

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
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F 280	Continued From page 76 coordinating the activities, was included in the outline and was reviewed by meeting attendees. 23. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed either she or the Regional Vice President had been present in the building daily since 01/31/15 after the facility was notified of the IJ on 01/30/15. Review of training records, QA meetings, and documented interviews with State Survey Agency personnel provided evidence of her presence in the facility. She stated her primary role had been one of corporate oversight, and she had been closely involved in developing and ensuring implementation of the facility's action plan on a daily basis. The DCO further stated she had maintained collaboration with the corporate office via the Regional Vice President. 24. Interview with the DCO, on 02/05/15 at 2:45 PM, revealed the facility's "Scabies Prevention and Control Plan" was based on implementation of the "Scabies Guidelines". She stated the guidelines, along with the "Scabies Fact Sheet" had been a foundation for training of staff. Continued interview revealed the new "Scabies/Rash Tracking Log" would be important for tracking rashes in the future, and met the intent of maintaining a high index of suspicion for scabies as a possible cause of an undiagnosed skin rash. Continued interview revealed as treatment had been initiated for all residents in the building, everyone was being tracked for effectiveness of the treatment. She further stated any resident who failed the current treatment program would be referred to the Dermatologist for follow-up. Review of the "Scabies Guidelines" revealed it was comprehensive approach to the prevention,	F 280			

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F 280	<p>Continued From page 77</p> <p>identification and treatment of scabies. Continued review revealed specific guidelines related to cleaning and disinfecting, and laundering, to prevent re-infestation or spread to other individuals.</p> <p>25. Review of Departmental Notes for 02/03/15 revealed the Responsible Party for each resident on the A wing was notified by telephone of scabies present in the building, and the facility's plan for treatment and contact isolation precautions. For those residents who were self-responsible, notification to the resident was made by Social Services.</p> <p>26. Review of the Physician orders dated 02/04/15 revealed all remaining residents on the A wing were to be treated for scabies, meaning that every resident in the facility had orders for treatment. Continued review revealed medication orders, and orders for contact isolation, were consistent with those for all other residents.</p> <p>Review of the MARs for those remaining A wing residents revealed treatment was initiated according to the Physician's orders.</p> <p>Observations, on 02/06/15 at 1:30 PM, 3:00 PM and 5:00 PM, revealed residents on the A wing were receiving baths or showers to remove the first application of Elimite cream. Continued observations revealed personal clothing, linens and privacy curtains were laundered, washable surfaces in the residents' rooms were disinfected, and non-washable items were wrapped in plastic and stored in the outbuilding, according to the facility's "Guidelines for Scabies".</p> <p>27. Clinical record review revealed Residents #1</p>	F 280		
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F 280 Continued From page 78
and #10, with confirmed diagnoses of scabies on 01/26/15, had follow-up appointments scheduled with the Dermatologist for 02/06/15.

28. Interviews and record reviews validated QA monitoring as follows:

Review of the "Scabies/Rash Tracking Log" revealed all residents in the building were included, as all had received treatment for scabies. Continued review revealed the DON or the Administrator signed off on each resident entry daily, beginning on 02/02/15 and ongoing.

Interview with the DON, on 02/06/15 at 1:50 PM, revealed each resident would stay on the log for at least seven weeks, to ensure the treatment was effective and all symptoms of itching and rashes were resolved. She stated the extra weeks would allow identification of re-infestation, as symptoms take two (2) to six (6) weeks to manifest.

Review of the "Skin Inspection Log" revealed each resident was added to the log when their bi-weekly skin assessment was completed, or any time a new skin concern was identified and an assessment was performed. Continued review revealed the DON or the Administrator signed off on the log each day, beginning on 02/02/15 and ongoing.

Interview with the DON, on 02/06/15 at 1:50 PM, revealed she and the Administrator reviewed the "Skin Inspection Log" daily to ensure the nursing staff was compliant in identifying, documenting and making appropriate notifications of new skin concerns. She stated the RN Supervisor would be responsible for reviewing the log on the

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F 280	<p>Continued From page 79</p> <p>weekends, and the DON and Administrator would review the weekend logs on Mondays. Continued interview revealed any concerns identified during the daily reviews would result in immediate re-education of the responsible staff.</p> <p>Review of the "Care Plan Audit Log" revealed the first weekly audit of Care Plans for residents being treated for scabies was completed and signed by the DON on 02/04/15. Currently, all resident Care Plans were reviewed as all residents received treatment.</p> <p>Interview with the DON, on 02/06/15 at 1:50 PM, revealed she would be reviewing the Care Plans weekly for a total of eight (8) weeks to ensure new revisions were made as indicated by the resident's response to treatment. She stated any identified concerns with her review of all logs would be addressed immediately by re-education. Continued interview revealed results from all audits would be presented at each monthly QA meeting for discussion.</p> <p>Interview with the Administrator, on 02/06/15 at 2:45 PM, revealed he had remained closely involved with the development and implementation of the facility's action plan related to the IJ. He stated, along with the DON and the DCO, he had ensured all staff was educated related to the facility's "Scabies Prevention and Control Plan". Continued interview revealed his role included reviewing audits daily, ensuring PPE and other needed supplies were readily available, speaking with families, and making observations to ensure the facility's plan was followed according to Physician orders and the written guidelines. The Administrator further stated all audits results would be reviewed at each QA</p>	F 280		

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F 280	Continued From page 80 meeting, with the next scheduled meeting being 02/09/15, and regular monthly meetings occurring on the first Monday of the month.	F 280		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of the facility's policy/procedure, the facility failed to have an effective system to ensure the necessary care and services related to the assessment, care, monitoring, evaluation and treatment of resident itching and rashes was provided to fifteen (15) of sixteen (16) sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14 and #16). Interview and record review revealed Permethrin cream, a treatment for Scabies (a very contagious microscopic human itch mite which caused an intense itching skin irritation) was prescribed and initiated from 07/21/14 through 07/23/14, for four (4) residents, Residents #5, #6, #7 and #9. On 07/27/14, seventeen (17) additional resident (Residents #1, #2, #3, #4, #8, #10, #11, #12 and #14, and Unsampled Residents A, B, C, D, E, F, G and H) were also	F 309 F309	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents identified to have been found affected by the deficient practice include Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #16, as well as unsampled residents A, B, C, D, E, F, G and H. Orders were received from Medical Director to treat 31/31 residents on B Wing per scabies protocol. This would include Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #14, #15, A, B, D, E, F, G, H, J, K. Orders received included contact isolation per protocol, Elimate cream one application to begin 1/27/15 and to repeat in 7 days and Stromectal tabs to be administered on day 1, 2, 8, 9, and 15. The 31/31 residents' responsible party/POA was notified of current skin condition and treatment orders by RN and Activities Director. On 1/26/15, all 31/31 B Wing residents were placed on contact isolation per facility guidelines. On 1/27/15 each of the 31/31 B Wing	

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F 309	Continued From page 81 treated with Permethrin for Scabies. However, there was no documented evidence on 07/27/14, the facility ensured the "Scabies" Policy was followed, to include placing the seventeen (17) residents in contact isolation and performing decontamination of resident areas. In August 2014, Residents #6 and #7 were again treated for Scabies, but there was no documented evidence the Scabies Policy was followed at that time. On 09/10/14, Resident #6 was also treated with Stromectol (an oral medication for treatment of Scabies) and on 01/03/15 with Permethrin cream for Scabies. Additionally, Resident #9 was treated again while hospitalized between 01/03/15 and 01/06/15 for Scabies, and again at the facility on 01/11/15. Five (5) of the sixteen (16) sampled residents, Resident #1, #2, #6, #7 and #11, developed skin related bacterial infections and required the administration of topical and/or oral antibiotic medication. Topical antibiotic ointment was ordered for Resident #2 on 07/27/14, Resident #11 on 08/01/14 and Resident #1 on 01/26/15. Oral antibiotics were ordered for Resident #6 on 09/10/14 and Resident #7 on 12/01/14. Observation revealed numerous residents scratching areas on their bodies, with some of the residents observed to have dark reddish spots, which appeared to be blood, on their clothing and bedding. Further observation revealed none of these residents were in contact isolation. Review of the facility's Census and Condition form revealed five (5) residents were identified to have rashes on 01/22/15. However, after the facility conducted a skin assessment sweep of residents, a total of fourteen (14) residents were identified to have rashes, with thirteen (13) of the fourteen	F 309	residents were treated with Elimate cream. Cream applied to all areas of the body from the neck down to the feet and toes by licensed nursing staff. The cream was left on for 8-14 hours. On 1/27/15-1/28/15 after completion of treatment, each resident was then bathed and provided a clean set of clothing. Bath/showers were given by CNAs and LPN, with the process overseen by 2 RNs. On 1/27/15, all 31/31 B Wing residents were started on Stromectol 3mg tabs per physician's orders. On 1/27/15 personal clothing, bed linens, privacy curtains and all other linen was removed from all 31/31 residents' rooms by laundry staff members and taken to laundry to be cleaned. Linens of B wing residents were washed separately from other residents in the center using the hot water and hot dryer cycles. Machine and dryer were disinfected with Clorox Healthcare Bleach Germicidal Cleaner. Non-washable personal belongings were placed in sealed bags or wrapped in plastic wrap and quarantined outside the center. These items were held in quarantine for a total of 14 days per guidelines. On 1/27/15 furniture and equipment throughout the center, including common areas and dining rooms on both A and B Wings and		

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F 309	<p>Continued From page 82</p> <p>(14) residents identified residing on the B wing of the facility, and one (1), Resident #13 residing on the A wing.</p> <p>Review of the Comprehensive Care Plans for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #14 revealed no documented evidence their care plans were revised for monitoring the effectiveness of the scabies treatment to ensure eradication of the contagious Scabies infestation.</p> <p>Additionally, during the Partial/Extended Survey, Resident #16, who resided on A wing and was not identified to have a rash during the facility's skin assessment sweep, was observed by the State Survey Agency to have itching and a rash. Per interview, Resident #16 had experienced the rash for approximately two (2) weeks.</p> <p>The facility's failure to have an effective system in place to ensure residents received the necessary care and services regarding Scabies treatment was likely to cause serious injury, harm impairment or death to a resident. Immediate Jeopardy was identified on 01/30/15, and found to exist on 07/27/14. The facility was notified of the Immediate Jeopardy on 01/30/15.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 02/05/15, with the facility alleging removal of the Immediate Jeopardy on 02/05/15. The State Survey Agency verified removal of the Immediate Jeopardy on 02/05/15 as alleged, prior to exit on 02/06/15, with remaining non-compliance at Scope and Severity of an "E", while the facility develops and implements a Plan of Correction, and the facility's Quality Assurance program monitors to ensure</p>	F 309	<p>31/31 resident rooms on B Wing was disinfected with Clorox Healthcare Bleach Germicidal Cleaner by housekeeping staff and monitored by Housekeeping/Laundry Supervisor. On 1/27/15 the MDS Coordinator revised the plan of care for all residents receiving treatment to address the current problem, treatment and interventions including isolation precautions, monitoring for side effects and as needed medication to address itching or other side effects.</p> <p>On 1/28/15- two A wing residents began treatment for rash identified upon further review of skin audits by Director of Nursing (this included Resident #13). PA notification resulted in orders for both residents including contact isolation, Elimite 5% cream repeat in one week and Stromectal 3mg tabs to be administered on day 1,2, 8,9, 15. Residents' rooms, clothing, personal items and all equipment were cleaned per protocol. Residents' responsible party/POA was notified by RN. Both residents were being treated for flu like symptoms and had not been in common areas since 1/23/15. On 2/4/15 Medical Director gave order to treat the remaining 34/36 A wing</p>		

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F 309 Continued From page 83
compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Scabies", effective 08/01/12, revealed Scabies was an itching skin irritation caused by the microscopic human itch mite which burrows into the skin's upper layers. The Policy revealed secondary bacterial infections might result from untreated Scabies. Review revealed Scabies was spread through skin-to-skin contact, or through contact with bedding, clothing, privacy curtains and some furniture. Per the Policy, the diagnosis of scabies might be established by recovering the mite from its burrow and identifying it microscopically. However, the Policy noted the failure to identify scrapings for microscopic examination as positive did not necessarily indicate a negative diagnosis of Scabies. Continued review of the Policy revealed it was "very difficult" to obtain a positive result as only one (1) or two (2) mites might cause multiple skin lesions. According to the Policy, often diagnosis was made from signs and symptoms and treatment followed without performing skin scrapings. The Policy stated procedures for individual cases were to: establish contact isolation immediately, including use of a gown with gloves "tightly" covering the cuff of the gown; contact the Physician, and if he/she ordered scrapings to contact the laboratory; however, negative scrapings were not significant and treatment should be done if symptoms were present; and obtain an order for treatment and obtain the treatment cream "stat" (immediately). The Policy revealed public areas should be cleaned before completion of the resident decontamination process so that "treated" residents did not use contaminated public areas.

