plans were revised was for best practices.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22976</p> <p>Based on observation, interview, record review and review of the facility's policy, the [NAME] Manual of Nursing Practice, Ninth Edition, it was determined the facility failed to ensure one (1) of thirty-three (33) sampled residents (Resident #428) received the necessary quality of care and treatment services in accordance with professional standard of practices.</p> <p>State Registered Nurse Aides (SRNAs #3 and #4) observed a change of condition for Resident #428. Staff were not able to obtain the resident's oxygen saturation level due to the resident being drenched in sweat. The resident's fingers were purple almost black in color. The facility had no documented evidence staff conducted a thorough assessment of Resident #428's physical condition including his/her respiratory status, nor documented evidence of staff's inability to obtain the resident's oxygen saturation level.</p> <p>Resident #428 was transported to the hospital and according to the hospital record he/she required eight (8) liters of supplemental oxygen per minute to maintain his/her oxygen saturation levels. In addition, Resident #428 was diagnosed with Sepsis (medical emergency caused by the body's response to an infection which could be life-threatening) due to Pneumonia and Acute Respiratory Failure due to Hypoxia (lack of adequate oxygenation).</p> <p>The facility's failure to ensure residents received quality of care and treatment has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/18/2022 and was determined to exist on 09/12/2021, in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on 02/18/2022.</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing.</p> <p>The findings include:</p> <p>Interview with Director of Nursing (DON) #5, on 03/04/2021 at 5:36 PM, revealed the facility did not have a policy regarding professional standard of practice. However, the facility utilized, the [NAME] Manual of Nursing Practice, Ninth Edition, to guide its nursing staff's practice to meet professional standards.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the [NAME] Manual of Nursing Practice, Ninth Edition, page 284, revealed for acute respiratory disorders the standards of care guidelines for respiratory compromise was for the nurse to perform a thorough systematic assessment. Continued review revealed the thorough systematic assessment was to include assessment of: mental status; vital signs; cardiovascular status and respiratory status. Further review revealed the nurse should evaluate for signs of hypoxia (low level of oxygen in the blood) when anxiety, restlessness, confusion, or aggression of new onset were noted. Further review revealed the nurse was to document the patient's condition to provide a record for continuity of care and notify the appropriate health care provider of significant findings of hypoxia; cyanosis, rapid and shallow respirations, abnormal breath sounds, change in behavior or level of consciousness (LOC).</p> <p>Review of Resident #428's closed medical record revealed the facility admitted the resident on 05/18/2021 with diagnoses which included Dementia, Delirium, Delusional Disorder, and Encephalopathy.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment completed for Resident #428 with a date of 08/03/2021 revealed the facility assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of five (5). Further review revealed the facility assessed the resident to require the extensive assistance of two (2) staff for transfers, bed mobility, and toileting. Continued review revealed the facility assessed the resident as always incontinent of bowel and bladder.</p> <p>Review of Resident #428's Comprehensive Care Plan revealed the facility had revised the plan of care for Resident #428 with a positive COVID status on 09/14/2021. Interventions included to place the resident in transmission based precautions, per the facility's COVID 19 protocol and administer medications as ordered.</p> <p>Review of the Nursing Progress Notes for Resident #428, dated 09/20/2021 at 11:34 AM, revealed thirty minutes earlier on 09/20/2021 at 11:00 AM, the resident was documented to have had a large emesis (vomit) which was dark black in color. Continued review of the 09/20/2021 Nursing Progress Note, revealed Resident #428's vital signs were noted as: blood pressure 173/83; pulse of 85; respirations of 18; and the resident's oxygen saturation was not able to be obtained. According to the Note, the physician was contacted and orders were received to send the resident to the hospital for evaluation and treatment. Further review of the Nursing Progress Notes for Resident #428 revealed no documented evidence of assessment of the resident's respiratory status from 6:00 AM until 11:00 AM on 09/20/2021 when the resident was sent out to the hospital.</p> <p>Review of the hospital's medical record for Resident #428 revealed when the resident arrived at the emergency room (ER) on 09/20/2021, the resident required oxygen at eight (8) liters per minute (LPM) to maintain his/her oxygen saturation Continued review revealed Resident #428 was noted to have crepitus (palpable or audible popping, crackling, grating, or a crunching sensation) lung sounds and had been diagnosed with Sepsis due to Pneumonia and Acute Respiratory Failure due to Hypoxia. Further review revealed Resident #428's fingers and toes were assessed as cyanotic (bluish or purplish discoloration of the skin due to lack of adequate oxygen) and the resident's lower extremities were mottled (blotches or spots indicating abnormal blood flow).</p> <p>Review of the hospital records revealed Resident #428 was placed on comfort measure at the hospital. Resident #428 passed away at the hospital six (6) days later on 09/26/2021.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 02/08/2022 at 4:06 PM, with State Registered Nurse Aide (SRNA) #3 revealed on the morning of 09/20/2021 at approximately 5:00 AM, Resident #428 would not take a drink for her. The SRNA stated they had checked on the resident every two hours. Continued interview revealed Resident #428's fingers had been purple almost black and she and SRNA #4 reported the changes to Licensed Practical Nurse (LPN) #6. SRNA #3 stated LPN #6 had not done anything for Resident #428. Further interview revealed due to LPN #6's not doing anything, she had decided to report her concerns regarding Resident #428 to the oncoming day shift nurse. The SRNAs stated there was no night shift supervisor on duty. However, she had not been able to report to the day shift nurse because LPN #6 had been with the day shift nurse at shift change for shift report. Further interview with SRNA #3 revealed since she couldn't talk to LPN #6, she attempted to notify the Director of Nursing (DON) and the Administrator, but they did not answer their phone.</p> <p>Interview on 02/08/2022 at 2:14 PM, with SRNA #4 revealed the SRNA had been working the night before the resident was sent to the hospital on 09/20/2021. SRNA #4 stated around 5:00 AM, Resident #428 had a change of condition and wasn't eating and drinking. Continued interview revealed the SRNA had been unable to obtain an oxygen saturation on Resident #428, and the resident's breathing was labored. He stated Resident #428 had been drenched in sweat and he thought the resident was going to die. Further interview revealed he and SRNA #3 reported everything regarding Resident #428's condition to LPN #6 multiple times. SRNA #4 stated LPN #6 told him that the resident was not going to die in the next two hours and day shift would take care of Resident #428 when they came in to work.</p> <p>Interview on 02/18/2022 at 2:58 PM, with LPN #6 revealed she had provided care for Resident #428 on the night shift on 09/19/2021 from 7:00 PM to 7:00 AM on the morning of 09/20/2021. LPN #6 stated she checked on the resident every hour. According to the LPN, she could not remember any concerns regarding Resident #428 not eating or drinking and had not been made aware of any changes in the resident's condition. Continued interview revealed LPN #6 denied any knowledge of SRNA #3 and SRNA #4 reporting concerns of Resident #428's fingers being purple/black and not being able to get an oxygen saturation level on the resident. LPN #6 stated if she had known of that information, she would have assessed Resident #428, and reported any changes of condition to the Physician and resident's family. Further interview revealed LPN #6 could not recall why she had not documented any Progress Notes on her shift for Resident #428 on 09/19/2021 through 09/20/2021.</p> <p>Interview on 02/18/2022 at 11:55 AM, with LPN #5 revealed the LPN could not recall very much about Resident #428, other than sending the resident to the hospital. LPN #5 stated sometimes the SRNAs got residents' vital signs and sometime she would get the vital signs. She stated she was not aware why vital signs for Resident #428 were not documented from 6:00 AM to 11:00 AM, or why there was no assessment documented either. Continued interview revealed residents were checked on every hour. However, she might have been busy and forgot to put Resident #428's vital signs in the computer. LPN #5 stated that might also have been why she had not made any notes for Resident #428 in the computer. Further interview revealed she could not recall Resident #428's fingers being blue, nor not being able to obtain an oxygen saturation level for the resident. LPN #5 further stated Resident #428 had experienced a change of condition, vomiting a large black emesis, and she called the Physician and sent the resident out to the hospital as she documented in his/her record.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with SRNA #8 on 02/19/2022 at 10:13 AM revealed he often provided care for Resident #428 on the COVID Unit from 09/15-20/2021. SRNA #8 stated the resident did not eat and drink well. However, he stated he could not document the resident's food and fluid intake because he was an agency staff and did not have computer access to chart care in the electronic medical record. Further interview revealed Resident #428 did not eat and drink very much and he thought it was normal for the resident and didn't report anything to the nurse.</p> <p>Interview on 02/19/2022 at 12:29 PM, with former Director of Nursing (DON) #1 revealed if a resident had a change of condition the nurse was supposed to assess the resident. Continued interview revealed the nurse assessing a resident's change in condition was also to document the findings of the assessment in the resident's electronic medical record, notify the Physician and document the notification and Physician's orders. According to the DON, residents on the COVID Unit, were required to have their respiratory status assessed every two (2) hours. The assessment should include: checking oxygen saturation levels, and if warranted, assessment of the resident's lung sounds because they were on the COVID Unit. The DON stated they reviewed residents' electronic medical records in the morning meeting, but she did not recall any concerns with Resident #428. Continued interview revealed former DON #1 was not aware assessments of the oxygen saturation level for Resident #428 had not been documented from 6:00 AM to 11:00 AM as required. The DON stated she did not recall any concerns with Resident #428 having had discolored fingers. However, she stated she expected this information to have been reported to the Physician as a change of condition for the resident. She stated she also expected Resident #428 to have been monitored by nursing staff. Further interview revealed she was not aware of any concerns regarding LPN #6 not assessing Resident #428 after SRNAs #3 and SRNA #4 reported to her they had not been able to obtain the resident's oxygen saturation level, and the resident was drenched in sweat with his/her fingers purple almost black. The DON stated she was not aware of any concerns with LPN #6 not assessing residents. She stated staff should have come to her and reported concerns of a nurse not checking on residents.</p> <p>Interview on 02/19/2022 at 1:05 PM, with the former Administrator #1 (who was the Administrator of record in September 2021) revealed she was not aware SRNA #3 and SRNA #4 had reported concerns regarding Resident #428 to LPN #6. She was not aware the LPN took no action to assess the resident and document her findings in accordance with professional standards of practice. The Administrator stated she was also not aware that LPN #6 had not assessed Resident #428 from 6:00 AM to 11:00 AM, prior to the resident being sent to the hospital. According to the Administrator, she monitored care provided for residents on the COVID Unit by having a daily conference call with the nurse assigned to work on the COVID Unit. Further interview revealed the Administrator also stated she monitored residents' care on the COVID Unit by reviewing the status of each resident. However, she could not recall any concerns regarding Resident #428. In addition, the Administrator stated the nurses should provide care in accordance with professional standards to ensure residents received the quality care necessary. She stated she was not aware that SRNAs #3 and #4 had any concerns with LPN #6. She stated they if the nurse was not checking on a resident for a change of condition, the staff should have reported the incident to her.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22976</p> <p>Based on observation, interview, record review and a review of the facility policy, it was determined the facility failed to have an effective system in place to ensure residents wounds were assessed and received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for four (4) of thirty-three (33) sampled residents (Residents #47, 19, #39, and #63).</p> <p>Record review and interview revealed the facility's Wound Nurse resigned from the facility in January 2022, and although the Administrator became aware that same month the Wound Assessments were not being completed consistently, there was no documented evidence of a skin sweep of all residents in order to identify any new pressure ulcers or identify if pressure ulcers were deteriorating. Wound Assessments were left for the staff nurses to complete. However, interview with the staff nurses revealed they were unaware they were to complete the Wound Assessments, had not had training related to measuring and staging of wounds, and were not comfortable completing this type of wound assessment. Review of the facility's Skin Care Standard of Practice revealed a skin assessment would be completed weekly by a licensed nurse and staging and measuring would be completed by the assigned nurse to maintain continuity in documentation of progression of wound healing. However, record review revealed these assessments were not consistently completed and there was no documented evidence of consistent monitoring of the progress of the residents' wounds. As a result, observation of skin assessments performed revealed there was deterioration of residents wounds and unidentified wounds.</p> <p>The facility's failure to ensure resident wounds were assessed and received necessary treatment and services has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022.</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing. Refer to F656 and F657</p> <p>The findings include:</p> <p>Review of the facility policy, titled Skin Care Standard of Practice dated July 2020, revealed the facility would ensure residents with pressure ulcers receive necessary treatment and services consistent with professional standards of practice to promote healing and prevent infection. Further review of the policy revealed a skin assessment would be completed weekly by a licensed nurse and staging and measuring would be completed by the assigned nurse to maintain continuity in documentation of progression of wound healing. Further review of the policy, revealed weekly documentation of wound status and response to healing including need to alter treatment would be included in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #47's closed medical record revealed the facility admitted the resident on 03/18/2019 with diagnoses including Malignant Neoplasm of the Brain and Lung, Diabetes Mellitus Type II, and Dementia with Behavioral Disturbance.</p> <p>Review of Resident #47's Physician's orders, dated 10/12/2020, revealed orders for weekly skin inspections.</p> <p>Review of Resident #47's Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) staff for bed mobility, and extensive assistance of two (2) staff for transfers. Continued review revealed the resident was assessed as always incontinent of bowel and bladder. Additional review revealed the facility assessed the resident as at risk for developing a pressure ulcer and as having one Stage IV pressure ulcer and three (3) suspected Deep Tissue Injuries (DTIs).</p> <p>Review of Resident #47's Comprehensive Care Plan (CCP), dated 01/04/2022, revealed the resident had a problem with impaired skin integrity including a Deep Tissue Injury (DTI) to the left heel, an unstageable pressure ulcer to the right outer foot, and a DTI to the left outer foot. The goal, with a target date of 04/04/2022, revealed the resident would have no unidentified skin issues through next review. The interventions included: assess the skin and report skin breakdown; treatments as ordered; treatment to the DTI to right outer foot and monitor until resolved; treatment to the left heel as ordered; and treatment to the left outer foot as ordered. However, the facility failed to revise the CCP with interventions to treat pressure ulcers. Further, the facility failed to ensure the CCP was followed. (Refer to F656 and F657).</p> <p>Review of Resident #47's Physician's orders, dated 01/07/2022, revealed orders for Doxycycline 100 mg (antibiotic medication) twice daily for a wound infection.</p> <p>Review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for treatment to clean the wound to the left outer foot with wound cleanser, pat dry, apply Santyl (a medicated ointment that removes dead tissues from wounds) and cover the wound with a foam dressing daily and as needed.</p> <p>Review of Resident #47's Physician's orders, dated 01/11/2022, revealed orders for left heel to be cleaned with Dakins solution, pat dry apply, Santyl (a medicated ointment that removes dead tissues from wounds) to the wound bed, cover with petroleum gauze cover with calcium alginate and cover with a foam dressing, change daily and as needed.