STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00354841, IN00356996, and IN00356986. Complaint IN00354841 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725, F809, F677, F600, and F868. Complaint IN00356996 -Substantiated. Federal/State deficiencies related to the allegations are cited at F725, F600, and F677. Complaint IN00356986 -Substantiated. Federal/State deficiencies related to the allegations are cited at F725, F809, F600, F677 and F868. Survey dates: June 22, 23, 24, 25, 28, 29, and 30, 2021 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type: Medicare: 12 Medicaid: 66 Other: 19 Total: 97 These deficiencies reflect State Findings cited in	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on June 22, 23, 24, 25, 28, 29 and 30, 2021.** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA**	

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

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed on July 9, 2021.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or			

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the physician and/or family, when a resident complained of heaviness in her chest and irregular heart rate for 1 of 2 residents reviewed for notification of changes. (Resident 48) Findings included: The clinical record for Resident 48 was reviewed for on 6/23/21 at 1:46 p.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, heart failure, diabetes mellitus, chronic obstructive pulmonary disease with exacerbation. The Quarterly MDS (Minimum Data Set) assessment, dated 5/11/21, indicated the resident was cognitively intact. The care plan, dated 4/20/21, indicated the	F 0580	**F 580 Notify of Changes (Injury/Decline/Room, etc)** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 48 continues to reside in the facility. Resident record has been reviewed for any identified changes in condition and the completion of notification to physician and/or family regarding the change in condition. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with a change in condition have the potential to be affected by the deficient practice.	07/23/2021

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	resident had decreased cardiac output. The interventions included, but were not limited to, evaluate blood pressure, change in level of consciousness, edema, and shortness of breath. The physician's order, dated 5/23/21, indicated to monitor for (SOB) shortness of breath every shift. SOB with activity and/or increased number of pillows to sleep, increased SOB with activity, unrelieved SOB, SOB with rest, and sits upright in chair to rest every shift for heart failure monitoring. Cardiac physician to see on next visit to facility, start date 6/21/21. Obtain EKG (Electrocardiogram) related to A-fib (Atrial fibrillation) and palpitations, dated 6/17/21. Amiodarone HCl Tablet 200 mg (milligram) Give 200 mg by mouth in the morning for A-fib, dated 3/24/21. Lasix tablet 40 MG (furosemide) give 40 mg by mouth in the morning for edema, dated 6/25/21. The nurse's noted, dated 6/17/21 at 4:35 p.m., indicated the NP (Nurse Practitioner) was in to assess the resident with new orders received to obtain EKG related to A-fib and palpitations. The physician's notes, dated 6/20/21 at 1:51 p.m., indicated the patient had an EKG done on Friday due to palpitations. The EKG interpretation reported normal sinus rhythm with prolonged QT (measures electrical properties of the heart) although the QT interval were not listed, and difficulties to see. The patient was currently without palpitations. The resident had a notable history for atrial fibrillation and was on amiodarone. The assessment included a QT prolongation. Recommended to follow up with the patient's cardiologist due to QT prolongations and the patient being on amiodarone. On inspection of the EKG the QT		A 30 day look back of documentation has been completed to review notification to physician and/or family regarding changes of condition. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for licensed nursing staff to provide education and expectations as it relates to “Notification for Changes in Condition” **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will review residents noted to have a change in condition for documentation of notification to the physician and/or family for 5 residents a week for 4 weeks, then 3 residents a week for 4 weeks, then 1 resident a week for 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Administrator/DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance	

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	appeared to be around 500 although difficult to interpret as it appeared a little blurry. He indicated if the patient develops any palpitations please notify the on call provider. During an interview, on 6/28/21 at 10:15 a.m., Resident 48 indicated the morning of 6/17/21 she turned her light and told the CNA (Certified Nursing Aide) her chest felt heavy and she could not get any air. She did have breathing problems, but that time she could feel her heart skipping beats. She asked the CNA to have the nurse come in. The resident indicated two hours later the QMA (Qualified Medication Aide) came in and told her "If it happens again sit up in bed and cough." The resident indicated staff did not take her vital signs or listen to her heart and lungs. The clinical record lacked documentation that an assessment was completed by a nurse, vital signs were taken, or a call was made to inform the physician or family. During an interview, on 6/28/21 at 2:10 p.m., the RDCO (Regional Director of Clinical Operations) indicated she could not find documentation in the clinical record where the resident's blood pressure, pulse or respirations had been taken and an assessment for the dates of June 16, 17, 18, 19, 20, 21, and 22, 2021. During an interview, on 6/29/21 at 10:10 a.m., LPN 3 (Licensed Practical Nurse) indicated a nurse should have done an summary assessment when her condition changed. Her vitals should have been taken. On 6/28/21 at 2:52 p.m., the RDCO provided a current copy of the document titled Notification for Changes in Condition, dated 10/30/13 and		is achieved or if ongoing monitoring is required.	

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	revised on included, but were not limited to, ..."A. The nurse aid will identify basic changes and promptly notify the nurse b. Nurses will be skilled at identifying changes in condition for a resident based upon their needs, medical status, and report those changes to the Unit Manager (UM)/designee i. For immediate change needs when no UM is on duty, the nurse will use good clinical judgement to call the MD or their supervisor if uncertain in a change in condition c. The UM will provide additional assessments to address any concerns and report unsolved issues to the DON (Director of Nursing)... ii 2. Document in the electronic medical record... iii b. The attending practitioner must be immediately notified of significant changes in condition, and the medical record must reflect the notification, response and interventions implemented to address the resident's condition 3.1-5(a)(2)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;			

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	Based on interview and record review, the facility failed to ensure the safety of residents from mental abuse and neglect for 2 of 3 residents reviewed for abuse and neglect. (Residents 81 and 87) Findings include: 1. The clinical record for Resident 81 was reviewed on 6/29/21 at 1:56 p.m. The diagnoses included, but were not limited to, Gillian-barre syndrome, acquired absence of a kidney, colostomy, protein-calorie malnutrition, difficulty walking, acquired absence of right leg below the knee, acquired absence of the left right hand, acquired absence of the left hand, peripheral autonomic neuropathy, and intervertebral disc degeneration of the lumbar region. The care plan, dated 10/6/20, indicated the resident had acute pain related to a history of Gillian-barre syndrome, neuropathy, degenerative joint disease, left below the knee amputation, and right transmetatarsal amputation. Interventions included, but were not limited to, observe for pain characteristics, onset, duration, and aggravating factors. The care plan, dated 10/6/20, indicated the resident had amputations of the bilateral hands, left below the knee amputation, and right transmetatarsal amputation. Interventions included, but were not limited to, monitor for pain management and document phantom pain. During an interview, on 6/28/21 at 9:20 a.m., Resident 81 indicated during incontinence care, CNA (Certified Nurses Aide) 8 and CNA 9, were rough with incontinence care. The resident asked	F 0600	**F 600 Free from Abuse and Neglect** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 81 continues to reside in facility. Resident has had no further concerns. Resident 87 has been identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. Interviews have been completed with residents able to be interviewed related to any concerns for abuse/neglect. Any identified concerns immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for licensed nursing staff to provide education and expectations as it relates to “Indiana Abuse, Neglect, and Misappropriation” policy. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Designee	07/23/2021

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	for a blanket and CNA 8 obtained one and re-entered the resident's room and "slammed" the blanket onto her leg. She indicated it hurt and the CNA said, he didn't understand because he had legs. After the resident complained, the CNA called her a racist. Resident 81 was very upset with his comments because she was an amputee and not a racist. During an interview, on 9/29/21 at 9:19 a.m., the RDCO (Regional Director of Clinical Operations) indicated a reportable was recently filed. CNA 8 and CNA 9 were both in Resident 81's room performing incontinence care. CNA 8 didn't provide dignity for the resident and was rude to LPN (Licensed Practical Nurse) 10. He was currently suspended and would not be brought back to work. CNA 8 was rough with incontinence care and she felt Resident 81 was not lying about the incident. She felt the environment was not good for CNA 8 to work in. No other residents on the hall had a complaint of abuse from CNA 8. LPN 10 tried to educate CNA 8 but he was not receptive. When they talked to CNA 8, he indicated he placed the blanket on the resident's feet and explained he didn't understand phantom pain. CNA 9 came into the resident's room too. She was also suspended during the investigation, but will return. CNA 8 was educated on the Code of Conduct training, but refused to sign the document. 2. Resident 87's clinical record was reviewed on 6/24/21 at 1:15 p.m. Diagnoses included, but were not limited to, chronic kidney disease, muscle weakness, lack of coordination, major depressive disorder, and cognitive communication deficit. The most recent Quarterly MDS assessment, dated 6/3/21, indicated the resident was		will interview for any concerns regarding abuse/neglect as follows: 5 interviewable residents a week x 4 weeks, then 3 interviewable residents a week x 4 weeks, then 1 interviewable resident a week x 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Administrator/DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	cognitively intact, always incontinent of bowel and bladder, and required extensive assistance of one staff member with toileting and personal hygiene. During an interview, on 6/24/21 at 11:35 a.m., Resident 87 indicated she had asked at 9:00 a.m. to be changed, because she was incontinent of urine. The nurse had told her she would have the aide come in and change her. The aide did not ever come in and change her, and the nurse then came in and changed her at 10:00 a.m. The aide did not come in to her room until 11:00 a.m. The resident stated "This CNA doesn't like me. She is verbally rude to me." The resident then began to cry and LPN 4 reassured the resident that everything would be ok, and asked her if she could identify the CNA. She indicated the name of the CNA, identifying her as CNA 15. During an observation, on 6/23/21 at 11:40 a.m., CNA 15 was in the hallway leaning against the railing entering information onto a hand held tablet. At 11:52 a.m., after finding another resident on the hall heavily incontinent of urine, LPN 4 approached CNA 15 and asked her to perform incontinent care on the resident. The CNA became argumentative, questioning the LPN in a raised and harsh tone as to why she was in her resident's rooms and would not go and change the resident. During an interview, on 6/28/21 at 9:35 a.m., Resident 87 indicated she was still upset about the incident with CNA 15. She felt she had been verbally abusive, and she tried not to think about it. The CNA never wanted to change her and often left her laying wet, on more than one occasion. The resident then pulled out her personal cell phone and showed photos she had taken of			

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herself lying in the bed, with what appeared to be a saturated area of the bed surrounding her. When she had been left in bed for a long period after having urinated it made her feel embarrassed. She had not refused care, the CNA just would not provide it.

During an interview, on 6/30/21 at 12:05 p.m., LPN 4 indicated she felt when she was speaking to Resident 87, she appeared to be afraid of CNA 15. She didn't want her to come back in her room and she was very emotional, almost in tears. She would have rather laid there wet than to have care provided by CNA 15. The aide had also been very rude to her.

The Abuse & Neglect & Misappropriation of Property policy, last revised 9/1/2017, provided on 6/22/21 at 1:00 p.m. by the Executive Director, included, but was not limited to, "Definitions ... Mental Abuse In Indiana, verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering ... Examples: Humiliation, harassment, threats of punishment or deprivation, bullying ... Neglect ... In Indiana, neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Examples: An action or lack of action that actually harms a resident such as ... 3) Failing to provide personal hygiene resulting in embarrassment, depression, or poor self-esteem ... It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents..."

These Federal tags relate to Complaints IN00354841, IN00356996, and IN00356986.

3.1-27(1)
3.1-27(3)

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F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure appropriate ADL (activities of daily living) care was provided for resident's related to showers and incontinent care, for 4 of 21 resident's reviewed for ADL care. (Residents 33, 19, 293, and 87) Finding includes: 1. The clinical record for Resident 33 was reviewed on 6/23/21 at 12:35 p.m. Diagnoses included, but were not limited to, quadriplegia, muscle weakness, polyneuorpathy, unspecified mood disorder, and generalized anxiety disorder. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 4/22/21, indicated the resident was cognitively intact; was totally dependent of two physical staff for bathing; and extensive assist of two physical staff for personal hygiene. During an interview, on 6/22/21 at 1:12 p.m., the resident indicated the staff did not always get her up to the shower and her sweatshirt was soiled and had food particles on it for three days. The resident's shower days were Sunday and Thursday on night shift, but were moved to day shift on 5/8/21 on Wednesday and Saturday. Review of the shower sheets for April, May and June 2021 indicated the resident missed her showers on the following days: 5/19, 5/22, 6/5,	F 0677	**F 677 ADL Care provided to Dependent Residents** **Corrective action for the residents found to have been affected by the deficient practice:** Resident #33 continues to reside in the facility. Resident shower/bathing preferences have been reviewed and updated in Point Click Care Resident #19 continues to reside in the facility Resident shower/bathing preferences have been reviewed and updated in Point Click Care Resident #293 has been identified as being affected by the deficient practice Resident # 87 has been identified as being affected by the deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. An audit of shower/bathing for all residents has been completed to ensure a minimum of 2 shower/bathing days have been	07/23/2021

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	6/13, 6/20 and 6/23. The resident has received only three showers during the 23 days on 6/3, 6/9 and 6/16. During an interview with LPN (Licensed Practical Nurse) 6, on 6/23/21 at 1:15 p.m., she indicated that as far as she knew when she worked, the resident was cooperative with getting her showers. During an interview with CNA (Certified Nurse Aide) 7, on 6/24/21 at 1:15 p.m., she indicated the resident did not refuse her showers, she wanted them. During an interview with RN 3, on 6/24/21 at 3:25 p.m., he indicated if staff were unable to give a resident their shower on the scheduled day it should have been re-scheduled for the next day. The staff member should talk to the resident and let them know they were unable to give the shower for whatever reason and ask the resident when they would like it given. 2. During an observation on, 6/24/21 at 11:00 a.m., Resident 19 was in bed. A strong odor of urine was observed as the resident's brief was removed by LPN 3. The resident's brief was soaked with urine, the draw sheet under the resident was saturated with brown tinged staining. LPN 4 indicated at this time, the resident was soaked through to the mattress underneath draw sheet. As the resident was rolled and the sheet and brief removed, a large, saturated area of the mattress was observed. The clinical record for Resident 19 was reviewed on 6/24/21 at 9:00 a.m. Diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms, lack of		scheduled and are reflected on their Kardex. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing and direct care staff to provide education and expectations as it relates to "ADL Care-Bathing" to include shower/bathing schedules, documentation and what to do for refusals. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit showers/bathing schedule and documentation of completed/refused shower/bathing for 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week for 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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communication, and weakness.