F 309 residents (this would include all remaining in the survey sample). Orders included contact isolation per protocol, Elimate 5% cream applied from neck down to toes, leave on 8-14 hours, repeat in one week and Stromectal 3 mg tags to be administered on day 1, 2, 8, 9 and 15. The remaining 34/36 resident rooms, clothing, personal items and equipment were cleaned per facility guidelines by nursing and housekeeping/laundry staff. Common areas cleaned per guidelines by housekeeping staff. In-service education in regards to proper storage of biohazard bags in the laundry area was given by the Administrator and Director of Clinical Operations beginning on 2/5/15 and extending through 2/6/15 for housekeeping, laundry and nursing staff.

Resident #16 was accompanied by center staff to a dermatology appointment on 2/4/15. Documentation in nurses' notes dated 2/4/15 support family notification of appointment and subsequent treatment orders. Resident #16

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F 309	<p>Continued From page 84</p> <p>Further review revealed it was recommended that residents sharing a room with a suspected Scabies case should be examined carefully, and it was recommended to prophylactically treat the roommate "due to the high level of contagiousness".</p> <p>Review of the facility's, "Care System Guideline, Skin Care", undated, revealed the purpose of the Guideline was to provide a system for evaluation of residents' skin at risk, identify individual interventions to address the risk and process for care of changes/disruption in their skin integrity. Per the Guideline a "weekly review" was to be performed of each resident's skin by the nurse and documented in the electronic medical record (EMR). The Guideline revealed the Director of Nursing (DON) or designee would be responsible for implementing and monitoring the facility's "skin integrity program".</p> <p>Interview with the Administrator, on 01/28/15 at 4:01 PM, revealed the facility had implemented an electronic medical record (EMR) system in August 2014. He stated the facility's process for skin integrity documentation was weekly skin assessments performed by the nurses, and if skin was intact, no further documentation was performed. Per interview, as the facility utilized an EMR, if residents were noted to have skin intact, the only report available from the EMR was the "Skin Inspection Report". The Administrator revealed if a resident's skin was not intact a "Wound Assessment" would be generated in addition to the "Skin Inspection Report".</p> <p>Review of the three (3) Dermatology consults obtained by the facility, on 01/26/15, revealed two (2) of the three (3) residents, Resident #1 and</p>	F 309	<p>discharged to home as planned with plan of care of 2/5/15.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. On 1/26/15, body audits were completed on all in-house residents by assigned RN and LPN staff.</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? The Administrator and Director of Nursing were in-serviced regarding Scabies in long term care facilities including prevention and control, by the Director of Clinical Operations on 1/26/15, to ensure the management team was prepared to follow through with staff education. On 1/26/15, the Administrator and Director of Nursing initiated education for staff members on contact isolation including applying and removing PPE prior to entering/exiting residents' room. On</p>		

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F 309	<p>Continued From page 85</p> <p>#10, were microscopically confirmed positive for Scabies. Continued review revealed the third resident, Resident #14, was microscopically negative for Scabies; however, per the Dermatologist's report the resident was being treated empirically (based on the Physician's experience and observation rather than on systematic logic) for Scabies because of his/her exposure to Scabies at the facility, as well as his/her clinical presentation being consistent for Scabies.</p> <p>1. Record review revealed Resident #1 was admitted to the facility on 09/12/13 with diagnoses which included: Sepsis, Urinary Tract Infection (UTI), Diabetes, Iron Deficiency Anemia and Chronic Kidney Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/01/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Review of Resident #1's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #1's Physician Orders, revealed an order for Permethrin Cream (topical treatment for Scabies) was ordered on 07/27/14, to be applied from neck down leave on for eight (8) to fourteen (14) hours then shower off, repeat in two (2) weeks, wash bed linen and laundry as directed. However, further review of the 07/27/14 order revealed no documented evidence Resident #1 was placed on contact isolation precautions, as per the facility's policy. Continued review of the Physician's Orders revealed on 08/14/14, Cocoa Butter Lotion was ordered to be</p>	F 309	<p>1/28/15, the Director of Nursing educated licensed staff on how to accurately complete a skin assessment, with a repeat education provided by the Director of Nursing for the licensed staff on 2/6/15. On 1/27/15, personal clothing, bed linens, privacy curtains, and all other linen were removed from all 31/31 B Wing resident rooms by laundry staff members and taken to laundry to be cleaned. Linens of B wing residents were washed separately from the other residents in the center using the hot water and hot dryer cycles. Machine and dryer were disinfected with Clorox Healthcare Bleach Germicidal Cleaner. Non-washable personal belongings were placed in sealed bags or wrapped in plastic wrap and quarantined outside the center. These items remained in quarantine for a total of 14 days per guidelines. This process was overseen by the Housekeeping/Laundry Supervisor. On 1/27/15, furniture and equipment throughout the facility including common areas on both A & B wing including dining rooms and 31/31 resident rooms were disinfected with</p>		

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F 309	<p>Continued From page 86 applied to the right shoulder and chest.</p> <p>Review of the Physician's and PA's Notes revealed on 08/24/14, the PA noted Resident #1 "still" had pruritis (itching) of the right shoulder area, neck and chest with some maculopapular which she had asked the Physician "to assess".</p> <p>Continued review of the Physician's orders revealed a Dermatology consult was ordered on 08/28/14; however, there was no documented evidence of a Dermatology consult in the record.</p> <p>Review of the 09/18/14, PA's Note revealed Resident #1 had a "rash" and "skin lesions". The PA noted Resident #1 "still" had some reddened maculopapular (flat, red area on the skin that is covered with small bumps) lesions on his/her shoulder and some scattered on his/her chest wall with a one (1) treatment of Triamcinolone (a topical steroid) cream, then Cetaphil Body Lotion for dryness. Continued review of the Physician's orders revealed an order on 09/18/14, for Cetaphil Moisturizing Lotion to trunk and upper extremities daily.</p> <p>Review of Resident #1's "Skin Inspection Report", revealed on 08/26/14 and 09/23/14, documentation which noted "skin not intact-existing". Review of the 08/26/14 "Wound Assessment Report", also generated through the facility's EMR if skin issues were noted, revealed Resident #1 was noted to have "dried scabs to upper torso and both upper extremities also noted with self-inflicted scratches to left clavicle" with no treatment required. Review of the 09/23/14 "Wound Assessment Report" revealed Resident #1 had "chronic cellulitis" to his/her left and right lower extremities with no treatment required</p>	F 309	<p>Clorox Healthcare Bleach Germicidal Cleaner by housekeeping staff and monitored by Housekeeping/Laundry Supervisor. On 1/27/15 staff was notified that the facility would be making treatment available for all employees. Staff was instructed to notify the Director of Nursing or Administrator of any sign/symptom of scabies. A list of sign/symptoms was provided to staff. The Director of Nursing began to distribute Elimite cream on 1/27/15 along with verbal instructions. A log is being maintained by Director of Nursing of employees that accept treatment. The Director of Nursing distributed questionnaire on 2/3/15 to staff members to address the effectiveness of medication, continued signs and symptoms and potential need for additional staff treatment.</p> <p>On 1/30/15, the Administrator and Director of Nursing initiated education on "Scabies Fact sheet" and "Guidelines for scabies" by handouts and discussion. The "Scabies Fact sheet" will also be included in new employee orientation and annual infection control</p>	

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F 309	Continued From page 87 noted Review of the PA's Note dated 09/25/14, revealed the PA noted Resident #1's rash was "no better", and the resident had a Dermatology appointment on 10/06/14, with orders for hypoallergenic laundry detergent, body wash and lotion. However, record review revealed no documented evidence Resident #1 had a Dermatology consult on 10/06/14 as noted. Review of the 10/07/14 Physician's Note revealed the Physician had seen Resident #1, with no orders noted regarding the rash noted by the PA on 09/25/14. Review of the 10/22/14 PA note, revealed the PA noted Resident #1 had "evidence of Stasis Dermatitis", with no new orders noted in regards to this. Review of the 11/14/14 Note revealed the PA noted Resident #1 had a "rash, "chronic Stasis Dermatitis", increased redness, warmth and "scaling", and had a 3 centimeter (cm) superficial excoriation with eschar (a dry, dark scab or falling away of dead skin) on his/her left thigh, with orders for Keflex (an oral antibiotic). Review of the PA's Note dated 12/17/14, revealed Resident #1 for follow up related to the "Stasis Dermatitis". Review of the 01/05/15 Note revealed the Physician noted Resident #1 had a "rash" to his/her "upper trunk" which was "persistent", with no new orders noted for treatment to the area. However, continued review of Resident #1's "Skin Inspection Report" revealed on 09/09/14, 10/13/14, 10/17/14, 10/24/14, 11/01/14, 11/08/14, 11/14/14, 11/21/14, 11/28/14, 12/06/14, 12/12/14, 12/19/14, 12/27/14, 01/02/15, 01/03/15, 01/09/15, 01/10/15 and 01/16/15, the nurses noted the resident's "skin intact". Even though there was	F 309	in-service as of 2/4/15. On 1/30/15, the Director of Clinical Operations in-serviced the Director of Nursing on infection control surveillance logs, tracking and trending of scabies/rash and the need for ongoing monitoring. On 1/30/15, the Director of Clinical Operations educated the MDS Coordinator on ensuring care plans for scabies/rashes include the specific problem, goal, interventions being taken, and monitoring for the effectiveness of interventions. The center established a Scabies Prevention and Control Plan as of 1/31/15 that includes: implementation of Scabies Guidelines based on CDC Guidelines, Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash, and any unresolved rashes after initial course of treatment will be referred to dermatologist. The center implemented the "Scabies/Rash Tracking Log for residents with rashes and new admissions that is completed by the Director of Nursing on weekdays and RN Supervisor on weekends and is reviewed daily for 6 weeks by the		

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F 309	<p>Continued From page 88</p> <p>documented evidence, in the Physician's/PA's Notes and Physician Orders, Resident #1 had a rash and was receiving treatment.</p> <p>Further review of Resident #1's "Wound Assessment Report", dated 01/17/15, revealed a "skin tear" was identified behind the resident's right ear with the "cause" documented as "self-inflicted scratching/picking". Review of the "Wound Assessment Report" dated 01/22/15, revealed the nurse documented Resident #1 had a "rash" which covered his/her "entire" left and right arms, and noted it to be a "reddened rash", with some areas "raised and some with scabs", and this was a "chronic condition for resident". Continued review of the 01/22/15 Report revealed Resident #1's "entire" abdomen and "entire" left thigh were also covered with a "reddened rash", with some areas "raised and some with scabs", and this was a "chronic condition for resident". Further review of the Report revealed the nurse noted the "cause" as "unknown" for all the areas. In addition, the nurse documented all the areas were being treated with Cetaphil lotion and body wash.</p> <p>Observation of Resident #1, on 01/22/15 at 11:30 AM, revealed the resident was sitting up in a wheel chair in his/her room. Observation revealed Resident #1 was actively scratching his/her arms, and his/her clothing and bed linens were spotted with a reddish brown blood like substance.</p> <p>Interview with Resident #1, on 01/22/14 at 11:30 AM, revealed he/she was "itching all over" especially on his/her back and neck. Resident #1 reported the itching had been going on "a long time" and he/she was "miserable". Continued</p>	F 309	<p>Administrator, DNS or the RN Supervisor. Also, the 'Skin Inspection Log' is completed by the Director of Nursing on weekdays and RN Supervisor on weekends and will be reviewed by the Administrator, DNS or the RN Supervisor daily for 4 weeks, to identify an issues and interventions will be implemented and the Care Plans of residents being treated will be reviewed by the Administrator, DNS or RN Supervisor weekly for 8 weeks to review interventions.</p> <p>How will the facility monitor performance to ensure solutions are sustained? The Director of Nursing will oversee 5 skin inspections weekly for 6 weeks to ensure accuracy of assessment and competency of licensed staff. Any discrepancy will be immediately addressed and nurse will be re-educated. 30 scabies educational post tests will be given out to staff by Administrator or Human Resources weekly for 6 weeks and then monthly for 6 months to ensure ongoing staff education and compliance. This sample shall include staff from all shifts</p>		

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interview, on 01/29/14 at 1:12 PM, revealed the itching made Resident #1 want to rub his/her skin and it was "aggravating".