</p> <p>Review of Resident #47's Wound Evaluation Form, dated 01/13/2022, revealed the resident had a facility acquired pressure ulcer to the left outer foot measuring 2.9 centimeters (cm) long by 2.0 cm wide; and a facility acquired Stage IV pressure ulcer to the left heel classified as a Deep Tissue Injury (DTI) measuring 6.0 cm long by 4.1 cm wide by 1.4 cm deep. Resident #47 did not have any other Wound Evaluations documented in the Electronic Medical Record.</p> <p>Review of Resident #47's January 2022 Treatment Administration Record (TAR) revealed the resident's ordered wound treatments were not documented as being completed on 01/04/2022, 01/16/2022, 01/23/2022, 01/28/2022, and 01/29/2022.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #47's Physician's orders, dated 01/31/2022, revealed orders to clean the wound to the right foot with wound cleanser, apply Santyl and cover with a nonstick foam dressing. However, there was no documented evidence of a wound to the right foot during this timeframe.</p> <p>Review of Resident #47's Physician's orders, dated 02/05/2022, revealed orders for Santyl to be applied daily to pressure ulcer other site stage IV; however, there was no wound site was identified in the order.</p> <p>Review of Resident #47's Physician's orders, dated 02/08/2022, revealed orders for intravenous Vancomycin (antibiotic) one (1) Gram every eight (8) hours and Zosyn one (1) Gram every six (6) hours for six (6) weeks for Osteomyelitis (bone infection).</p> <p>Review of Resident #47's Physician's Note, dated 02/11/2022, revealed there were recent skin changes to the left heel, and x-ray imaging was obtained. Imaging concerning for Osteomyelitis and C-reactive protein (a blood test used to check for inflammation) elevated at 120.4 mg/l (milligrams per liter) (normal range is considered less than 10 mg/l). Per the Note, the resident was to continue on antibiotic coverage in the form of Vancomycin and Zosyn (antibiotic medication).</p> <p>Review of Resident #47's Physician's orders dated 02/14/2022, revealed orders for skin inspection to be completed on Tuesdays on the evening shift.</p> <p>Review of Resident #47's February 2022 TAR, revealed the ordered wound treatments were not documented as being completed on 02/04/2022, 02/06/2022, 02/11/2022, 02/12/2022, 02/13/2022, and 02/15/2022.</p> <p>There was no documented evidence of weekly skin assessments or Wound Evaluations for measurements/staging documented from 01/13/2022 until 02/16/2022, over a month later, when the State Survey Agency (SSA) Representative asked to observe a skin assessment for Resident #47.</p> <p>Observation of a skin assessment for Resident #47, conducted on 02/16/2022 at 3:07 PM, by Registered Nurse (RN) #1, revealed the resident's Deep Tissue Injury to the left outer foot had opened and increased in size to 4.0 cm long by 3.5 cm wide by 0.2 cm deep. The Stage IV pressure ulcer to the left heel had increased in size to 6.0 cm long by 2.0 cm wide by 0.2 cm deep. Additionally, the resident was noted to have an area of brown eschar to the right lateral foot measuring 2.0 cm long by 1.5 cm wide with no depth. Per record review, the brown eschar to the right lateral foot was an unidentified area until this skin assessment. The area to the right lateral foot was observed without a dressing in place prior to this skin assessment.</p> <p>Interview with Registered Nurse (RN) #1, on 02/16/2022 at 3:10 PM, revealed the wound on Resident #47's right foot should have been covered with a dressing and she was not aware the wound was not covered. According to the nurse the area to the resident's right lateral foot was not new, but she was not aware of when the area developed. Per interview, the area was supposed to have a treatment to be cleaned with 1/2 strength Dakins (a wound cleanser) and Santyl (an ointment to remove dead tissue from a wound) and covered with a foam dressing. However, there was no documented evidence of a Physician's order for 1/2 strength Dakins and Santyl.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse (LPN) #LPN #7, on 02/22/2022 at 8:35 AM revealed she was an Agency nurse and was often assigned to Resident #47. Per interview, she did not receive any training on wounds during her orientation. When the LPN was questioned if she completed skin assessments and wound treatments, she stated she was unable to perform wound treatments/ or wound assessments as she was not comfortable with this and would pass the treatments/assessments off to the next shift to complete. However, she did not know if the next shift was completing the treatments/assessments that she did not complete.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 02/22/2022 at 5:18 PM, revealed she was the former wound nurse and assessed and measured wounds weekly and made wound rounds with the physician. Per interview, it was her responsibility to complete weekly skin assessments as well as complete wound assessments weekly. Further, she left the facility in January of 2022 and the floor nurses were supposed to take over measuring the wounds weekly and document wound assessments in the Electronic Medical Record (EMR) system. According to the wound nurse she documented the wound assessments on paper because of problems with the computer system deleting information, and then handed the assessments and measurements to the Administrator. Per interview she started back at the facility as the wound nurse on 03/02/2022.</p> <p>Interview with Director of Nursing (DON) #3, on 02/21/2022 at 4:44 PM, revealed he had started at the facility in January 2022. Further interview revealed he was not aware Resident #47 had pressure ulcers, nor was he aware skin assessments and wound measurements for Resident #47 were not being completed. According to the DON, he was new to long term care and was in training and was monitoring residents by making rounds in the facility, but was still trying to learn and did not monitor for anything specific. Further interview revealed a resident's pressure ulcers/wound could get worse or become infected if not being monitored and treated, or if the correct treatment was not ordered.</p> <p>Interview with the Medical Director, on 02/24/2022 at 1:27 PM, revealed she was also the primary care physician for Resident #47 and stated the resident had declined and was more debilitated in recent months due to Cancer. Per interview, the resident was diagnosed with a left heel deep tissue injury. Further, the resident was started on Doxycycline for a Stage IV pressure ulcer, but the resident was frail and the wound wouldn't heal. She stated the resident was later diagnosed with Osteomyelitis and a Peripherally Inserted Central Catheter (PICC) line was placed for intravenous antibiotics. According to the Physician, she did look at notes and tried to track down a time line for Resident #47's wounds and noted two (2) of the resident's wounds had deteriorated. Further interview revealed some of the treatment orders were incorrect as there was confusion related to the wounds on the right and left lower extremities. Per interview, the order dated 01/31/2022, to clean the wound to the right foot with wound cleanser, apply Santyl and cover with nonstick foam dressing should not have been ordered.</p> <p>44371</p> <p>2. Review of Resident #19's medical record revealed the facility admitted the resident on 11/09/2021 with diagnoses including Osteomyelitis, Methicillin Resistant Staphylococcus Aureus (MRSA) infection, unspecified site, Pressure Ulcer, and Paraplegic. Further review of Resident #19's medical record revealed no skin assessments were completed on admission.</p> <p>Review of Resident #19's Braden Scale for Predicting Pressure Sore Risk, dated 11/09/2021, revealed Resident #19 was at mild risk for pressure ulcers with a total score of fifteen (15).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 131 Meadowlark Drive Richmond, KY 40475	
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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #19's Physician's orders, dated 11/10/2021, revealed orders to monitor wound on mid back for signs and symptoms of worsening or non healing every shift until resolved. Resident #19's Physician's orders dated 11/16/2021, revealed orders to monitor wounds on right outer foot for signs and symptoms (s/s) of worsening or non healing every shift until resolved, and monitor wounds on right outer leg for s/s of worsening or non healing every shift until resolved.</p> <p>However, there was no documented evidence of treatment orders for Resident #19's wounds.</p> <p>Review of Resident #19's Admission Minimum Data Set (MDS) Assessment, with a reference date of 11/15/2021, revealed the facility assessed the resident as at risk for pressure ulcers and also as having two (2) Stage III pressure ulcers that were present at admission on 11/09/2021. Further review revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating intact cognition. Continued review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for transfers.</p> <p>There was no documented evidence of a Wound Assessment until 12/07/2021, which was twenty-eight (28) days after admission. Review of Resident #19's Initial Wound Assessment Note, dated 12/07/2021, revealed the following:</p> <ol style="list-style-type: none"> 1) Wound to the right gluteal cleft resolved, scar tissue present. 2) Wound to the right outer knee measured Length-2.0 centimeters (cm) x Width-1.5 cm x Depth-unable to be determined (UTD), no odor, slough covering wound bed, small amount of bloody drainage noted when wound cleaned. This description did not indicate the type of wound or stage of wound. 3) Wound to mid back measured Length-2.0 cm x Width-1.0 cm with no Depth recorded, no odor but large amount of bloody drainage when cleaned. This description did not indicate the type of wound or stage of wound. 4) Wound to right outer calf measured Length-15 cm x Width-4.0 cm x Depth-0.2 cm, area of wound close to 12 O'clock noted to have small area of slough noted, bright red epithelization and granulation present. This wound was described as a Stage III pressure ulcer. 5) Wound to right outer foot at base of fifth toe measured Length-2.5 cm x Width-2.0 cm x Depth-0.1 cm, small amount of bloody drainage noted when cleaned, granulation and epithelization present, no odor. This description did not indicate the type of wound or stage of wound. 6) Wound to right outer foot measured Length-1.5 cm x Width-1.5 cm x Depth-0.2 cm, small amount of bloody drainage noted when cleaned. This description did not indicate the type of wound or stage of wound. <p>Review of the Resident #19's Comprehensive Care Plan, dated 12/08/2021, revealed the resident had two (2) Stage III pressure ulcers on the outside of the right foot; a wound to the right outer leg on the side of the knee; a wound to the mid back spine and a wound to the right outer leg. The goal with a target date of 03/08/2022 revealed the resident would remain free from any unidentified skin issues through next review. Interventions included: assess skin and report redness, rashes, bruises, abrasions or skin breakdown; pressure reduction mattress; provide wound care as ordered by the physician; and provide medications and treatments as per orders.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>However, there was no documented evidence the CCP was implemented, nor was the CCP revised with interventions to treat the resident's wounds. (Refer to F656 and F657)</p> <p>Review of Resident #19's Physician's orders, dated 12/08/2021, revealed orders to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown.</p> <p>Review of Resident #19's January 2022 Treatment Administration Record (TAR), revealed the intervention for wound treatment to the two (2) Stage III Pressure ulcer on the outside of the right foot with wound cleanser and pat dry. Apply Santyl and cover with border gauze daily at 7:00 AM. However, the treatment was not signed to indicate the treatment was completed at 7:00 AM on 01/01/2022 and 01/02/2022.</p> <p>There was no Physician's order found in the medical record for intervention.</p> <p>Resident #19's Physician orders, dated 01/14/2022, revealed orders for Iodosorb External Gel 0.9% (Cadexomer Iodine), one (1) application to back daily between 7:00 AM and 6:59 PM. Cleanse wound to back with wound cleanser, pat dry, and apply Iodosorb to wound, cover with dry dressing. Change daily and PRN (as needed).</p> <p>Review of Resident #19's Physician's orders, dated 02/05/2022, revealed orders for Vaseline gauze to right leg and foot an wrap with Gauze every three (3) days.</p> <p>Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment to apply skin prep to scar tissue at right gluteal cleft daily for prevention of breakdown at 7:00 AM, was not signed to indicate the treatments were completed for thirteen (13) days including 02/01/2022, 02/02/2022, 02/03/2022, 02/04/2022, 02/05/2022, 02/08/2022, 02/09/2022, 02/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, 02/15/2022, and 02/18/2022.</p> <p>Interview with Registered Nurse (RN) #1, on 02/19/2022 at 11:20 AM, revealed she did wound care for Resident #19 on 02/18/2022, but had no explanation as to why this treatment was not charted.</p> <p>Review of Resident #19's February 2022 TAR, revealed the intervention to monitor the wound on the resident's mid back was not signed to indicate monitoring at 7:00 AM for seven (7) days including 02/02/2022, 02/04/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/11/2022, 02/13/2022, and 02/15/2022.</p> <p>Review of Resident #19's February 2022 TAR, revealed the intervention for wound treatment air mattress was not signed at 7:00 AM for six (6) days including 02/02/2022, 02/04/2022, 02/05/2022, 02/11/2022, 02/12/2022, and 02/13/2022.</p> <p>Interview with Resident #19, on 02/10/2022 at 9:41 AM, revealed he/she did not receive the wound care treatment like the doctor ordered. The resident stated he/she did not currently have a bandage on his/her back.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse (LPN) #4, on 02/10/2022 at 10:15 AM, revealed she was assigned to Resident #19, but had not checked on Resident #19's bandages today. She further stated she had no knowledge if the resident had his/her bandages on or when they were changed last . Further interview with LPN #4, on 02/10/2022 at 10:45 AM, revealed the resident's dressing to the mid back was not in place and the dressing to the resident's right leg should have been changed a few days ago and she would change the dressings.</p> <p>Observation on 02/14/2022 at 9:41 AM, revealed there was no bandage on Resident #19's resident's back. The resident's right leg was wrapped in gauze, dated 02/10/2022. Per the TAR, Resident #19's bandage to the right leg was to be changed on 02/12/2022, two (2) days prior.</p> <p>Interview with LPN #4, on 02/20/2022 at 4:00 PM, revealed she did change Resident #19's right leg bandage on 02/12/2022 and she had no explanation as to how the bandage was dated 02/10/2022. Continued interview revealed she could see how it could be a concern if wound bandages were not changed timely. Further, she did not perform Wound Assessments and she did not know who was responsible for performing Wound Assessments and she had never been instructed to do this.</p> <p>Observation on 02/16/2022 at 9:41 AM, of a skin assessment for Resident #19 performed by the Education Director, revealed the mid back wound measured Length-7.0 cm x Width-7.0 cm with an open area in the center which measured 1.0 cm x 1.0 cm x 0.5 cm with purulent drainage; the resident's right calf wound measured Length-22 cm x Width-7.0 cm x Depth-0.25 cm ; right great toe wound measured Length-2.0 cm x Width-3.5 cm x (no depth) and was scabbed; right inner ankle wound measured 2.5 cm x 4.5 cm x (no depth) and was scabbed. The Education Director did not stage the wounds during this skin assessment. This Wound Assessment was completed seventy-one (71) days after the last wound assessment, after Surveyor intervention.</p> <p>Interview, on 02/16/2022 at 1:40 PM, with the Education Director Nurse, revealed until January 2022 the wound nurse was responsible for all skin and wound assessment and documentation as well as rounding with the Physician to view the wounds. Additional interview revealed the nurses were responsible for the skin assessments and wound treatments at this time. She was unaware skin assessments and wound treatments were not being completed as ordered. She stated after the nurse completed a treatment or assessment, the nurse was responsible to document on the Treatment Administration Record (TAR) in the Electronic Medical Record.</p> <p>The following is a comparison of Resident #19's wounds noted in the Electronic Medical Record (EMR) for the Initial Wound assessment dated [DATE], which was completed 28 days after admission, and the next Wound Assessment, dated 02/16/2022, completed seventy-one (71) days after the last documented assessment, and after Surveyor intervention.</p> <p>Wound Assessment on 12/07/2021:</p> <ol style="list-style-type: none"> 1. right gluteal cleft resolved on 12/7 2. right outer knee 2.0 cm x 1.5 cm x UTD 3. mid back 2.0 cm x 1.0 cm x depth was left blank 4. right outer calf 15 cm x 4.0 cm x 0.2 cm <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5. right outer foot pinky 2.5 cm x 2.0 cm x 0.1 cm</p> <p>6. right outer foot 1.5 x 1.5 x 0.2</p> <p>Wound Assessment on 02/16/2022:</p> <p>1. right gluteal cleft resolved 12/7</p> <p>2. right outer knee nothing observed</p> <p>3. mid back 7 cm x 7 cm x 0.5 cm, larger</p> <p>4. right outer calf 22 cm x 1.0 cm x 2.5 cm larger and had increased depth appearance moist, pink-color, drainage-moderate serous (Clear). Surrounding tissue-discolored</p> <p>5. right outer foot pinky dark spot observed</p> <p>6. right outer foot dark spot observed</p> <p>7. right great toe with scab 2.0 cm x 3.5 cm, NEW AREA</p> <p>8. right inner ankle with scab 2.5 cm x 4.5 cm NEW AREA</p> <p>Continued review of the Wound Assessment revealed from 12/07/2021 until 02/16/2022, the wound to Resident #19's mid back became larger; the area to the right outer calf became larger and increased in depth; and new unidentified areas were found on the resident's Right great toe and Right inner ankle.</p> <p>Interview with Registered Nurse (RN) #1 on 02/19/2022 at 2:42 PM, revealed she was often assigned to Resident #19 and was unaware of any deterioration of the resident's wounds as she had not been completing Wound Assessments. She stated the nurses had not been trained to do Wound Assessments and she was not sure which staff member was responsible for completing them.