The most recent Admission MDS assessment, dated 6/4/21, indicated the resident was cognitively intact, always incontinent of urine, and required extensive assistance of one physical staff member with toileting and personal hygiene.

The care plan, dated 4/5/21, indicated the resident was incontinent of urine related to impaired mobility and would remain free of skin breakdown due to incontinence. Interventions included, but were not limited to, apply barrier cream as needed, check resident for incontinence, wash, rinse and dry perineum, change clothing as needed after incontinence episodes, and change incontinence brief as needed.

During an interview, on 6/24/21 at 11:15 a.m., Resident 19 indicated he had not been changed since 4:30 a.m. or 5:00 a.m., and had been laying in bed for quite some time. He had asked to be changed, but no one had changed him yet. He assumed they were busy.

During an interview, on 6/24/21 at 11:50 a.m., LPN 4 indicated there appeared to only be four residents on the hall who were fully incontinent and did not have catheters or bedside commodes. There was no reason at all why any of the residents should be fully saturated the way Resident 19 was.

3. During an observation, on 6/24/21 at 11:52 a.m., LPN 4 removed resident 293's brief. She indicated the resident was soiled, and upon removing the brief and top sheet the resident was visibly soiled through the brief to the mattress,

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which was saturated under the sheet. She went to ask CNA 15, who was at in the hallway, to assist her with resident care. The CNA became very argumentative, with a harsh tone. She asked LPN 4 why she was in her resident's room. LPN 4 indicated she was checking the resident's and needed her to come in and change the resident. CNA 4 then became more argumentative, stating, "I don't care what you need me to do. Why was you in my resident's room? Why are you concerned with my resident being wet ... That resident is always wet, [Name of Resident 19] is always wet, she's always going to be wet. She's a heavy wetter. I'm not concerned with her being wet." She indicated she had changed the residents last at 9:00 a.m., and as it was now 12:00 p.m. they were " ... supposed to be wet ..." The Scheduler approached CNA 4 and indicated he would provide care to the resident and she was needed by the ED.

During an observation of care, on 6/24/21 at 12:04 p.m., the Scheduler and LPN 6 provided perineal care for Resident 293. The resident's brief was removed, her skin was very moist and reddened with impressions of the brief on her skin. The nurse indicated the resident was soaked all the way through and did not appear to have any barrier cream on.

During an interview on 6/30/21 at 12:05 p.m. LPN 4 indicated Resident 293 had been very wet, and the first thing the aide had said was she was a heavy wetter, though she was not moving to answer call lights and was instead using a tablet. Residents should not be wet like that, they could have skin breakdown, pressure areas, excoriation, and urinary tract infections.

The clinical record for Resident 293 was

reviewed on 6/24/21 at 1:00 p.m. Diagnoses included, but were not limited to, Parkinson's disease, cognitive communication deficit, and weakness.

The most recent Quarterly MDS, dated 4/29/21, indicated the resident was severely cognitively impaired, always incontinent of urine, and was totally dependent for toileting and personal hygiene requiring assistance of two or more physical staff members.

The care plan, dated 1/29/21, indicated the resident was incontinent of urine and bowel and would remain free of skin breakdown due to incontinence. Interventions included, but were not limited to, apply barrier cream as needed, check resident for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Change incontinence brief as needed.

4. Resident 87's clinical record was reviewed on 6/24/21 at 1:15 p.m. Diagnoses included, but were not limited to, chronic kidney disease, muscle weakness, lack of coordination, major depressive disorder, and cognitive communication deficit.

The most recent Quarterly MDS assessment, dated 6/3/21, indicated the resident was cognitively intact, was always incontinent of bowel and bladder, and required extensive assistance of one physical staff member with toileting and personal hygiene.

During an interview, on 6/24/21 at 11:35 a.m., Resident 87 indicated she had asked at 9:00 a.m. to be changed because she was wet. The nurse had told her she would have the aide come in and

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change her. The aide did not ever come in and change her, and the nurse then came in and changed her at 10:00 a.m. The aide did not come into her room until 11:00 a.m.

During an interview on 6/24/21 at 12:00 p.m., LPN 6 indicated she was the nurse on the 400 hall and had earlier in the shift asked CNA 15 to change Resident 87. After she asked her, she was occupied with another resident for some time, and when she went to follow up and found the resident had not been changed, she then provided the care herself.

The Perineal Care - Male & Female policy, last revised 3/9/21, provided on 6/30/21 at 2:07 p.m., by the ED, included, but was not limited to, "... It is the policy of this facility to provide resident care that meets the psychosocial, physical, emotional needs and concerns of the residents... Perineal care is performed on residents who are unable or unwilling to maintain body cleanliness and/or who are incontinent of bowel and bladder.

The routine Resident Care policy, last revised 4/6/16, provided on 6/30/21 at 2:07 p.m. by the ED, included, but was not limited to, "... 2... Provide routine daily care by a certified nursing assistant... including but not limited to... h. Toileting, providing care for incontinence with dignity and maintaining skin integrity... 3. Unlicensed staff: b... i. Assisting or provides for personal care 1. bathing... 4. toileting..."

These Federal tags relate to Complaints IN00354841, IN00356996, and IN00356986.

3.1-38(a)(2)(A)
3.1-38(a)(3)

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, record review, and interview, the facility failed to ensure skin assessments and treatments were completed, which resulted in the development and worsening of an arterial wound for 1 of 25 residents reviewed for Quality of Care. (Resident 29) Findings include: During an observation of wound care, on 6/22/21 at 10:45 a.m., Resident 29's wound was treated per physician's order by LPN (Licensed Practical Nurse) 3 and LPN 4. The wound bed was shallow, no drainage or odor, however the surrounding tissue appeared slightly reddened. LPN 4 indicated the resident was on an antibiotic for cellulitis. The clinical record was reviewed for Resident 29 on 6/24/21 at 8:50 a.m. The resident's diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes, chronic pain, and history of venous thrombosis and embolism. The care plan, dated 10/6/20, indicated the resident had potential impairment to skin integrity related to decreased mobility, sensory impairment, constantly moist, cognitive	F 0684	**F 684 Quality of Care** **Corrective action for the residents found to have been affected by the deficient practice:** Resident #29 continues to reside in the facility. Resident has treatment order in place and documentation on the eMar of treatments completed. Resident weekly skin assessments in place. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All Residents with wounds have the potential to be affected by the deficient practice. A 30 day look back of skin assessments and wound treatment documentation has been completed. Any identified concerns have been immediately addressed. **Measures/systemic changes put into place to ensure the**	07/23/2021

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	impairment, problem with friction and shearing, and chairfast, and would not develop any new areas of skin breakdown through next review date. Interventions included, but were not limited to, follow facility protocols for treatment of injury, weekly skin assessment to include review/check of footwear. The care plan, dated 6/3/21, indicated the resident was at risk for altered skin integrity due to incontinence, immobility, type 2 diabetes, chronic kidney disease, and congestive heart failure. Interventions included, but were not limited to, administer treatments as ordered by medical provider, complete weekly skin checks, and evaluate existing wound daily for changes. The skin assessment, dated 4/21/21, indicated the resident did not have any new areas of skin impairment. The physician's order, dated 5/4/21, indicated staff were to perform a weekly skin check and complete the skin observation tool. The clinical record lacked documentation of any weekly skin checks for the week of 4/28/21 or 5/5/21. The skin grid non-pressure, dated 5/8/21, indicated the resident had a new non-pressure area to the left toe, which was first observed on 5/8/21. The assessment indicated the nurse practitioner would assess and determine, area appeared to be a dry, dark scab to the second digit of the left foot measuring 1 cm (centimeter) x (by) 1 cm. The physician's order, dated 5/8/21, indicated to apply betadine swab sticks 10% (percent) to the		**deficient practice does not recur:** The Administrator/DON/Designee held an in-service for licensed nursing staff to provide education and expectations as it relates to the "Skin and Wound Management" with focus on weekly skin assessments and documentation of treatment completion. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Wound Nurse/Designee will audit weekly skin assessments and completion of treatments being documented for 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week for 4 weeks to ensure documentation is completed for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	left second toe twice daily. The nurse's note, dated 5/8/21 at 3:47 p.m., indicated the CNA (Certified Nursing Aide) had reported a new area to the nurse after she got the resident up and ready for a visit with his family member. The nurse did not have time to complete an assessment before the family member called the nurse down to inform her of the area. The family member was upset that another nurse had not informed the nurse of the area. The wound assessment note, dated 5/11/21, indicated the resident had a new area of skin impairment measuring 0.89 cm in length by 0.89 in width. The clinical record lacked documentation of any weekly skin assessments between the dates of 5/12/21 and 6/1/21. The TAR (Treatment Administration Record) lacked documentation of daily wound assessments for day shift of the left second digit ulcer on May 10, 14, 17, 18, 24, 25, and 28. The wound assessment note, dated 5/18/21, indicated the wound measured 1.21 cm in length by 1.14 cm in width, which was an increase from the prior weeks measurements. The nurse's note, dated 5/24/21 at 2:20 p.m., indicated the resident's toe was assessed per family request and a new order was put into place to apply Santyl to a necrotic spot and hydrogel to the granulated wound bed, cover with normal saline moistened gauze and wrap with kerlix. The TAR for the month of June lacked			

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documentation of the following treatments:

- The order to assess the wound to the left foot second digit was not documented as completed on day shift on June 1, 7, 8, 11, 13, 14, 15, 17, or 21.

- The order to apply betadine 10% swab sticks to the left foot second digit every day and night shift was not documented as completed on 6/10/21, 6/11/21, and 6/13/21.

- The order to cleanse the left foot second digit with normal saline and apply calcium alginate to the ulcer and cover with a dry dressing was not documented as completed on 6/17/21 and 6/21/21.

- The order to encourage the resident to not wear shoe to left foot related to ulcer was not documented as completed on June 11, 13, or 17.

- The order to apply surgical shoe to LLE when out of bed related to ulcer was not documented as completed on June 11, 13, or 17.

The wound assessment note, dated 6/15/21, indicated the wound measured 1.57 cm in length by 1.71 cm in width, by 0.5 cm in depth and probed to bone, with exposed bone.

The nursing note, dated 6/16/21 at 2:49 p.m., indicated the CNA had reported to the nurse the resident had drainage to wound on left second toe. The wound had eschar remaining and treatment was done. Later in the day the resident's family member reported the area of eschar was off and the toe was bleeding. The MD was notified with new orders to obtain an x-ray, and new orders for an antibiotic and treatment

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change.

The nurse's note, dated 6/16/21 at 3:08 p.m., upon assessment of foot with nurse practitioner, the eschar covering to ulcer was off and the wound was observed with granulation/slough noted to wound bed. Redness to toe top of foot and swelling to foot and ankle area with purple discoloration to left lateral foot 2 cm x 5 cm.

During an interview on 6/22/21 at 11:58 a.m., the resident's family member indicated he had an ulcer on top of his 2nd toe on his left foot. Another family member had been the one to find it and had let nursing staff know. Sometimes it had no dressing in place. Before they changed it to a dressing, it had just had an order to apply betadine and at times she came in and could tell the betadine had not been applied, as it noticeably change the skin color when it had been applied.

During an interview on 6/30/21 at 11:24 a.m., RN 17 indicated the resident had went for a visit with his family member. She had taken off his shoes and socks and was inspecting his feet, and they came and got her and pointed out the wound. The CNA had got him dressed and up because it was time for his visit, and she had reported the wound to her, but had not had a chance to assess it yet. Skin assessments should be done weekly at least. When weekly skin assessments were due, they pop up on the assessments tab. It was the weekly skin check assessment. She could not see any skin assessment in the UDA (assessment tab), between 4/21/21 and 5/11/21, or between the ones she completed on 5/11/21 and 6/1/21. Orders were signed off on after they are assessed and done. She would not sign something off if she didn't do the treatment, but if the resident refused treatment, she would document that on

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	the TAR. During a confidential interview, between 6/22/21 and 6/30/21, Staff K indicated there should have been a weekly skin assessment between the assessments on 4/21/21 and 5/11/21. There should be one completed every 7 days. The assessments were not done anywhere else. The nurses should be signing the TAR when they complete a treatment or order. The TAR was a problem at the facility. They had a wound nurse, she was doing a great job, but then they got rid of the wound nurse. She had taken the load for so long; it was an adjustment for the nurses. They weren't used to doing the wounds. The most current Skin Care & Wound Management Overview policy, last revised 5/30/29, was provided, on 6/25/21 at 1:20 p.m., by the RDCO (Regional Director of Clinical Operations). The policy included, but was not limited to, " ... Skin care and wound management program includes, but is not limited to ... daily monitoring of existing wounds ... 3 ... Risk factors may include, but are not limited to ... co-morbid conditions ... friction and shear ... healed pressure ulcer ... cognitive impairment ... increased moisture on skin ... decreased activity ... impaired blood flow ... decreased sensory perception ... infection ... 6. Evaluate for consistent implementation of interventions and effectiveness at clinical meeting ... Treatment ... 3. Obtain a physician's order ... 5. Document treatment on the Treatment Administration Record ..." 3.1-37(a)			
F 0686 SS=H	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to identify and prevent the development and worsening of pressure ulcers for 7 of 9 residents reviewed for pressure ulcers, which resulted in the development of four in house pressure ulcers, and the worsening of four pressure ulcers. (Resident 60, 36, 9, 33, 81, 67, and 19) Findings include: 1. During an observation, on 6/22/21 at 11:08 a.m., the wound care nurse indicated Resident 60's left buttock wound was a Stage 4 with exposed muscle. The nurse removed the old dressing and a moderate amount brownish drainage was noted on the dressing. The wound was cleaned with NS (Normal Saline) and the peri wound was intact. The nurse packed the wound with calcium alginate and applied a foam dressing. No odor was noted. The wound was about the size of a silver dollar. The wound bed was red and no drainage was noted draining from	F 0686	**F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Corrective action for the residents found to have been affected by the deficient practice:** Resident #60 continues to reside in the facility. Resident #60 care plan has been reviewed to ensure appropriate interventions are in place to identify and prevent development and worsening of pressure ulcers. Any identified concerns were immediately addressed. Resident #36 continues to reside in the facility. Resident #36 care plan has been reviewed to ensure appropriate interventions are in place to identify and prevent development and worsening of pressure ulcers. Any identified concerns were immediately addressed.	07/23/2021