Observation, on 01/22/15 at 3:13 PM, of a skin assessment completed by Registered Nurse (RN) #1 for Resident #1 revealed the resident had a rash with scabbing to both arms, both upper legs, shoulders and front and back of his/her torso. Further observation revealed RN #1 did not remove Resident #1's Unna Boots (a compression gauze dressing filled with zinc paste used to treat venous issues) on his/her lower legs as they were not due to be changed.

Interview with RN #1, on 01/22/15 at 3:13 PM, at the time of the skin assessment, revealed Resident #1 had a history of being treated for Scabies. RN #1 revealed Resident #1 had reported a rash and itching for at least a month or longer. Additional interview, on 01/26/15 at 9:15 AM, with RN #1 revealed she did not know what the itching or rash was, and reported staff was not utilizing any type of contact isolation precautions in regards to the rash.

Review of a Dermatology Consult dated 01/26/15, revealed Resident #1 was diagnosed with a positive microscopic confirmation of Scabies.

Further review of the Physician's Orders revealed on 01/26/15, Bacitracin ointment (a topical antibiotic) for a wound behind the right ear; Permethrin Cream to be applied topically from the neck down, leave on eight (8) to fourteen (14) hours then wash off and repeat the treatment in one (1) week; and, Contact Isolation Precautions. On 01/27/15, Stromectol tablets (oral Scabies Treatment medication) were ordered; and, on

F 309 including weekends. Any employee who is unable to answer 100% of post test questions correctly will receive additional education by the Director of Nursing, Administrator or RN Supervisor. The Scabies Fact Sheet will be included in new employee orientation and the annual infection control In-service as of 2/4/15. Evaluation and monitoring of each resident receiving treatment will consist of skin inspection for resolution of prior rashes and observation of all residents at risk for new skin eruptions in 2-6 weeks per CDC guidelines. Skin inspections will be completed by licensed nursing staff on all residents twice weekly starting 1/31/15 for 6 weeks and then weekly thereafter. The physician will be notified at the time of findings and treatment will be initiated per physician orders. Review of surveillance tracking and trends of rashes will be presented by the Director of Nursing to the monthly QAPI committee for further measures and/or additional training on an on-going basis. The QAPI meetings have been

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F 309	Continued From page 90 01/29/15 Benadryl was ordered for itching. Interview with the Director of Nursing (DON), on 01/26/15 at 1:00 PM, revealed a Physician's order for a Dermatology Consult was received on 08/28/14. The DON revealed Resident #1's primary nurse called the Dermatology office indicated on the order, and was advised this Dermatologist did not accept Resident #1's insurance, which was Medicaid. Continued interview revealed the Physician was aware of this information. According to the DON, she was not aware if more than one (1) Dermatologist was contacted by the nurse. She stated Resident #1's family was contacted; however, the family declined to pay for the Dermatology consult. Per interview, therefore, Resident #1 did not receive the Dermatology consult to properly diagnose and treat the on-going rash and itching. 2. Record review revealed Resident #10 was admitted to the facility on 08/05/10, with diagnoses which included Peripheral Vascular Disease, Depressive Disorder, Dementia with Behaviors and Joint Contractures. Review of the Quarterly MDS Assessment, dated 11/13/14, revealed the facility assessed Resident #10 to have a BIMS score of three (3) of fifteen (15), indicating the resident was severely cognitively impaired. Review of Resident #10's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments. Review of Resident #10's Physician Orders revealed on 07/27/14, Permethrin Cream was ordered; however, further review of the 07/27/14 order revealed no documented evidence	F 309	scheduled with the Medical Director to ensure monthly attendance.	3/10/15

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F 309	<p>Continued From page 91</p> <p>Resident #10 was placed on contact isolation precautions, as per the facility's policy. Continued review of the Physician's Orders revealed on 08/03/14 Cetaphil cleansing bar and Cetaphil lotion was ordered to be applied to Resident #10's extremities and trunk two (2) times a week on shower days.</p> <p>Review of the EMR "Skin Inspection Report" revealed on: 08/26/14, 09/02/14, 09/09/14, 09/15/14, 09/22/14, 09/29/14, 10/06/14, 10/13/14, 10/20/14, 10/27/14, 10/31/14, 11/03/14, 11/10/14 and 11/18/14 the nurses documented Resident #10's "skin intact". Continued review of the "Skin Inspection Report" revealed on 11/24/14, 12/01/14, 12/08/14, 12/13/14, 12/15/14, 12/22/14, 12/29/14, 01/05/14 and 01/12/15 the nurses documented Resident #10's skin as "skin not intact-existing". Review of the "Wound Assessment Report" dated 11/25/14, 12/01/14, 10/08/14, 12/15/14, 12/22/14, 12/29/14, 01/05/15, 01/06/15, 01/12/15, 01/19/15 revealed the nurses documented Resident #10 had an area of irritation/excoriation on his/her left center of the coccyx.</p> <p>Review of the "Wound Assessment Report" dated 01/23/15, revealed the nurse documented Resident #10 had a "rash" on his/her "entire chest" area, with the "cause" noted as "yeast/fungus", which measured 20 cm by 20 cm, and on the "right lower quadrant" which measured 15 cm by 15 cm. Further review of the 01/23/15 "Wound Assessment Report" and the Physician's Orders revealed the Physician was notified and a telephone order was obtained for Triamcinolone cream mixed with Cetaphil lotion to be applied to the "rash" on Resident #10's chest and abdomen.</p>	F 309			

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F 309	<p>Continued From page 92</p> <p>Review of the "Nursing" Notes revealed a Dermatology Consult was obtained on 01/26/15, with a positive microscopic confirmation of Scabies. Review of the Physician's Note and Orders dated 01/26/15, revealed orders for Permethrin Cream and Stromectol tablets and Contact Isolation Precautions.</p> <p>Observation, on 01/28/15 at 5:03 PM, of a skin assessment, performed by RN #1, revealed a red raised rash area to Resident #10's back, abdomen, both upper thighs, right lower leg, and left arm. Although, the "Wound Assessment Report" dated 01/23/15, revealed Resident #10 only had a "rash" on his/her "entire chest" area on that date.</p> <p>Interview with RN #1, on 01/26/15 at 9:15 AM, revealed she did not know what the cause of the itching or rash was and reported staff was not utilizing any type of contact isolation precautions.</p> <p>3. Record review revealed Resident #3 was admitted to the facility on 03/22/13, with diagnoses which included Anxiety, Idiopathic Pericarditis (inflammation of the sac around the heart), Chronic Airway Obstruction, Diabetes, Chronic Pain Syndrome and Depressive Disorder. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 01/19/15, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Review of Resident #3's Comprehensive Care Plan revealed the facility had care planned the resident on 06/24/13, to be at risk for impaired skin integrity related to recurrent bilateral Cellulitis.</p>	F 309		

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F 309	<p>Continued From page 93</p> <p>Review of Resident #3's Physician Orders revealed Permethrin Cream was ordered on 07/27/14 to be applied from the neck down, leave on for eight (8) to fourteen (14) hours, shower off, wash bed linen and laundry as directed, and repeat the treatment in two (2) weeks. However, further review of the 07/27/14 order revealed no documented evidence Resident #3 was placed on contact isolation precautions, as per the facility's policy.</p> <p>Review of Resident #3's EMR "Skin Inspection Report", revealed on 08/07/14 documentation of "skin not intact-new". However, review of Resident #3's "Weekly Skin Assessment" forms, which were in place prior to the facility going to an EMR, revealed no documented evidence of a skin assessment performed on 08/07/14. Review of the Physician's Order dated 08/07/14, revealed a Dermatology Consult was ordered related to a continued rash. Review of Resident #3's Comprehensive Care Plan for risk of impaired skin integrity, revealed documentation dated 08/07/14, stating to schedule a Dermatology follow-up; however, it was noted the resident was not an established patient, and the Dermatologist was not accepting new patients. Continued record review revealed no documented evidence the facility attempted to contact other Dermatologists who might be accepting new patients to ensure treatment was obtained for Resident #3 as per the Physician's Orders.</p> <p>Review of the "Weekly Skin Assessment" form dated 08/11/14 revealed Resident #3 had a "blister to knee" with a new order written; however, there was no documented evidence of a rash on the resident's body. Review of the</p>	F 309		

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F 309	<p>Continued From page 94</p> <p>Physician's Assistant's (PA's) Notes for Resident #3 revealed on 08/12/14, the PA asked the Physician "to see" Resident #3, related to the rash on his/her chest which did not look improved, and he/she was status post (s/p) steroid treatment and Permethrin treatment. However, there was no documented evidence the Physician examined Resident #3 until 10/08/14. Review of the "Weekly Skin Assessment" form dated 08/13/14, revealed the resident had a skin tear to his/her right arm with treatment "in progress" and no "other skin issues noted", even though the PA noted Resident #3 to have a "rash" on his/her chest on 08/12/14 which she had asked the Physician "to see".</p> <p>Continued review of the Physician's Orders revealed no documented evidence of additional treatment orders for the "rash" until 08/17/14, when an order was received for Cetaphil Lotion for a rash to the resident's right axilla and bilateral upper extremities.</p> <p>Review of the EMR "Skin Inspection Report" revealed on 09/09/14 and 09/22/14, the nurses noted Resident #3's "skin intact". However, review of the Orthopedic Consultant Physician's Note dated 09/25/14, revealed Resident #3 was noted to have complaints of pain in the left rib area/mid-axillary line, with "itching at site". Additionally, review of the 09/29/14 "Skin Inspection Report" revealed Resident #3's "skin not intact-existing". A "Wound Assessment Report" was requested by the State Survey Agency for 09/29/14, to determine why Resident 3's skin was noted not to be intact, but no documented evidence was provided, even though per interview with the Administrator this was the facility's process since implementation of the</p>	F 309			

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F 309	<p>Continued From page 95 EMR.</p> <p>Continued review of the "Skin Inspection Report" revealed on 10/06/14, Resident #3's skin was noted to be intact. However, review of the Physician's Note dated 10/08/14, revealed Resident #3 had a "rash". Review of the PA's Note dated 10/09/14, revealed the PA had examined Resident #3 related to "bilateral Cellulitis of lower extremities", with no documentation related to the "rash". Review of the Physician's Orders revealed no documented evidence of further treatment for the "rash" until 10/13/14, five (5) days later.</p> <p>Review of the "Skin Inspection Report" dated 10/13/14, revealed the nurse noted "skin not intact-new". Review of the "Wound Assessment Report" dated 10/13/14, generated as a result of Resident #3's skin not being intact, revealed the resident had a "rash" on his/her "entire back" with the "cause" noted to be "allergic reaction/adverse drug reaction". Continued review of the 10/13/14 "Wound Assessment Report" and Physician's Orders revealed orders were received for oral Benadryl twice a day PRN (as necessary), which had a stop date of 10/15/14, and Cetaphil body wash and lotion twice a day on bath days for treatment of the rash.</p> <p>Review of the "Skin Inspection Report" dated 10/20/14, revealed Resident #3's skin was noted to be intact. However, review of the "Wound Assessment Report" dated 10/20/14, revealed Resident #3 had a "rash" on his/her "entire back", with the "cause" noted to be "accident/other trauma", and the nurse documented the "rash" had improved, continue to use "Cetaphil wash and lotion". Additionally, review of the Physician's</p>	F 309		
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F 309	<p>Continued From page 96</p> <p>Order dated 10/21/14, revealed oral Benadryl was ordered "now" and then every six (6) hours as needed for itching and rash. Continued review of the Physician's Orders revealed the Benadryl was discontinued on 10/22/14.</p> <p>Review of the "Skin Inspection Report" dated 10/27/14, revealed the nurse documented Resident #3's "skin not intact-existing". Review of the "Wound Assessment Report" dated 10/27/14, revealed Resident #3 had a "rash" to his/her "entire chest" which had "improved" with the "cause" noted to be "unknown". Continued review of the "Wound Assessment Report" dated 10/27/14, revealed Cetaphil lotion to body twice daily on bath days had been ordered on 10/13/14.</p> <p>Continued review of the "Skin Inspection Report" revealed on 11/03/14, Resident #3's skin was noted to be intact. However, review of the "Wound Assessment Report" dated 11/03/14, revealed Resident #3 had a "rash" on his/her "entire back", with the "cause" noted to be "moisture", and the nurse documented "pending treatment orders". However, there was no documented evidence of further treatment orders for the "rash" until 11/07/14, four (4) days later.</p> <p>Review of the PA's Note dated 11/07/14, revealed Resident #3 still had a maculopapular "rash" on his/her chest wall, with Triamcinolone cream ordered. Review of the Physician's Order dated 11/07/14, revealed an order for Triamcinolone Cream and Cetaphil lotion to be mixed and applied to rash on chest twice daily for ten (10) days.</p> <p>Review of the "Wound Assessment Report" for the date of 11/10/14, revealed Resident #3 had a</p>	F 309			