</p> <p>Interview with Resident #19's Physician, on 02/24/2022 at 1:27 PM, revealed she was aware the resident sometimes refused care, especially wound treatments. However, she stated it was her expectation for staff to try to perform wound treatments, and to ensure wound measurements, staging and description of wounds were documented weekly. Further, it was her expectation that all wounds have a treatment in place, and Resident #19 should have had a treatment in place from admission related to pressure ulcers.</p> <p>3. Record review revealed the facility admitted Resident #39 on 12/20/2021, with diagnoses that included: Pressure Ulcer of right buttock, unstageable; other, Chronic Pain; Polyneuropathy, unspecified; Pressure Ulcer of right buttock, Stage 3; Adult Failure to Thrive; Hyperglycemia, unspecified; and Acute Kidney Failure, unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #39's Admission MDS assessment dated , 12/24/2021 revealed the facility assessed the resident as at risk for pressure ulcers, and with one (1) unstageable deep tissue injury (DTI) which were present on his/her admission on 12/21/2021. Continued review of the Admission MDS revealed a care plan had been developed for Resident #39's admission wounds. Further review revealed the facility assessed Resident #39 to have a BIMS score of six (6), indicating he/she was severely impaired in cognition.</p> <p>Review of the Braden Scale for Predicting Pressure Sore Risk for Resident #39, dated 01/31/2022, revealed the facility had assessed the resident as at high risk for pressure ulcers, as indicated by the total score of twelve (12).</p> <p>Review of the facility's initial Wound Assessment for Resident #39, dated 12/21/2022, revealed the resident had a wound measuring 12.2 cm in length x 7 cm in width x 0 cm depth. Continued review revealed the wound was noted as dry, black in color, and with macerated (skin exposed to moisture for too long which appears as soggy, soft, or whiter than usual). Further review the documentation noted no drainage, odor or pain had been present at the wound site. Review further revealed no documented evidence of the wound having been Staged or the location of the wound.</p> <p>Review of Resident #39's Comprehensive Care Plan, dated 12/21/2021, revealed the facility had care planned the resident for a Stage III Pressure Ulcer to the right buttock. Review revealed the interventions included for staff to assess the resident's skin and report redness, rashes, bruises, abrasion or skin breakdown. Continued review revealed the interventions also included: a pressure reduction cushion; air mattress as ordered; provide incontinence care as needed; provide wound care as ordered by the Physician; and treatment to the resident's buttocks as ordered.</p> <p>Review of the Physician's order, dated 01/07/2022, revealed an order for Santyl (debriding agent) External Ointment 250 unit/gm (collagenase) to be applied to Resident #39's buttock daily between 7:00 AM and 6:59 PM. Continued review of the 01/07/2022 Physician's order revealed the order also included to cleanse the wound to the right buttock with wound cleanser, pat dry, apply Silvadene cream (topical antimicrobial drug used as an adjunct for the prevention and treatment of wound sepsis) to the outer perimeter of the wound, and apply the Santyl ointment to the eschar the on wound. Further review of the 01/07/2022 Physician's order revealed the wound was to be covered with border gauze and change the dressing daily and as needed (prn).</p> <p>Continued review of Resident #39's medical record revealed the next documented Wound Assessment was eighteen (18) days later, was noted on a Physician's Note, dated 01/07/2022. Review of the Physician's Note revealed Resident #39 a telehealth wellness visit had been completed for the resident. Review of the Physician's Note revealed Resident #39 had an Unstageable (US) Wound on his/her sacral area, which was worse, deeper, and getting bigger with no tunneling or eschar. Further review of the Note revealed wound measurements documented as 4 cm in length x 2 cm in width. Review further revealed no documented evidence of the wound depth or color of the wound.</p> <p>Further review of Resident #39's medical record revealed a Wound assessment dated on 01/11/2022 at 5:03 PM by an unknown author, (four [4] days after the telehealth visit), which noted the resident's wound measurements where 11.8 cm in length x 6.8 cm in width x 0 cm in depth, and the wound was black in color, necrotic, with discolored tissue. Further review of the Wound Assessment revealed the wound had small/minimal drainage, no odor, and no pain, and the wound was not worse. Review further revealed no documented evidence of the wound's location or the Stage of the wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In addition, review of Resident #39's medical record revealed a Wound assessment dated [DATE] at 5:10 PM by an unknown author, which noted the wound as measuring 12.4 cm in length x 7.4 cm in width x 0 cm in depth. Continued review of the Wound Assessment revealed the tissue was broken, with moderate serosanguineous drainage, with an odor present, no pain and the wound noted as not worse. Further review revealed the Wound Assessment did not have the location of the wound or Stage of the wound documented.</p> <p>Review of the February 2022 MAR for Resident #39 revealed no documentation noting the Silvadene wound treatment as having been completed as ordered for the dates of the 2nd, 4th, 5th, 11th, 12th, 13th, and 15th of that month, a total of seven (7) days. Further review revealed staff were to initial the time and date on the MAR after completing application of the Silvadene wound treatment; however, the area for staff's initials for those dates was blank.</p> <p>Review of the February 2022 TAR for Resident #39 revealed no documentation noting the ordered wound treatment, (cleanse wound, apply Silvadene and oil emulsion, wet to dry gauze twice daily on coccyx every 12 hours) had been completed at 9:00 AM for the dates of the 01/11/2022, 02/12/2022, 02/13/2022, 02/14/2022, and 02/15/2022, a total of five (5) days. Continued review of the February 2022 TAR revealed no documentation noting the ordered wound treatment had been completed at 9:00 PM for the dates of the 9th, 11th, 12th and 13th, a total of four (4) days. Further review revealed staff were to initial the time and date on the TAR after completing application of the ordered wound treatment; however, the area for staff's initials for those dates was blank.</p> <p>Interview with Resident #39, on 02/16/2022 at 11:30 AM, revealed the resident felt bad. Resident #39 stated he/she had sores on his/her bottom, and the areas hurt. Further interview revealed the resident was unable to state when the sores (wounds) were acquired; however, stated the nurses looked at the sores, just not daily.</p> <p>Observation, on 02/16/2022 at 11: 30 AM during care provided by Agency SRNA #1, revealed Resident #39 had two (2) dressings on his/her buttock. One (1) dressing (the top one) was dated 02/14/2022 (two [2] days previously); however, orders revealed the dressing was to have been changed daily.</p> <p>Interview with Agency SRNA #1 on 02/16/2022 at 11:30 AM, revealed she had worked at the facility for nine (9) months on the day shift, from 7:00 AM to 7:00 PM. She revealed she was assigned to Resident #39's care that day. Per interview, Resident #39 was total care for all his/her ADLS. Continued interview revealed Resident #39 had a really big bed sore on his/her [TRUNCATED]</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22976</p> <p>Based on interview and record review it was determined the facility failed to ensure one (1) of thirty-three (33) sampled residents (Resident #428) maintained sufficient fluid and nutritional intake to maintain proper hydration, nutrition, and health. Resident #428 did not meet estimated fluid needs in September of 2019, from [DATE] through [DATE]. Interviews with staff revealed the resident ate five (5) times in eight (8) days. Additionally, staff had not documented the resident's intake on [DATE], [DATE], and [DATE]. There was no evidence that any action was taken to address the resident's poor intake. Subsequently, the facility failed to identify the resident was at risk for dehydration and was malnourished.</p> <p>On [DATE], the resident was transferred to the hospital for a change of condition. Upon admission to the hospital, the resident was diagnosed with Severe Dehydration and Malnutrition. The facility's failure to intervene when the resident declined in his/her fluid and meal intake presented and immediate jeopardy to residents.</p> <p>The facility's failure to ensure residents received sufficient fluid and nutritional intake to maintain proper hydration, nutrition, and health has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], in the areas of 42 CFR 483.10 Resident Rights (F580) at the highest scope and severity (s/s) of a J, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657) at the highest s/s of a J, and 42 CFR 483.25 Quality of Care (F684 and F692) at the highest s/s of a J. The facility was notified of Immediate Jeopardy on [DATE].</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on [DATE], which alleged removal of the Immediate Jeopardy effective [DATE]. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on [DATE]. The Immediate Jeopardy is ongoing.</p> <p>Refer to F580 and F657</p> <p>The findings include:</p> <p>Interview with the Administrator, on [DATE] at 3:12 PM, revealed the facility did not have a policy for nutrition and hydration.</p> <p>Review of a closed medical record for Resident #428 revealed the facility admitted the resident on [DATE] with diagnoses to include Dementia, Delirium, Delusional Disorder, and Encephalopathy.</p> <p>Review of Resident #428's laboratory results from, [DATE], revealed the resident's Blood Urea Nitrogen (BUN) level was 39 milligrams per deciliter (mg/dL), [DATE] revealed the resident's BUN was 36 mg/dL, and in [DATE], the resident's BUN was 36 mg/dL (normal range ,d+[DATE] mg/dL).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 131 Meadowlark Drive Richmond, KY 40475	
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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #428's Nutritional Care Plan, dated [DATE], revealed the facility developed a care plan that stated Resident #428 had problems chewing and swallowing. The care plan further revealed the facility identified that the resident was at risk for nutrition and hydration. The goal was for the resident to remain free of signs and symptoms of dehydration for ninety (90) days and to maintain a consistent body weight. Further review of Resident #428's care plan revealed the resident had interventions that included allowing for the resident's likes/dislikes, providing follow-up education/encouragement if preferences were in compliance with prescribed diet, monitoring the resident's weight, providing snacks and supplements as ordered, and provide nutritional counseling as needed. Further review of the resident's care plan revealed it was not revised to reflect concerns identified with the resident's decrease in meal and fluid intake.</p> <p>Review of Resident #428's nutritional assessment completed by the Dietitian, dated [DATE], revealed the facility assessed the resident to require 1475 to 1770 milliliters (ml) of fluid daily. Further, the resident was on a regular consistency, thin liquids diet for fortified foods at all meals. The resident was assessed to weigh one-hundred and thirty point six (130.6) pounds. Continued review revealed the resident received peanut butter sandwiches and ice cream at lunch and dinner. Further, the assessment stated the resident was stable at the time for nutritional and hydration status.</p> <p>Review of Resident #428's weight, dated [DATE], revealed the resident weighed one-hundred and thirty (130) pounds; however, the resident refused to be weighed in [DATE].</p> <p>A review of Resident #428's Quarterly Minimum Data Set (MDS) Assessment, completed [DATE], revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of five (5), which indicated the resident to have severely impaired cognition. The assessment indicated the resident required extensive assistance of one (1) staff for eating.</p> <p>Further review of the MDS revealed the resident was assessed to weigh one-hundred and thirty (130) pounds with no loss or gain in the past month or six (6) months.</p> <p>Review of Resident #428's meal intake documentation from [DATE] through [DATE], revealed on [DATE]; the resident refused all meals and ate less than twenty five (25%) percent; on [DATE], the resident had no food intake documented; on [DATE], the resident ate seventy five to one-hundred (,d+[DATE]%) percent of breakfast, but refused lunch and dinner; on [DATE], the resident had no documented intake at breakfast and refused lunch and dinner eating less than twenty five (25%) percent; on [DATE], the resident refused breakfast, ate lunch at fifty to seventy-five (,d+[DATE]%) percent and refused dinner; on [DATE], the resident had no breakfast intake documented, refused lunch, ate less than twenty five (25%) percent and ate twenty-five to fifty (,d+[DATE]%) percent for dinner; on [DATE], the resident ate fair with fifty to seventy-five (, d+[DATE]%) percent for breakfast; no documented intake for lunch, and ate poor for dinner, eating twenty-five to fifty (,d+[DATE]%) percent; on [DATE] and [DATE], the resident had no documented intake. Further, there was no evidence found in the resident's medical record to indicate staff notified the physician that the resident had decreased food intake.</p> <p>Further review of Resident's #428's average daily food and fluid intake report, dated [DATE], revealed the facility documented the resident's average fluid intake was 240.50 milliliters (ml), which was less than the resident's estimated fluid needs of 1475 to 1770 milliliters (ml) per day.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #428's laboratory results, dated [DATE], revealed a Comprehensive Metabolic Panel (CMP) was drawn and had hemolyzed (an indication that the red blood cells in that sample were destroyed in some way). The results were contaminated; however, there was no evidence the labs were redrawn.</p> <p>Interview with Registered Nurse RN(#4), on [DATE] at 11:34 AM, revealed she documented she received the resident 's labs, on [DATE] and contacted the physician. However, she stated she could not recall the CMP not being able to be completed because of its contamination. According to RN #4, she was agency and was new to the facility. The RN stated she did not have computer access to reorder labs in the computer and could not recall if she notified the physician about reordering the CMP.</p> <p>Further review of Resident #428's closed medical record revealed the resident tested positive for COVID-19, on [DATE], and was transferred to the facility's designated COVID unit.</p> <p>Review of the Nursing Progress Notes, dated [DATE] at 10:25 AM, revealed the resident appeared lethargic and the resident's fingers and toes on the right side and three (3) fingers on the left hand were purple in color. However, there was no documented evidence the resident's physician was notified the resident consumed less than twenty-five (25%) percent of his/her average food intake since [DATE], and that the resident had not met his/her fluid needs.</p> <p>Further review of Resident #428's closed medical record revealed, on [DATE] at 2:33 PM, Resident #428's physician conducted a telehealth visit with the resident. Review of the Physician's Orders, dated [DATE], revealed orders for support medication (Vitamin C and Aspirin). Further review of the physician's orders revealed staff were advised to offer the resident fluids to maintain adequate hydration. However, there was no documented evidence the physician was notified the resident was failing to meet his/her fluid needs and had only consumed twenty-five (25%) percent of his/her meals since [DATE].</p> <p>Review of Resident #428's Nurses' Progress Notes, dated [DATE] at 8:59 AM, signed by Registered Nurse (RN)#2, revealed Resident #428 continued to have purple fingers and toes. However, there was no documentation that the resident's physician was notified that the resident's fingers and toes remained discolored. Further, there was no documented evidence the physician was notified of the resident's refusal of his/her meals and fluids.</p> <p>Further review of Resident #428's Nurses' Progress Notes, dated [DATE] at 11:00 AM, revealed the resident vomited a large amount of dark black colored emesis, and the resident's oxygen saturation was not able to be obtained. The staff notified the resident's physician, who instructed staff to transfer the resident to the hospital for further evaluation and treatment.</p> <p>Review of Resident #428's hospital record, dated [DATE], revealed the hospital admitted the resident with the diagnoses of Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection.</p> <p>Further review of the hospital record revealed the resident weighed one-hundred- and twenty-two-point eight (122.8) pounds, approximately an eight (8) pound weight loss since August. Further review of the hospital record revealed Resident #428's condition declined, he/she was placed on comfort measures and expired at the hospital on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with Registered Nurse (RN) #2, on [DATE] at 10:31 AM, revealed she had cared for the resident, on [DATE], and remembered the resident's fingers being discolored and thought, the resident had a medical condition. Further, she stated the resident's purple fingers would not have been considered a change of condition for the resident. According to the RN, she was able to obtain oxygen saturations for the resident and did not recall any concerns. Per interview, she stated she used her personal phone for the resident's telehealth visit. She stated the resident's physician was aware of his/her purple fingers. RN #2 revealed she was unaware of the resident's refusals with his/her fluids and meals. She further revealed that had she been made aware of the resident's refusals, she would have reported the resident's change in fluid/meal intake to the physician.