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	the wound. The nurse's admission assessment, dated 10/17/19, indicated the resident did not have any pressure injuries or skin impairments to the left buttock on admission. The clinical record for Resident 60 was reviewed, on 6/24/21 at 8:42 a.m. The diagnoses included, but were not limited to, dependence on respirator (ventilator), tracheotomy, muscle weakness, and gastrostomy. The Significant Change MDS (Minimum Data Set) assessment, dated 8/12/20 indicated the resident was severely cognitively impaired. The resident required total dependence of two physical staff for ADL's (activities of daily living). The resident was a risk for developing pressure ulcers and the resident currently had no pressure ulcers. The resident currently had pressure reducing cushions on chair and bed. The Skin Grid Pressure assessment, dated 2/23/21, indicated the resident had a new Stage III pressure injury to the left buttock, measuring 3 cm (centimeters) in length, by 3.5 cm in width by 0.1 cm in depth with serous drainage, epithelialization tissue and slough present. The wound was facility acquired. Treatment included for staff to cleanse wound with normal sailine, pat dry, apply Medi honey to the wound bed, and cover with dressing until resolved every 12 hours and as needed with a start date 2/24/21. The wound treatment, dated 2/27/21, indicated to cleanse left buttock ulcer with NS, pat dry, apply skin prep to periwound bed, apply Santyl and the calcium alginate to wound bed only, cover with boarder foam. The current care plan, dated 6/23/21, indicated		Resident #9 continues to reside in the facility. Resident #9 care plan has been reviewed to ensure appropriate interventions are in place to identify and prevent development and worsening of pressure ulcers. Any identified concerns were immediately addressed. Resident #33 continues to reside in the facility. Resident #33 care plan has been reviewed to ensure appropriate interventions are in place to identify and prevent development and worsening of pressure ulcers. Any identified concerns were immediately addressed. Resident #81 continues to reside in the facility. Resident #81 care plan has been reviewed to ensure appropriate interventions are in place to identify and prevent development and worsening of pressure ulcers. Any identified concerns were immediately addressed. Resident #67 no longer resides in the facility. Resident #19 continues to reside in the facility. Resident #19 care plan has been reviewed to ensure appropriate interventions are in place to identify and prevent development and worsening of pressure ulcers. Any identified concerns were immediately addressed. **Corrective action taken for those residents having the**	

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	the resident had a Stage III pressure ulcer to the left buttock. Interventions included, but not limited to, air mattress in place, educated resident's representative about proper skin care to prevent skin breakdown, encourage resident to frequently shift weight, evaluate skin for area of blanching or redness, evaluate ulcer characteristics, keep skin clean and well lubricated, limit sitting to 60 minutes; off load wound, reposition per facility protocol: turn side to side and front to back, while in bed every 1 to 2 hours as resident tolerated. Revision, dated 3/12/21, indicated to monitor ulcer for signs of progression or decline, notify family of new onset findings, notify provider if no sign of improvement on current wound regimen, provide wound care per treatment order. The current physician's order, dated 6/24/21, indicated, but were not limited to, cleanse with NACI (Sodium Chloride), pat dry, pack lightly with Ca+ (Calcium) Alginate, skin prep peri-wound, cover with foam dressing every day and night shift for wound care and as needed. Wound prevention indicated staff were to cleanse coccyx with soap and water, pat dry, apply skin prep to coccyx and cover with 4 x (by) 4 bordered foam. Complete daily wound assessments, document abnormalities in progress notes, and document level of pain at wound site every night shift for wound management of the left buttock. The Skin Grid Pressure assessment, dated 3/4/21, indicated the left buttock wound had deteriorated. The measurements were length 4.5 cm, width 3.5 cm, depth 0.1 cm. The wound was classified as unstageable. The wound care orders, dated 3/4/21, included,		**potential to be affected by the same deficient practice:** All residents at risk for or who currently have pressures ulcers have the potential to be affected by the deficient practice. An audit of all resident Braden scores has been completed to determine who is at risk for pressure ulcers and an audit of the current wound log to determine who currently has pressure ulcers. Further, an audit has been completed to ensure current and appropriate interventions are in place to prevent new or worsening pressure ulcers. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the “Skin Care & Wound Management Overview” and prevention of new or worsening wounds to include appropriate completion of Braden Scores. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Wound Nurse/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week	

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	but were not limited to, Santyl Ointment 250 units/gm (grams), apply to left buttock topically every day shift for wound care. The order was discontinued 3/5/21. The night shift treatment orders included, cleanse left buttock ulcer with NS, pat dry, apply skin prep to peri wound only, apply Santyl and then calcium alginate to wound bed only, and cover with a foam border. The discontinued date was 4/23/21. The Skin Grid Pressure assessment, dated 3/11/21, indicated the stage III pressure wound to left buttock had deteriorated. The measurements were 5 cm in length, by 5 cm in width, by 0.1 in depth with granulation tissue, eschar and slough were present. The wound bed was reddened, necrotic and white tissue with serous drainage. No tunneling was noted. The wound was not improving with current treatment. Treatment recommendations were to continue current treatment orders. The Wound Evaluation form, dated 3/11/21, indicated A new pressure wound to the coccyx, measuring 1 cm in length, by 0.5 cm in width, 0.1 cm in depth, unstageable, eschar present, necrotic wound bed, and serous drainage. Treatment included a border foam and skin prep every three days. The Wound Evaluation form, dated 3/18/21, indicated the resident has a stage III pressure wound to the coccyx , measuring 0.9 in length, by 0.6 in width, by 0.1 in depth, wound bed pink and reddened, medium amount serous drainage, surface 0.54 cm exudate: moderate serous granulation tissue 100%. Treatment included a border foam and skin prep every three days. The Skin Grid Pressure assessment, dated		for 4 weeks to ensure the resident has an accurate Braden Score and current/appropriate wound prevention interventions to prevent new or worsening pressure ulcers. This will occur for no less than 3 months and compliance is maintained. The DON/Wound Nurse/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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3/25/21, indicated the wound had improved, measuring 5.5 cm in length, by 5.5 cm in width, by 3 cm in depth, granulation tissue, slough present, wound bed reddened and yellow, with serous drainage. Surface area 30.25 cm 2, 40% slough, 60% granulation. The wound was in an inflammatory stage and was unable to progress to a healing phase because of biofilm. Bedside excisional debridement was completed by the wound doctor. Tunneling was present. Treatment included skin prep to peri-wound, santyl and calcium alginate to wound bed and cover with bordered foam.

The Skin Grid Pressure assessment, dated 4/8/21, indicated the had wound improved, measuring 6 cm in length, by 4 cm in width, by 2.5 cm in depth, granulation tissue and slough present, serous drainage. Surface area 24.00 cm 2 (square centimeters) 30% slough 70%. Surface area 24.00 cm 2 30% slough 70% granulation tissue. The wound was in an inflammatory stage and was unable to progress to the healing phase due to biofilm. Excisional debridement completed at bedside by the wound care doctor. Treatment continues with Santyl. Calcium alginate and foam dressing.

The Wound Evaluation form, dated 4/8/21, indicated the stage II pressure wound to the coccyx was healed.

The Skin Grid Pressure assessment, dated 4/22/21, indicated the left buttock pressure wound was a stage IV, measuring 6 cm in length, by 4 cm in width, by 3 cm in depth, granulation tissue and slough present, reddened and yellow wound bed, serous drainage. The surface area 24.00 cm 2, 10% slough, 90% granulation. The wound was an inflammatory stage, and unable to

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	progress to healing phase due to biofilm. Excisional debridement completed at bedside by the wound care doctor. Treatment continues with Santyl, calcium alginate and a foam dressing. The Wound Evaluation form, dated 4/27/21, indicated the first assessment of existing wound by new care provider. Stage IV pressure ulcer acquired in house. Moderate amount serosanguinous drainage, tunneling at 12:00, measuring 3.20 cm in depth, exposed muscle and exposed bone, attached edges. Treatment includes calcium alginate and border foam. Ensure compliance with turning protocol and speciality bed. The Wound Evaluation form, dated 5/5/21, indicated left buttock pressure wound was a stage IV, tunneling at 12:00, 80% granulation 20% slough, depth 2.50 cm, pack iodaform in tunnel, friable, exposed muscle, and exposed bone, moderate serosanguinous drainage, cleanse with normal saline, calcium alginate border foam. Ensure compliance with turning protocol, wedge/foam cushion for offloading, and speciality bed. The Wound Evaluation form, dated 6/1/21, indicated left buttock pressure ulcer was a stage IV measuring length 2.75 cm, width 1.60 cm, and depth 2.50 cm. Tunneling at 12:00 and packed tunnel with iodaform. The wound had exposed muscle and improving. There was a moderate amount of serosanguinous drainage and no odor. Treatment included cleanse wound with NS, calcium alginate and a border foam dressing. Ensure compliance with turning protocol, wedge/foam cushion for off loading and speciality bed.			

During an interview, on 06/22/21 at 11:03 a.m., the resident's family member indicated he was the resident's essential caregiver. He assisted with the resident's care, but could not turn her due to his health condition. He was the one that found the pressure wound on the resident's left buttock. He indicated the wound was black and about the size of a soda can. He asked the CNA (Certified Nurses Aide) what it was and she left the room and got the resident's nurse, and when the nurse saw the wound she stated, "Oh my God."

During an interview, on 6/22/21 at 11:08 a.m., the wound care nurse from a wound care agency indicated the resident's stage III wound was facility acquired. The resident's wound was a Stage 4 with 100% granulation with exposed muscle. The measurements included depth 3 cm and tunneling, width 1.56 cm and length 1.07 cm. There was no foul odor and a moderate amount serosanguinous drainage. The wound nurse indicated the wound was healing and the peri wound was intact.

During an interview, on 6/30/21 at 9:50 a.m., RN 17 indicated the residents with pressure ulcer should have a special mattress, cushion in wheelchair, use Braden Scale to identify potential for skin breakdown, weekly skin assessments, and CNA reporting any skin issues to the nurse. The facility had a wound care nurse. The skin assessment on Feb 17, 2021 indicated the resident did not have any skin issues. The stage III pressure ulcer was found on February 23, 2021 with the next skin assessment. If the resident had a skin issue present before the wound became a stage III it should have been found.

2. The clinical record for Resident 36 was reviewed on 06/23/21 at 2:09 p.m. The diagnoses

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	included, but was not limited to, type 2 diabetes mellitus, atrial fibrillation, atherosclerotic heart disease, muscle weakness, cognitive communication deficit, dysphagia, tobacco use, dementia, hyperlipidemia, and chronic ulcerative proctitis. The Quarterly MDS assessment, dated 4/28/21, indicated the resident was alert and oriented. The resident required the assistance of one physical staff member for mobility and ALS's. The resident was at risk for pressure ulcers and currently had one unstagable pressure ulcer. The care plan, dated 2/1/21, indicated the resident was at risk for impaired skin integrity. The interventions included, but were not limited to, approach: Educate Resident / Representative about proper skin care to prevent skin breakdown, causes of pressure ulcers, encourage the resident to frequently shift her weight, offload her heels, turn every 2 hours. Position the resident to reduce causes of friction or shear, provide skin care per facility guidelines, utilize pillows or foam wedges to avoid direct contact with bony prominences and utilize pressure relieving devices on appropriate surfaces. The Weekly Skin Checks lacked documentation on 2/5/21, 2/12/21, 2/19/21, 2/26/21, 3/12/21, 3/19/21, 3/26/21, 4/2/21, 4/9/21, 4/16/21, and 5/4/21 of any new skin conditions. The Skin Grid Pressure evaluation, dated 4/20/21, indicated the resident had a new pressure area to the left heel. The suspected deep tissue injury measured 4.5 cm long by 2.5 cm wide. The Wound Evaluation, dated 4/27/21, indicated			

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the resident's pressure ulcer to the left posterior heel measured 1.46 cm long, by 1.73 cm wide, by 0.10 cm deep. The wound had 100 % granulation and was a Stage 3 pressure ulcer. The wound bed was friable with hyper-granulation, moderate serosanguinous drainage. The dressing change frequency was three times per week, cleanse the wound with normal saline, pressure reduction with offloading, ensure compliance with turning protocol, specialty bed, dressings of Medihoney, with a secondary dressing of bordered foam.

The Wound Evaluation, dated 5/25/21, indicated the wound to the left posterior heel measured 0.66 cm long by 0.70 cm wide by 0.20 cm deep. There was 70% granulation, 30% slough/eschar and was friable. The treatment orders continued with a specialty bed.

The Wound Evaluation, dated 6/1/21, indicated the wound to the left posterior heel measured 0.95 cm long by 0.69 cm wide by 0.10 cm deep. There was 100% granulation and the wound bed was friable. The treatment orders were to cleanse wound with normal saline, pressure reduction/offloading, ensure compliance with turning protocol, specialty bed, dressings of skin prep. The wound was improving.