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F 309	<p>Continued From page 97</p> <p>"rash" on his/her "entire chest", with the "cause" noted to be "bacterial/viral infection", and the nurse noted orders had been received on 11/07/14, for Triamcinolone cream to be mixed with Cetaphil lotion and applied to the rash area twice a day for ten (10) days. However, there was no documented evidence of additional orders to treat the "rash" even though the nurse documented the PA was notified on the "Wound Assessment Report".</p> <p>Review of the "Skin Inspection Report" revealed on 11/17/14, Resident #3's skin was noted to be intact. However, review of the "Wound Assessment Report" dated 11/17/14, revealed Resident #3 had a "rash" on his/her "entire back", with the "cause" noted to be "yeast/fungus", and the nurse documented Triamcinolone cream mixed with Cetaphil lotion to be applied to the rash twice a day for ten (10) days was ordered on 11/07/14, Cetaphil lotion and body wash had been ordered on 10/13/14 twice a day on bath days. However, there was no documented evidence of further orders received to treat the "rash", even though the nurse documented the Physician was notified.</p> <p>Further review of the "Skin Assessment Report" for the dates of 11/24/14 through 01/19/15 revealed the nurses documented Resident #3's "skin not intact-existing". Review of the "Wound Assessment Report" for the date of 11/24/14, revealed Resident #3 had a "rash" to his/her "entire chest", with the "cause" noted to be "yeast/fungus", and Cetaphil lotion and body wash had been ordered on 10/13/14 twice a day on bath days. However, there was no documented evidence of additional orders for treatment of the "rash", even though the nurse</p>	F 309		
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F 309	<p>Continued From page 98 documented the Physician was notified.</p> <p>Review of the "Wound Assessment Report" for the dates of 12/01/14 through 01/19/15, revealed Resident #3 had a "rash" on his/her "entire back" and "entire chest", with the "cause" noted to be "yeast/fungus", with no documented evidence of a change in treatment for the "rash" areas. Review of the PA's Note dated 12/17/14, revealed Resident #3 continued to have an anterior chest wall "rash", and reported his/her clothes made him/her "itch". Continued review of the PA's 12/17/14 Note and Physician's Orders revealed orders for Triamcinolone cream to be applied to the resident's chest twice daily for one (1) week; Atarax (an anti-histamine used to treat the itching related to allergies) for the resident's itching; the resident's clothes were to be washed in Dreft detergent; and, he/she was to wear a hospital gown for one (1) week.</p> <p>Review of the PA's Note dated 01/15/15, revealed Resident #3 continued to have the chest rash, and the Physician had "recently seen" the resident and diagnosed him/her with Xerosis (abnormally dry skin), with no new orders received for treatment to the rash area.</p> <p>Review of the Physician's Note dated 01/16/15, revealed Resident #3 had a "rash".</p> <p>Continued review of the EMR "Wound Healing Progress Report" revealed documentation of measurements of the "rash" on Resident #3's chest and back for the dates of 10/13/14, 10/20/14, 10/27/14, 11/03/14, 11/10/14, 11/17/14, 11/24/14, 12/01/14, 12/12/14, 12/15/14, 12/22/14, 12/29/14, 01/05/15, 01/12/15 and 01/19/15. Further review of the "Wound Healing Progress</p>	F 309			

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F 309	<p>Continued From page 99</p> <p>Report" revealed the rash on Resident #3's chest measured 20 centimeters (cm) by (x) 20 cm on all those dates; and the rash on the resident's back measured 20 cm x 20 cm on all dates, except 01/12/15 and 01/19/15, when it was noted to measure 15 cm x 15 cm.</p> <p>Further review of the Physician's Notes and Physician's Orders dated 01/26/15, revealed the Physician noted Resident #3 had a "rash" to his/her chest, and ordered Contact Isolation Precautions and Permethrin cream and Stromectol tablets "per orders for Scabies prophylactic" (course of action used to prevent disease).</p> <p>Observation and interview, on 01/22/14 at 1:14 PM, revealed Resident #3 was sitting up on the edge of his/her bed actively scratching his/her left shoulder and arm. Resident #3 stated he/she was "itching all over" and was "very embarrassed" even in his/her own room because if the privacy curtain was not pulled, "you can see me scratching everything". Continued observation revealed the resident to have reddish brown blood like spotting on his/her clothing and bed linens.</p> <p>Observation, on 01/22/15 at 3:45 PM, of Resident #3's skin assessment performed by Registered Nurse (RN) #1, revealed a rash covering the front and back of the resident's torso and both arms.</p> <p>Interview with RN #1, on 01/26/15 at 9:15 AM, revealed she did not know what the cause of Resident #3's itching or rash was. RN #1 stated staff was not utilizing any type of contact isolation precautions.</p>	F 309		
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F 309	<p>Continued From page 100</p> <p>4. Record review revealed Resident #14 was admitted to the facility, on 06/05/14, and re-admitted on 08/11/14, with diagnoses which included Chronic Airway Obstruction, Muscle Weakness, Cognitive Communicate Deficit, Alzheimer's Disease and Post-inflammatory Pulmonary Fibrosis. Review of the Quarterly MDS Assessment, dated 11/22/14, revealed the facility assessed Resident #14 to have a BIMS score of six (6) out of fifteen (15), indicating severe cognitive impairment. Review of Resident #14's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #14's Physician Orders revealed, an order dated 07/27/14, for Permethrin Cream to be initiated. However, further review of the 07/27/14 order revealed no documented evidence Resident #14 was placed on contact isolation precautions, as per the facility's policy.</p> <p>The Surveyor requested the "Skin Assessment Report" and "Wound Assessment Report" for the months of September 2014 through January 2015; however no documented evidence of the Reports were provided.</p> <p>Continued review of the Physician's Orders revealed an order dated 01/19/15, for oral Benadryl to be given for itching, which was discontinued on 01/27/15.</p> <p>Observation, on 01/26/15 at 9:38 AM, of a skin assessment performed by RN #1, revealed Resident #14 to have a rash with scattered scabbing to his/her back, shoulders, chest, abdomen and both legs. Additionally, continued</p>	F 309			

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F 309	<p>Continued From page 101</p> <p>observation on 01/26/15 at 9:29 AM, revealed Resident #14 to be sitting upright in his/her bed aggressively scratching at his/her body and pulling at his/her clothing, and yelling out, "I need something for the itch" "I'm about to die" and "Please help me, I'm itching to death". Record review revealed Resident #14 was sent to the Dermatologist on 01/26/15, with the resident being microscopically negative for Scabies; however, the Dermatologist recommended treating him/her empirically related to his/her exposure to Scabies in the facility, as well as, the resident's clinical presentation being consistent with Scabies.</p> <p>Further review of the Physician's Note and Physician's Orders dated 01/26/15 revealed Resident #14 had a "rash" with the "etiology unknown", and orders for oral Benadryl PRN for "itching" times twenty-one (21) days, Aquaphor lotion to body once daily, Permethrin and Stromectol and Contact Isolation Precautions.</p> <p>5. Record review revealed, Resident #5 was admitted to the facility on 04/16/12, with diagnoses which included Depression, Hypothyroidism, Osteoarthritis, Difficulty in walking, Muscle Weakness and Tremor. Review of the Quarterly MDS Assessment, dated 12/02/14, revealed the facility had assessed Resident #5 to have a BIMS score eight (8) out of fifteen (15), indicating moderate cognitive impairment. Review of Resident #5's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity on 12/14/12, with interventions which included weekly skin assessments.</p>	F 309	

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F 309	<p>Continued From page 102</p> <p>Review of Resident #5's Physician Orders revealed on 06/13/14 a steroid was initiated related to a rash and on 07/06/14 a steroid oral dose pack was initiated.</p> <p>Review of Resident #5's "Weekly Skin Assessment" forms revealed, on 07/06/14, a rash was identified to his/her "upper chest" area and on 07/19/14 a generalized rash was noted to his/her arms and torso.</p> <p>Continued review of the Physician's orders revealed on 07/23/14 Permethrin Cream (Scabies treatment) was ordered. However, further review of the 07/23/14 orders revealed no documented evidence Resident #5 was placed on contact isolation precautions, as per the facility's policy.</p> <p>Continued review of the Physician's Orders revealed on 07/30/14 Atarax was ordered for itching and on 07/31/14 there was an order to monitor the resident for seventy-two (72) hours for increased rash; however, review of the Nursing Notes revealed no documented evidence of seventy-two (72) monitoring and review of Resident #5's care plan revealed no documented evidence the care plan was revised to include the seventy-two (72) hour monitoring.</p> <p>Review of the Physician's and PA's Notes revealed on 09/25/14, the PA documented Resident #5 had a maculopapular rash "scattered on chest, abd. (abdomen), back and extremities", had been treated in the past with Permethrin time's two (2), steroids and emollients.</p> <p>Continued review of the PA's 09/25/14 Note revealed "similar" residents with rash seen by Dermatologist that week and diagnosed with Contact Dermatitis, and the PA had asked the</p>	F 309		

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F 309	<p>Continued From page 103</p> <p>Physician "to see" the resident. Further review of the PA's Note dated 09/25/14 revealed orders were given for treatment of the rash.</p> <p>Review of the Physician's orders revealed an order dated 09/25/14 to start Hydroxyzine three (3) times a day with meals for "itching/anxiety" and discontinue all previous skin/bathing orders, no fragrance/colored lotions, use hypoallergenic laundry detergent for resident's clothing, use Cetaphil body wash on shower days, mix Triamcinolone cream and Cetaphil and apply to trunk and extremities daily for ten (10) days, then use Cetaphil lotion daily.</p> <p>Review of the "Weekly Nursing Note" revealed on 09/28/14, Resident #5's skin was checked as "intact"; however, the narrative notes documented the resident had a rash to the torso and bilateral arms with Cetaphil/Triamcinolone mixture ordered.</p> <p>Review of the PA's Note dated 10/02/14, revealed Resident #5's rash "looking improved" and "itching" had decreased. Review of the "Weekly Nursing Note", dated 10/06/14 revealed the skin was checked to have "open areas", with the narrative noting "rash to the bilateral arms" had "greatly improved". Review of the PA's Note dated 10/22/14, revealed Resident #5 had "notable anxiety", was slapping at himself/herself, saying he/she "was miserable". Continued review of the PA's 10/22/14 Note revealed the PA documented the Hydroxyzine had not "seemed to help", and in the past he/she had done "much better" with Ativan (an anti-anxiety medication). Further review of the PA's 10/22/14 Note revealed Resident #5's Hydroxyzine was discontinued and Ativan was to be initiated for a diagnosis of</p>	F 309			

