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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)4)A)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	**Attachment A** **Statement of Licensure Violations**	

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

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A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Based on observation, interview, and record review, the facility failed to timely reposition 1 of 4 residents (R54), reviewed for pressure ulcers in a sample of 35. This failure resulted in R54 acquiring an open area with drainage to his scrotum. The facility also, failed to treat pressure ulcers per Physician Orders (wound dressings) for 3 of 4 residents (R27, R62, R234), reviewed for pressure ulcers in a sample of 35.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These regulations were not met as evidence by:

Based on observation, interview, and record review, the facility failed to timely reposition 1 of 4 residents (R54), reviewed for pressure ulcers in a sample of 35. This failure resulted in R54 acquiring an open area to his scrotum. The

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facility also, failed to treat pressure ulcers per Physician Orders (wound dressings) for 3 of 4 residents (R27, R62, R234), reviewed for pressure ulcers in a sample of 35.

Findings Include:

1. On 04/17/19 at 10:30AM, R54 was lying on his back in bed, with 2 incontinent pads underneath him with a draw sheet lying under the incontinent pads. No positioning devices were noted on the bed nor under R54's body. V7, Registered Nurse (RN)/Wound Nurse, and V13, Certified Nursing Assistant (CNA), assisted R54 with rolling onto his right side. As R54 was positioned, onto his right side, there were red and white linear deep creases extending from his left mid back down extending down to his left mid-thigh area. There were copious amounts of dried stool noted to his buttocks, extending down to the middle of his bilateral thighs. On top of the dried stool was a large amount of soft stool noted to the rectal area. After V13, CNA, performed incontinent care, R54 was noted having 2 pressure ulcers to his left ischium and a open wound noted to his scrotum, that was bleeding. V7, RN, stated, she was "not aware" of the new area to R54's scrotum and would classify the area as "open wound with drainage." V7, RN, measured the wound and found it to be 0.3 centimeters (cm) in length by 1 cm in width, and 0.2 cm in depth. V7 stated, it was a "Stage 2 pressure ulcer." V7 further stated, the open area to R54's scrotum appeared to be "shearing," at which time R54 asked V7, "How can it be shearing, if there's a draw sheet under me?" V7 did not respond to R54's question. After, V7 applied treatments to R54's left ischium, she stated, she was going to call the Physician to obtain an order for R54's scrotum. V13, CNA, informed R54, that she was going to

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roll him onto his left side. When R54 was rolled onto his left side, R54 was noted to have deep creases of red and white striations (linear marks) extending from his right scapula down to his right mid-thigh area. There was a pressure ulcer to his right ischium. V7, RN, measured the wounds and found them to be "10 cm by 14 cm and not blanchable."

On 04/17/19, at 10:30AM, after receiving wound treatment to his pressure ulcers, R54 stated he hadn't been checked on or turned since "yesterday (04/16/19) afternoon; they (the facility) don't answer my call light, that was on for over an hour and a half last night." R54 further stated, his dressing changes aren't done timely to his pressure ulcers.

Face Sheet dated 04/22/19, document R54 was admitted to the facility on 03/11/19. The face sheet also, documents R54 having Neuromuscular Dysfunction of the Bladder, Stage 4 pressure ulcers to his right and left buttocks, having "Quadriplegia, C5-C7 Complete," and a Tracheostomy.

R54's Minimum Data Set (MDS), dated 03/11/19, documents R54 having a Brief Interview Mental Status (BIMS) score of 14, indicating cognition intact. The MDS further documents R54 being totally dependent on staff for all Activities of Daily Living (ADLs).

R54's Care Plan dated 03/05/19, documents R54 being at high risk for abnormal muscle tone on his bilateral lower extremities. R54's Care Plan further documents for R54: "Check every two hours and prn (as needed), for incont (incontinent) of bowel and need total assist with incont care."

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Pressure Ulcer Risk Assessment dated 04/01/19, documents R54 scoring a 7, indicating a very high risk for skin breakdown.