The Wound Evaluation, dated 6/15/21, indicated the wound to the left posterior heel measured 0.77 cm long by 0.83 cm wide by 0.20 cm deep. There was 95% granulation and 5 % slough/eschar and the wound bed was friable (easily crumbled or pulverized) and the wound was worsening. The periwound was macerated. The dressing change frequency twice daily, cleanse the wound with wound cleanser, pressure reduction/offloading, ensure compliance with

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turning protocol, wedge/ foam cushion for offloading, specialty bed, dressings of skin prep. The secondary dressings were for a bordered gauze.

The Wound Evaluation, dated 6/22/21, indicated the wound to the left posterior heel measured 0.19 cm long by 0.08 cm wide, by 0.20 cm deep. There was scant serosanguinous drainage, the odor was malodorous. The dressing was to be changed every other day, cleanse the wound with normal saline, ensure compliance with turning protocol. The dressings were for Medihoney with a secondary bordered gauze setting.

The Treatment Administration Records indicated for April 2021, the following missed documentation:

- Pressure reducing mattress every night shift for prevention. No documentation on 4/9/21.

- Daily Wound assessment not documented as completed on 4/28/21.

- Heel lift boots at all times every shift for wound management. Not documented as completed on 4/28/21.

The Treatment Administration Records indicated for May 2021, the following missed documentation:

- Daily Wound assessment not documented as completed on 5/22/21, 5/26/21 and 5/27/21 on the day shift and 5/7/21 and 5/21/21 on the night shift.

- Wound care; left heel-cleanse with normal saline, pat dry, apply Medihoney to wound bed

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and cover with bordered foam every shift every Monday, Wednesday, Friday for wound care. Not documented on 5/7/21 and 5/21/21 on the night shift.

The Treatment Administration Records indicated for June 2021, the following missed documentation:

- Daily Wound assessment not documented as completed on 6/3/21, 6/11/21, 6/8/21, 6/11/21, and 6/14/21 on the day shift.

3. The clinical record for Resident 9 was reviewed on 6/23/21 at 2:00 p.m. The diagnoses included, but were not limited to, atherosclerotic heart disease, chronic obstructive pulmonary disease, dementia, cervical spinal stenosis, chronic pain syndrome, iron deficiency anemia, dysphagia, hyperlipidemia, and benign prostatic hyperplasia with lower urinary tract symptoms.

The quarterly MDS assessment, dated 6/24/21, indicated the resident was alert and oriented. The resident required the extensive physical assistance of two staff members for bed mobility. The resident was at risk for pressure ulcers and currently had three unstagable pressure ulcers.

The care plan, dated 3/17/21, indicated the resident was at risk for altered skin integrity related to immobility. The interventions were to administer treatments as ordered by the medical provider; apply appropriate pressure reducing appliances to bed and to wheelchair; complete the skin at risk assessment upon admission, readmission, quarterly, and as needed and complete Weekly Skin checks.

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	The care plan, dated 3/17/21, indicated the resident was at risk for impaired skin integrity. The interventions were to evaluate the skin for areas of blanching or redness, monitor for moisture, and apply barrier product as needed; position the resident to reduce causes of friction or shear; provide skin care per facility guidelines and as needed; and utilize pressure relieving devices on appropriate surfaces. The nurse's note, dated 3/16/21 at 3:06 p.m., indicated the resident's skin was wet, dry, and intact with a small area or excoriation noted to the mid spine and left mid back. The Skin Admission Assessment, dated 3/16/21, indicated the resident had no skin issues. The Physician's Order, dated 3/16/21, indicated for a pressure reducing mattress to bed every shift and a pressure reducing cushion to chair every shift for prevention. The Physician's Order, dated 3/17/21, indicated for a nutritional supplement drink plus 237 ml (milliliters) two times a day for supplement and to float heels every shift for preventative. The Weekly Skin Assessment, dated 3/23/21, indicated the resident had no skin issues. The Skin Grid Non-Pressure assessment, dated 3/26/21, indicated the right iliac crest had a friction or shear measuring 2 cm long, by 2 cm wide, by 0 depth. The abrasion was pale red or pink with bloody exudate with small drainage. The treatment was to cleanse the area with normal saline, pat dry, and apply a border foam dressing.			

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The Grid Non-Pressure assessment, dated 3/26/21, indicated the upper mid vertebrae had a friction or shear measuring 2 cm long, by 2 cm wide, by 0 deep. The abrasion was pale red or pink with bloody exudate and a small amount of drainage. The treatment was to cleanse the area with normal saline pat dry, and apply border foam.

The Skin Grid Non-Pressure assessment, dated 3/26/21, indicated an all over skin moisture associated breakdown of the coccyx. The wound was pale red or pink. The treatment was to cleanse the wound with normal saline, pat dry, and apply prescription butt cream to the affected area, turn and reposition every two hours.

The Physician's Order, dated 3/26/21, indicated the resident was to be on a low air loss mattress every shift for skin breakdown prevention.

The Skin Grid Non-Pressure assessment, dated 4/2/21, indicated the upper mid vertebrae had a friction or shear, measuring 2 cm by 2 cm by 0 deep. The abrasion was yellow tan with serous exudate. This shearing wound bed had slough in it. A consult with the medical doctor was initiated. The current orders of the foam dressing were continued.

The Skin Grid Non-Pressure assessment, dated 4/2/21, indicated the area to the coccyx measured 0.5 cm long by 1.2 cm wide. The area was red, moist, and grainy, with optimal granulation, and serous exudate. The shearing wound extended to the right buttock. The wound was not focused on the coccyx. The medical doctor was consulted for management due to the location. The current order of the foam dressing was continued.

The Skin Grid Non-Pressure assessment, dated 4/2/21, indicated the right iliac crest friction or shearing was resolved.

The Skin Grid Pressure assessment, dated 4/8/21, indicated the area to the coccyx measured 0.5 cm long, by 0.5 cm wide, by 0.1 cm deep and was a Stage II. Granulation tissue was present, with a reddened wound bed, serous exudate, and medium drainage. This wound was classified as a shearing wound and extended to right buttock. Wound was now focused in coccyx. The medical doctor was consulted to ensure improvement and resolution of wound. The medical doctor re-classified wound as a stage II pressure injury.

The Skin Grid Pressure assessment, dated 4/8/21, indicated the upper mid vertebrae measuring 1 cm long, by 1 cm wide, by 0.1 cm deep and was a stage II. There was redness with granulation tissue present with serous exudate and medium drainage. The wound was classified as a shearing wound. The medical doctor was consulted to ensure improvement and resolution. The doctor reclassified the wound as a stage II pressure injury.

The Skin Grid Pressure assessment, dated 4/15/21, indicated the wound to the coccyx measured 0.5 cm long, by 0.3 cm wide, by 0.1 cm deep and was a stage II. Granulation tissue was present with a reddened wound bed, blood tinged exudate, and medium drainage.

The Skin Grid Pressure assessment, dated 4/22/21, indicated the area to the upper mid vertebrae measured 0.5 cm long by 0.5 cm wide by 0.1 cm deep and was a stage II. The area was

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	reddened with granulation tissue present and a serous exudate with medium drainage. The treatment ordered was to apply a foam dressing. The Weekly Skin Checks, dated 5/5/21 and 5/12/21, indicated the treatment was continued to the buttocks as ordered. A Physician's Order, dated 5/5/21, indicated staff were to complete weekly head to toe skin assessments. The nurse must complete the skin observation tool. Document any new areas on the form and complete a change in condition every day shift every Wednesday. The Weekly Skin Check, dated 5/15/21, indicated the MASD (Moisture Associated Skin Damage) to the sacrum was a new non-pressure skin condition. A Physician's Order, dated 5/25/21, indicated to encourage the resident to turn and reposition every two hours, every shift for preventative. A Physician's Order, dated 6/1/21, indicated to apply protective boots to bilateral heel related to prevention every shift for prevention. A Physician's Order, dated 6/2/21, indicated to apply skin prep to bilateral heels every shift for wound care. Daily wound assessment. Document abnormalities in progress notes. Document level of pain at wound site every shift for wound management to the left heel. A Physician's Order, dated 6/2/21, indicated perform wound care of the mid back with wound cleanser, pat dry, apply skin prep to peri-wound and cover with foam every day shift for Wound care.			

The Skin/Wound Notes, dated 6/8/21 and 6/15/21, indicated a comprehensive skin and wound evaluation for MASD to the sacrum, left heel DTI (deep tissue injury) and mid upper back. The wounds to the right mid back (previously identified as right upper and lower back) stage 2 pressure ulcer reopened, left heel DTI, MASD sacrum, DTI to right lateral ankle.

The nurse's note, dated 6/15/21 at 5:45 p.m., indicated a new order per the medical doctor and verified per the nurse practitioner for a pharmacy butt cream. Apply to buttocks topically every day and night shift 15 grams, Zinc Oxide 10% Ointment 15 grams, Nystatin Ointment 15 grams, hydrocortisone 1% Ointment 15 grams, Bacitracin Ointment and apply to the bilateral buttock topically every 8 hours as needed.

The Treatment Administration Records for April 2021 indicated the following missed documentation:

- Resident to be on Low Air Loss Mattress every shift for skin breakdown prevention. Not documented as completed on 4/15/21 and 4/29/21 on the day shift and on 4/27/21 on the night shift.

- Turn and reposition every two hours every shift for preventative. Not documented and completed on 4/15/21 and 4/29/21 on the day shift and on 4/27/21 on the night shift.

- Apply House barrier cream to the bilateral buttocks every shift for prevention. Not documented as completed on 4/15/21 and 4/29/21 on the day shift and on 4/27/21 on the night shift.

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- Float heels every shift for preventative. Not documented as completed on 4/15/21 and 4/29/21 on the day shift and on 4/27/21 on the night shift.

- Provide wound care to the coccyx of cleansing with normal saline, pat dry, apply skin prep to peri-wound and cover with bordered foam every shift for wound care. Not documented as completed on 4/15/21.

- Provide wound care for the right mid-upper back by cleansing with normal saline, pat dry, apply skin prep to peri-wound and cover with 4 x 4 bordered gauze every day shift for wound care. Not documented as completed on 4/15/21.

- The weekly head to toe skin assessments by the nurse completed on the skin observation tool. Document any new areas on the form and complete a change in condition every night shift. Not documented as completed from 4/1/21 to 4/28/21. The order was discontinued on 4/29/21.

- Daily Wound assessments for the coccyx were not documented as completed on 4/15/21. The order was discontinued on 4/23/21.

- Daily Wound assessments for the right mid-upper back were not documented as completed on 4/15/21 and 4/29/21. The order was discontinued on 5/25/21.

The Treatment Administration Records for May 2021 indicated the following missed documentation:

- Daily Wound assessment of the sacrum not documented as completed on 5/24/21, 5/25/21,

5/28/21, and 5/31/21. The order was discontinued on 6/15/21.

- Cleanse wound to Sacrum with normal saline; pat dry, apply skin prep to peri-wound, apply Medihoney to wound bed, cover with border foam gauze every shift for wound management. Not documented as completed on 5/31/21. The order was discontinued on 6/1/21.

- Daily Wound assessment of the right mid-upper back was not documented as completed on 5/10/21, 5/14/21, 5/17/21, 5/18/21, and 5/24/21. The order was discontinued on 5/25/21.

The Treatment Administration Records for June 2021 indicated the following missed documentation:

- The Resident was to be on a Low Air Loss Mattress every shift for skin breakdown prevention. Not documented as completed on 6/11/21 and 6/13/21 on the day shift and 6/12/21 on the night shift.

- Daily Wound assessment for the left heal was not documented as completed on 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/14/21, 6/15/21, and 6/21/21 on the day shift and on 6/12/21 on the night shift.

- Staff were to encourage the resident to turn and reposition every two hours every shift for preventative. Not documented as completed on 6/11/21 and 6/13/21 on the day shift and on 6/12/21 on the night shift.

- Float the resident's heels every shift for preventative. Not documented as completed on 6/11/21 and 6/13/21 on the day shift and on 6/12/21 on the night shift.

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- Daily Wound assessment of the sacrum was not documented as completed on 6/1/21, 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/14/21, and 6/15/21 on the day shift and on 6/12/21 on the night shift.

- Provide wound Care for the mid back of cleansing the area with wound cleanser, pat dry, and apply skin prep to peri-wound and cover with foam every day shift for wound care. Not documented as completed on 6/11/21 and 6/13/21.

- Staff were to apply protective boots to bilateral heel related to prevention every shift for prevention. Not documented as completed on 6/11/21 and 6/13/21 on the day shift and on 6/12/21 on the night shift.

- Staff were to apply skin prep to bilateral heels every shift for wound care. Not documented on 6/11/21 and 6/13/21 on the day shift and on 6/12/21 on the night shift.

- Daily Wound assessment for the right mid-upper back were not documented as completed on 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/14/21, 6/15/21, and 6/21/21.

During a confidential interview, between 6/22/21 and 6/24/21, Staff F indicated the pillow had not been placed correctly under Resident 9, to relieve the pressure under the resident's back. He felt there had been an increase of pressure ulcers since the wound nurse was no longer working at the facility. The pressure ulcer increase was due to a staffing issue. The nurses were used to the CNAs turning and repositioning the residents and the wound nurse caring for them. The staff weren't using the wedges correctly.

4. The clinical record for Resident 33 was reviewed, on 6/24/21 at 9:00 a.m. The diagnoses included, but was not limited to, nicotine dependence, polyneuropathy, muscle weakness, acute embolism and thrombosis of deep veins of the right upper extremity, quadriplegia, sepsis, pressure ulcer of the sacral region, acute kidney failure, and schizoaffective disorder.

The care plan, dated 1/18/21, indicated the resident was at risk for impaired skin integrity. The interventions included, but were not limited to, education to prevent skin tears and abrasions, education on use of lift device, and utilizing pressure reducing devices.