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F 309	Continued From page 104 "Severe Anxiety". Review of the "Weekly Nursing Notes" revealed on 10/26/14, the skin was checked to have "open areas" with the narrative indicating a "left hip wound", but no mention of a rash; however, review of the PA's Note dated 10/27/14, revealed Resident #5 had a "rash" still, and the PA ordered to continue with Zyrtec (an allergy medication) "for now". Review of a Psychiatric Consult Report, dated 10/30/14, revealed Resident #5 was seen and reported he/she stayed nervous because the "bumps" were coming back and they itched. Review of the "Weekly Nursing Note" dated 11/01/14, revealed the skin was checked, with the narrative indicating the open area was to the resident's left hip, the rash had improved, but the resident continued to complain of itching which the Physician and PA had "seen" and felt was due to the resident's "Anxiety". Review of the Physician's Note dated 11/10/14, revealed Resident #5 had an "itch", with no new orders noted for treatment to the "itch". Review of the PA's Note dated 11/21/14, revealed Resident #5 had a "skin lesion", "rash better", with no "new lesions". Continued review of the PA's Note dated 11/21/14, revealed an order to add Benadryl PO (by mouth). Review of the "Weekly Nursing Note" dated 11/22/14 revealed the skin was again checked to have open areas, with the narrative noting this was related to the left hip wound, with no documented evidence of a rash noted, but it was noted he/she continued to scratch with Benadryl administered for itching and the Physician was aware. Copies of Resident #5's "Skin Assessment Report" and "Wound Assessment Report" were	F 309			

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F 309	<p>Continued From page 105</p> <p>requested from August 2014 through November 2014; however, no documented evidence of those was provided by the facility.</p> <p>Review of the Physician's Note dated 01/26/15, revealed Resident #5 had a "rash", "chronic" itch, and orders were received for Permethrin cream and Stromectol tablets for treatment of Scabies was ordered, with Contact Isolation Precautions also ordered.</p> <p>Copies of Resident #5's "Skin Assessment Report" and "Wound Assessment Report" were requested from 11/22/14 through 01/25/15; however, no documented evidence of those was provided.</p> <p>Observation, on 01/26/15 at 2:10 PM, of a skin assessment performed by Licensed Practical Nurse (LPN) #1, revealed the resident to be actively scratching his/her neck, upper chest and shoulders. Further observation revealed, blisters red in color on the soles of the feet, a rash to the anterior trunk and legs and left arm with scabs noted on the shoulders, arms and legs.</p> <p>Interview with RN #1, on 01/26/15 at 9:15 AM, revealed she did not know what the cause of the itching or rash was and reported staff was not utilizing any type of contact isolation precautions.</p> <p>6. Record review revealed, Resident #6 was admitted to the facility, on 12/17/13, with diagnoses which included General Osteoarthritis, Chronic Airway Obstruction, Sciatica (back pain), and Adult Failure to Thrive. Review of the Annual MDS Assessment, dated 01/11/15, revealed the facility assessed Resident #6 to have a BIMS score of six (6) out of fifteen</p>	F 309		

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F 309	<p>Continued From page 106</p> <p>(15), indicating severe cognitive impairment. Review of Resident #6's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #6's Physician Orders revealed on 06/09/14, Hydrocortisone Cream was ordered for a rash on the chest and axillary areas to be applied twice per day for ten (10) days and on 07/06/14, Hydrocortisone Cream, Benadryl and an oral steroid dose pack was ordered.</p> <p>Review of Resident #6's "Weekly Skin Assessments" revealed on 07/10/14 and 07/17/14, a rash was assessed to the resident's upper chest with a treatment "in progress "</p> <p>Review of Resident #6's Physician Orders revealed on 07/21/14, Permethrin cream was initiated; however, further review of the 07/21/14 order revealed no documented evidence Resident #6 was placed on contact isolation precautions, as per the facility's policy.</p> <p>Review of Resident #6's "Weekly Skin Assessments" revealed on 07/24/14, a rash was still identified on his/her chest and back; however, on 07/31/14, the nurse documented Resident #6's skin was clean, dry and intact with no "skin issues noted".</p> <p>Review of the Physician's/PA's Notes revealed on 08/08/14, the PA was examining Resident #6 for a "chief complaint" of a "rash" on his/her "upper back, diagnosed with "Dermatitis", with orders received for Cetaphil lotion "to help itching".</p> <p>Review of Resident #6's "Weekly Skin</p>	F 309	

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F 309	<p>Continued From page 107</p> <p>Assessments" revealed on 08/07/14, the resident was noted to have a generalized rash which "remains" and on 08/14/14, it was documented the "rash continues", with no open areas noted.</p> <p>Continued review of the Physician's Orders revealed on 08/21/14, a Dermatology Consult was obtained with recommendations for Permethrin cream (scabies treatment) to be initiated. Continued review revealed on 09/10/14, a Dermatology Consult was obtained with Bactrim DS (an antibiotic medication) was ordered twice a day for fourteen (14) days and Ivermectin (generic for Stromectol, a treatment for scabies) both to be given orally; however, further review of the Physician's Orders revealed no documented evidence Resident #6 was placed on contact isolation precautions, as per the facility's policy.</p> <p>Review of the Physician's Note dated 10/07/14, revealed Resident #6 had been seen by Dermatology who recommended treating the rash with Permethrin cream.</p> <p>Review of the PA's Note dated 11/19/14, revealed the PA was seeing Resident #6 for a "chief complaint" of a "rash", on his/her legs. Continued review of the 11/19/14 Note, revealed Resident #6 had been seen by the Dermatologist that day who recommended a steroid dose pack which the PA agreed with. Further review of the 11/19/14 Note revealed Resident #6 had a follow up appointment with the Dermatologist on 12/01/14, and the PA ordered a hypoallergenic lotion and hypoallergenic laundry detergent.</p> <p>Further review of the Physician's Orders revealed on 11/18/14, one dose of oral Benadryl was ordered and on 11/19/14 a steroid dose pack was</p>	F 309			

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F 309	Continued From page 108 ordered. Continued review revealed on 01/02/15 a Dermatology Consult was obtained again with the Dermatologist documenting, Resident #6's Pruritic Dermatitis "still" made him "think" the resident might have Scabies. Continued review of the Dermatology Consult revealed this was discussed with Resident #6's nephew, and "even though" he/she was treated in September 2014, it did not mean he/she could not have Scabies. The Dermatology Consult noted Resident #6's nephew informed the Dermatologist "the entire nursing home was treated" then, as "some" residents had Scabies. Further review of the Dermatology Consult dated 01/02/15, revealed Clobetasol (a highly potent topical steroid) was ordered to be applied to the resident's "affected areas of itching" on his/her arms, Permethrin cream to be applied from the neck down to the toes, leave on overnight, wash off and repeat in one (1) week and Stromectol was also ordered. However, further review of the Physician's Orders revealed no documented evidence Resident #6 was placed on contact isolation precautions, as per the facility's policy. Review of Resident #6's "Skin Assessment Report" and "Wound Assessment Report" were requested from August through December 2014; however, no documented evidence of those was provided. Review of the "Nursing" Note dated 01/02/15 at 2:10 PM, revealed Resident #6 had been seen by the Dermatologist, and the resident's PA was notified of the Dermatologist's recommended orders and agreed. Review of the 01/03/15 "Nursing" Note revealed at 9:20 PM, that evening Resident #6 had received the application of the Permethrin cream as ordered on 01/02/15.	F 309			

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F 309 Continued From page 109

However, there was no documented evidence Resident #6 was placed in contact isolation as per the facility's policy.

Review of the "Wound Assessment Report" dated 01/03/15, revealed a "rash" had been identified on Resident #6's right inner thigh, right upper arm, left arm, back of his/her neck, perineal area and the top of his/her left hand, with papules and itching present and the "cause" was noted as "unknown" and treatment orders pending; even though Resident #6 had been seen by the Dermatologist on 01/02/15, with orders received for treatment of the rash.

Review of the 01/08/15, "Wound Assessment Report" revealed Resident #6 continued to have a "rash" to the right inner thigh area, right and left arm, back of the neck, perineal area and top of the left hand, with the "cause" again noted to be "unknown", and "treatment orders pending" noted again.

Review of the "Wound Assessment Report" revealed on 01/15/15, the resident continued to have a rash in the same areas, with it also noted to now also be on the resident's left inner shin area, with the "cause" continuing to be documented as "unknown", and treatment orders pending still noted. Further review of the "Wound Assessment Report" revealed on 01/23/15, the rash remained in all the areas noted on 01/15/15, the "cause" still noted to be "unknown" and treatment orders noted to be pending.

Review of the Physician's Note dated 01/26/15, revealed Resident #6 had a "rash" which the Physician documented the resident had been "recently" seen by the Dermatologist. Continued

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F 309	<p>Continued From page 110</p> <p>review of the 01/26/15 Note, revealed the Physician questioned the rash being Scabies versus Bullous Impetigo (a bacterial skin infection). Review of the Physician's Orders dated 01/26/15, revealed the Physician ordered Permethrin cream and Stromectol tablets to be administered prophylactically, and Contact Isolation Precautions to be initiated on 01/26/15.</p> <p>Observation, on 01/26/15 at 2:00 PM, revealed Resident #6 to be sitting up in a chair fully dressed, and to be actively scratching at his/her lower right leg area. Interview with Resident #6, on 01/26/15, at the time of observation, revealed the rash and itching had been going on "forever". Resident #6 revealed the rash would "go away a little then come right back". Continued interview revealed it was very irritating and embarrassing especially in church. Further interview revealed he/she no longer attended church like he/she used to enjoy doing, because of the rash and itching.</p> <p>Observation, on 01/26/15 at 2:10 PM, of Resident #6's skin assessment, performed by LPN #1, revealed the resident to have a rash with scabs to both legs with three (3) red areas to his/her lower to middle back.</p> <p>7. Record review revealed the facility admitted Resident #7 on 05/17/14, with diagnoses which included status post Cerebrovascular Accident (CVA) with Left Hemiplegia (paralysis to one side of the body), Esophagitis, Barrett's Esophagus, Esophageal Reflux, Alzheimer's disease and Dementia. Review of the Quarterly MDS Assessment dated 12/15/14, revealed the facility assessed Resident #7 to have a BIMS score of eight (8) out of fifteen (15), indicating moderate</p>	F 309			

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F 309	<p>Continued From page 111</p> <p>cognitive impairment. Review of Resident #7's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #7's Physician Orders revealed Permethrin cream was ordered on 07/21/14; however, further review of the 07/21/14 order revealed no documented evidence Resident #7 was placed on contact isolation precautions, as per the facility's policy. Review of the Physician's/PA's Notes revealed on 08/12/14, the PA documented Resident #7 had been treated with Permethrin cream two (2) times for a "rash" noted on his/her upper extremities and trunk, with orders for Cocoa Butter lotion to his/her dry skin following the Permethrin treatment, and for the Physician to "follow-up". Continued review of the Physician's Orders revealed on 08/12/14, Cocoa Butter Lotion was ordered and Permethrin cream was again ordered on 08/20/14.</p> <p>Review of Resident #7's "Nursing" Notes revealed on 08/20/14 at 7:38 PM, the nurse documented Resident #7 had "dried scabbed areas to upper arms and trunk" with new orders received.</p> <p>The facility provided "Weekly Nursing Note" documents which revealed on 10/14/14 Resident #7 had scabbed areas on the left should and left leg, with a notation the resident is known to scratch and pick at areas, and the Physician had seen the resident on 10/08/14, with the Physician noting his/her rash and "chronic itch" currently had a treatment in place.</p>	F 309			

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F 309	<p>Continued From page 112</p> <p>Review of the "Weekly Nursing Note" documentation revealed on 10/21/14 the nurse noted Resident #7's skin was intact with the narrative noting the resident had "small scattered dried scabs noted to left shoulder and a few scattered on left upper leg and abdomen", with a treatment in place.</p> <p>Review of the PA's 10/31/14 Note revealed Resident #7 was seen by the PA for a "rash" on his/her trunk, upper extremities and neck. Continued review of the 10/31/14 Note and Physician's Orders revealed the PA ordered Cetaphil body wash on shower days, Triamcinolone cream mixed with Cetaphil lotion apply to skin twice a day for ten (10) days, then use Cetaphil daily PRN, and use Dreft hypoallergenic laundry detergent for clothes/linens.</p> <p>Review of the "Weekly Nursing Note" dated 11/04/14, 11/12/14, 11/19/14, 11/25/14 and 12/02/14, revealed the nurses documented the resident's skin had scattered dried healing scabs.</p> <p>However, review of the 11/30/14 "Nursing" Note revealed the nurse noted Resident #7 was observed to "scratch self", having to "contort self somewhat to reach" left shoulder and left leg due to having Left Hemiplegia. Continued review of the 11/30/14 Note revealed the nurse noted Resident #7 had "old scratch marks and small scabs on" his/her left shoulder and left leg, and the resident "cites itching as cause of self-scratching". Per the 11/30/14 Note, an Advanced Practice Registered Nurse (APRN) and the resident's PA were notified of areas on the left side of Resident #7's body with new orders received.</p>	F 309			

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Review of the Physician's Orders revealed Aquaphor Lotion was ordered on 11/30/14 and Claritin (allergy medication) was ordered 12/01/14.