The facility's Wound Report fails, to list the measurements of R54's open area to his scrotum at the time of treatment on 04/17/19.

Pressure Ulcer Wound Sheet report dated 04/09/19, documents R54 having "Stage IV-Full Thickness loss with exposed bone, tendon or muscle. Sough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling." The wound sheet further documents R54 having the following measurements: 3 centimeters (cm) by 9 cm by 1 cm in depth, having undermining, with a large amount of serious exudate, with the surrounding skin having maceration. The current treatment, per the wound sheet, documents: Normal Saline/Wound Cleanser, "Cleanse, pack with Santyl, and calcium alginate, cover with gauze and dry dressing, change daily and PRN (as needed)." The report also, states that R54 has a low air loss mattress.

On 04/22/19, at 2:28PM, V2, DON, stated the facility does not have wound measurements from when V7, RN, performed the treatment to R54's wounds with surveyor present on 4/17/19, and that "she (V7) didn't write them down, and we (facility) was not aware of the new area to R54's scrotum until you (surveyor) pointed it out to her (V7)."

On 04/22/19 2:59PM, V18, R54's Nurse Practitioner, would expect R54 to have been turned and repositioned at least every 2 hours given R54 is a quadriplegic.

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On 04/24/19 at 9:21AM, V29, Medical Director and R54's Physician, stated she would have expected R54, to have been turned and repositioned per facility protocol, given the extent of his wounds and condition. V29 further stated, she would have expected to have R54's open area to his scrotum to have been documented in R54's Clinical Record.

04/23/19 at 2:45PM V2, DON, stated the expectation is for staff to turn and position anyone dependent on care, especially R54, given his condition and being a quadriplegia, and being admitted with Stage 4 pressure ulcers. V2 further stated, R54's Physician called the open area to R54's scrotum as maceration, and if the area is macerated, that means R54 is more susceptible to pressure ulcers.

2. On 04/16/19 at 10:50 AM, V7, RN, stated R234's pressure ulcer started out as moisture and shearing and the next day it was an open area with necrotic tissue. V7, RN, stated the facility sent him out to the hospital to have the area debrided and he came back last week and had a wound vac. V7 removed R234's left ischial pressure ulcer dressing and observed a Stage 4 pressure ulcer measuring 2.0 centimeters (cm) x 4.0 cm x 3.5 cm.

On 04/17/19 at 1:08PM, R234 stated, "I found out my (pressure relieving cushion) was not blown up, it was flat. My cushion not having air in it could have helped me get the pressure ulcer. I'm up a lot in my wheelchair and I don't want to lay down all the time. The head person in Therapy pumped up the cushion when we found out it was flat. I found out my (pressure relieving cushion) didn't have air in it right when I got this pressure

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ulcer."

On 04/22/19 at 1:50PM, V32 Therapy Manager/Coordinator, stated, "I have put air in (R234's) cushion a couple times before. If there wasn't enough air in the cushion, he would be sitting on a metal plate that's inside the cushion. The only way air could get out of the cushion is if there was a leak or if someone let it out with the pump. I don't know who's supposed to check for air in the cushion, I supposed it's to be the CNA's."

Electronic Medical Record, (EMR), for R234, dated 04/18/19, documents, "Diagnosis Information Functional Quadriplegia."

Weekly Nursing Skin Assessments, for R234, dated 03/22/19, documents in part a new area "Right thigh (rear) Schering (sic) approx. (approximately) 3.0 x 2.0 x 0.1 cm, surrounding skin normal denies pain."

Weekly Nursing Skin Assessments, for R234, dated 03/29/19, documents, new area "UTD (unable to determine) ulcer necrotic eschar/slough covering wound bed, odor present, moderate yellow drainage, denies pain, peri wound white unbleachable, 6/2 x 4.4 x UTD cm resident sent to hospital for evaluation."