</p> <p>An interview with State Registered Nurse Aide (SRNA) #4, on [DATE] at 2:14 PM, revealed he cared for Resident #428 the night before the resident was sent to the hospital on [DATE]. SRNA #4 stated at approximately 5:00 AM on [DATE], he could not obtain an oxygen saturation on the resident and could not get the resident to take in any fluids. The SRNA stated the resident's breathing was labored and he/she was drenched in sweat. SRNA #4 stated, I thought (the resident) was going to die. Further interview revealed he notified Licensed Practical Nurse (LPN) #6 of the resident's condition multiple times during the night, but the LPN did not notify the resident's physician.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on [DATE] at 2:58 PM, revealed she had provided care to Resident #428 on the night shift from 7 PM-7 AM, [DATE] through [DATE]. However, LPN #6 denied any staff reported a change in Resident #428's condition to her. She stated if staff told her of the resident 's change in condition, she would have notified the resident's physician.</p> <p>Interview with the Unit Manager, on [DATE] at 3:36 PM, revealed she attended the Daily Clinical Review (DCR) meetings. Per interview, she stated residents' labs, new physician orders, bowel reports, and food and fluid intake reports, were reviewed in the clinical meetings for any concerns. The Unit Manager revealed she did not recall concerns discussed in the clinical meetings related to Resident #428's decrease in fluid and meal intake. Further interview with the Unit Manager revealed she could not explain why Resident #428's Comprehensive Metabolic Panel (CMP) was not obtained after his/her report came back contaminated. Further, she stated it was important to obtain the CMP for Resident #428 to monitor for his/her metabolic status.</p> <p>Further interview with the Unit Manager, on [DATE] at 3:36 PM, revealed that during the month of September, she worked the floor, providing nursing coverage, as many of the staff were off sick due to COVID. She further stated staff were unable to work, however, the facility utilized agency staff. Per interview, she stated she had not noticed Resident #428's decline. Continued interview with the Unit Manager revealed the Director of Nursing (DON) would have picked up her duties in the Daily Clinical Review (DCR) meetings and would have referred the resident to the Interdisciplinary Team (IDT) with the resident's identified concerns.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with Dietitian #1, on [DATE] at 2:47 PM, revealed she was responsible for revising the nutritional services plan of care for Resident #428. According to the Dietitian, she was not aware the resident was not eating and/or drinking. Per interview, staff did not alert her when the resident was not meeting his/her estimated fluid needs. The Dietitian revealed she met with the IDT weekly to review concerns with the residents' nutrition and hydration needs. Further, she stated the resident had improved from the previous month, thus changed the resident's weights from weekly weights to monthly weights. Per interview, it was for this reason, Resident #428 was not discussed in the IDT meetings. Further, she revealed she was unaware of the resident's decline in [DATE]; however, added she should have been made aware by staff.</p> <p>Interview with the Former Director of Nursing (DON) #1, on [DATE] at 12:29 PM, revealed the facility's procedure for ensuring the residents' hydration and nutrition were addressed was to provide the residents with food and fluids at meals; offer snacks, and staff were to pass water/ice to the residents on each shift. Further, the DON stated she conducted the daily clinical review (DCR) meetings with the members of the interdisciplinary team (IDT) and reviewed any concerns that had developed. According to the DON, if staff failed to document rather or not a resident ate or drank, the IDT might not have known when a resident refused his/her fluid and/or meal intakes. Per interview, the IDT would not have addressed the residents' concerns with hydration/nutrition if the residents' did not trigger for these concerns. DON #1 stated Resident #428 was monitored by the IDT, prior to September, but had improved. Additionally, she stated the Unit Managers and the nurses were responsible for reviewing the residents' lab values when received.</p> <p>Further interview with the Former Director of Nursing (DON) #1, on [DATE], revealed the average daily intake reports were printed by the resident's Unit Manager or the DON, if the unit manager was working the floor. Continued interview revealed the report was then reviewed weekly in the IDT meetings. According to the DON, she was not aware of any concerns with Resident #428 not meeting his/her estimated fluid needs. Further, DON #1 stated that if the IDT was made aware of the resident's concerns, the Dietitian would have revised the resident's plan of care with interventions to address his/her poor nutrition and hydration. Per interview, she stated that if the Interdisciplinary Team (IDT) was made aware of the resident's decline and his/her decreased estimated meal/fluid intakes, the physician would have been notified and orders would have been obtained from the physician for intravenous fluids, or the resident would have been sent to the hospital.</p> <p>Interview on [DATE] at 1:05 PM, with the Former Administrator, who was the Administrator in September of 2021, revealed she was not aware of any concerns with Resident #428 not eating and drinking on the COVID unit. Further interview with the Former Administrator revealed it would have been her expectation that staff would take action and try to increase the resident's fluid/food intake and notify the physician if a resident refused his/her hydration and nutritional needs.</p> <p>Interview with Physician #1, on [DATE] at 2:25 PM, revealed he was made aware of Resident #428's discolored fingers and toes during the telehealth visit on [DATE]. Continued interview revealed the physician stated that he expected to be notified if the resident's condition continued or worsened, as it would indicate further oxygenation problems. According to the physician, he was never made aware that Resident #428's refusals of fluid and meal intake. Per interview, staff had not alerted him the resident was not meeting his/her estimated fluid needs. According to the physician, he would have expected the contaminated CMP results to be redrawn for Resident #428 to monitor the resident's metabolic status.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Further interview with Physician #1, on [DATE] at 2:25 PM, revealed he visited Resident #428 in the hospital and the resident's condition had declined since the telehealth visit on [DATE]. Physician #1 stated he had not been notified of Resident #428's decline prior to the resident's hospitalization . Further interview with the physician revealed if he had been made aware that the resident was not eating and drinking, he would have ordered labs, intravenous (IV) fluids, and may have sent the resident to the hospital sooner.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001</p> <p>Based on observation, interview, record review, review of the Centers for Disease Control and Prevention's (CDC), Vaccine Storage and Handling, review of product inserts for the Afluria Quadrivalent vaccine, and review of the facility's policies, it was determined the facility failed to ensure clinical staff maintained records for the disposition of controlled drugs in sufficient detail to enable an accurate reconciliation. The facility failed to store and destroy controlled drugs to ensure there was no potential for diversion or abuse. The facility failed to ensure medications were returned to the pharmacy after being discontinued or after a resident was deceased or discharged from the facility. The facility failed to ensure drugs, biologicals, and vaccines were stored per currently accepted professional principles; and, failed to ensure appropriate environmental controls to preserve their integrity for two (2) of two (2) medication storage rooms and three (3) of four (4) medication carts.</p> <p>Observation of the refrigerators in two (2) medication storage rooms centrally located for Halls A and B and Halls C, D, and E revealed medication was stored in the medication refrigerator doors, with a refrigerator temperature outside of the acceptable range of 36- 46 degrees Fahrenheit. Review of temperature logs for both refrigerators revealed staff failed to log temperatures consistently. Further observation revealed the vaccine storage refrigerator, located in the Education Training Director's (ETD) office, was not monitored for the appropriate environmental controls to preserve the integrity of fourteen (14) unopened boxes of flu vaccine.</p> <p>Observation of three (3) medication carts located on Halls B, C, D, and E revealed medications were not stored in the original, labeled packaging received from the pharmacy. Further observation revealed discontinued controlled drugs were stored in the Director of Nursing's (DON) office in a locked file cabinet drawer. However, observations throughout the survey revealed the DON's office was often open and unoccupied, leaving the controlled drugs not double locked.</p> <p>The findings include:</p> <p>Review of the Centers for Disease Control and Prevention's (CDC), Vaccine Storage and Handling, updated [DATE], revealed proper vaccine storage and handling played critical roles in efforts to prevent vaccine-preventable diseases. Vaccines exposed to storage temperatures outside the recommended ranges could have decreased efficacy, creating limited protection; and, exposure to temperatures 32 degrees Fahrenheit or colder could destroy potency. Per CDC recommendations, vaccine temperatures should be monitored and documented at least twice daily if the refrigerator did not have a temperature monitoring device, which read minimum and maximum temperatures. Further review revealed best practices for storage of vaccines was to ensure that vaccines were not stored on the top shelf, floor, or door of the refrigerator as the temperature in these areas may differ significantly from the temperature in the body of the unit.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy, Medication Storage, no date, revealed the purpose of the policy was to ensure that medications were stored safely, securely, and in a manner that ensured the integrity of the medications and the safety of the residents in accordance with the Kentucky Cabinet for Health and Family Service guidelines. Further review revealed medications requiring refrigeration would be stored at the appropriate temperature according to the pharmacy or manufacturer labeling. Additionally, the temperature of the medication refrigerators should be maintained between 36- and 46 degrees Fahrenheit. Per the policy, medications should be stored in the original, labeled packaging received from the pharmacy.</p> <p>Review of facility's policy, Schedule II Controlled Substance Medication, not dated, revealed the purpose of the policy was to provide guidelines for the facility to follow related to the handling of controlled substances within the facility, in a manner that promoted proper storage and compliance with state and federal regulations. Both liquid and solid oral doses (capsules and tablets) should have a corresponding inventory sheet. When a Controlled Substance was administered, the licensed nurse must document the dose given on the declining inventory sheet. Per the policy, Schedule II, III, IV, and V drugs shall not be accessible to any personnel other than designated medical personnel, licensed nurses, and the pharmacy. These drugs would be stored under double lock, separate from other medications. The keys to the locked storage, which contained Controlled Substances, must always be in the possession of a licensed nurse. Per the policy, Schedule II Controlled Substances were to be destroyed in accordance with federal regulations and witnessed by two (2) persons, each of whom shall be a licensed nurse or pharmacist.</p> <p>Review of facility's policy, Medication Disposal/Destruction, not dated, revealed the purpose of the policy was to ensure the facility would adhere to all federal, state, and local regulations related to medication disposal and destruction. The policy stated that until all Controlled Substances, which were discontinued, were destroyed, they must be stored under the supervision of the Director of Nursing and were to be destroyed in accordance with federal regulations. The policy stated that the facility would maintain a record of all discontinued medications for a period of three (3) years.</p> <p>Review of the facility's form, Refrigerator Temp Log, dated ,d+[DATE], for the A/B Hall medication refrigerator revealed the temperature log was incomplete. Refrigerator temperatures were not documented for eight (8) days - [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].</p> <p>Review of the facility's form, Refrigerator Temp Log, dated ,d+[DATE], for the C/D/E Hall medication refrigerator revealed incomplete documentation for eight (8) days - [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Per the form, temperatures ranged between 32- degrees and 36- degrees Fahrenheit.</p> <p>A review of product inserts for the Afluria Quadrivalent vaccine (flu vaccine) revealed temperature storage should be between 36 and 46 degrees Fahrenheit.</p> <p>1. Observation, on [DATE] at 3:44 PM, of the A/B Hall medication storage room revealed the medication storage refrigerator was not locked. The thermometer was located in the rear of the refrigerator on the top shelf, near the freezer compartment. The thermometer read 45 degrees Fahrenheit. Five (5) vials of Daptomycin (an antibiotic) 500 milligrams (mg) were stored in the refrigerator door. Two (2) insulin (a hormone which regulates blood glucose levels) pens were stored in the door. Additionally, one (1) vial of insulin Lispro belonged to a discharged resident, and one (1) vial of insulin Lispro belonged to a deceased resident.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Inspection of the A/B Hall Refrigerator, on [DATE] at 4:00 PM, revealed the refrigerated controlled drug lockbox had one (1) bottle of Lorazepam (an anti-anxiety medication, Schedule IV controlled substance) 2 milligrams/milliliter (mg/ml) oral concentrate; labeled as Cubex Refill (medication delivery system). The bottle was in a plastic bag, which was sticky on the outside and had liquid spillage on the inside of the bag. The bottle of Lorazepam 2 mg/ml did not have a declining inventory sheet, as required by the facility's policy. Eight (8) milliliters (ml) remained out of the original thirty (30) mls.</p> <p>3. Observation, on [DATE] at 4:46 PM, of the C/D/E Hall medication storage room revealed the medication storage refrigerator was locked. The temperature of the refrigerator was 30- degrees Fahrenheit. The freezer section had a large amount of ice build-up. The narcotic lockbox was stored in the door of the refrigerator. Observation of the narcotic lockbox contents revealed one (1) vial of Lorazepam 2 mg/ml injectable and one (1) bottle of liquid Morphine Sulfate Oral Solution (Schedule II opioid medication to treat moderate to severe pain) 100 mg/5 ml; both labeled for Resident #66, who was deceased on [DATE]. Neither declining inventory sheet had a beginning balance; however, according to the prescription labels, the remaining balance of medication documented was correct.</p> <p>Continued observation of the lock box, on [DATE] at 4:46 PM, revealed one (1) bottle of Lorazepam 2 mg/ml oral concentrate was filled for a resident on [DATE], who had been discharged from the facility on [DATE]. There was no declining inventory sheet for this medication. Twenty (20) mls remained in the bottle.</p> <p>4. Observation and interview with DON #3, on [DATE] at approximately 5:06 PM, revealed discontinued medications were placed in plastic bags in his office. He further stated that discontinued controlled medications were stored in a locked file cabinet in his office. Observation of the file cabinet revealed it was locked with a keyed lock. When asked to open the file drawer storing the discontinued controlled narcotics, DON #3 stated he did not have the keys on his person. He stated, I need to go out to my truck to get the keys. DON #3 retrieved the keys and opened the drawer. Observation of the drawer revealed it was filled with multiple cards of controlled drugs, pill bottles, and vials of injectable medication, which dated back to , d+[DATE]. Per interview with DON #3, he could not explain why the facility had such a large number of controlled drugs stored or why they had not been destroyed. DON #3 stated he just started as DON on [DATE] and should have destroyed the controlled medications.</p> <p>Continued interview with DON #3, on [DATE] at 5:06 PM, revealed if a controlled medication was expired or discontinued, it was the facility's protocol for the nurse to notify the DON. The DON would count the controlled drug with another nurse and lock it up in the DON's office until two (2) nurses could destroy the medication. DON #3 stated, Generally, controlled drugs should be destroyed immediately and was unable to state why they had not been destroyed. According to DON #3, it was his expectation that the nursing staff alerted him regarding any expired or discontinued scheduled narcotics on the day it was expired or discontinued to assure all controlled drugs were accounted for, stored, and destroyed properly. DON #3 further stated this was important to ensure the safety of all residents.</p> <p>5. Observation of the medication storage refrigerator, located in the Education Training Director's (ETD) office, on [DATE] at 2:30 PM, revealed the temperature of the refrigerator was 46 degrees Fahrenheit. The thermometer was located on the middle shelf. There were fourteen (14) unopened vials of Afluria Quadrivalent vaccines stored in the refrigerator door.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the ETD, on [DATE] at 10:20 AM, revealed she was recently hired into the position of ETD. She stated she was responsible for monitoring vaccines. She stated she was not aware of a temperature monitoring log, as she had only been in the position of ETD for a couple of weeks. Further interview revealed that she did not know if all staff members who received vaccine deliveries and those who handled or administered vaccines were trained in vaccine-related practices to include storage and monitoring. She stated storing vaccines at the proper temperature was important to maintain the integrity of the vaccine, which was important for infection control and the safety of the residents.