Review of the 12/07/14 "Nursing" Note revealed Resident #7 had an "abrasion/excoriation" to the back of his/her neck and back measuring 7 cm by 3 cm with "green drainage" and odor present. The Note revealed an APRN was notified and orders received for Keflex 500 milligrams (mgs) by mouth twice a day for seven (7) days, and Bactroban (antibiotic ointment) to be applied to the affected area and covered with a dry dressing twice a day until healed. Review of the 12/08/14 "Nursing" Note revealed the order for treatment to the area on Resident #7's neck and back was changed to Silvadene cream (a topical antibiotic used to treat and prevent infections of the skin) to be covered with a dry pad twice a day until healed.

Further review of the "Weekly Nursing Note" revealed on 12/09/14, the resident had a "wound on back of neck and down back " with orders for an antibiotic related to infection in the wound.

Review of the PA's Note dated 12/11/14, revealed Resident #7 had "scratched the back" of his/her neck "so bad" there was a large excoriated area with erythema (redness). Per the 12/11/14 Note, Resident #7 had received Keflex (an antibiotic medication) and the area on his/her neck was "improving". The PA noted Resident #7 also had "excoriation" to his/her trunk and extremities secondary to "itching", with "multiple things" having been tried without "much improvement". Further review of the Note and PA's orders dated

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F 309	<p>Continued From page 114</p> <p>12/11/14, revealed the PA ordered to continue the antibiotic, Atarax for the Pruritus and Prednisone. Review of the 12/17/14 PA's Note revealed Resident #7 was seen for follow-up for the Pruritus and Cellulitis, with the PA noting the resident's "skin looks better", with orders to continue with the Atarax.</p> <p>However, Review of Resident #7's "Skin Inspection Report" revealed from 08/26/14 through 12/09/14, the resident's skin was noted as "skin intact, even though the PA and Physician had been treating Resident #7 for a skin rash.</p> <p>Resident #7's "Wound Assessment Report" forms were requested from 12/09/14 through 01/24/15, however, no documented evidence of those was provided.</p> <p>Continued review of the "Weekly Nursing Note" documentation revealed the nurses noted Resident #7 to have intact skin on 12/30/14, 01/06/14, 01/13/15 and 01/20/15.</p> <p>Further review of the "Nursing" Notes revealed the area on Resident #7's neck and back was monitored and treated until 01/01/15 at 11:54 AM, when a nurse noted the "abrasion to back of neck" was now "resolved", and the Silvadene treatment was discontinued. Additional review of the "Nursing" Note dated 01/24/15 at 8:34 AM, revealed Resident #7 had a skin tear to his/her left lower extremity which the resident stated "it itched so I scratched it". Review of the 01/24/15 Note revealed the area was open and measured approximately 4 cm by 1 cm with erythema noted around it. Further review of the 01/24/15 Note revealed new orders were received for treatment of the area. Further review revealed a "Nursing"</p>	F 309			

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Note dated 01/26/15, which stated the Physician had ordered contact isolation, Permethrin cream and Stromectol tablets "per orders for Scabies prophylactic".

Review of the Physician's Note dated 01/26/15, revealed Resident #7 had a "rash", and his/her roommate had received treatment for Scabies. Continued review of the Note and Physician's Orders dated 01/26/15, revealed orders for Permethrin cream and Stromectol tablets to be administered prophylactically, with Contact Isolation Precautions to be initiated on 01/26/15

Observation, on 01/26/15 at 1:47 PM, of Resident #7's skin assessment performed by LPN #1, revealed the resident to have a rash to both feet and between the toes, on the back, the chest, abdomen, legs and upper left arm. Further observation revealed scabs were scattered on the chest, abdomen, arm and legs. However, review of the current "Weekly Nursing Notes" and "Nursing" Notes revealed no documented evidence Resident #7 had the areas of rash observed.

Interview with RN #1, on 01/28/15 at 9:15 AM, revealed she did not know what the cause of the itching or rash was and reported staff was not utilizing any type of contact isolation precautions.

8. Record review revealed the facility admitted Resident #8 on 01/28/14, with diagnoses which included Depressive Disorder, Anxiety, Irritable Bowel Syndrome, Sicca Syndrome (an autoimmune disease), Joint Disease and Lupus Erythematous (an inflammatory autoimmune disease causing scaly red patches on the skin, especially on the face). Review of the Quarterly

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F 309	<p>Continued From page 116</p> <p>MDS Assessment, dated 01/14/15, revealed the facility assessed Resident #8 to have a BIMS score of six (6) out of fifteen (15), indicating the resident was severely cognitively impaired. Review of Resident #8's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #8's Physician Orders revealed on 06/30/14, Hydrocortisone Cream was ordered to be applied to a rash each shift and Benadryl orally as needed for itching for seven (7) days. Continued review revealed on 07/06/14, and 07/14/14 Hydrocortisone Cream and Benadryl were re-ordered and on 07/15/14, a steroid dose pack was ordered. Further review of the Physician's Orders revealed on 07/27/14, Permethrin Cream was ordered. However, further review of the 07/27/14 order revealed no documented evidence Resident #8 was placed on contact isolation precautions, as per the facility's policy.</p> <p>Review of the Physician's and PA's Notes revealed on 08/22/14, the Physician documented Resident #8 had a "rash", with no new orders noted.</p> <p>Review of the PA's Note dated 10/09/14, revealed Resident #8 had a "rash" which was dry and scaly on his/her arms, some on his/her hands and some "scattered" on the abdomen and trunk. Continued review of the 10/09/14 PA Note and Physician's Orders revealed diagnoses of "Dermatitis" and "Xerosis", with orders for Cetaphil body wash on shower days, Triamcinolone cream mixed with Lac-Hydrin lotion to upper extremities and trunk twice a day</p>	F 309		

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F 309	<p>Continued From page 117</p> <p>for ten (10) days, then Lac-Hydrin lotion daily for dry skin and notify the PA if "rash" did not improve. However, review of the "Skin Inspection Report" revealed on 10/09/14, the nurse documented Resident #8's skin was intact. Review of the "Skin Inspection Report" on 10/16/14, revealed the resident's skin was noted as "skin not intact-existing". The "Wound Assessment Report" for 10/16/14 was requested; however, no documented evidence was provided.</p> <p>Review of the "Skin Inspection Report" revealed on 10/30/14, Resident #8's "skin intact". However, review of the "Wound Assessment Report" dated 10/30/14, revealed the resident had a rash on his/her "entire chest" area with the cause noted as "unknown", with the narrative stating "rash was almost resolved when today resident began to scratch again", with treatment applied and Physician notified.</p> <p>Review of the 10/31/14 PA's Note revealed the PA had performed a follow-up visit related to the "rash", which had not improved. Continued review of the 10/31/14 Note revealed Resident #8 had received "new clothes" and the PA ordered a Prednisone pack and Dreft detergent for his/her clothes. Review of the "Wound Assessment Report" for 11/06/14, revealed Resident #8 had a rash on his/her entire chest area, with the cause documented as "unknown". Review of the PA's 11/07/14 Note revealed she had followed up on Resident #8's rash had "improved", but the PA noted it might require a "maintenance steroid if necessary". Review of the PA's Note dated 11/10/14, revealed the PA was again following up on Resident #8's "rash", and the PA ordered Prednisone again.</p>	F 309		
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F 309	<p>Continued From page 118</p> <p>Continued review of the "Wound Assessment Reports", dated 11/13/14, 11/20/14, 11/21/14, 11/27/14, 12/04/14, 12/08/14, 12/11/14 and 12/18/14 revealed the nurse continued to note Resident #8 had a rash on his/her entire chest area, with the cause documented to be "self-inflicted scratching/picking".</p> <p>Review of the Physician's Note dated 12/18/14, revealed Resident #8 had an "itch" on the left hand, and had received Prednisone "chronic for rash". Review of the Physician's Note dated 01/26/15, revealed Resident #8 still had a "rash" for which he ordered to "treat as Scabies exposure". Continued review of the Note and the Physician's Orders, for 01/26/15 revealed the Physician ordered contact isolation precautions, Permethrin cream and Stromectol tablets to be administered prophylactically.</p> <p>Observation, on 01/26/14 at 2:20 PM, of a skin assessment performed by LPN #1, revealed Resident #8 to have a rash to the top of his/her feet, a rash with scabs and blisters to his/her back, shoulders, arms, legs, and torso.</p> <p>9. Record review revealed Resident #9 was re-admitted to the facility on 01/02/14, with diagnoses which included Pneumonia, Acute Kidney Failure, Muscle Weakness, Difficulty Walking and Cognitive Communication Deficit. Review of the Annual MDS Assessment dated 12/30/14, revealed the facility assessed Resident #9 to have a BIMS of three (3) out of fifteen (15), indicating severe cognitive impairment. Review of Resident #9's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p>	F 309		
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F 309	<p>Continued From page 119</p> <p>Review of Resident #9's Physician Orders revealed: on 06/09/14, Resident #9 was identified to have a rash to his/her back with Hydrocortisone Cream to be applied twice each day for ten (10) days; on 07/06/14, Hydrocortisone Cream and oral Benadryl were ordered; and on 07/22/14, Permethrin Cream was ordered for the treatment of Scabies. However, further review of the 07/22/14 order revealed no documented evidence Resident #9 was placed on contact isolation precautions, as per the facility's policy.</p> <p>Review of the EMR "Skin Inspection Report" revealed on: 08/26/14, 09/02/14, 09/09/14, 09/16/14, 09/23/14, 09/30/14, 10/07/14, 10/14/14, 10/21/14, 10/22/14, 10/27/14, 10/28/14 nurses documented Resident #9's skin as "skin intact". However, review of the EMR "Wound Assessment Report" dated 10/28/14 revealed the nurse documented Resident #9 had a "right upper shoulder rash" which measured 8 cm by 8 cm, with the "cause" documented as "unknown", and was "pending treatment orders". Review of the "Nursing" Note dated 10/28/14, revealed Resident #9 was complaining of "itching", the PA was notified and orders were received for Zyrtec 10 mg by mouth daily for two (2) weeks. Review of the Physician's Order dated 10/28/14 revealed the order for Zyrtec.</p> <p>Review of the EMR "Skin Inspection Report" dated 11/04/14 revealed the nurse noted Resident #9's skin as "intact". However, review of the EMR "Wound Assessment Report" dated 11/04/14 revealed Resident #9 had a "rash" to his/her "right upper shoulder", with the "cause" noted to be "unknown", and the area was</p>	F 309		
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"pending treatment orders". However, review of the Physician's Orders revealed no documented evidence of a treatment order received, and no documented evidence the "rash" was monitored until 11/07/14.

Review of the Physician's and PA's Notes revealed on 11/07/14, the PA had seen Resident #9 for follow-up for a "rash". The Note stated Resident #9 "still" had a "pruritic rash", some maculopapular on his/her anterior chest, abdomen and thighs. Further review of the 11/07/14 Note and Physician's Orders revealed the PA documented the "rash" was questionable for allergy and ordered a Prednisone pack and Triamcinolone cream mixed with Cetaphil to rash areas on extremities and trunk twice a day for one (1) week, and Dreft laundry detergent.