Nurses Notes for R234, dated 03/29/19, documents as follows: 03/29/19 11:07AM received order to obtain wound culture(cx) of wound to buttocks. 3:44PM obtained order received to send to Hospital ER (Emergency Room) for Eval. (Evaluation) and treatment.

Hospital Report, for R234, dated 03/29/19, documents, "Buttock, Debrided Tissue Left

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Decubitus Ulcer."

Care Plan for R234, dated 04/19/19, documents, "I am at risk for skin breakdown r/t (related to) impaired mobility, bowel incontinence, dx (diagnosis) quadriplegia Interventions *pressure relief mattress on bed and pad in chair"

MDS for R234, dated 01/22/19, documents R234's BIMS score as 15, indicating cognition intact. R234's Functional Status for bed mobility and toileting documents R234 being totally dependent on staff and requires extensive assistance of two persons for transfers. The MDS further reports, R234 being incontinent of bowel and having an indwelling catheter.

Manufactures guidelines documents, (pressure relieving cushion) (dated 2013) documents: "Note: DO NOT sit on an improperly inflated cushion. under-inflated and over inflation of the cushion sections reduce or eliminate the cushion's benefits and could increase risk to the skin and other soft tissue. The cushion is most effective when there is 1/2 inch (1.5 cm (centimeters)) to 1 inch (2.5 cm) of air between the user's bottom and the seating surface."

3. R27's wound sheet dated, 04/12/19, documents, R27 has a Moisture Associated Skin Damage (MASD) to coccyx/sacral area, date of onset 11/21/18. Measurements on 04/12/19 are 1.5 cm X 0.3 cm X 0.1 cm.

R27's Braden score dated 02/21/19, documents R27 scoring 14, indicating moderate risk for skin breakdown.

R27's MDS dated 02/14/19, documents a BIMS score of 15, indicating cognition intact.

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R27's Physician Order Sheet (POS) dated 04/23/19 documents Foam Dressing to sacrum, QOD (every other day) and PRN (as needed) every day shift, every 2 day(s) for wound care.

R27's care plan dated, 02/12/18 documents, "Focus: I am at risk for skin breakdown, related to impaired mobility, bowel and bladder incontinence, morbid obesity. Interventions include, administer my treatments as ordered."

On 04/15/19, at 11:12AM, R27 stated, "My dressing is not on, they are not putting dressings on it anymore."

4. On 04/16/19, at 2:40PM, V19, CNA, and V20, CNA, assisted R62 to the bathroom. V19 removed R62's soiled disposable brief and no dressing was on R62's pressure ulcer to the sacrum.

R62's Pressure Ulcer Wound Sheet, dated 04/10/19, documents, Onset of pressure ulcer 04/10/19, site left sacrum, acquired in house, stage 2, measurements 2 cm X 0.5 cm X 0.1 cm.

R62's Braden Score, dated 11/28/18, documents 15 (at risk).

R62's MDS dated 03/27/19 documents, R62's BIMS is 8 (moderately impaired).

R62's Physician Order Sheet (POS) dated 04/10/19, documents, Calmoseptine Ointment 0.44-20.6% (Menthol-Zinc Oxide), Apply to left sacrum topically, one time a day, for open area stage 2, cover with foam dressing.

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R62's Care Plan, dated 04/10/19, documents, Focus: Open area stage 2 noted on sacrum, Interventions: Treatment to sacrum as ordered.

On 04/16/19, at 3:20PM, V7 Wound Nurse stated, "The dressings should be on, I should be notified if it comes off, and I wasn't."

Facility policy entitled Pressure Ulcer/Skin Breakdown-Clinical Protocol, revised on April 2018, documents, "Assessment and Recognition. 1. The nursing staff will assess and document significant risk factors for developing pressure ulcers. 2. The nurse will describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue."

Facility policy entitled Turning a Resident on his/her side away from you, revised October 2010, documents, "Purpose. The purposes of this procedure are to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment."