The care plan, dated 4/27/21, indicated the resident had impaired skin integrity or was at risk for altered skin integrity. The interventions indicated to administer treatments as ordered by medical provider; apply appropriate pressure reducing appliances to bed and to wheelchair; complete skin at risk assessment upon admission, readmission, quarterly, and as needed; complete weekly skin checks; and evaluate existing wound daily, for changes such as redness, edema, drainage, pain, foul odor.

The Clinical Admission Evaluation, dated 1/15/21, indicated the resident had a Stage IV pressure ulcer to the coccyx and unstageable area to the left Ischium.

The Skin Grid Pressure assessment, dated 1/21/21, indicated the Stage IV pressure ulcer to the sacrum was first observed on 1/15/21 and measured 4.5 cm long, by 7.5 cm wide, by 3.0 cm deep and was obtained prior to admission. The wound bed was red or pink with moderate

blood tinged exudate and medium drainage. The surface area had 100 % granulation.

The Skin/Wound note, dated 2/4/21, indicated new orders were given per the medical doctor to discontinue the wound vac. Cleanse the sacral ulcer with normal saline, pat dry, apply skin prep to the peri wound bed, apply calcium alginate, and cover with border foam.

The Skin Grid Pressure assessment, dated 2/11/21, indicated the stage IV wound to the sacrum had deteriorated. The wound measure 6 cm long by 8 cm wide by 3 cm deep.

The Skin Grid Pressure assessment, dated 2/18/21, indicated the stage IV wound was still deteriorating and measured 6.0 cm long by 8.5 cm wide by 3.0 cm deep. The exudate was serous with medium drainage. New orders were given per the medical doctor to cleanse the sacral ulcer with Anasept spray, pat dry, apply skin prep to the peri wound bed, apply calcium alginate with silver to the wound bed only, and cover with border foam every shift for wound care.

The physician's note, 2/21/21, indicated the resident not had a fever of 102.3 degrees and a heart rate of 124. The sacral ulcer had a foul smelling odor. The plan was to obtain an ulcer wound culture. Start intravenous fluids with vancomycin and zosyn. The resident had sepsis, septic shock, and was transferred to the emergency room.

The Skin Grid Pressure assessment, dated 3/2/21, indicated a new suspected deep tissue injury to the left heel which was acquired at the hospital. It measured 3.0 cm long, by 3.0 cm wide, by 0 depth. There was also a new SDTI to

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	the right heel which measured 3.0 cm long, by 4.0 cm wide, by 0 depth. The Skin Grid Pressure assessment, dated 3/4/21, indicated the stage IV pressure ulcer to the sacrum measured 8.0 cm long, by 14 cm wide, by 3.0 cm deep. Documented as improved. New treatment orders were recommended. The right heel was now a stage II and measured 2.5 cm long, by 3.5 cm wide, by 0 depth. The Skin Grid Pressure assessment, dated 3/11/21, indicated the left heel SDTI measured 1.0 cm long, by 1.5 cm, wide by 0 depth. The Skin Grid Pressure assessment, dated 3/18/21, indicated the stage IV had deteriorated and measured 8.7 cm long, 11.5 cm wide, and 3.0 cm deep. The Skin Grid Pressure assessment, dated 3/4/21, indicated the right heel SDTI measured 3.5 cm long by 2.5 cm wide by 0 and had deteriorated. The Skin Wound note, dated 3/25/21, indicated a late entry from the Interdisciplinary Team wound note: Resident continued to be followed by the medical doctor for treatment of the stage 4 to the sacrum, which had improved, the stage 3 to the right heel which had improved, and the SDTI to the left heel which was unchanged. All interventions were to remain the same at this time. Will continue to follow weekly for wound management. The Skin Grid Pressure assessment, dated 4/1/21, indicated the right heel pressure ulcer was now a stage III and measured 1.5 cm long,			

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	by 2.5 cm , by 0.1 cm deep. The stage IV to the sacrum measured 8.0 cm long, by 10.5 cm wide, by 4.5 cm deep and was improving.The Skin Grid assessment, dated 4/15/21, indicated the stage III pressure ulcer to the right heel had healed.The 4/19/21 Weekly Skin Check indicated no skin conditions or changes, ulcers, or injuries.The Skin Grid assessment, dated 4/22/21, indicated the stage IV to the sacrum measured 8.0 cm long, by 10 cm wide, by 4.0 cm deep. The surface area had 20% thick adherent devitalized necrotic tissue with 80% granulation and had improved. Excisional debridement completed at bedside by the medical doctor. The peri wound was pink, with no odor, a medium amount of drainage, blood tinged exudate, granulation tissue and eschar were present.The Wound Evaluation, dated 5/4/21, indicated the stage IV sacral pressure ulcer measured 5.88 cm long, by 5.06 cm wide, by 4.50 cm deep. Tunneling was 2.00 cm deep at 1 to 3 o'clock. The surface area had 100 % granulation and the wound was Stable. There was exposed muscle and exposed bone. There was moderate serosanguinous drainage. There was malodorous odor. The orders were for daily treatments to cleanse the wound with wound cleanser, calcium alginate, secondary dressing of a bordered foam. pressure reduction/offloading, ensure compliance with turning protocol, and			

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	specialty bed. Weekly Skin Check, dated 5/8/21, indicated the wound to the sacrum was a stage IV with undermining and copious amounts of putrid, foul drainage. Call out to on-call nurse practitioner new order for Clindamycin 300 mg four times daily for 14 days, Florastor 250 mg two times daily for 4 days, and antibiotic versus every eight hours for 14 days.The Wound Evaluation, dated 6/1/21, indicated the stage IV pressure ulcer to the sacrum measured 8.66 cm long, by 4.62 cm wide, by 4.00 cm deep. There was 4.0 cm tunneling at 3 o'clock.The surface area had 100 % granulation. The treatment was to lightly pack the wound with Dakin's fluffed kerlix. There was a heavy amount of serosanguinous drainage. Apply a bordered foam dressing, Kling/Kerlix, Surgical debridement done to ulcer site. Minor surgery with an identified risk factor. Devitalized epidermis, dermis subcutaneous, muscle, and bone tissue removed including, but not limited to biofilm, to keep the ulcer in an active state of healing. The site was cleaned, bleeding was controlled via hemostasis, as per procedure documentation, dressing was applied, and the ulcer was covered with ordered dressing.The Wound Evaluation, dated 6/22/21, indicated the stage IV to the sacrum measured 7.23 cm long, by 4.24 cm wide, by 3.00 cm deep. The tunneling was at 2.90 cm at 3 o'clock, The surface area had 95 % granulation, with 5			

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	% slough/eschar. Factors Affecting Healing: Patient has frequent incontinence which can decrease healing rate of wound. Recommend providing incontinence care as needed, as needed. Increased moisture at wound site can promote poor prognosis of wound healing. Please keep wound site always covered and avoid contamination with feces.5. The clinical record for Resident 81 was reviewed on 6/24/21 at 10:04 a.m. The diagnoses included, but were not limited to, Guillain-Barre Syndrome, acquired absence of a kidney, colostomy, protein-calorie malnutrition, gastrostomy, neuromuscular dysfunction of bladder, anemia, extended spectrum beta lactamase (ESBL), urogenital implants, bacteremia, muscle weakness, dysphagia, acquired absence of the right leg below the knee, acquired absence of the right hand and left hand, weakness, peripheral vascular disease, cognitive communication deficit, and interferer disc degeneration of the lumbar region. The annual MDS assessment, dated 5/27/21, indicated the resident was alert and oriented. The resident required the extensive assistance of two physical staff members for bed mobility. The resident was at risk for pressure ulcers and currently had one Stage III pressure ulcer. The care plan, dated 12/14/17 and last revised on 10/6/20, indicated the resident had the potential for impairment to the skin integrity related to impaired mobility			

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	with Guillain-Barre. The interventions included, but were not limited to, needed pressure reducing cushion to protect the skin while up in a chair, pressure reducing mattress to protect the skin while in bed, keep skin clean and dry, and perform weekly skin assessment to include review/check of footwear.The care plan, dated 3/8/21, indicated the resident was at risk for altered skin integrity. The interventions included to administer medications as ordered, monitor for side effects and effectiveness. Administer treatments as ordered by medical provider. Apply pressure relieving/reducing mattress to bed and a cushion to the wheelchair. Complete skin at risk assessment upon admission, readmission, quarterly, and as needed. Complete Weekly Skin checks. Evaluate existing wound daily for changes. The Weekly Skin Checks, dated 1/4/21 and 1/11/21, indicated no skin issues.The Weekly Skin Check, dated 1/18/21, indicated a pharmacy butt cream to the buttocks for preventative measures. Treatment to the feet was in place as a preventative measure.The Weekly Skin Check, dated 2/8/21, indicated no skin issues. The Weekly Skin Check, dated 2/15/21, indicated a new red rashy area to the abdomen. On 2/22/21, the resident was sent out to the hospital. A nurse's note, dated 2/26/21, indicated the resident was readmitted to the facility at 7:00 p.m.			

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	She had a Stage II pressure to the coccyx, measuring 1.25 cm long and 0.5 cm wide and a Stage II pressure ulcer to the mid upper back, measuring 2 cm long and 1 cm wide. The nurse's note, dated 3/5/21, indicated the resident had new skin areas. There was no description documented.The nurse's note, dated 3/11/21, indicated the resident was sent to the emergency room for increased confusion.The Re-Admission Skin Evaluation, dated 5/4/21, indicated an unstageable wound to the right ischium, measuring 3.0 cm long by 2.0 cm wide by 0.1 cm deep. Slough was present. The wound bed was yellow. No exudate was present. The peri wound's appearance was pink or normal for ethnic type.The Admission Skin Evaluation, dated 5/4/21, indicated a stage I to the sacrum, measuring 4 cm long by 3 cm wide. Granulation tissue was present. Reddened wound bed. No exudate. Pharmacy butt cream was ordered.The Skin/Wound Note, dated 5/6/21 at 6:22 p.m., indicated the Comprehensive Skin and Wound evaluation, for new admission to the facility, for a pressure ulcer of the left ischium and a deep tissue injury to the sacrum. The Wound Evaluation, dated 5/6/21, indicated the unstageable of the left Ischium, measured 1.40 cm long, by 1.58 cm wide, by 0.20 cm deep. The dressing was to be changed daily, cleanse wound with normal saline, Santyl dressing, with a secondary dressing of			

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	bordered foam.The Wound Evaluation, dated 5/6/21, indicated the SDTI to the sacrum, The periwound had erythema. A pharmacy butt cream was ordered twice daily. The Wound Evaluation, dated 5/11/21 indicated the unstageable to the left ischium measured 1.79 cm long, by 1.20 cm wide, by 0.20 cm deep. The surface area had 10 % granulation, with 90 % slough/eschar, Dressing changes daily to cleanse wound with normal saline, Santyl dressing, with a secondary dressing of bordered foam.The Wound Evaluation, dated 5/25/21, indicated the SDTI to the sacrum healed.The Wound Evaluation, dated 6/1/21, indicated the stage III to the left ischium, measuring 0.29 cm long, by 0.45 cm wide, by 0.10 cm deep. The surface area had 100 % granulation with scant serosanguinous drainage. The dressing changes were to be performed daily, cleanse the wound with normal saline, Medihoney dressing, secondary dressing of bordered gauze.The Wound Evaluation, dated 6/8/21, indicated The stage III to the left buttock reopened on 6/3/21 due to trauma. The surface area had 100 % granulation with moderate drainage. Dressing changes were to be performed daily, cleanse wound with wound cleanser, secondary dressing of bordered foam. Ensure compliance with turning protocol, wedge/foam cushion for offloading, mattress overlay.The Wound Evaluation,			

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	dated 6/15/21, indicated stage III to the left buttock, measured 4.45 cm long, by 1.52 cm wide, by 0 depth. The wound bed was friable, 100 % epithelializationModerate drainage. The dressing changes were ordered daily, cleanse wound with wound cleanser, secondary dressing of bordered foam. Ensure compliance with turning protocol, wedge/foam cushion for offloading, mattress overlay.The Treatment Administration Records for January 2021 indicated the following missed documentation:- Pressure reducing mattress to bed every shift for prevention was not documented on 1/27/21.The Treatment Administration Records for May 2021 indicated the following missed documentation:- Daily Wound assessment for the left ischium were not documented as completed on 5/14/21 and 5/21/21.- Santyl Ointment 250 unit/gm applied to left ischium topically every day shift for wound care, cleanse wound to left ischium with wound cleanser, pat dry, apply skin prep to peri-wound, apply Santyl to wound bed and cover with bordered foam was not documented as conducted on 5/14/21 and 5/21/21.- Daily wound assessment for the coccyx was not documented as completed on 5/14/21 and 5/21/21 on the day shift and 5/14/21 on the night shift.- Pressure relieving cushion to wheelchair every shift was not documented as completed on 5/21/21 on			

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	the day shift.- Staff to turn and reposition the resident every two hours every shift for Skin Care Prevention was not documented as completed on 5/21/21 on the day shift and 5/14/21 on the night shift. The Treatment Administration Records for June 2021 indicated the following missed documentation:- Daily Wound assessment for the left ischium was not documented as completed on 6/4/21, 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/14/21, 6/15/21, 6/17/21 and 6/21/21.- Daily Wound assessment for the upper back was not documented as completed on 6/4/21, 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/14/21, 6/15/21, 6/17/21 and 6/21/21.- The resident was to have weekly head to toe skin assessment completed. Nurse must complete the skin observation tool and document any new areas on the form and complete a change in condition every day shift every Monday for Skin Check were not documented as completed on 6/21/21.- Santyl Ointment 250 unit/gm applied to left ischium topically every day shift for wound care, cleanse wound to left ischium with wound cleanser, pat dry, apply skin prep to peri-wound, apply Santyl to wound bed and cover with bordered foam was not documented as completed on 6/4/21, 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/17/21, 6/21/21, and 6/22/21.- Daily Wound assessment for the coccyx was not documented as completed on 6/4/21, 6/7/21, 6/8/21, 6/11/21, 6/13/21, 6/14/21,			