Review of the "Wound Assessment Report", dated 11/11/14 revealed Resident #9 continued to have the "rash" on his/her "right upper shoulder", with the "cause" now noted to be "yeast/fungus", with the measurements continuing to be 8 cm by 8 cm. However, the PA noted Resident #9 had a "pruritic rash" on his/her chest, abdomen and thighs. Continued review revealed no documented evidence of the "rash" being documented in those areas of Resident #9's body. Further review revealed the narrative stated orders received on 11/07/14 for Triamcinolone cream mixed with Cetaphil to rash on extremities and trunk twice daily for one (1) week and Cetaphil body wash on shower days.

Review of the "Skin Inspection Report" dated 11/14/14 and 11/21/14 revealed nurses documented Resident #9's skin as "intact". However, review of a "Wound Assessment

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F 309	<p>Continued From page 121</p> <p>Report" dated 11/18/14 and 11/19/14 revealed Resident #9 continued to have the "rash" on his/her "right upper shoulder" which was noted to be "improving" with measurements of 7 cm by 7 cm. Continued review revealed the nurse documented "no treatment required", even though the treatment ordered on 11/07/14 had been completed on 11/14/14, and no further treatment was in place except the Cetaphil body wash on shower days.</p> <p>Review of a "Wound Assessment Report" dated 11/18/14 and 11/19/14 revealed Resident #9 continued to have the "rash" on his/her "right upper shoulder" which was noted to be "improving" with measurements of 7 cm by 7 cm. Continued review revealed the nurse documented "no treatment required", even though there was currently no treatment in place other than the Cetaphil body wash obtained on 11/07/14.</p> <p>Review of the "Skin Inspection Report" dated 11/25/14, revealed the nurse documented Resident #9's "skin not intact-existing". Review of the "Wound Assessment Report" dated 11/25/14 revealed Resident #9 continued to have the "rash" on his/her "right upper shoulder" which was again noted to be "improving" with measurements continuing to be 7 cm by 7 cm, and the "cause" documented as "unknown". Continued review revealed the nurse documented "no treatment required", even though there was no treatment currently in place other than the Cetaphil body wash obtained on 11/07/14.</p> <p>Review of the "Skin Inspection Report" dated 12/02/14, revealed the "rash" continued on Resident #9's "right upper shoulder", was noted to be "improving" again, with the measurements 6</p>	F 309			

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F 309	<p>Continued From page 122</p> <p>cm by 6 cm, and the "cause" noted as "unknown". Continued review revealed the nurse documented "no treatment required", even though there was no treatment currently in place to treat the area other than the Cetaphil body wash obtained on 11/07/14.</p> <p>However, review of the PA's Note dated 12/05/14 revealed Resident #9 had a "rash", with Claritin (an allergy medication) ordered. Review of the Physician's Orders revealed the Claritin was discontinued on 01/03/15.</p> <p>Review of the "Skin Inspection Report" dated 12/09/14 revealed the nurse documented Resident #9's skin as "intact". However, review of the "Wound Assessment Report" dated 12/10/14 revealed Resident #9 continued to have a "rash" to his/her "right upper shoulder" which was again noted to be "improving" with measurements of 6 cm by 6 cm, the "cause" noted as "accident/other trauma", and was "pending treatment orders". However, review of the Physician's Orders revealed no documented evidence of a treatment order for the "rash" on 12/10/14.</p> <p>Review of the PA's Note dated 12/11/14 revealed Resident #9 had a "rash" noted on his/her anterior trunk and extremities with excoriation "from scratching". Continued review of the Note and Physician's Order revealed the PA ordered Atarax PRN (as needed) for the resident's "itching".</p> <p>Review of the PA's Noted dated 12/15/14 revealed Resident #9 had a "lesion" on the right mid-clavicle, with documentation indicating "try to clarify laundry detergent". Review of the "Skin</p>	F 309		

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Inspection Report" dated 12/16/14 revealed the nurse documented Resident #9's skin as "intact". However, review of the "Wound Assessment Report" dated 12/16/14 revealed Resident #9 continued to have a "rash" to his/her right upper shoulder which was again noted to be "improving" with measurements of 6 cm by 6 cm, the "cause" noted as "accident/other trauma", with the 11/07/14 order for Cetaphil body wash on shower days noted. However, review of the Physician's Orders revealed no documented evidence of further treatment obtained for the "rash" on 12/16/14.

Review of the "Skin Inspection Report" dated 12/24/14 and 12/30/14 revealed the nurse documented Resident #9's skin as "skin not intact-existing". Review of the "Wound Assessment Report" dated 12/24/14 revealed Resident #9 continued to have a "rash" to his/her right upper shoulder which was again noted to be "improving" with measurements continuing to be 6 cm by 6 cm, the "cause" noted as "accident/other trauma". Continued review of the "Wound Assessment Report" revealed with the 11/07/14 order for Cetaphil body wash on shower days noted. Even though Resident #9 continued to experience the "rash", review of the Physician's Orders revealed no documented evidence of further treatment obtained for the "rash" on 12/24/14 or 12/30/14.

Review of the "Nursing" Note dated 01/02/15 at 6:25 PM revealed Resident #9 had a "rash" noted to his/her trunk and bilateral lower extremities, and the PA was at the facility and had assessed the resident. However, review of the PA's Note dated 01/02/15 revealed Resident #9 had a "pruritic rash" on his/her trunk, face and upper

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F 309	<p>Continued From page 124</p> <p>extremities. Continued review of the Note and Physician's Orders revealed the PA's orders on 01/02/15 included Prednisone in a tapered dose and Zyrtec by mouth every night for one (1) week.</p> <p>Continued record review revealed Resident #9 was sent to the hospital and admitted on 01/03/15, and re-admitted to the facility on 01/06/15. Review of the Physician's Orders revealed the Zyrtec was re-ordered, and was to be given every day at bedtime. Review of the Comprehensive Care Plan for the risk for impaired skin integrity revealed documentation dated 01/06/15, which stated Resident #9 had returned from the hospital where he/she was treated for Scabies while there. However, there was no documented evidence Resident #9 was placed in contact isolation precautions as per the facility policy when he/she returned from the hospital.</p> <p>Review of the "Nursing" Note dated 01/07/15 at 7:56 PM, revealed orders were received to "repeat Permethrin cream treatment on 01/11/15". Review of the "Nursing" Note dated 01/11/15 at 9:41 PM revealed "Permethrin cream applied topically to body as ordered". However, there was no documented evidence Resident #9 was placed in contact isolation precautions as per the facility policy.</p> <p>Review of the "Wound Assessment Report" dated 01/13/15 and 01/20/15, revealed Resident #9 continued to have the "rash" to his/her "right upper shoulder" which continued to be noted as "improving" even though the measurements continued to remain 6 cm by 6 cm. Continued review revealed the "cause" remained noted as "accident/other trauma", and the 01/06/15 order</p>	F 309		

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F 309	<p>Continued From page 125</p> <p>for Zyrtec was noted. However, there was no documented evidence of additional orders to treat the "rash", even though the nurse noted the Physician was notified on the "Wound Assessment Report".</p> <p>Review of the PA's Note dated 01/20/15 revealed Resident #9 was examined by the PA for "recurrent edema"; however, there was no documentation regarding the resident's rash.</p> <p>Observation, on 01/25/15 at 2:40 PM, of a skin assessment, performed by LPN #1, revealed Resident #9 to have a rash to his/her upper back, shoulders and scabs to both knees.</p> <p>Review of the Physician's Note and Orders dated 01/26/15, revealed Resident #9 had a "rash", with orders received for Permethrin cream and Stromectol tablets as per the Scabies prophylactic, with Contact Isolation Precautions also ordered.</p> <p>Interview with RN #1, on 01/26/15 at 9:15 AM, revealed she did not know what the cause of the itching or rash was and reported staff was not utilizing any type of contact isolation precautions.</p> <p>10. Record review revealed Resident #2 was admitted to the facility on 05/25/14, with diagnoses which included Anxiety, Chronic Airway Obstruction, Muscle Weakness, Late Effect Cerebral Vascular Disease and Congestive Heart Failure. Review of the Quarterly MDS Assessment, dated 11/16/14, revealed the facility assessed Resident #2 to have a BIMS score of eleven (11) out of fifteen (15), indicating the resident was moderately cognitively impaired. Review of Resident #2's Comprehensive Care</p>	F 309		

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F 309	<p>Continued From page 126</p> <p>Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #2's Physician Orders revealed an order dated 07/27/14, for Permethrin Cream (treatment for Scabies) to be applied from the neck down, leave on for eight (8) to fourteen (14) hours, shower off, wash bed linen and laundry as directed, and repeat the treatment in two (2) weeks. However, further review of the 07/27/14 order revealed no documented evidence Resident #1 was placed on contact isolation precautions, as per the facility's policy. Review of the Physician's Order dated 08/17/14, revealed Cetaphil Lotion was ordered for a rash noted to right axilla and bilateral upper extremities. Review of the Physician's and PA's Notes for Resident #2 revealed the PA noted on 09/25/14, the resident stated his/her "back itches", and he/she had previously had dermatitis involving the upper extremities and chest which had resolved. Continued review of the PA Note revealed Resident #2 had a "faint maculopapular rash on back", which was diagnosed as Dermatitis, the PA thought was "exacerbated by increased heat". Further review revealed the PA's orders included Cetaphil lotion mixed with Triamcinolone cream and to use hypoallergenic laundry detergent. Review of the Physician ' s Note dated 10/08/14, revealed the Physician documented Resident #2 was being seen for follow up of a "recent rash"; however, there was no documented evidence of new orders related to the rash.</p> <p>Continued review of the Physician ' s Orders revealed on 11/05/14, Hydrocortisone (a topical steroid used to treat inflammation of the skin) Cream was ordered for seven (7) days to an</p>	F 309			

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F 309	<p>Continued From page 127</p> <p>ankle rash. Continued review of the Physician's Orders revealed on 11/28/14, the Cetaphil Lotion and body wash was re-ordered. Review of the Order dated 12/12/14, revealed Prednisone (an oral steroid) was ordered each day until 12/16/14. Further review of the Physician's Orders revealed on 01/10/15, one (1) time dose of oral Benadryl (an anti-histamine) was ordered. Review of the Order dated 01/15/15, revealed Triamcinolone Cream mixed with Cetaphil Lotion was ordered again to be applied to a rash on the resident's legs/thighs for seven (7) days. Additionally, review of the Physician's Order dated 01/26/15, revealed Permethrin cream and Stromectol tablets were both ordered, with Contact Isolation Precautions also ordered.</p> <p>Review of the 01/15/15 Note, documented by the PA revealed Resident #2 had a maculopapular rash on his/her legs, "mostly thigh" area, which the resident stated was "better", with "no pruritis today". Continued review of the Note revealed the orders included Cetaphil lotion mixed with Triamcinolone cream.</p> <p>However, review of Resident #2's "Skin Inspection Report", dated 08/26/14, 09/02/14, 09/09/14, 09/16/14, 09/23/14, 09/30/14, 10/07/14, 10/14/14, 10/22/14, 10/28/14, 11/04/14, 11/11/14, 11/28/14, 12/02/14, 12/12/14, 12/16/14, 12/23/14, 12/24/14, 12/30/14, 01/06/15, 01/07/15, 01/13/15, and 01/20/15, revealed the nurses noted the resident's "skin intact". Even though there was documented evidence, in the Physician's/PA's Notes and Physician Orders, Resident #2 had a rash and was receiving treatment.</p> <p>Review of the "Wound Assessment Report" dated 01/22/15, revealed the nurse had identified a</p>	F 309			

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F 309	Continued From page 128 macular (small, flat, red spots) rash to Resident #2's lower left back, the front of the right lateral thigh and the front of the left inner thigh with treatment orders "pending". Further review of the 01/22/15 Report revealed under "cause" the nurse documented "unknown". Observation on 01/22/15 at 11:30 AM, revealed Resident #2 was lying on the bed in his/her room actively scratching his/her arm. Interview with Resident #2, on 01/23/14 at 9:35 AM, revealed he/she was "itching all over". Resident #2 revealed he/she was told by the facility he/she had dry skin. Additional interview on 01/29/14 at 1:15 PM, revealed the scratching and itching made Resident #2 "feel nervous" like he/she "was withdrawing from something". Observation, on 01/22/15 at 3:30 PM, of Resident #2's skin assessment, performed by RN #1, revealed rash areas on both his/her thighs, the right side of the abdomen, the left axillary (armpit) and lower right side of the back. Observation revealed Resident #2's index finger on the left hand also had two (2) reddened areas and his/her left forearm had reddened areas. Further review of the Physician ' s Notes revealed on 01/26/15, the Physician noted Resident #2 had a "rash" and "pruritis" to his/her bilateral legs. Review of the Physician's Orders dated 01/26/15, revealed Contact Isolation Precautions and Permethrin cream and Stromectol tablets were both ordered. Record review also revealed Resident #2 was Resident #1's room mate who had a microscopic confirmation of Scabies on 01/26/15. However,	F 309			

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F 309 Continued From page 129
there was no documented evidence a Dermatology Consult was ordered for Resident #2.