</p> <p>Continued interview with DON #3, on [DATE] at 5:06 PM, revealed he was unaware of the temperature range for medication storage and did not know that medications should not be stored on shelves in the refrigerator door.</p> <p>Interview with the Administrator, on [DATE] at 2:30 PM, revealed all vaccines were stored in the ETD's office, and the ETD was responsible for monitoring vaccines and documenting temperatures on the temperature log. Additionally, she stated she did not know if all staff members that received vaccine deliveries or those that handled or administered vaccines were trained in vaccine-related practices, to include storage and monitoring, but she would ask. The Administrator did not provide this information.</p> <p>6. Observation of the B Hall medication cart, on [DATE] at 4:00 PM, revealed four (4) loose vials of Ipratropium Bromide/Albuterol inhalation solution (used to treat chronic obstructive pulmonary disease {COPD} and asthma) located in the bottom drawer of the cart. The vials were not in their protective foil pouch and were not stored in a box labeled with a resident's name. Additionally, there were three (3) opened protective foil packages of Ipratropium Bromide/Albuterol inhalation solution without dates and not stored in a box labeled with a resident's name. Five (5) loose Calcium Carbonate pill packages belonging to Resident #65 were found loose in the bottom drawer. Further, inspection revealed Resident #74's (discharged) Fluoxetine (used to treat depression) and Xarelto 20 mg capsules (used to prevent blood clots) and Resident #28's (discharged) Xarelto 10 mg with Aspirin (used to prevent blood clots) remained in the cart. Resident #3's Fluticasone Propionate nasal spray (a steroid used to treat allergies) package was opened but not dated. Resident #43's Ipratropium Bromide/Albuterol inhalation solution was opened, and undated. Resident #54, who resided on Hall C, had medication in Hall B's cart. Review of the medication cart's narcotic lockbox revealed one card with a total of thirty (30) Lorazepam 2 mg tablets belonging to Resident #22 was still on the cart. Resident #22 had been transferred to the hospital on [DATE].</p> <p>7. Observation of the C Hall medication cart, on [DATE] at 4:30 PM, revealed three (3) bottles of opened ophthalmic solution, with no open date, were loose in the cart and not in their original packaging. Further observation revealed one (1) Albuterol package opened with no open date noted.</p> <p>Interview with Kentucky Medication Aide #2 (KMA), on [DATE] at 2:48 PM, revealed the night nurse was responsible for monitoring the temperature of the medication refrigerators. She stated that the medication refrigerators should be between 36 and 46 degrees Fahrenheit. KMA #2 stated the DON would remove discontinued narcotics from the cart after a count was completed. She further stated that the KMAs/nurses were responsible for removing discontinued or deceased residents' medications from the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with KMA #1, on [DATE] at 4:23 PM, revealed each KMA or nurse assigned to the medication cart was responsible for removing discontinued or deceased residents' medications from the medication cart. She further stated that when a narcotic was discontinued, the KMA/nurse would let the DON know, so he could remove it from the cart. KMA #1 stated the night nurse was responsible for monitoring the temperature of the medication refrigerators. KMA #1 stated she did not know the temperature range for storing medications in a refrigerator.</p> <p>Interview with LPN #1, on [DATE] at 11:30 AM, revealed it was the responsibility of the nursing staff to ensure medications were stored according to the facility's policy. She stated the nurse or KMA assigned to the cart had the responsibility for maintaining it and ensuring it was stocked. She further stated if a resident was discharged or deceased, the nurse assigned to the medication cart was responsible for removing the medications. If controlled drugs needed to be removed and destroyed, the nurse should notify the DON immediately. Per the interview, she stated storing medications according to the manufacturer's recommendations and CDC guidelines were necessary for the safety of all residents. LPN #1 stated the medication refrigerator should be between 36 and 46 degrees Fahrenheit.</p> <p>Interview with LPN #8, on [DATE] at 3:01 PM, revealed the night nurse was responsible for monitoring the temperature of the medication refrigerators. However, he stated he did not know the temperature ranges for storing medications in a refrigerator. He stated nurses were responsible for removing discontinued medications from the medication cart. He further stated when a narcotic was discontinued, the nurse was to let the DON know. The DON would remove it from the cart after a count was completed and take it to be destroyed.</p> <p>Interview with LPN #14, on [DATE] at 5:30 PM, revealed the night nurse was responsible for monitoring and documenting the temperature of the medication refrigerators. When interviewed related to why the refrigerator's temperatures were not documented every night shift, LPN #14 could not recall why he had not documented the refrigerator temperatures. When interviewed related to the facility's policy regarding temperature monitoring, he stated it was to monitor the daily temperature to ensure it remained between 32- and 40- degrees Fahrenheit. He stated nurses were responsible for removing discontinued medications from the medication cart. He further stated that when a narcotic was discontinued the nurse was to inform the DON. The DON would remove it from the cart after a count was completed and take it to be destroyed.</p> <p>Interview with LPN #2, on [DATE] at 8:29 AM, revealed it was the responsibility of the nursing staff to ensure medications were stored according to the facility's policy. He stated that the nurse assigned to the medication cart was responsible for removing discontinued drugs and notifying the DON of controlled medications that needed to be removed and destroyed. Continued interview revealed storing medications according to the manufacturer's recommendations and CDC guidelines was necessary for the safety of all residents.</p> <p>Interview with Registered Nurse (RN) #1, on [DATE] at 4:04 PM, revealed it was the responsibility of the nursing staff to ensure medications were stored according to the facility's policy to ensure the safety of all residents.</p> <p>Interview with DON #3, on [DATE] at 5:06 PM, revealed it was his expectation that all nursing staff followed the facility's policies and procedures related to medication storage and labeling. The DON stated if an item was found to be expired, labeled, and or stored improperly, it was his expectation that nursing staff returned or discarded the medication according to the facility's policy.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. Observations, on [DATE] at 8:30 AM, 9:50 AM, 1:13 PM, and 3:10 PM revealed the door to DON #5's office was unlocked and unattended resulting in the discontinued medications and controlled drugs unsecured by a double lock system.</p> <p>Observation of a count of discontinued controlled drugs, on [DATE] at 4:15 PM, with DON #5, revealed thirty-eight narcotic cards; four (4) bottles of controlled medications; and, three (3) vials of controlled injectables. Additional observation revealed four (4) gray storage bags filled with discontinued medication waiting for the pharmacy to pick up.</p> <p>Interview with the facility's Pharmacist, on [DATE] at 9:27 AM, revealed when a non-controlled medication had been discontinued, it should be removed from the cart and placed in a secure container in the medication room. Medications being sent back to the pharmacy should then be placed in sealable bags by licensed nurses and Kentucky Medication Aides (KMA). He stated it was the facility's responsibility to alert the pharmacy courier that there were medications to be returned. If the courier did not take the medications, the DON was to notify the pharmacy. Further interview revealed that discontinued controlled drugs should be counted and placed under double lock for destruction. Then they were to be destroyed according to the facility's policy. The Pharmacist stated standard practice was to log the controlled drugs and destroy them immediately, or at least in frequent intervals of no longer than two (2) weeks. He stated he would not expect that there would be a stockpile of controlled drugs slated for destruction and stored in the facility for over two (2) weeks. He stated the pharmacy made recommendations, but each facility should follow its policies according to regulatory processes.</p> <p>Interview with the Regional Quality Manager (RQM), on [DATE] at 5:18 PM, revealed all discontinued controlled drugs should be counted and then destroyed when two (2) nurses were available. She stated nurses were responsible for removing from the cart any discontinued medications and medications of deceased residents. The RQM could not explain why such a large number of controlled drugs were stored and not destroyed.</p> <p>Continued interview with the RQM, on [DATE] at 4:37 PM, revealed her expectation was that every controlled substance had a declining inventory sheet with an accurate accounting of the inventory and completed documentation of when the medication was given, to whom it was given, how much medication was administered, and by whom it was administered. Additionally, the RQM stated it was her expectation that each controlled substance was counted by two (2) nurses before and after each shift.</p> <p>Additional interview with the RQM, on [DATE] at 1:28 PM, revealed nursing staff, including the DON, should monitor the temperature of the medication refrigerators nightly to maintain the integrity of medications and vaccines. Further interview revealed the facility did not find declining inventory count sheets for the controlled drugs. She stated she could not determine who took the sheets. The RQM stated declining inventory controlled drug count sheets should remain with the medication at all times.</p> <p>Interview with DON #5, on [DATE] at 5:36 PM, revealed she was hired on [DATE]. She stated all controlled drugs had been destroyed after she started in the position of DON on [DATE]. She stated it was her expectation that nurses followed the facility's policy regarding medication storage, labeling and destruction of medications. Per interview all controlled medications should be double locked to include those in the DON's office for destructions. The DON's office should be locked when the DON was not in the office to ensure controlled medications remained double locked until destroyed.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Additional interview with the Administrator, on [DATE] at 1:57 PM, revealed the facility did not have a policy related to medication refrigerator temperatures. Per interview, the Administrator stated she was not clinical and the DON would be able to answer questions related to medication refrigerator temperatures, the storage of and destruction of controlled medications.</p>

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>39953</p> <p>Based on interview, record review, and review of the facility's Administrator's and Director of Nursing's Job Descriptions, it was determined the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>The facility failed to maintain substantial compliance, after the 05/21/2020, Abbreviated Survey, in the areas of 42 CFR 483.10 Notification of Change (F580); 42 CFR 483.25 Quality of Care (F684); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657); and 42 CFR 483.70 Resident Records-Identifiable Information (F842). During the 05/21/2020 survey, F580, F657 and F684 were cited at the Immediate Jeopardy level.</p> <p>Observations, interview, and record review revealed the facility's administration failed to use its resources to provide quality care and services to meet the needs of the residents. (Refer to F580, F656, F657, F684, F686, F692, F842, F867, F880, and F886)</p> <p>In addition, the facility's administration failed to ensure the facility maintained the standard levels of care and services for its residents. (Refer to F658, F695, F761 and F812).</p> <p>The facility's failure to be administered in a manner that enabled the effective use of its resources has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing.</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the facility's, Job Description for the Administrator, undated, revealed the Administrator's operational responsibilities included the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that governed nursing facilities to assure the highest degree of quality of care would be provided to residents at all times. Continued review revealed the Administrator's essential functions included facility and compliance management, and facility staffing and retention. The Administrator was responsible to ensure excellent care for residents was maintained by overseeing and monitoring resident care services delivered. Per review of the Job Description, the Administrator worked with and supervised personnel in the facility to provide opportunity for instruction, guidance, and counsel as necessary to ensure a complete understanding of responsibilities. Further review revealed the Administrator would ensure the maintenance of accurate medical records for auditing and regulatory compliance within appropriate approved guidelines.</p> <p>Review of the facility's Job Description for the Director of Nursing (DON), undated, revealed the DON's responsibilities were to plan, organize, develop, and direct the overall operation of the facility's nursing department, in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities, as directed by the Administrator, to assure the highest degree of quality of care was provided for residents at all times. Continued review revealed the essential functions of the DON position included supervision and evaluation of all nursing services provided in the facility. The DON was responsible for ensuring that the medical records and reports concerning resident care were maintained. Further review revealed the responsibility of the DON included determining staffing needs and to ensure orientation and training of nursing services personnel. In addition, the DON was also responsible for communicating to the Administrator, nursing concerns and identified problem areas with the developed plans of action to address the concerns/problem areas.</p> <p>Interview with the facility's [NAME] President of Operations (VPO), on 02/25/2022 at 10:30 AM, revealed there was not a job description for the Regional Quality Manager (RQM) position.</p> <p>Interview with the Regional Quality Manager (RQM), on 02/24/2022 at 12:22 PM, revealed she provided oversight of the clinical processes in the facility. She stated she provided clinical resources and support for the Director of Nursing (DON) and the Administrator through Quality Assurance (QA) review.</p> <p>Review of the 05/21/2020 Abbreviated Survey's Plan of Correction, and the 03/04/2022 findings revealed the facility failed to maintain compliance and be administrated in a manner to provide quality care and services. The facility was cited at actual harm and Immediate Jeopardy on both surveys. The facility was previously cited deficiencies, on 05/21/2020 related to notification to the provider secondary to a change in a resident's conditions; providing care to residents per standards of practice; revisions to the care plan with changes in a resident and their necessary care; pain management with a resident's change in condition; and maintaining accurate and consistent medical documentation/records. The same areas of deficient practice were identified on the 03/04/2022 survey.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview with Director of Nursing (DON) #1, on 02/25/2022 at 1:00 PM, revealed she had been the DON at the facility from the spring of 2020 until mid-November 2021. Continued interview revealed her job was to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently. She stated the Regional Quality Manager (RQM) had been present in the building weekly and provided resources and education directly for her. Further interview revealed, she was uncertain if her job description or responsibilities had been reviewed with her upon hire. DON #1 further stated the RQM's involvement in Quality Assurance (QA) reviews in the facility was how deficient practices were identified. Per interview, the DON was responsible for addressing deficient practices identified by the RQM.</p> <p>Interview with the Regional Quality Manager (RQM), on 02/24/2022 at 12:22 PM, revealed she had been the RQM for one (1) and a half years at the facility and had been the acting DON #2, from December 23, 2021, until January 24, 2022. However, she had been out of the facility most of December 2021. Per interview, she was not part of the administration of the facility while acting as the DON, or as the RQM. Continued interview revealed she had no power in the facility for making changes in either role. However, she stated her job was to provide clinical resources and support to the DON and the Administrator through the ongoing QA review. Further interview revealed she had gone over the DON #1's job responsibilities with her and had also discussed with her the state and federal regulations.</p> <p>Interview with DON #3, on 02/16/2022 at 2:15 PM, revealed he had been in the DON role for only one (1) month, from January 24, 2022, until February 18, 2022. Per interview, the Administrator had reviewed his DON job description and responsibilities with him upon hire, and he was considered part of the facility's Administration. Continued interview revealed he had been responsible for the overall operations of the facility's nursing department while in the DON role. However, he stated he had no long-term care background experience and had not received training from the facility related to the responsibilities of the DON role. Continued interview revealed he was told upon hire he would receive training from another DON at a sister facility; however, he had not been provided that training. In addition, he stated he was not familiar with the state and federal regulations for long-term care. He further stated he had been responsible for the care needs of the facility's residents and the supervision of its nursing staff. DON #3 stated that he ensured residents received the necessary care and services and provided the supervision of nursing staff as required through the department's morning clinical meeting. He stated that in the meetings orders, change in condition, incidents, admissions/transfers/discharges, etc., that occurred within the last twenty-four (24) hours were reviewed.