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	6/15/21, 6/17/21 and 6/21/21.- A pressure relieving cushion to the resident's wheelchair every shift was not documented as completed on 6/4/21, 6/11/21, 6/13/21, and 6/17/21 on the day shift.- Staff were to turn and reposition the resident every two hours every shift for Skin Care Prevention was not documented as completed on 6/4/21, 6/11/21, 6/13/21, and 6/17/21 on the day shift.- Zinc oxide apply to the coccyx topically every day and night shift for Skin Care was not documented as completed on 6/11/21, 6/13/21, and 6/17/21 on the day shift. 6. The clinical record for Resident 67 was reviewed on 6/14/21 at 1:55 p.m. The diagnoses included, but was not limited to, acute respiratory failure with hypoxia, moderate protein-calorie malnutrition, chronic heart failure, chronic kidney disease Stage II, transient ischemic attack and cerebral infarction, edema, dysphagia, cognitive communication, and malignant skin cancer. The admission MDS assessment, dated 5/25/21, indicated the resident was alert and oriented. The resident required the assistance of tow physical staff members for bed mobility. The resident was at risk for pressure ulcers and currently had 1 unstagable pressure ulcer upon admission.The care plan, dated 5/27/21, indicated the resident had an unstageable pressure ulcer to the coccyx. The interventions were to educate the resident and representative about			

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	proper skin care to prevent skin breakdown and on the importance of keeping skin clean and moisturized; encourage the resident to frequently shift weight; evaluate the skin for areas of blanching or redness, ulcer characteristics, for redness of the bony prominences, for signs of progression or declination; and provide wound care per treatment order. The resident was to be turned and repositioned every 2 to 3 hours. The clinical record review lacked documentation of an At Risk for Skin Breakdown care plan.The Admission Skin Assessment, dated 5/18/21, indicated the resident had an unstageable pressure ulcer to the coccyx measuring 1.7 cm long, by 0.7 cm wide, by 0.2 cm depth. Slough was present and the wound bed was yellow. The treatment order was for Medi honey with a bordered gauze.The Weekly Skin Check, dated 5/21/21, indicated the resident had no skin areas. The Treatment Administration Records for May 2021 indicated the following missed documentation:- Pressure reducing mattress to bed every shift for Prevention was not documented as completed on 5/21/21.The clinical record review lacked documentation of weekly skin checks after 5/21/21 until 6/22/21 nurse's note. The Skin/Wound Note, dated 6/22/21 at 11:57 a.m., indicated the unstageable pressure ulcer was now a Stage III to the coccyx with MASD to the			

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	sacral area which now had fungal infection.The Treatment Administration Records for June 2021 indicated the following missed documentation:- The wound care to the coccyx was not documented as completed on 6/13/21, 6/18/21, 6/21/21, and 6/22/21. - Pressure reducing mattress to the resident's bed every shift for Prevention was not documented as completed on 6/13/21, 6/18/21, 6/21/21, and 6/22/21 on the day shift and on 6/12/21 on the night shift. - Staff were to turn and reposition the resident every two hours every shift for Wound prevention was not documented as completed on 6/13/21, 6/18/21, 6/21/21, and 6/22/21 on the day shift and on 6/12/21 on the night shift. During an interview, on 6/30/21 at 10:47 a.m., the RDCO (Regional Director of Clinical Operations) indicated if the staff didn't document in the Treatment Administration Records, then they didn't complete it.7. During an observation of wound care on 6/24/21 at 11:00 a.m., LPN 3 and LPN 4 performed wound care for Resident 19 per the current physician's order. The resident's brief was removed, and a strong odor of urine was observed. The brief was saturated with urine, which had soaked through to the bed mattress. There was a ring of brown staining on the drawsheet underneath the resident. The wound measured approximately 1 cm in length, by 1 cm in width, by 0.2 cm in			

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	depth, fully granulated, pink wound bed, very shallow, with clear edges.During an observation, on 6/24/21 at 11:52 a.m., LPN 4 approached CNA 15 to ask her to provide care for incontinent residents. CNA 15 was observed speaking to LPN 4 in an argumentative manner, telling her Resident 19 was " ... always wet ..." and that he was, " ... supposed to be wet ..."The clinical record for Resident 19 was reviewed on 6/24/21 at 9:00 a.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, heart failure, osteoporosis, benign-prostatic hyperplasia with lower urinary tract symptoms, dependence on respirator, and weakness.The Admission MDS assessment, dated 6/4/21, indicated the resident was cognitively intact, always incontinent of urine, and required extensive assistance of one physical staff member with toileting and personal hygiene. Resident had one unstagable pressure ulcer upon admission and was at risk for pressure ulcers. The admission skin assessment, dated 4/3/21, indicated the resident had an unstageable pressure ulcer to the coccyx, but did not describe the wound or provide an assessment of measurements and wound status.The care plan, last revised on 4/5/21, indicated the resident had impaired skin integrity to his coccyx related to impaired mobility. Interventions included, but were not limited to, administer treatments as			

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	ordered by medical provider and complete weekly skin checks. The physician's orders, dated 4/5/21, indicated to conduct daily wound assessments and document them on the TAR, turn and reposition every 2 hours, cleans coccyx with normal saline, pat dry, skin prep periwound and apply Santyl and Calcium Alginate to the wound bed and cover with bordered foam every day shift. Daily wound assessments were to be completed and documented on TAR as well as orders to turn and reposition Q (every) 2 hours.The Skin Grid Pressure assessment, dated 4/5/21, indicated the wound measured 2.6 cm in length by 2.5 cm in width, by 0.5 cm in depth and was unstageable with 100% slough (necrotic tissue) to the wound bed. The clinical record lacked documentation of a treatment order being put into place until 4/6/21, three days after the resident's admission. The TAR lacked documentation of completion of the following treatments and interventions: -Turn and reposition every 2 hours, on the following dates: Day shift: 4/17/21, 4/20/21, 5/14/21, and 6/20/21. Night shift 4/16/21 and 5/30/21. -Santyl cleanse coccyx every day shift pat dry, apply Santyl then calcium alginate and cover with border foam, no documentation of completion on 4/17/21. -Cleanse with normal saline, pat dry, apply Santyl and then calcium alginate, cover with			

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	bordered foam. One missed treatment on 4/8/21. -Daily wound assessment of coccyx, on the following dates: 5/14/21, 5/27/21, and 6/20/21. The wound assessment, dated 4/15/21, indicated resident had an unstageable pressure to coccyx present on admission measuring 2.5 cm in length by 1.5 cm in width, by 0.5 cm in depth with slough present to 100% of the wound bedThe wound assessment, dated 4/22/21, indicated the wound was debrided and improved, measuring 2.5 cm in length, by 1.5 cm in width, by 0.4 cm in depth, and was reclassified as a stage III by the wound care doctor. The wound assessment, dated 4/27/21, indicated the wound had improved and measured 1.87 cm in length by 1.86 cm in width by 0.2 cm in depth. Wound orders changed to cleanse NS pat dry, apply skin prep to peri wound and apply medi honey to wound bed and cover with bordered gauze every night shift. The wound assessment, dated 5/4/21, indicated the wound measured 1.55 cm in length by 1.5 cm in width, by 0.2 cm in depth. The wound assessment, dated 5/11/21, indicated the wound increased in size to 1.9 cm in length by 1.09 cm in depth by 0.2 cm in depth, with friable tissue (tissue that bleeds easily and can indicate infection) to the wound bed. The wound assessment, dated 5/18/21, indicated the wound measured 1.49 cm in length by 0.86 cm in width by 0.2 cm in depth, and had friable			

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	tissue to the wound bed. The wound assessment, dated 5/25/21, indicated the wound measured 1.19 cm in length by 0.83 cm in width by 0.2 cm in depth, friable tissue remained to the wound bed, and the treatment was changed to cleanse with normal saline, and apply hydro silver and bordered gauze for seven days. The order to apply hydro silver was completed on 6/1/21. The clinical record lacked documentation of a treatment order being in place from 6/1/21 until an order for cleanse with normal saline, apply medihoney, and bordered gauze was put into place on 6/22/21. The wound assessment, dated 6/1/21, indicated the wound measured 1.07 cm in length by 0.83 cm in width, however the depth had increased to 1 cm. The wound assessment, dated 6/8/21, indicated the wound measured 0.82 cm in length, by 0.58 cm in width, and 0.8 cm in depth. The wound assessment, dated 6/15/21 indicated the wound increased in size to 1.16 cm in length by 0.61 cm in width by 0.4 cm in depth. The wound assessment, dated 6/22/21, indicated the wound measured 0.79 cm in length, with an increase in width to 0.81 cm, and a depth of 0.1 cm. During an interview, on 6/24/21 at 11:15 a.m., Resident 19 indicated he had not been changed since 4:30 a.m. or 5:00 a.m. He had asked to be changed, but no one had changed him yet. During an interview, on 6/30/21 at 12:05 p.m., LPN 4 indicated			

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	Resident 19 had been very wet. Residents should not be wet like that. It could contribute to skin breakdown and pressure areas. During an interview, on 6/30/21 at 12:16 p.m., LPN 3 indicated nursing staff should be signing the TAR when treatments were completed. They had a wound nurse, and she was doing a great job, but they got rid of the wound nurse. She had taken that load for so long. It was an adjustment for the nurses. They weren't used to doing the wounds. During a confidential interview, between 6/22/21 and 6/30/21, Staff C indicated she had seen skin breakdown where residents were soaked.The most current Skin Care & Wound Management Overview policy, last revised 5/30/19, was provided, on 6/25/21 at 1:20 p.m., by the RDCO (Regional Director of Clinical Operations. The policy included, but was not limited to, "3 ... Risk factors may include, but are not limited to ... co-morbid conditions ... friction and shear ... healed pressure ulcer ... cognitive impairment ... increased moisture on skin ... decreased activity ... impaired blood flow ... decreased sensory perception ... infection ... 6. Evaluate for consistent implementation of interventions and effectiveness at clinical meeting ... Treatment ... 3. Obtain a physician's order ... 5. Document treatment on the Treatment Administration Record ..."3.1-40(a)(1)3.1-40(a)(2)			

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F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, record review, and interview the facility failed to ensure adequate staffing which contributed to the lack of resident care, timely meals, timely assessments, adequate ADL (activities of daily living) care, and the development and worsening of pressure ulcers. This deficient practice had the potential to affect 122 residents residing in the facility. Findings include:	F 0725	**F 725 Sufficient Nursing Staff** **Corrective action for the residents found to have been affected by the deficient practice:** The deficient practice was identified as having the potential to affect 122 residents residing in the facility. **Corrective action taken for**	07/23/2021

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	1. Multiple residents developed stage III and IV pressure ulcers, or experienced worsening of pressure ulcers. Staff interviews contributed these to the overall lack of care due to insufficient staffing. Several staff members indicated there was not enough staff to keep residents turned and repositioned, provide incontinent care, and complete skin assessments. Cross Reference F686. 2. During an observation, on 6/24/21 at 12:37 p.m., LPN (Licensed Practical Nurse) 3 conducted a sweep of the incontinent residents on the 300 Hall. Several residents were found to be incontinent, with brown rings on one resident's draw sheet and strong odors of urine observed on at least two other residents. During an observation, on 6/29/21 at 1:44 p.m., 9 call lights were sounding and lit up on the board and one nurse was sitting at the nurse's station working on her computer. During an interview, on 6/29/21 at 10:40 a.m., Resident 91 indicated she had been left sitting up in her wheelchair and incontinent for several hours. There was no one available to help. They did not have enough staff, especially at night. During an interview, on 6/22/21 at 9:30 a.m., Resident 25 indicated she had waited one week to receive a shower. Occasionally her bedding wasn't changed. During an interview, on 6/22/21 at 1:54 p.m., Resident 81 indicated she had to wait for 2 hours at times for her call light to be answered. Her ostomy bag burst while she was waiting for care one time. Slow staff response had been an issue		**those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. The facility staffing pattern has been reviewed to ensure adequate staffing is in place to provide resident care, timely meals, timely assessments, adequate ADL (activities of daily living) care, and prevention of new or worsening pressure ulcers. The facility has incentives in place to promote hiring of nurses and CNAs. Further, the facility has contracted with agency groups to assist in staffing the facility adequately. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Regional Director of Operations/Administrator held an in-service with the Schedule Coordinator to provide education and expectations as it relates to adequate staffing. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Schedule Coordinator/Designee will review the daily schedules Monday through Friday to include weekend schedules to ensure adequate staffing is in place as an ongoing practice. This will occur	

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	for a year. During a confidential interview between 6/22/21 and 6/30/21, Staff J indicated it was hard to change the bedding and give the residents showers at the same time. She was just helping out the other aides by changing the bedding. She was normally by herself on the hall. During an interview, on 6/23/21 at 11:08 a.m., Resident 18 indicated there wasn't enough staff. In April she wet the bed while waiting for staff to help her transfer onto the bedside commode. During a confidential interview between 6/22/21 and 6/30/21, Staff E indicated she had problems with turning and repositioning the residents as scheduled. She was the only aide on the hall with one nurse. 3. Resident 48 experienced heaviness on her chest and an irregular heart rate and it took 2 hours for the QMA (Qualified Medication Aide) to come in and check on her. Cross Reference F580. 4. Resident 243 experienced an episode of hyperglycemia due to no one checking his blood sugar or administering his insulin, and no one would answer his light during the night. Cross Reference F760. During a continuous observation on 6/24/21 starting at 12:10 p.m., of the 400 unit two residents' lights were on for 35 minutes without staff answering them. A visitor was walking down the hall and heard a resident yelling for help. He came to the nurse's station and waited 2 to 3 minutes before finding staff to inform them a		for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	resident was yelling for help. Observations of the 100, 200, 300, and the 400 halls indicated 11 residents had their call light on. No staff was observed answering the call lights. During an interview, on 6/22/21 at 11:03 a.m., a family member indicated he was the resident's essential caregiver. He assisted with the resident's care. He was the one that found the pressure wound on the resident's left buttock. The wound was black and about the size of soda can. He asked the CNA what it was and she went and got the nurse. When the nurse saw it she stated "Oh my God". During an interview, on 6/30/21 at 12:15 p.m., Resident 48 indicated she was very upset because she was supposed to go see the doctor today and no one scheduled transportation. Her daughter took off work to go with her. They waited for a couple of hours and when she asked the staff no one knew anything about her doctor's appointment. She requested the day before to get her hair washed before going to the doctor and the day shift CNA stated she would get to her as soon as she could. She got off work at 6:00 p.m., and did make it in to wash the residents hair. The CNA told her the night shift CNA would wash her hair, but no one had time to do it so she did not get her hair washed. She was getting sick and tired of staff not having the time to help her with her ADL's. She ask for very little and when she needed help with her care she did not get it. During an interview, on 6/29/21 at 2:00 p.m., Resident 11 indicated the problem was in the evening when the staff switched shifts and on the weekends. It took them two hours for the staff to feed her and then her food was cold. She was unable to fed herself due to her disease process			

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and staff did not answer the call lights when needed.
5. Resident 29 developed an arterial wound and experienced worsening of the wound due to skin assessments and treatments not being completed per order.