(B)

2 of 2 Licensure Findings

300.610a)
300.1210a)
300.1210b)2)
300.1210c)
300.3240a)

Section 300.610 Resident Care Policies

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a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These regulations were not met as evidence by:

Based on interview and record review, the facility failed to provide Range of Motion (ROM) exercises to 4 of 7 residents (R15, R59, R72, R78) reviewed for ROM, in a sample of 35. This failure resulted in R59 and R72 having a decline in Range of Motion.

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Findings Include:

1. R59's Face Sheet dated 4/23/19, document, R59 having a contracture of her right hand, right ankle, and left ankle.

Minimum Data Set (MDS) dated 3/27/19, documents R59 being totally dependent on staff for Activities of Daily Living (ADLs). The MDS further documents R2 having functional limitation in Range of Motion with impairment to her bilateral upper and lower extremities.

R59's Care Plan dated 3/28/19, documents R59 being on a Restorative program for Active Range of Motion (AROM) due to having diagnoses of Degenerative Joint Disease, Arthritis, and Parkinson's. The Care Plan further, documents R59 having a goal and interventions as follows: Goal: Seated therapy exercises times 20 repetitions in all directions. Reaching for cones times 5, forwards, laterally, crossing midline and up. Interventions include: to document daily compliance, progress towards meeting goals, notify nurse if she experiences declines in her ability to complete AROM tasks and to record the minutes of task completed. The intervention also, includes, "(R59) Seated there (therapy) ex (exercises) 1.5-2# AROM x (times) 15 reps (repetitions). Reach for cones 2 x fwd (forward), laterally, crossing midline and up."

R59's Physical Therapy Plan of Care with a start of care date of 10/31/2018, documents, "Functional Deficit Other. LLE (left lower extremity) ankle plantarflexion contracture -36 (negative) degrees from neutral reports R (right) foot hurts more than L (left) at times reports discomfort in back of (sic) calf when stretching with too much intensity." The Plan of Care further

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documents, "Goal Patient (R59) will improve LLE ankle plantarflexion contracture to -26 degrees from neutral and RLE ankle plantarflexion contracture -9 degrees from neutral."

R59's Rehabilitation Screen dated 4/17/19, completed by V33, Physical Therapist, documents that R59 has shown a decline in ROM. The Screen further documents, "Comments/Recommendations: RLE (right lower extremity) plantar flexion -43 (degrees) and LLE Plantarflexion -55 (degrees)."

On 4/16/19 at 10:25 AM, R59's daughter stated, her mother "Isn't getting any restorative ROM, she hasn't been getting that for a long time."

2. MDS dated 4/02/19, documents R72 having a Brief Mental Interview Status (BIMS) score of 15, indicating cognition intact. The MDS further documents R72 having impairment on both sides of his upper and lower extremities and requiring extensive assistance.

Care Plan undated, documents R72 being on a Restorative Program as follows: "Focus I have impaired mobility related to decreased strength and endurance. Goal. ROM to both hands times 10 repetitions 7 days a week."

R72's Physical Therapy Plan of Care with a start of care date of 9/04/2018, documents that R72 has a contracture to his right hand and that the long term goal is for R72 to improve from -55% extension of his right 2nd Metatarsophalangeal (mp), -70 degrees to his right 3rd mp, -72 degrees his right 4th mp, and -65 degrees his right 5th mp to increase within normal limits (wnl) of the left. The goal date was for 9/24/18.

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R72's Rehabilitation Screen dated 4/17/19, documents R72 having a decline in the following digits: right 3rd mp -80 degrees, right 5th mp -90 degrees.

On 4/15/19 02:40 PM, R72 stated he does get walked, but denies receiving ROM to his bilateral hands, and the facility doesn't have a restorative aide.

3. Face Sheet dated 4/23/19, documents R78 having a contracture of her right hand.

Care Plan initiated on 1/18/2018 and revised on 3/6/19, documents, "Restorative level 1: at risk for decreased strength, endurance, and ADLs," related to Cerebral Vascular Accident (CVA) and Dementia. The Care Plan lists R78 having the following interventions: "Nurse to review program routinely and address residents progress toward meeting goals. PROM to r (right) hand 3-5 reps before applying splint in the am (morning). Record minutes of task completed in the POC (plan of care)."