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview with the Administrator, on 02/25/2022 at 1:00 PM, revealed she had been in the role for four (4) months and had a temporary license. She stated she was responsible for ensuring the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Continued interview revealed her job description was reviewed with her by the VPO when she was hired into the Administrator role. Per interview, she had the State Operational Manual in her office to use as a resource. The Administrator stated she was responsible for the care needs of the facility's residents and for the supervision of its staff. She stated she was the DON's direct supervisor. The Administrator revealed she believed the facility addressed the identified 05/21/2020 Survey concerns through its Quality Assurance (QA) program. Further interview revealed she was not aware of any continued audits related to the notification of change, care plans, quality of care, and resident records. The Administrator further revealed she had not reviewed the facility's previous survey results, nor the QA documents prior to accepting the role of Administrator. She stated that she had not reviewed the previous survey results because it occurred when she was a social worker and not an Administrator at the facility. Further interview revealed she ensured her responsibilities were accomplished through ongoing quality reviews completed by the RQM and DON. She stated that she talked with the VP of Ops, RQM and DON daily about what was going on in the facility. Continued interview revealed she relied on the RQM's and DON's oversight of clinical processes in the facility to ensure all clinical staff and processes were in place, per the Policy and Procedure.</p> <p>In addition, interview on 02/25/2022 at 1:00 PM, with the Administrator revealed she was not aware of any of the deficiencies cited during the current survey having been addressed in the facility's QA Committee meetings:</p> <p>Interview with the former VPO, on 02/25/2022 at 2:51 PM, revealed her current role was to provide support for the facility's Administrator. Continued interview revealed she was unaware of concerns that had been identified within the facility, prior to the State Survey Agency's (SSA) arrival in the facility for the current survey. She stated she had been the VPO for six (6) years and had provided oversight for the Administrator. The VPO revealed she was in contact with the Administrator daily and was present in the facility twice a month to provide support and resources. Per the VPO, the facility had experienced changes in leadership, specifically the Administrator, and the DON. Further interview revealed she had worked with the Administrator to help her understand the Administrator role as she transitioned into the new role. The VPO further stated she would continue to provide oversight of the Administrator and would be watching over the daily operations of the facility.</p>		

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<p>F 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>39953</p> <p>Based on interview, record review, and review of the facility's policy, it was determined the facility's Governing Body failed to ensure facility policies were implemented regarding management and operation of the facility.</p> <p>The Governing Body failed to ensure compliance in the areas of 42 CFR 483.10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657; 42 CFR 483.25 Quality of Care, F684 and F697; and 42 CFR 483.70 Administration, F842 during the 05/21/2020 Abbreviated Survey. Continued non-compliance was cited during this Survey at 42 CFR 483.10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657; 42 CFR 483.25 Quality of Care, F684 and F697; and 42 CFR 483.70 Administration, F842.</p> <p>The facility's failure to ensure the Governing Body implemented policies has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022.</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing.</p> <p>Refer to F580, F656, F657, F684, F686, F692, F697, F726, F835, F837, F842, F867 and F880</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Madison Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 131 Meadowlark Drive Richmond, KY 40475	
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<p>F 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the facility's policy titled, Governing Body, undated, revealed the Governing Body consists of the [NAME] President of Operations (VP of Ops), the Regional Quality Manager (RQM), the Administrator and the Director of Nursing (DON). Per policy, the VP of Ops would be notified of state reportable events, falls with injury and unusual event/occurrences, and Statement of Deficiency/Plan of Correction status. Additionally, the VP of Ops, the RQM, and the DON would conduct routine follow up to include staffing, reportable events, Statement of Deficiency/Plan of Correction (SOD/POC) status, and policy and procedure. Continued review revealed the RQM and the DON would review general clinical issues such as risks, acute readmissions, interventions, systems, tracking/trending, and SOD/POC status. The Governing body would review the facility operational status including Regulatory Compliance, Quality Measure Improvement, Staff Development, and Census Development. Further, the Governing body would review the Clinical Score Card including evaluation of Quality Assurance (QA), infection, tracking/trending, investigations, outcomes, and hospital readmissions. The Governing body would also schedule meetings for all the Regional, Administrators, and the DONs to review education, policy/procedure updates and annual mock surveys.</p> <p>Review of the Statements of Deficiencies (SOD) for the Abbreviated Survey dated 05/21/2020, revealed Immediate Jeopardy was cited at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657), and 42 CFR 483.25 Quality of Care (F684) all at a S/S of a J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684). Deficient practice was also cited at 42 CFR 483.25, F697 at a S/S of a G and 42 CFR 483.70 Administration, F842 at a S/S of a D. An acceptable Allegation of Compliance was received on 05/13/2020, which alleged removal of Immediate Jeopardy on 05/13/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/13/2020 as alleged. However, the Governing Body failed to ensure compliance was maintained.</p> <p>During this Survey, repeat deficiencies from the Abbreviated Survey dated 05/21/2020 include 42 CFR 483.10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F657; 42 CFR 483.25 Quality of Care, F684 and F697; and 42 CFR 483.70 Administration, F842. Immediate Jeopardy (IJ) was cited at 42 CFR 483.10 Resident Rights, F580; 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656 and F657; 42 CFR 483.25 Quality of Care, F684, F686 and F692; all a Scope and Severity (S/S) of a J. Additionally, Immediate Jeopardy (IJ) was cited at 42 CFR 483.70 Administration, F835 and F837 at a S/S of an L, and F842 at a S/S of a J; 42 CFR 483.75 Quality Assurance and Performance Improvement, F867, at a S/S of an L; and 42 CFR 483.80 Infection Control, F880, at a S/S of an L. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F684, F686, F692) and 42 CFR 483.45 Pharmacy Services (F760), at a s/s of an F.</p> <p>Interview with the [NAME] President of Operations, on 02/23/2022 at 11:56 AM, and 02/25/2022 at 10:30 AM, revealed when the company ownership changed in 2018, she no longer had a job description. Further interview revealed there was not a job description for the Regional Quality Manager (RQM).</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the facility's, Job Description for the Administrator, undated, revealed the Administrator's operational responsibilities included the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulation that governed nursing facilities to assure the highest degree of quality of care would be provided to residents at all times. Continued review revealed the Administrator's essential functions included facility and compliance management, and facility staffing and retention. Review revealed the Administrator was responsible to ensure excellent care for residents was maintained by overseeing and monitoring resident care services delivered. Per review of the Job Description, the Administrator worked with and supervised personnel in the facility to provide opportunity for instruction, guidance, and counsel as necessary to ensure complete understanding of responsibilities. Further review revealed the Administrator would ensure the maintenance of accurate medical records for auditing and regulatory compliance within appropriate approved guidelines.</p> <p>Review of the the facility's, Job Description for the Director of Nursing (DON), undated, revealed the DON's responsibilities were to plan, organize, develop, and direct the overall operation of the facility's nursing department, in accordance with current federal, state, and local standards, guidelines, and regulation that govern nursing facilities, as directed by the Administrator, to assure the highest degree of quality of care was provided for residents at all times. Continued review revealed the essential functions of the DON position included supervision and evaluation of all nursing services provided in the facility. Per review of the DON's Job Description, the DON was responsible for ensuring the medical records and reports concerning resident care were maintained. Further review revealed the responsibility of the DON included determining staffing needs and to ensure orientation and training of nursing services personnel. In addition, review revealed the DON was also responsible for communicating to the Administrator, nursing concerns and identified problem areas with the developed plans of action to address the concerns/problem areas.</p> <p>Interview with Director of Nursing (DON) #1, on 02/25/2022 at 1:00 PM, revealed she was the DON at the facility from the spring of 2020 until mid-November 2021. Additionally, the Governing Body would include the Administrator and the RQM as she reported to them. Further, DON #1 revealed she was aware of the deficiencies cited during the Abbreviated Survey, on 05/21/2020. However, she was not aware of continued audits related to those deficient areas. Further she relied on the RQM to identify clinical areas of deficiency and to give direction to achieve regulatory compliance.</p> <p>Interview with the Regional Quality Manager (RQM), on 02/25/2022 at 12:45 PM, revealed she had been the RQM for one and a half years at the facility and was the acting DON #2, from December 23, 2021 until January 24, 2022. Additionally, she was part of the Governing Body, as per the facility's policy. Per interview, she audited clinical systems, Quality Indicators and reviewed the overall operational status of the nursing department. She stated she also provided weekly clinical support and Quality Assurance (QA) reports to the DON and the Administrator. Further, she reviewed regulatory compliance with the DON and the Administrator. Continued interview revealed she was aware of the deficiencies cited during the last Abbreviated Survey dated 05/21/2020. However, she was not fully aware of the extent of clinical systemic issues that were currently occurring in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview with the Administrator, on 02/25/2022 at 1:00 PM, revealed she had worked at the facility in her role, for four (4) months and had a temporary license. Per interview, she was unfamiliar with who the Governing Body was and their responsibilities. However, she stated it was her responsibility as the Administrator, to ensure all processes established in the facility were maintained, to include the Quality Assurance and Assessment/ Quality Assessment Performance Improvement (QAA/QAPI) program. Continued interview revealed the Administrator was not aware of the previous Plan of Correction for the Abbreviated Survey in May of 2020, which occurred prior to her role at the facility as the Administrator. Further, she was not aware of clinical systemic issues at the facility and stated she was not clinical as she was a social worker until she became the Administrator.</p> <p>Interview with the [NAME] President of Operations (VP of Ops), on 02/25/2022 at 2:50 PM, revealed she had been in the role since 2016. Per interview, as VP of Ops she was part of the Governing Body, as per the facility's policy. She stated her current role was to provide support to the Administrator. Continued interview revealed the facility was required to maintain their own policies and procedures to meet regulatory requirement. Per interview, the facility's policies and procedures were from the previous company. She stated she provided resources and help getting these policies and procedures implemented, but did not make clinical decisions. Further interview with the VP of Ops, revealed she was unaware of the concerns identified within the facility, but would offer support and resources as needed.</p> <p>Continued interview with the [NAME] President of Operations, on 02/25/2022 at 2:50 PM, revealed she was not involved in the monthly Quality Assurance (QA) meetings and did not give the facility direction on their QA. However, she was aware of the QA action plans and any concerns discussed in QA, as she reviewed the facility's QA on a shared drive and also discussed QA with the Administrator. Additionally, neither the Administrator or the RQM communicated the concerns related to deficient practices which were identified by the State Survey Agency (SSA), prior to the SSA arrival into the facility. Per interview, the facility should have had systems/audits in place to identify issues with clinical practices and reported them to her to ensure follow up review and correction. The VP of Ops stated she would provide oversight to the Administrator and monitor the facility's daily operations with routine visits.</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635</p> <p>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure resident records were complete, and staff accurately documented care and services provided for six (6) of thirty-three (33) sampled residents (Residents #19, #28, #39, #47, #63, and #428).</p> <p>The facility admitted Resident #19, on [DATE], with two (2) Stage III Pressure Ulcers to the outside of the right foot; a wound to the right outer leg on the side of the knee; a wound to the mid spinal area; and, a wound to the right outer leg. However, at times, the facility failed to consistently document the care and assessment of the ulcers, as orders. The resident's wounds were not documented on from [DATE] until [DATE] (28 day).</p> <p>The facility admitted Resident #39 on [DATE] with a Stage III Pressure Ulcer to the right buttock. Documentation revealed a lapse in weekly wound assessments with no documented evidence that the facility conducted the resident's wound assessments until [DATE] (18 days later).</p> <p>Record review revealed the facility admitted Resident #47 on [DATE]. Resident #47's Physician's Orders, dated [DATE], revealed orders for weekly skin inspections. However, there was no documentation that the facility conducted the skin assessments including measurements and the progression of the resident's pressure areas from [DATE] until [DATE]. Assessment on [DATE], revealed the ulcers had declined and the resident had developed Osteomyelitis (a bone Infection).</p> <p>The facility admitted Resident #63 on [DATE] with a Stage II Pressure Ulcer to the coccyx and staples to the left above the knee amputation. However, the facility failed to document assessments of the resident's areas until [DATE], thirty-four (34) days after admission to the facility, at which time the wounds had declined.</p> <p>The facility failed to ensure Resident #428's food and fluid intake was completely and accurately documented for seventeen (17) days, from [DATE] until [DATE]. Resident #428 was admitted to an acute care hospital on [DATE]. Resident #428's admission diagnoses were Acute Kidney Injury secondary to Severe Dehydration and Severe Malnutrition.</p> <p>In addition, Resident #28 did not have accurate documentation concerning administration of Gabapentin (a Schedule V pain medication given for the resident's Diabetic Neuropathy) on the Medication Administration Record (MAR). The MAR revealed documentation that the resident received Gabapentin for thirteen (13) days when he/she did not because the facility had failed to obtain the medication. The resident's medication was not in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's failure to ensure medical records were accurately maintained has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on [DATE].</p> <p>An acceptable Immediate Jeopardy Removal Plan was received on [DATE], which alleged removal of the Immediate Jeopardy effective [DATE]. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on [DATE]. The Immediate Jeopardy is ongoing.</p> <p>Refer to F692, F697 and F761.</p> <p>The findings include:</p> <p>Review of the facility's, Skin Care Standard of Practice Policy, dated ,d+[DATE], revealed the facility would assess all residents on admission, readmission, quarterly, and with each change in condition that would compromise the skin. Per the policy, the baseline skin assessment would be completed within 24 hours of admission and documented in the medical record. Staging and measuring of the wound would be completed by the assigned nurse to maintain continuity in documentation of progression of wound healing.</p> <p>1. Review of Resident #19's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Osteomyelitis, Methicillin Resistant Stapholococcus Aureus (MRSA), Pressure Ulcer, Paraplegia, and Hypothyroidism. The facility admitted Resident #19 with Pressure Ulcers to his/her back and right leg.</p> <p>Review of Resident #19's Admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident to be at risk for pressure ulcers. Resident #19 had two (2) Stage III pressure ulcers that were present on admission on [DATE]. In addition, Resident #19's Brief Interview for Mental Status' (BIMS) score was fifteen (15) of fifteen (15), which indicated the resident's cognition was intact.</p> <p>Review of Resident #19's Care Plan, dated [DATE], revealed the resident had two (2) Stage III pressure ulcers on the outside of the right foot; one (1) on the right outer leg by the side of the knee; one (1) on the mid-back spine; and, one (1) on the right outer leg. Staff were to provide wound care and treatments as ordered by the physician.