Cross Reference F684.

During observations, on 6/24/21, between 11:00 a.m. and 12:00 p.m., Residents 19 and 293 were observed to be incontinent of urine, their beds were saturated. Resident 19's bed had brown staining and a strong odor.

During the Resident Council meeting, on 6/24/21 at 2:04 p.m., several residents indicated they did not get the help and care they needed without waiting for long periods. Their medications were late and sometimes they did not even get them. Meals were delivered late because there was no kitchen staff.

During an interview, on 6/24/21 at 11:15 a.m., Resident 19 indicated he had not been changed since 4:30 a.m. or 5:00 a.m. He had fallen out of bed the night before because he could not reach his call light, it was tied around his TV and he kept reaching and eventually fell out of bed. He waited approximately 20 to 30 minutes before anyone finally found him. He did not have any injuries. He had asked to be changed, but no one had changed him yet.

During an interview, on 6/24/21 at 11:35 a.m., Resident 87 indicated she had asked at 9:00 a.m. to be changed because she was wet. The nurse had told her she would have the aide come in and change her. The aide did not ever come in and change her, and the nurse then came in and

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	changed her at 10:00 a.m. The aide did not come in to her room until 11:00 a.m. During an observation, on 6/27/21 at 12:16 a.m., the 100 hall had dirty linens, including washcloths and soiled incontinence pads in the doorways of rooms 101, 103, 106, and 107. A strong odor of urine was noted on the 200 hall. The facility was staffed with four nurses, three CNA's, and one respiratory therapist. During a confidential interview, between 6/22/21 and 6/30/21, Staff H indicated they were short staffed. Her hall had a lot of "heavy wetters ..." and it made it hard when she had to take care of two hallways. She ran one hall by herself and the aides shared another hallway. She had not stopped since she got to the facility. She had only had time to complete three bed checks, the first one had taken several hours, because she had to pass meal trays and feed people. Staffing had been very rough, people called in or did not show up, she did not have enough time to always check and change everyone, she could not get her charting done. She tried to turn everyone that needed it, every two hours, but there were times she could not. During a confidential interview, between 6/22/21 and 6/30/21, Staff A indicated everything was lacking due to a lack of staffing. There was one nurse for 15 patients that a majority were total care, and they still had to be turned. Nobody was getting the care they needed, no one was getting baths. It took two people to change most of these people, they were not getting taken care of. At night, half the time they did not have all four nurses, and one person for 32 to 34 residents. During a confidential interview between, 6/22/21			

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	and 6/30/21 Staff B indicated the current staffing was not how the facility usually ran. She usually ran her hall by herself and sometimes ran two halls alone. It was a lot to have 30 plus patient to care for and be told she couldn't have help. "I'm drowning, and there's no life preserve". Showers were lacking, residents went days without showers. Some aides didn't change residents as frequently as they're supposed to, the night before, the night shift person was doing 100 and 400 halls by herself. That was too much. People were wet when they shouldn't be and it was because there was no time. They worked 13 to 14 hours without lunch breaks. When people called in they tied to get replacements but they don't. There was no consequences to no call no shows. People had done it multiple times. Meals were typically late, the patients got hungry and it affected their mood. It affected everything. During a confidential interview between, 6/22/21 and 6/30/21, Staff C indicated teamwork was lacking. There had been multiple times she came in and was pulled to the kitchen. She was very overwhelmed. She would work 12 hours in the kitchen. One weekend another CNA and her were on the hall together and they didn't get breakfast. They had to go in the kitchen and just throw breakfast together. Aides had walked out and left residents soaked. She had seen skin breakdown where residents were soaked. It was because there was not enough time to change them. It got overwhelming and people just walked out. During a confidential interview, between 6/22/21 and 6/30/21, Staff G indicated the nursing staff had to at times do the cooking in the kitchen. The IP (Infection Preventionist), DON, and ED had all walked out. They couldn't do their jobs if they didn't have staff. Showers were awful, they			

weren't showering the residents, they didn't have kitchen staff. They were lucky to have one aide on every hall. The 100 and 400 halls were ran with one aide and those were total care patients.

During a confidential interview, between 6/22/21 and 6/30/21, Staff D indicated it was the worst place she'd ever worked. There was no food and no one in the kitchen and meals were late. Sometimes nurses did not pass medications until lunch time. Staffing had been a struggle since day one. Residents were not turned every 2 to 3 hours. " ... when I leave here at night I hurt, my heart and my soul hurt ..."

During a confidential interview, between 6/22/21 and 6/30/21, Staff E indicated the staffing was terrible. Since she started working there she had been on the hall by herself. It was very busy, and hard to maintain everything all at once. She had been an aide many years but she needed at least one more aide on her hall. She didn't have time to do charting. She had residents who were two person assists and she just had to do them by herself. There were a lot of times they didn't have staff to even make the meals. They had people who would pick up and then not come in and then they worked short. They would one aide for two or three halls.
6. The clinical record for Resident 33 was reviewed on 6/23/21 at 12:35 p.m. Diagnoses included, but were not limited to, quadriplegia, muscle weakness, polyneuorpathy, unspecified mood disorder, and generalized anxiety disorder.

The Quarterly Minimum Data Set (MDS) assessment, dated 4/22/21, indicated the resident was cognitively intact; was totally dependent of two physical staff members for bathing.

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	During an interview, on 6/22/21 at 1:12 p.m., the resident indicated the staff did not always get her up to the shower. Review of the shower sheets for April, May, and June, 2021 indicated the resident had the following missed showers: 5/19, 5/22, 6/5, 6/13, 6/20 and 6/23. The resident had only received three showers in the past 23 days on 6/3, 6/9 and 6/16. During a confidential interview between 6/22/21 and 6/30/21, Staff D indicated there was not enough staff to give the residents their showers every time they were scheduled. These Federal tags relate to Complaints IN00354841, IN00356996, and IN00356986. 3.1-17(a)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on and record review and interview, the facility failed to ensure the administration of medication in a timely and accurate manner for 1 of 9 residents reviewed for medication administrations. (Resident 243) Findings include: The clinical record for Resident 243 was reviewed on 6/24/21 at 2:30 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, depression, diabetes, GERD (gastroesophageal reflux disease), hypertension, hypophosphatemia, insomnia, intestional	F 0760	**F 760 Residents are Free of Significant Med Errors** **Corrective action for the residents found to have been affected by the deficient practice:** Resident #243 no longer resides in the facility. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient	07/23/2021

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	malrotation, malnourished, myalgia, and underweight. The current care plan, dated 6/25/21, indicated the resident had diabetes type 1 with neuropathy and history of DKA (diabetic ketoacidosis). Interventions include, but were not limited to, administer insulin injections per orders, obtain blood sugars per orders. Report abnormal findings to medical provider, resident/resident's representative. The physician's order, dated 6/24/21, indicated the resident was prescribed the following: - insulin glargine (Lantus) 100 units/ml (milliliter), inject 6 units at bedtime - insulin lispro 100 units/ml, 0 to 7 units 4 times a day and 0 to 7 units as needed for high blood sugar - insulin lispro 100 units/ml, 1 to 15 units 3 times a day with meals and 0 to 7 units as needed for high blood sugar. Review of the physician orders, on 6/28/21 at 3:09 p.m., indicated the insulin lispro 100 units/ml inject 0 to 7 units four times a day, insulin lispro 100 units/ml inject 0 to 7 units as needed for high blood sugar, and insulin lispro 100 units/ml 1 to 15 units 3 times a day (morning, afternoon and evening) was not transcribed into the resident's electronic medical record and given as ordered by the physician. The review of the Weights and Vital Sign Summary record indicated the resident's blood sugar was 92 on 6/24/21 at 9:00 p.m. His blood sugar was not checked again until 7:42 a.m. and was documented at 148. The resident's blood sugar was checked at 8:00 a.m., per the residents request and his blood sugar was 532.		practice. A 30 day look back has been completed for timely and accurate medication administration. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Medication Administration" as it relates to timely and accurate administration. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will audit 5 residents a week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week for 4 weeks to ensure medication has been administered timely and accurately. This will occur for no less than 3 months and compliance is maintained. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	During an interview, on 06/25/21 at 10:10 a.m., LPN 18 (Licensed Practical Nurse) indicated when she started her shift the resident stated to her he needed his blood sugar checked. The resident told her no one had check his blood sugar and he felt like his blood sugar was high. The LPN asked the off going night shift nurse if the resident's blood sugar was checked and she checked it at 6:00 am and it was 148. The LPN went in to inform the resident the night shift nurse stated she did check his blood sugar and it was 148. The resident stated the nurse did not check his blood and he had not had all of his insulin. The LPN checked the resident's blood sugar and it was 532. The resident knew it was high because he had not had his insulin. During an interview, on 6/25/21 at 11:00 a.m., Resident 243 indicated his blood sugar at 6:00 p.m., on admission, was 478. He received 6 units of Lantus at 8:00 p.m., but he had not received his lispro insulin that the doctor ordered. He had asked the night shift nurse to check his blood sugar at 2:00 a.m. and she did not come back to check his blood sugar at 2:00 a.m. The nurse did not check his blood sugar at 6:00 a.m., like she said she did. He knew his blood sugar was running high, "I can tell when my blood sugar was high or low because my body tells me." No one came in to answer his light. When the day shift nurse came on she checked his blood sugar and it was 532. He had not ate anything during the night or that morning. During an interview, on 6/25/21 at 1:45 p.m., the RDCO (Regional Director of Clinical Operations) indicated the discharge medications from the hospital should have been ordered when the resident was admitted to the facility. The			

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	nurse had the physician's orders. She indicated she did not know why the medications were not ordered. The nurse's note, dated 6/27/21 at 11:40 p.m., indicated the physician was notified the resident's blood sugar was 406 at bedtime, and he does not have a sliding scale for bedtime. The physician ordered staff to give lispro insulin 10 units one time and recheck the resident's blood sugar in two hours. The clinical record lacked documentation staff rechecked the resident's blood sugar in two hours after giving the insulin. During an interview, on 6/29/21 at 10:10 a.m., LPN 3 indicated the discharge insulin orders should have been ordered. They don't use a sliding scale, but the nurse should have called the physician and clarified the orders. The Medication Administration policy and procedure, last revised 12/14/17, provided on 6/28/21 at 2:35 p.m., included, but was not limited to, "...gg Medications that are refused or withheld or not given will be documented i. Critical medications that are refused including insulin, warfarin, heparin or other anticoagulants will be followed up with physician contact..." 3.1-48(c)(2)			
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.			

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	§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on observations and interview, the facility failed to ensure resident's were provided meals at their scheduled meal times, or within a reasonable time frame. This deficiency had the potential to affect all 97 residents that reside in the facility. Findings include: During an observation, on 6/22/21 at 12:45 p.m., the first lunch meal cart arrived late to the 300 Hall. The second meal cart for the 300 hall arrived at 1:00 p.m. The QMA, Activities Director, Social Worker, and 3 CNA's were observed delivering the meal trays to the residents. During an observation, on 6/25/21 at 9:18 a.m., the 100 hall had just received the breakfast meal cart. During an interview on 6/22/21 at 12:28 p.m., CNA 11 indicated last week everyone had walked out. Human Resources left first, then everyone	F 0809	**F 809 Frequency of Meals/Snacks at Bedtime** **Corrective action for the residents found to have been affected by the deficient practice:** The deficient practice was identified to potentially affect 97 residents that were residing in the facility. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents at risk for or who currently have pressures ulcers have the potential to be affected by the deficient practice. A review of the current meal schedule was completed and adjusted to provide meals witin a reasonable time frame. **Measures/systemic changes put into place to ensure the**	07/23/2021

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	followed. The residents don't get the care they should and have to wait on staff. The kitchen needed to get staff. Getting meals on time was a problem. One time the residents weren't served lunch until 3:00 p.m. Another time they didn't get dinner until 9:30 p.m. During an interview, on 6/22/21 at 12:34 p.m., Resident 7 indicated the residents use to receive their breakfast coffee at 7:00 a.m. They did not receive their coffee until 9:00 a.m. The meals were always late. Last week lunch wasn't served until 3:00 p.m., and supper was served at 9:30 p.m. During an interview, on 6/22/21 at 12:54 p.m., CNA 19 indicated they didn't normally have as much help to serve meals, as they had today. There was normally one aide and no one helped at all to serve the meals. During an interview, on 6/22/21 at 9:30 a.m., Resident 25 indicated meals were late. Breakfast had arrived at 10:00 a.m. and lunch had been served at 2:00 p.m. During an interview, on 6/22/21 at 10:55 a.m., Resident 75 indicated the food could be better. It was cold sometimes. It sat in the hall forever. Dinner was at 8:30 p.m. the other night. The kitchen staff walked out and they got it late. Breakfast was sometimes late at around 9:00 a.m. Lunch was served at 1:00 p.m. to 1:30 p.m. a few times. During an interview, on 6/22/21 at 11:56 a.m., Resident 25 indicated the food was always late. During an interview on 6/23/21 at 11:09 a.m., Resident 18 indicated the food was nasty, most		**deficient practice does not recur:** The Administrator/DON/Designee held an in-service for nursing staff to provide education and expectations as it relates to the "Meal Service Times". **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Designee will audit meal service at varying times to include weekends 5 Days a week x 4 weeks, then 3 Days a week x 4 weeks, then 1 Day a week for 4 weeks to ensure residents were provided meals at their scheduled meal times or within a reasonable time frame. This will occur for no less than 3 months and compliance is maintained. The Administrator/DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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of the time it was cold.