Occupational Therapy Plan of Care for R78, dated 12/28/18 documents in part the reason for the referral being, "history of right-hand contracture impacting the patient's (R78) ability to perform self-care." The Occupational Therapy Plan of Care further documents, "(R78) will improve muscle strength to 4-5 good minus (full ROM against gravity and minimal resistance) in order to self-feed."

MDS dated 4/03/19, documents R78 requiring extensive assistance with dressing and eating. The MDS also, documents R78 having "Function

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Limitation in Range of Motion," with impairment to her upper extremity on one side and impairment to her bilateral lower extremities." The MDS further documents R78 having a BIMS score of 11, indicating moderately impaired cognition.

Rehabilitation Screen for R78, dated 4/17/19, documents, "R (right) 2nd mp (Metatarsophalangeal) -30 degrees, 3rd mp -65 degrees, 4th mp -75 degrees, 5th -25 degrees."

The facility failed to provide a prior Rehabilitation Screen for R78.

On 4/16/19 09:10 AM V2, Director of Nursing (DON) stated that the facility has had some concerns with getting a Restorative Aide and in the past the facility had 2 aides, including weekends, but that one aide went on leave of absence and the other aide quit. V2 further stated that V5, Restorative Nurse, has been doing restorative 5 days per week, but "No, Restorative won't be done until we get the other person hired."

On 4/17/19 at 12:30 PM, V5, Restorative Registered Nurse stated restorative ROM was done up until March 18, 2019 when the restorative aide quit. V5 further stated, "I had no help, everyone was being pulled to the floor. I can't do it all by myself. I didn't verify that ROM was being done."

On 4/24/19 at 9:21AM, V29, Medical Director, stated she would expect the facility to follow their policy with regard to Range of Motion and Restorative programing to for the prevention of contractures or further decline in contractures.

4. R15's Care Plan dated 4/10/19 documents

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that R15 is at a Restorative level 2 and is at risk for decline in joint mobility. The care plan further documents R15's interventions to include passive range of motion to all joints for 5-10 repetitions as tolerated BID. The Facility Restorative Daily Attendance record fails to document R15 receiving any services.

On 4/17/19 at 12:30 PM V5, Restorative Nurse, stated she has done Passive Range of Motion (PROM) on R15, but not daily, and states CNA's are supposed to do it also.

R15's Rehabilitation Screen dated 4/17/19, documents R15 having ROM deficits as follows: right 2nd mp -30 degrees, right 3rd mp -65 degrees, right 4th mp -75 degrees, and right 5th mp -25 degrees.

R15's Occupational Therapy Plan of Care dated 12/28/18 provided by the facility, does not list any ROM deficits for R15's Metaphalangeals.

Facility Policy entitled Resident Mobility and Range of Motion, revised on July 2017, documents in part, "Policy Statement 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. "The policy further documents in part, "8. Documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs."

Facility Policy entitled Range of Motion Exercises, revised October 2010, documents in part that the purpose of the ROM exercises is to exercise the

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resident's joints and muscles. The Policy further documents in part, "Documentation. 1. The date and time that the exercises were performed. 2. The name and title of the individual(s) who performed the procedure. 3. The type of ROM exercise given. 4. Whether the exercise was active or passive. 5. How long the exercise was conducted. 6. If and how the resident participated in the procedure of any changes in the resident's ability to participate in the procedure. 7. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the treatment, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the exercises. 2. Report other information in accordance with facility policy and professional standards of practice."

Facility Policy entitled Resident Mobility and Range of Motion, revised July 2017, documents in part, "Policy Statement 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. 8. Documentation of the resident's progress toward the goals and objectives will include to address any changes or decline in the resident's condition or needs."

(B)