</p> <p>Review of Resident #19's [DATE] Treatment Administration Record (TAR) revealed inconsistency (did not document) in documentation for the intervention of wound treatment to the two (2) Stage III Pressure Ulcers on the outside of the right foot. The treatment consisted of using wound cleanser, pat dry, apply Santyl (a topical medication to promote wound healing) and cover with border gauze daily at 7:00 AM. However, the treatment was not signed (blank) to indicate the treatments were completed at 7:00 AM on [DATE] and [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #19's February 2022 TAR, revealed inconsistency (blanks) in documentation for the intervention of wound treatment to apply skin prep to scar tissue at the right gluteal cleft for prevention of breakdown (daily) at 7:00 AM, However, the treatment was not signed (blank) to indicate the treatments were completed for fourteen (14) days including [DATE] - [DATE]; [DATE] - [DATE]; [DATE]; [DATE]; [DATE] - [DATE]; and [DATE].</p> <p>Review of Resident #19's February 2022 TAR revealed inconsistency in documentation for monitoring of the resident's wound and wound treatment on his/her mid back. The TAR was not signed (blank) to indicate this monitoring/treatment was done at 7:00 AM for seven (7) days including [DATE], [DATE], [DATE], [DATE] - [DATE], and [DATE].</p> <p>Review of Resident #19's February 2022 TAR revealed inconsistency in documentation for wound treatment with an air mattress. Further review revealed this intervention was not signed (blank) at 7:00 AM for six (6) days, including [DATE], [DATE], [DATE] and [DATE] - [DATE], to indicate the resident had an air mattress.</p> <p>Interview with Resident #19, on [DATE] at 9:41 AM, revealed he/she did not receive the wound care treatment like the doctor had ordered. The resident stated he/she did not have a bandage on his/her back. An observation, during the interview, revealed there was no bandage on the resident's back, and the resident's leg was wrapped in kerlex dated [DATE]. Per the TAR, Resident #19's bandage was to be changed on [DATE]. Record review revealed the dressing change was documented as changed on [DATE]. However, an observation made on [DATE] revealed the bandage had not been changed since [DATE].</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on [DATE] at 3:26 PM, revealed she did not think Resident #19 had any treatments. She stated she thought the resident might have a treatment on his/her foot two (2) times a week or every three (3) days. She stated if the resident refused, she just charted it and told the Administrator.</p> <p>Interview with Registered Nurse (RN) #1, on [DATE] at 11:20 AM, revealed she did wound care on Resident #19, on [DATE], but she had no explanation why it was not charted.</p> <p>2. Review of Resident #39's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Essential (Primary) Hypertension; Other Chronic Pain; Polyneuropathy, Unspecified; Pressure Ulcer of the Right Buttock, Stage III; Adult Failure to Thrive, Pressure Ulcer of the Right Buttock/Unstageable; and Acute Kidney Failure, Unspecified.</p> <p>Review of Resident #39's Admission MDS Assessment, dated [DATE], revealed the facility assessed Resident #39 to be at risk for pressure ulcers. The resident had one (1) unstageable deep tissue injury that was present on admission on [DATE]. A care plan was developed. In addition, Resident #39 had a BIMS' score of six (6) of fifteen (15), indicating severe cognitive impairment.</p> <p>Review of Resident #39's Care Plan, dated [DATE], revealed the resident had a Stage III pressure ulcer of the right buttock. Staff was to provide wound care as ordered by the physician; air mattress as ordered; and treatment to buttocks.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the February 2022 Medication Administration Record (MAR) for Resident #39 revealed no documentation noting the Silvadene wound treatment as having been completed as ordered for the 2nd, 4th, 5th, 11th, 12th, 13th, and 15th of that month, a total of seven (7) days. Further review revealed staff were to initial the time and date on the MAR after completing application of the Silvadene wound treatment. However, the area for staff's initials for those dates was blank.</p> <p>Review of the February 2022 TAR for Resident #39 revealed no documentation noting the ordered wound treatment (cleanse wound, apply Silvadene and oil emulsion, wet to dry gauze twice daily on coccyx every 12 hours) had been completed at 9:00 AM for the dates of the 11th, 12th, 13th, 14th, and 15th, a total of five (5) days. Continued review of the February 2022 TAR revealed no documentation noting the ordered wound treatment had been completed at 9:00 PM for the 9th, 11th, 12th and 13th, a total of four (4) days. Further review revealed staff were to initial the time and date on the TAR after completing application of the ordered wound treatment; however, the area for staff's initials for those dates was blank.</p> <p>Interview with Resident #39, on [DATE] at 11:25 AM revealed the resident felt bad. The resident additionally stated he/she had sores on his/her bottom, and they hurt. Resident #39 stated the nurses looked at the sores, but not daily.</p> <p>Interview with LPN #7 (an agency nurse), on [DATE] at 1:35 PM, revealed she had been to the facility eight (8) times and had not received any training from her agency or the facility on wound care, wound assessment, or documentation of wounds. Additionally, she did not know the treatment order for Resident #39's wounds.</p> <p>3. Review of Resident #63's medical record revealed the facility admitted the resident, on [DATE], with diagnoses that included Acquired Absence of Left Leg Above Knee, Acute Respiratory Failure with Hypoxia, and Peripheral Vascular Disease, Unspecified.</p> <p>Review of Resident #63's Admission MDS Assessment, dated [DATE], revealed the facility assessed Resident #63 to be at risk for pressure ulcers. Resident #63 had one Stage II Pressure Ulcer on the coccyx and a surgical wound that was present on admission on [DATE]. In addition, the facility assessed Resident #63 with a BIMS' score of fifteen (15) of fifteen (15), which indicated intact cognition.</p> <p>Review of Resident #63's Baseline Care Plan, dated [DATE], revealed the resident had a Stage II Pressure Ulcer to his/her coccyx and an above the knee (AKA) amputation to the left lower extremity. Continued review revealed staff were to provide wound care and treatment as ordered by the Physician; and, provide a pressure reduction mattress.</p> <p>Review of Resident #63's [DATE] TAR revealed no documented evidence of staff's initials to indicate Resident #63's coccyx wound treatment had been provided on the 14th, 15th, 16th, 18th, 20th, 24th, 25th, and on the 28th, for a total of eight (8) days.</p> <p>Review of Resident #63's [DATE] TAR revealed no documented evidence of staff's initial to indicate wound monitoring of Resident #63's left AKA had been provided on the 18th, 20th, 24th, and 28th, a total of four (4) days.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #63's February 2022 TAR revealed no documented evidence of staff's initials to indicate the wound treatment ordered for Resident #63's coccyx had been provided on the 1st, 2nd, 3rd, 4th, 5th, 8th, 12th, 13th, 15th, 16th and 18th, a total of eleven (11) days.</p> <p>Review of the February 2022 TAR revealed no documented evidence of staff's initials to indicate Resident #63's wound treatment/monitoring for his/her left AKA had been provided as ordered for the 1st, 2nd, 3rd, 4th, 5th, 8th, 12th, 13th, 15th, 16th, 18th, a total of eleven (11) days.</p> <p>Interview with Resident #63, on [DATE] at 1:25 PM, revealed his/her wound care at the facility had been irregular. Resident #63 stated, that it was supposed to be done to his/her stump twice daily and his/her coccyx daily. However, Yesterday the resident's wound treatments had been missed. Resident #63 stated his/her stump treatment was a daytime treatment, but the stump treatment was not done until 2:00 AM that morning.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, on [DATE] at 4:15 PM, revealed there was no reason why the MAR/TAR's were incomplete. She stated if the wound treatments were done, they needed to be documented.</p> <p>4. Review of Resident #47's closed medical record revealed the facility admitted the resident on [DATE] with diagnoses that included Malignant Neoplasm of the Brain and Lung, Diabetes Mellitus Type II, and Dementia with Behavioral Disturbance.</p> <p>Review of Resident #47's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of five (5) of fifteen (15), which indicated severe cognitive impairment. Additional review revealed the facility assessed the resident as at risk for developing a pressure ulcer and as having one (1) Stage IV pressure ulcer and three (3) suspected Deep Tissue Injuries (DTIs) on his/her feet. Review of Resident #47's Physician's Orders revealed the resident was ordered to have wound care daily and as need for wounds to the left and right feet.</p> <p>Review of Resident #47's Care Plan, dated [DATE], revealed the resident had a problem with impaired skin integrity including a DTI to the left heel, an unstageable pressure ulcer to the right outer foot, and a DTI to the left outer foot. Interventions included: treatments as ordered; treatment to the DTI to the right outer foot and monitor until resolved; treatment to the left heel as ordered; and, treatment to the left outer foot as ordered.</p> <p>Review of the [DATE] TAR for Resident #47's wound care revealed the resident's ordered wound treatments were not documented as being completed on [DATE], [DATE], [DATE], [DATE], and [DATE], a total of five (5) days.</p> <p>Review of the February 2022 TAR for Resident #47's wound care revealed the resident's ordered wound treatments were not documented as being completed on [DATE] - [DATE]; [DATE] - [DATE], and [DATE], a total of seven (7) days.</p> <p>In addition, there was no documented evidence of weekly skin assessments or Wound Evaluations for measurements/staging documented from [DATE] until [DATE], over a month later, when the State Survey Agency (SSA) Surveyor asked to observe a skin assessment for Resident #47.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #47's Physician's Orders, dated [DATE], revealed orders to clean the wound to the right foot with wound cleanser, apply Santyl and cover with a nonstick foam dressing. However, there was no documented evidence of a wound to the right foot during this timeframe.</p> <p>Interview with LPN #4, on [DATE] at 9:45 AM, revealed when she was assigned to Resident #47 she might not have done the resident's treatments. She stated she could not remember and was not aware of the resident's wounds getting worse. Also, she stated sometimes treatments would be documented and deleted out of the electronic medical record (EMR) because the computer system had problems.</p> <p>5. Review of Resident #428's closed medical record revealed the facility admitted the resident on [DATE] with diagnoses which included Dementia, Delirium, Delusional Disorder, and Encephalopathy.</p> <p>Review of Resident #428's most recent Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident to be severely cognitively impaired with a BIMS' score of five (5) of fifteen. Further review revealed the facility assessed the resident to require the extensive assistance of two (2) staff for transfers, bed mobility, and toileting. Continued review revealed the facility assessed the resident as always incontinent of bowel and bladder.</p> <p>Review of Resident #428's Food and Fluid intake documentation for [DATE] revealed the resident's food and fluid intake was not documented on [DATE]. The lunch meal was not documented on [DATE]; lunch and supper meal not documented on [DATE]; lunch and supper were not documented on [DATE]; lunch and supper not documented on [DATE]; no meal intakes were documented on [DATE], [DATE]; no meal intakes were documented, for breakfast and lunch was not documented on [DATE], no meal intake was documented on [DATE]; breakfast and lunch were not documented on [DATE], breakfast and lunch was not documented on [DATE]; no meal intake was documented on [DATE]; breakfast was not documented on [DATE]; breakfast was not documented on [DATE]; and lunch was not documented on [DATE]. No meal intake was documented on [DATE]; and, breakfast was not documented on [DATE].</p> <p>Review of the Hospital Record for Resident #428 revealed the resident was transferred to an acute care hospital on [DATE] and admitted with diagnoses that included Acute Kidney Injury due to Severe Dehydration, Sepsis due to Pneumonia, Severe Malnutrition, Acute Respiratory Failure, and COVID-19 Viral Infection. Resident #428 died at the hospital on [DATE].</p> <p>Interview with State Registered Nurse Aide (SRNA #4) on [DATE] at 2:14 PM revealed he could remember being told to push fluids for Resident #428 but could not remember who told him. SRNA #4 stated all the residents on the Covid Unit were being encouraged to eat and drink but, he could not recall documenting the extra fluids in the system.</p> <p>Interview with SRNA #5 on [DATE] at 2:35 PM revealed Resident #428 required assistance with feeding. SRNA #5 stated she had problems charting intakes in the system. She stated she worked with a lot of agency SRNAs, who did not have a log in to document food and fluid intakes in the electronic medical record system.</p> <p>An interview with SRNA #7 on [DATE] at 10:30 AM revealed she worked on the floor at times and documented meals intakes for Resident #428. She stated at times the computer would not allow her to document. SRNA #7 stated when information was entered on the computer it would be deleted out.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with SRNA #8, on [DATE] at 10:13 AM, revealed the SRNA often took care of Resident #428. However, he did not have a computer log in PASSWORD?to document food and fluid intake.</p> <p>6. Review of the medical record for Resident #28 revealed the facility admitted the resident on [DATE] with diagnoses that included Diabetes Type 2. Orders were received for Gabapentin 100 mg (milligrams) three time daily for diabetic neuropathy pain.</p> <p>Review of Resident #28's Medication Administration Record (MAR) for [DATE] and February 2022 revealed the resident's Gabapentin was documented as being administered on [DATE] -[DATE]; [DATE]-[DATE]; and, on [DATE]-[DATE]. However, the resident did not have Gabapentin available at the facility to be administered during this time.</p> <p>Interview with Kentucky Medication Aide (KMA) #1 on [DATE] at 4:41 PM revealed if she had marked the medication as being administered on [DATE]-[DATE] for Resident #28 it would have been an oversight. She stated the medication was not available.</p> <p>Interview with Licensed Practical Nurse LPN #4 on [DATE] at 9:45 AM revealed if she was working with only a KMA to assist she may not get all medications documented. She further stated if she had documented a medication as given that was not available it was by accident.</p> <p>Interview with Licensed Practical Nurse (LPN) LPN #7, on [DATE] at 8:35 AM revealed she was an agency nurse and if she didn't document medications as being administered, she may have given the medications and did not document it. LPN #7 stated if the medication was not available, she may have not documented in the medical record or forgot to make a note.</p> <p>Interview with Director of Nursing (DON) #3, on [DATE] at 4:44 PM, revealed he had started at the facility in [DATE]. Further interview revealed he was not aware Resident #47 had pressure ulcers, nor was he aware skin assessments and wound measurements for Resident #47 were not being completed or documented. According to the DON, he was new to long term care, was in training, and was monitoring residents by making rounds in the facility, but was still trying to learn and did not monitor for anything specific.</p> <p>Interview with the Director of Education, on [DATE] at 10:19 AM, revealed she had made rounds with the Physician, on [DATE], and transcribed treatment orders for Resident #47's wound care. She stated she mistakenly got the left foot wound and the right foot wound mixed up and was not aware why Santyl was ordered for a wound to the right foot when the Physician wanted skin prep only applied to the wound. The Director of Education stated she could not explain why the treatment order was not specific or accurate to which wound and the location of the wound.</p> <p>Interview with the Medical Director, on [DATE] at 1:27 PM, revealed she was concerned that wound care and measurements were not getting completed and documented in the medical record. Further interview revealed she intended for the unstageable wound to Resident #47's right foot to be treated with skin prep to keep the wound closed. Per interview, the order dated [DATE], to clean the wound to the right foot with wound cleanser, apply Santyl, and cover with a nonstick foam dressing should not have been ordered. The Medical Director stated she did look at the notes and tried to track down a time line for Resident #47's wounds and noted two (2) of the resident's wounds had deteriorated.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with the Director of Education, on [DATE] at 1:40 PM, revealed she had worked at the facility since [DATE]. However, she had been in her current role since February 2022. Per the interview, she stated the wound nurse, when she was at the facility, was responsible for all skin and wound assessments and documentation as well as rounding with the physician for wounds. She stated, after completion of a wound treatment or assessment, the nurse was responsible to document it on the TAR and MAR in the electronic medical record (EMR).</p> <p>Interview with the Regional Quality Manager (RQM), who was a Registered Nurse (RN), on [DATE] at 3:00 PM, revealed documentation of wound treatments on the TAR and the MAR and wound assessments was essential to determine the effectiveness of skin/wound care the residents received.</p> <p>Additional interview with the Regional Quality Manager, on [DATE] at 12:22 PM, revealed there were no excuses for the wound treatments not being completed and documented on the TAR.</p> <p>Interview with Director of Nursing (DON) #4, on [DATE] at 2:15 PM, revealed skin and wound assessments should be accurately and thoroughly completed and documented weekly in the EMR, by the assigned nurse responsible for the resident.