During an interview on 6/25/21 at 9:29 a.m., LPN 4 indicated he normally did not serve breakfast. The kitchen had been a "... hot mess..." Four people had walked out over the weekend and dinner had been really late.

During an interview, on 6/29/21 at 12:52 p.m., Resident 7 indicated the kitchen had a problem, the meals were always late.

During an interview, on 6/25/21 at 9:10 a.m., the RDCO (Regional Director of Clinical Operations) indicated there was no assigned halls for staff during meal service. Everyone was supposed to help.
2. During an observation, on 6/25/21 at 9:18 a.m., the 400 hall trays were left sitting on the cart at the end of the hall. Eight trays on the cart had not been served. LPN 3 came and began passing trays during the observation.

During an observation of the 300 hall, on 6/25/21 at 9:22 a.m., CNA 5 was observed passing meal trays to resident rooms and indicated there were still four resident's who had not received their trays. The trays were not finished until 9:26 a.m.

During the resident council meeting on 6/24/21 at 2:04 p.m., several residents voiced concerns of meals not being served on time. They indicated sometimes it was 2:00 p.m. before they received lunch, the food was cold when they got it, the night prior it was 8:00 p.m. or later before they received dinner. Nurses couldn't pass medications because they were too busy trying to pass the meals. Meals were late because there was no kitchen staff.

During an interview, on 6/25/21 at 9:20 a.m., LPN 3 indicated it was almost 9:30 a.m. and they were just now doing breakfast, he normally did not serve but the CNA was busy giving care.

During an interview, on 6/25/21 at 9:27 a.m., CNA 5 indicated the trays came up an hour or so late, which was a pretty normal occurrence.

During an interview on 6/25/21 at 9: 28 a.m., the Social Services Designee indicated she had just finished passing trays about 5 minutes prior. It was close to 8:30 a.m. when trays came and almost 9:30 a.m. by the time they got them all passed.

During an interview on 6/25/21 at 9:30 a.m., LPN 6 indicated the trays were late, they came between 8:30 and 9:00 a.m. The meals were consistently late and had been for a long time. They never had enough staff to pass them.

During a confidential interview, between 6/22/21 and 6/30/21, Staff A indicated she did not have time to complete her tasks because she often had to pass meal trays when they were late.

During a confidential interview, between 6/22/21 and 6/30/21, Staff B indicated meals were typically late. The patients got hungry and it affected their mood. "It affected everything."

During a confidential interview, between 6/22/21 and 6/30/21, Staff C indicated she was often pulled to work in the kitchen, one weekend they did not get breakfast and they had to go into the kitchen and cook breakfast for the residents.

During a confidential interview, between 6/22/21

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and 6/30/21, Staff D indicated one day there was no food and no one in the kitchen at 9:00 a.m. Nursing staff and the maintenance director had to go in and do the cooking. Breakfast did not come until around 10:30 a.m. or 11:00 a.m., lunch was around 3:00 p.m., and dinner around 6:30 p.m. or 7:00 p.m.

During a confidential interview, between 6/22/21 and 6/30/21, Staff E indicated they didn't have staff to even make the meals. They had burnt food and food that wasn't cooked. It got to a point where nursing staff would have to make bologna sandwiches just so the residents had food.

The document titled, "Meal Service Times", was provided on 6/30/21 at 2:00 p.m., by the ED (Executive Director). The times for meals were listed as follows:

- Breakfast: 100 Hall - 7:15 a.m., 200 Hall- 7:25 a.m., 300 Hall- 7:35 a.m., 400 Hall- 745 a.m., Main Dining- 8 a.m.

- Lunch: 100 Hall- 11:45 a.m., 200 Hall- 11:55 a.m., 300 Hall- 12:05 p.m., 400 Hall- 12:15 p.m., Main Dining- 12:25 p.m.

- Dinner: 100 Hall- 4:45 p.m., 200 Hall 4:55 p.m., 300 Hall- 5:05 p.m., 400 Hall- 515 p.m., Main Dining 5:25 p.m.

The Frequency of Meals policy, last revised 9/2017, provided on 6/30/21 by the Executive Director, included, but was not limited to, " ... At least three daily meals will be provided, at regular times, comparable to normal meal times in the community ... Procedures ... 3. The Dining Services Director will ensure that each meal is served within the designated time frame unless

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	155659	A. BUILDING 00 B. WING	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

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	there is an emergency situation or a resident request ... These Federal tags relate to Complaints IN00354841 and IN00356986. 3.1-21(c)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation and interview, the facility failed to ensure food was served and stored under sanitary conditions during 2 of 3 kitchen observations. Findings include:	F 0812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** **Corrective action for the residents found to have been affected by the deficient practice:** The identified deficient practice	07/23/2021

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	1. During an observation of the kitchen on 6/22/21 at 9:15 a.m., the following concerns were observed: - The stove was heavily soiled with a caked on black and brown substance. - The right side of the convection oven next to the stove and the left side of the stove had yellow and brown streaks running the length of the convection oven and stove - yellow and brown food-like particles were also noted in the streaks. - The floor between the stove and convection oven had a 1 foot by 1 foot black greasy build up with food like particles in it. - The grease trap on the grill had a heavy build up of black greasy substance. - In the dry storage room, there was an area 6 foot in length by 2 inches wide of black dirt on the floor under the shelf and behind the door and in the corners. There were rice cereal, marshmallows, sweet sweetener packets, sugar packets, and mayonnaise packets on the floor and under the shelves - there was also a steak knife under the shelf. - The ice scoop was inside the ice machine in the ice - storage box was on the wall next to the machine. 2. During an observation of the kitchen, on 6/24/21 at 10:40 a.m., while accompanied by the Corporate Dietary Manager, the following concerns previously identified on 6/22/21 at 9:15 a.m. were observed: - The left side of the stove and the right side of the convection oven were noted to have streaks of yellow and brown substance running down the length of the equipment. Food -like particles were also noted in these streaks.		identifies the facility failed to ensure food was served and stores under sanitary conditions during 2 of 3 kitchen observations. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** A Sanitation Audit of the facility kitchen has been completed to ensure food is being served and stored under sanitary conditions. Identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Dietary Manager/Designee held an in-service for Dietary staff to provide education and expectations as it relates to ensuring food is being served and stored under sanitary conditions. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Designee will complete a sanitation audit 3 Days a week x 4 weeks, then 2 Days a week x 4 weeks, then 1 Day a week for 4 weeks to ensure food is being served and stored under sanitary conditions. This will occur for no less than 3 months and compliance is maintained. The Administrator/Designee will present the results of these audits	

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	- The grease trap on the grill was heavily soiled with caked on black greasy substance. - The stove had dried on black and brown substance. - The floor between the convection oven and the stove remained with black greasy build up with food particles in it. - The ice scoop was inside the ice machine in the ice. The box for the scoop was located adjacent to the machine. Additional concerns were also identified at this time: - The entire stainless steel wall behind the stove had greasy smears and brownish streaks. - The water drain ledge to the steamer had a moderate amount of yellowish liquid with food particles in it. - One foot of ceiling around the vent above the cook's food prep area was noted to have a moderate amount of gray dust that swayed in the breeze. - The stainless steel doors to the walk in refrigerator and freezer and surrounding stainless steel were noted to be streaked and smeared. - The 2 inch stainless steel edging around the stove hood was observed to have brown sticky to touch streaks. During an interview with the Corporate Dietary Manager at this time, she indicated she had been cleaning the kitchen since the survey began on 6/22/21, but it was not being done like it should have been because of being short staffed and new employees. 3.1-21(i)(3)		monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0868 SS=E	483.75(g)(1)(i)-(iii)(2)(i) QAA Committee			

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Bldg. 00	§483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.			
	Based on record review and interview, the facility failed to identify unresolved quality deficiencies. This deficiency had the potential to affect all 97 residents who currently resided in the facility. Findings include: The current QAPI (Quality Assurance and Performance Improvement) Plan Policy, dated 10/1/17, provided on 6/22/21 at 1:00 p.m., included, but was not limited to, "... III. a. The facility leadership will: i. Use performance indicators from multiple sources to monitor the quality of care and services and satisfaction of residents... ii. The facility will track, investigate and monitor events that must be investigated every time they occur and action plans will be implemented to prevent a reoccurrence..." During this Annual recertification survey, from 6/22/21 to 6/30/21, three deficiencies were	F 0868	**F 868 QAA Committee** **Corrective action for the residents found to have been affected by the deficient practice:** The deficient practice was identified to potentially affect 97 residents that were residing in the facility. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** A review of the last year of surveys has been completed to identify any unresolved quality deficiencies. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Regional Director of	07/23/2021

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	repeated citations from prior surveys: F686, F725, and F760. The facility's Quality Assurance Committee did not implement appropriate measures to correct identified issues or prevent the deficiencies as follows: Pressure Ulcers: The facility could not provide documentation of audits of skin assessments or ongoing QAPI monitoring of measures to improve wounds. Sufficient Staffing: The facility could not provide documentation of QAPI measures to improve staffing. Significant Medication Errors: The facility could not provide any audits or proof of QAPI measures to address repeated deficiencies for medication errors. During an interview, on 6/30/21 at 1:17 p.m., the Executive Director (ED) and Regional Director of Operations indicated the staffing issues were due to staff calling in. They had not implemented the use of Agency staff until last week. They wouldn't be used daily, but just when staff were low. QAA (Quality Assessment and Assurance) was supposed to be monitoring the facility for wounds. The PIP template was ready for use and was in place for the staff to use. QAA had also discussed the medication administration issues. They felt the nurse would administer the medications but then come back later in their shift to sign it out. Monitoring with a plan of correction was in place. He was unsure of how often audits were conducted. If issues were brought to their attention, they were discussed in		Operation/Regional Director of Clinical Services /Designee held an in-service with the Interdisciplinary Team Members to provide education and expectations as it relates to the "QAPI (Quality Assurance and Performance Improvement) Plan " Policy and identifying unresolved quality deficiencies. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Regional Director of Operations/ Regional Director of Clinical Operations/Designee will audit previous citations for identification of unresolved quality deficiencies weekly for 12 weeks or until compliance is met and no less than 3 months. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.6	

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	the meetings. If a deviation from performance was occurring, different meetings were held each week and it was discussed for improvement plans. During a subsequent interview on 6/30/21 at 2:31 p.m., the ED indicated the issues were still ongoing due to the DON (Director of Nursing) turnover and ED turnover. These Federal tags relate to Complaints IN00354841 and IN00356986. 3.1-52(b)(2)			
F 0881 SS=F Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to ensure the antibiotic stewardship policy and procedure was followed related the monitoring of antibiotic use. This deficient practice had the potential to affect all 97 residents currently residing in the facility. Findings include: During the review of the Infection Control/Antibiotic Stewardship binder, on 6/29/21 at 9:13 a.m., the following concerns were observed:	F 0881	**F 881 Antibiotic Stewardship Program** **Corrective action for the residents found to have been affected by the deficient practice:** The deficient practice was identified to potentially affect 97 residents that were residing in the facility. **Corrective action taken for those residents having the potential to be affected by the**	07/23/2021

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	The months of February, March, and April lacked documentation of criteria for infections, antibiotic dosages and stop dates. The Antibiotic Review Log did not consistently track and monitor types or dates of onset for infections, prescribed antibiotics, outcomes of infection, or monthly antibiotic reports. During an interview on 6/30/21 at 10:48 a.m., the RDCO (Regional Director of Clinical Operations) indicated she would expect logs to be filled out, and obviously there were not things filled out. The document titled, Infection Prevention and Control Program, last revised 3/5/21, provided on 6/22/21 at 1:00 p.m., by the Executive Director, included, but was not limited to, "... E. Tracking and Reporting Antibiotic Use and Outcomes... a) Process Measures: (1) Tracking how and why antibiotics are prescribed (2) Review Antibiotic starts to determine the clinical assessment, prescription and antibiotic selectin [SIP] are in accordance with policy and procedures..."		**same deficient practice:** The Director of Nursing has implemented the Antibiotic Stewardship program to ensure tracking includes documentation of criteria for infections going forward. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** Then Regional Director of Clinical Services /Designee held an in-service with the Director of Nursing to provide education and expectations as it relates to the “Antibiotic Stewardship “ Policy and documentation of criteria for infections. The Director of Nursing held an in-service with the licensed nursing staff to provide education and expectations as it relates to the “Antibiotic Stewardship “ Policy and documentation of criteria for infections. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Regional Director of Clinical Operations/Designee will audit the documentation of criteria for infections for completion weekly x 12 weeks or compliance is met and for no less than 3 months. Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any	

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			patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.6	