</p> <p>Continued interview with the Medical Director, on [DATE] at 1:27 PM, revealed she noticed a change in the quality of documentation after the wound nurse left, as agency nurses were not invested in providing the best care possible. According to the Medical Director many of the residents' wounds got worse. The Medical Director stated it was unsafe to practice in such an environment with wound treatments not being done or documented, and she could not defend the facility for any of this.</p> <p>Interview with the Administrator, on [DATE] at 12:58 PM, revealed if a nurse did not follow Physician's Orders for wound treatments, the wound could get worse. She stated she would expect staff to complete the wound treatments and document it. She stated she expected nursing to follow the Physician's Orders and accurately and completely document to take credit for their work.</p> <p>44371</p> <p>22976</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>32635</p> <p>Based on observation, interview, record review, review of facility policy, and review of the facility's Plan of Correction submitted for 05/21/2020 survey, it was determined the facility failed to have effective processes in place to address system failures through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. As a result, the facility failed to identify quality of care deficiencies, failed to develop and implement plans of action to correct identified quality of care deficiencies, and failed to ensure standards for quality of care regarding performance improvement measures were achieved and sustained. This was evidenced by deficient practice cited at F580, F657, F684, and F842, which had previously been cited on 05/21/2020.</p> <p>During the 05/21/2020 survey, Immediate Jeopardy was identified at 42.CFR 483.10 Resident Rights (F580), 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F657); 42 CFR 483.25 Quality of Care (F684); and 42 CFR 483.70 Resident Records-Identifiable Information (F842). The facility submitted an acceptable Plan of Correction (POC) alleging compliance as of 05/13/2020. However, the facility failed to maintain substantial compliance resulting in current deficient practice being cited at the Immediate Jeopardy level in the same areas.</p> <p>The facility's failure to have an effective Quality Assurance Program in place has caused or is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/25/2022 and was determined to exist on 09/12/2021, 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) at the highest scope and severity (s/s) of a J, 42 CFR 483.25 Quality of Care (F686) at an s/s of a J, 42 CFR 483.70 Administration (F835 and F837), at the highest s/s of an L; and F842 at an s/s of a J, 42 CFR 483.75 Quality Assurance and Performance Improvement (F867) at an s/s of an L, and 483.80 Infection Control (F880) at an s/s of an L. The facility was notified of Immediate Jeopardy on 02/25/2022. An acceptable Immediate Jeopardy Removal Plan was received on 03/03/2022, which alleged removal of the Immediate Jeopardy effective 03/03/2022. However, the State Survey Agency was unable to validate the removal of the Immediate Jeopardy prior to exit on 03/04/2022. The Immediate Jeopardy is ongoing.</p> <p>Refer to F580, F657, F684, and F842</p> <p>The findings include:</p> <p>Review of the facility's policy titled, QAPI Plan Standard of Practice, dated 06/2020, revealed the purpose of the Quality Assurance and Performance Improvement (QAPI) program was to provide overall guidance to the facility, to provide excellence in quality of care and support quality of life through patient centered care. Continued review revealed the facility conducted an annual Facility Assessment review, systematic performance evaluation, problem analysis and implementation of improvement strategies to achieve its quality goals. Further review revealed the scope of the facility's QAPI activities was to include all service areas and be supported by the facility's QAPI Interdisciplinary Team (IDT) members.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the Job Description for the Administrator, undated, revealed the Administrator was responsible for the facility's day-to-day functions in accordance with current federal, state, and local standards, guidelines, and regulation that governed nursing facilities to assure the highest degree of quality of care was provided at all times for residents. Continued review revealed the essential functions of the Administrator position included facility and compliance management, and facility staffing and retention. Review revealed the Administrator was responsible for ensuring excellent care of facility residents which was maintained through the overseeing and monitoring of patient care services being delivered. Further review revealed the Administrator was to work with and supervise facility personnel in order to provide opportunity for instruction, guidance, and counseling as necessary to ensure personnel had complete understanding of their responsibilities. Review further revealed the Administrator ensured the maintenance of accurate medical records for auditing and regulatory compliance within appropriate approved guidelines.</p> <p>Review of the Acceptable Plan of Correction (POC), for the Abbreviated Survey dated 05/21/2020, revealed for the deficient practice which had been cited at F580, the facility had provided education for licensed nurses regarding physician notification with changes of condition in residents, and the documentation required for physician notifications. Continued review of the POC revealed for the deficient practice cited at F684, the facility implemented resident skin inspections to include new/undocumented skin impairments and pain assessment. Further review of the POC revealed for the deficient practice cited at F842, residents' care plans were updated with new interventions related to a change in resident status in the electronic medical record. The POC review revealed for the deficient practice cited at F657, the facility provided education for licensed nurses related to the regulatory requirement that resident care plans were to be updated when a change of condition occurred for a resident.</p> <p>Further review of the Plan of Correction (POC), for the survey dated 05/21/2020, revealed the DON, Unit Manager or Wound Nurse, or weekend Registered Nurse (RN) supervisor would review the audits initiated on 05/08/2020 on a daily basis for Physician orders. Review of the POC further revealed for the audits which had been initiated for validating updated care plan and skin/wound assessments, the DON, Unit Manager or Wound Nurse, or weekend Registered Nurse (RN) supervisor would review the audits until the facility achieved regulatory compliance. In addition, the POC review additionally revealed the results of the facility's monitoring/auditing would be reviewed a minimum of weekly in the facility's QAPI meetings being held to track the facility's progress toward regulatory compliance. Finally, review of the POC for the 05/21/2020 survey revealed the QAPI meetings included, but were not limited to the: Administrator, Director of Nursing, Unit Managers, Human Resources, Business Office Manager, Social Services Director, Activities Director, Dietary Manager, Minimum Data Set (MDS) Coordinator and Medical Records.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the facility's Quality Assurance (QA) Committee meeting documentation revealed meetings held on 05/05/2021, 05/26/2021, which were concerning mock surveys results and actions, with the attendees noted as former Administrator #1, Medical Director, Director of Nursing (DON) #1 and current Administrator (#2), who had been the former Social Services Director (SSD). The same attendees were noted for the 06/12/2021, and 07/30/2021 meetings, and for the 08/03/2021, and 08/26/2021 meetings the attendees included former Administrator #1, DON #1 and current Administrator #2 (former SSD). Continued review revealed for the 09/17/2021, and 10/15/2021 meetings the attendees included Administrator #2 and former Registered Nurse (RN)/Education Training Director #2. Review of the 11/23/2021, and 11/30/2021 meetings revealed the attendees included Administrator #2, and DON #1. Further review revealed Administrator #2, DON #2 were noted as attending the 12/30/2021 meeting, and the Medical Director noted as attending by phone.</p> <p>Interview on 02/22/2022 at 5:18 PM, with former Wound Nurse #1 revealed she had informed the Administrator in November 2021, that there were issues with the facility's wound care and treatment and documentation. Continued interview revealed at that time the facility implemented changes to its weekly skin assessment protocol and direct care nurses were provided a schedule for skin assessments and responsibility to complete the assessments weekly. According to the Wound Nurse, she had worked as a direct care nurse, Unit Manager and the Wound Nurse in the months of November 2021 and December 2021.</p> <p>She revealed; however, she was responsible for weekly wound assessments and wound care for residents who had wounds.</p> <p>Further interview with the former Wound Nurse #1, on 02/22/2022 at 5:18 PM, revealed she had been working one hundred and twenty (120) to one hundred and fifty (150) hours per week in November and December 2021 and had not been able to complete her Wound Nurse care duties. She stated she had informed the Administrator #2, at that time, that she could not do what needed to be done with residents' wounds. The Wound Nurse stated she had also informed Administrator #2 at the same time that she had identified direct care nurses were not completing the documentation for things such as assessment and treatment administration records. Further interview revealed the Administrator #2 asked her to complete a skin sweep of all residents' skin status in the facility in January 2022, which she had completed and documented. The Wound Nurse stated she provided the hand-written reports to the Administrator after completing the skin sweep. She further revealed she had become frustrated with the situation and no longer worked as a full-time nurse at the facility. Continued interview revealed she had not worked at the facility since 01/24/2022. In addition, the Wound Nurse revealed she attended the Daily Clinical Reports (DCR) meetings, to discuss and review anything new with residents in the past twenty-four (24) hours and check to see if everything had been done related to the resident's care. She further stated she could not attend every DCR meeting due to working on the units as assigned.</p> <p>Interview with the Assistant Minimum Data Set (MDS) Coordinator #1, on 02/24/2022 at 8:55 AM, revealed Monday through Friday, she attended the DCR meetings. Continued interview revealed in the DCR meetings Physicians' orders, labs, residents' skin assessment progress notes were reviewed, and residents' care plans updated. The MDS Coordinator revealed she attended the facility's monthly QAPI meetings, where she made changes to residents' care plans. Further interview revealed she had not identified any issues concerning the care plans.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview with Registered Nurse (RN) #1, the Director of Nursing (DON) on 02/25/2022 at 12:21 PM, revealed she was responsible for completing the facility's Quarterly review of residents' falls. She revealed her responsibilities also included: attending weekly resident falls meetings; performing audits of residents' laboratory (lab) results; and reviewing new and discontinued Physician's orders in the DCR meetings. Continued interview revealed she attended the facility's Interdisciplinary Team (IDT) meetings and discussed changes in residents' conditions, residents' medication refusals, followed up to ensure skin and wound care had been completed, and residents' care plans revised as necessary. She stated the DON's position was to assist in ensuring the facility was administered in a manner which enabled it to use its resources effectively and efficiently. The DON further revealed she took part in the facility's monthly QAPI meetings, QAPI Committee members, including herself, had not identified any issues with the residents' wounds.</p> <p>Interview on 02/25/2022 at 1:00 PM, 02/25/2022 at 4:56 PM and 02/25/2022 at 6:09 PM, with Administrator #2 revealed around the time of the 05/21/2020 Abbreviated Survey she had participated in the facility's Quality Assurance (QA) program as the Social Services Director (SSD). Interview revealed; however, she could not recall what had been audited at that time, or when the facility had achieved compliance as she had not been a clinical person for the deficient practice cited at F580, F657, F684, and F842. She stated the POC dated 05/21/2020 had been reviewed in the facility's QA Committee meetings. Continued interview revealed when she had been hired as the Administrator, in November 2021, she was not made aware of any ongoing audits regarding the facility's previous POCs.</p> <p>An additional interview with the Administrator on 02/25/2022 at 1:00 PM; 4:56 PM, and 6:09 PM, revealed she assumed the ongoing audits that were discussed in the QA Committee meetings, and that the facility had achieved regulatory compliance. She revealed the facility's QA Committee had not identified concerns in those areas since she had become the Administrator. The Administrator revealed she relied on the clinical leads, the DON and Regional Quality Manager (RQM), to bring any concerns to the QA Committee's and her attention. Further interview revealed; however, she was not aware of any concerns with the clinical practices within the facility. She further stated she was not familiar with the facility's Governing Body or that the Governing Body was responsible for establishing and implementing policies regarding the management and operation of the facility. In addition, the Administrator revealed it was her responsibility to ensure all facility processes established by the [NAME] President of Operations (VPO) were maintained including the facility's Quality Assessment and Assurance (QAA) and QAPI programs.</p> <p>Interview with the Regional Quality Manager (RQM) on 02/24/2022 at 12:22 PM, revealed she was aware of the concerns regarding residents' wounds, weights, and clinical documentation within the facility and had informed the Administrator of the concerns. Interview revealed the RQM stated she reviewed the facility's systems, processes, Quality Indicators, and made recommendations to the Administrator and DON. Per interview, the RQM reviewed documentation for quality indicators and the nursing departments process, such as falls, skin, weights, labs, etc. She then compiled the review into a report she provided to the DON and the Administrator, per email or verbal report, weekly. Continued interview revealed if concerns were identified in her review, she would discuss her findings with the DON and the Administrator and strongly recommended a process on how to make change; but it was ultimately up to the Administrator and the DON to implement the change. In January, 2022, she identified wound/skin assessment were not documented/completed weekly in the medical record.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Further interview with the RQM, on 02/24/2022 at 12:22 PM, revealed; however, any changes that would be made, after discussing the concerns with the Administrator, were ultimately up to the Administrator and the DON. Continued interview revealed the facility's resident wound system was broken due to the lack of documentation by nursing staff. She stated she had informed the Administrator of identified concerns regarding the lack of documentation for residents' wounds and wound care. Further interview revealed for the facility's QA, the DON was supposed to audit resident's labs to ensure none were missed, and audit residents' skin and wounds weekly. The RQM revealed; however, the facility had no documented evidence of audit sheets for 05/21/2020 through 12/2021. She further revealed due to the high turnover of facility DON's from 12/23/2021 to 02/24/2022, the audits had not been completed and had not been available for review in the DCR meetings.</p> <p>Interview on 02/25/22 at 3:00 PM, with the [NAME] President of Operations (VPO), revealed she had worked in her role since 2016 and she provided oversight and support for the Administrator. The VPO stated the RQM notified the Administrator of any clinical areas of concern for the facility. Continued interview revealed the RQM audited the facility's QA processes through use of a clinical score card, which had been conducted on 05/2021. The VPO revealed if any issues were identified by the RQM, the issues were worked through in the facility's QA process. She stated the RQM visited the building weekly and reported any identified concerns from the visits to her (VPO). Further interview revealed the RQM had not communicated any identified concerns regarding residents' wounds or the facility's wound process. She further revealed the facility had a process in place to audit residents' wounds weekly and determine if wound treatment had been completed as per the facility's policy. In addition, the VPO further stated the RQM reviewed the documentation in residents' electronic medical record for any omissions and reported any documentation issues or other identified issues to the DON.</p> <p>Interview on 02/24/2022 at 1:30 PM, with the facility's Medical Director revealed she participated with the Administration and DON and other leadership personnel to oversee any clinical issues regarding medical care. Continued interview revealed she took part in the facility's regular QA meetings and had provided her input during that process. The Medical Director revealed there had not been any routine QA meetings for 01/2022 and 02/2022 until the occurrence of the facility's standard survey. She stated the facility's Administration was responsible for the oversight of its resources to ensure and maintain best care practices for residents. Further interview revealed the Medical Director had identified lapses in the facility's documentation of residents' wound assessments which were to be documented in order to know if a resident's wound had improved or worsened. In addition, the Medical Director stated she had identified the inconsistent documentation in residents' Medication Administration Records (MARs) and Treatment Administration Records (TARs) and had informed the Administrator of that information.</p>		