Interview with RN #1, on 01/26/15 at 9:15 AM, revealed staff was not utilizing contact isolation precautions with Resident #2 prior to 01/26/15. She stated she did not know what the cause of Resident #2's itching or rash was.

11. Record review revealed, Resident #11 was admitted to the facility on 09/03/85, with diagnoses which included Mild Cognitive Impairment, Convulsions and Intellect Disability. Review of the Quarterly MDS Assessment, dated 01/16/15, revealed the facility assessed Resident #11 to have a BIMS score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Review of Resident #11's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments, and to pay close attention to bony prominence.

Review of Resident #11's Physician Orders revealed, Permethrin Cream was ordered on 07/27/14. However, further review of the 07/27/14 order revealed no documented evidence Resident #11 was placed on contact isolation precautions, as per the facility's policy. Review of the "Weekly Skin Assessment" form, which was in place prior to the facility implementing the EMR, revealed 07/28/14, the nurse documented Resident #11 to have clean, dry and intact skin, however, also noted the resident continued to have "self-inflicted scratch marks", with no documented evidence of the location of the scratch marks.

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F 309	Continued From page 130 Continued review of the Physician's Orders revealed: on 08/01/14 Bacitracin ointment (antibiotic) was ordered to be applied on the left lower leg on 08/01/14 related to scratches, and skin prep to be applied to the scabs on second toe. Review of the "Weekly Skin Assessment" form, which was in place prior to the facility implementing the EMR, revealed on 08/04/14, the nurse documented Resident #11 to have clean, dry and intact skin; however, also noted the resident continued to have "self-inflicted scratches" to his/her bilateral upper and lower extremities. Review of the "Weekly Skin Assessment" form dated 08/18/14, revealed the nurse documented Resident #11 to have clean, dry and intact skin; however, also noted the resident continued to have "scratches on" his/her bilateral upper and lower extremities "where resident" had "scratched self, with a treatment in progress. Review of the EMR "Skin Inspection Report" for the dates of 08/27/14, 09/03/14, 09/10/14, 09/16/14, 09/22/14, 09/29/14, 10/06/14, 10/13/14 and 10/14/14 revealed the nurses documented Resident #11's "skin intact". However, review of the "Weekly Nursing Note" dated 10/14/14, revealed Resident #11 was "currently" being treated for "self-inflicted scratches to left lower leg", which the resident "frequently" picked at "both hands and lower legs". Continued review of the Physician's Orders revealed on 10/17/14, the Bacitracin ointment and skin prep were both discontinued due to the scratches being healed, and Keri Lotion was also discontinued, with Cetaphil Lotion ordered to Resident #11's extremities at bedtime.	F 309			

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F 309	Continued From page 131 Further review revealed, Benadryl Cream was ordered on 12/01/14 for scratches and Permethrin cream and Stromectol tablets, both for the treatment of Scabies, with Contact Isolation Precautions was initiated on 01/26/15. Continued review of the facility's EMR "Skin Inspection Report" revealed Resident #11 continued to be assessed by the nurses to have "skin intact for the dates of 10/20/14, 10/27/14, 11/03/14, 11/10/14, 11/18/14, 11/24/14, 12/01/14. However, review of the PA's Note and Physician's Order dated 12/01/14 revealed Resident #11 had "excoriation" to his/her left lower extremity, with an order for Benadryl cream to be applied to the resident's left lower leg scratches two (2) times a day for one (1) week. Review of the "Nursing" Noted dated 12/01/14, revealed the PA had visited Resident #11 and ordered the Benadryl cream for "itching". Further review of the facility's EMR "Skin Assessment Report" revealed the nurses continued to document Resident #11's "skin intact on 12/08/14, 12/15/14, 12/22/14, 12/29/14, 01/05/14, 01/12/15, 01/13/15 and 01/19/15. Review of the Physician's Note and Orders dated 01/26/15, revealed Resident #11 had excoriation to his/her left hand and left leg, with orders which included Aquaphor lotion to body once daily and PRN for Xerosis, Benadryl every six (6) hours PRN for itching times twenty-one (21) days, Permethrin Cream and Stromectol tablets per Scabies prophylactic and Contact Isolation Precautions. Observation, on 01/26/15 at 2:05 PM, of Resident	F 309			

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F 309	<p>Continued From page 132</p> <p>#11's skin assessment performed by LPN #1, revealed the resident had scabs to the left wrist and left leg, and also a rash with scabs to the right arm and abdomen and chest.</p> <p>12. Record review revealed Resident #12 was admitted to the facility on 03/12/14, with diagnoses which included Bronchitis, Muscle Weakness, Congestive Heart Failure and Dementia. Review of the Quarterly MDS Assessment, dated 11/20/14, revealed the facility assessed Resident #12 to have a BIMS score of three (3) out of fifteen (15), indicating severe cognitive impairment. Review of Resident #12's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.</p> <p>Review of Resident #12's Physician Orders revealed: on 06/12/14, an oral steroid was initiated related to a rash; and on 07/27/14, Permethrin Cream was ordered for Scabies treatment. However, further review of the 07/27/14 order revealed no documented evidence Resident #12 was placed on contact isolation precautions, as per the facility's policy. Review of the "Nursing" Note dated 08/12/14 revealed Resident #12 was again treated with the Permethrin cream as ordered; however there was no documented evidence the resident was in contact isolation precautions as per facility policy.</p> <p>Review of the facility's EMR "Skin Assessment Report" revealed the nurses documented Resident #12's "skin intact from 08/19/14 through 11/07/14. Continued review of the "Skin Assessment Report" revealed on 11/14/14 and 11/21/14 the nurses documented "skin not</p>	F 309		

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F 309	<p>Continued From page 133</p> <p>intact-existing". The Surveyor requested the "Wound Assessment Report" for the assessment dates of 11/14/14 and 11/21/14; however no documented evidence was provided even though per interview this was the facility's process.</p> <p>Continued review of the EMR "Skin Assessment Report" revealed the nurses documented Resident #12's "skin intact" on 11/28/14 and 12/05/14, and on 12/12/14, the resident's skin was noted as "skin not intact-existing". The Surveyor requested the "Wound Assessment Report" for the assessment dates of 12/12/14; however no documented evidence was provided even though per interview this was the facility's process.</p> <p>Further review of the EMR "Skin Assessment Report" revealed on 12/19/14 Resident #12's "skin intact", and on 12/23/14 the resident's skin was again noted as "skin not intact-existing". The Surveyor requested the "Wound Assessment Report" for 12/23/14; however no documented evidence was provided. Additionally, review of the "Skin Assessment Report" revealed on 12/26/14 and 01/02/15 Resident #12's "skin intact" was again noted. However, review of the PA's Note dated 01/07/15 revealed Resident #12 had a maculopapular rash on his/her trunk "mostly in V-neck area", which the PA noted the Physician was to "assess" the rash in the AM (morning). Record review revealed no documented evidence the Physician assessed the area on the morning of 01/08/15 however. Review of a verbal order obtained from the Physician on 01/08/15 at 11:00 AM, revealed an order was for Cetaphil lotion to areas of dry skin noted on Resident #12's trunk and upper extremities every day and PRN; however, there</p>	F 309			

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F 309	<p>Continued From page 134</p> <p>was no mention of the rash noted by the PA on 01/07/15.</p> <p>Review of the "Skin Inspection Report" dated 01/09/15, revealed the nurse documented Resident #12's "skin intact" even though the PA noted a maculopapular rash on the resident's trunk on 01/07/15. Review of the "Weekly Nursing Note" dated 01/10/15 and 01/16/15 revealed Resident #12 had "dry skin" to both upper extremities and was "encouraged" not to "scratch", and lotion applied as ordered. However, there was no documented evidence of the rash noted by the PA on 01/07/15.</p> <p>Observation, on 01/23/15 at 9:50 AM, revealed Resident #12 dressed in clothing walking in the hallway, actively scratching his/her left arm, with scabbing on the arm. Further observation revealed, Resident #12's clothing had reddish brown blood like spots on the sleeves of his/her shirt.</p> <p>Continued record review revealed Resident #12 was sent to the hospital after becoming "unresponsive" on 01/24/15, was admitted for a diagnosis of Acute Renal Failure. Review revealed Resident #12 returned to the facility on 01/31/15.</p> <p>Review of the facility's "Departmental Notes" revealed a Note documented by the DON on 01/25/15 which stated on 01/08/15 the Physician and she had "went to see" Resident #12 at the request of the PA. Per the Note, Resident #12 was examined by the Physician "related to dry scabbed area to upper extremities" with a new order received for Cetaphil lotion daily and PRN related to Xerosis. However, further record</p>	F 309		

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review revealed no documented evidence of a Physician's Note dated 01/08/15 related to the Physician's examination of indicated in the DON's Note dated 01/25/14.

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13. Record review revealed, Resident #4 was admitted by the facility on 09/13/12, with diagnoses which included Anxiety, Acute Kidney Failure, Chronic Airway Obstruction, Diabetes, Anxiety, Depressive Disorder and Dementia with Behavior Disturbances. Review of the Annual MDS Assessment, dated 02/14/15, revealed the facility had assessed Resident #4 to have a BIMS score of seven (7) out of fifteen (15), indicating severe cognitive impairment. Review of the Comprehensive Care Plan revealed the facility care planned Resident #4 to be at risk for impaired skin integrity on 12/14/14, with interventions which included weekly skin assessments.

Review of Resident #4's "Weekly Skin Assessment" forms, which were utilized prior to the EMR, revealed on 07/17/14, the Resident was noted to have small scattered scabs to both arms related to "picking self" and on 07/19/14, multiple scabs were noted to the trunk and arms secondary to "chronic picking" with a rash noted to both forearms.

Review of Resident #4's Physician's Orders, revealed Permethrin Cream (treatment for Scabies) was ordered on 07/27/14, to be applied from the neck down, leave on for eight (8) to fourteen (14) hours, shower off, wash bed linen and laundry as directed, and repeat the treatment in two (2) weeks. However, further review of the 07/27/14 order revealed no documented evidence. Resident #4 was placed on contact isolation

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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
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F 309	<p>Continued From page 136 precautions, as per the facility's policy.</p> <p>Review of Resident #4's "Weekly Skin Assessment" forms revealed on 08/03/14, Resident #4 was noted to have scattered scabs over both arms from "chronic picking". Even though Resident #4 was noted to be a chronic "picker", there was no documented evidence of new orders having been obtained, after the order from 07/27/14 for the treatment of scabies, until 09/14/14, when the Physician noted a rash on the resident's trunk.</p> <p>Review of the Physician's Note dated 09/14/14, revealed the Physician assessed Resident #4 to have "some lesions on" his/her trunk" and a red and raised rash". Continued review revealed the Physician diagnosed Resident #4 with Tinea corporis (ringworm), and ordered Lotrisone cream to the "rash on the trunk for the ringworm until clear". Continued review of the Physician's Orders revealed Lotrisone (an anti-fungal) Cream was ordered for a rash to Resident #4's trunk on 09/19/14, which was discontinued on 10/17/14.</p> <p>Review of the "Nursing" Note dated 09/19/14, revealed new orders had been received from the Physician which included "apply Lotrisone cream to rash on trunk twice a day until resolved".</p> <p>Review of the "Nursing" Note dated 09/24/14, revealed the nurse documented Resident #4 was "often non-compliant, a picker with sores".</p> <p>Review of the "Nursing" Note dated 09/25/14, revealed "new orders" had been received from the PA, to discontinue all previous skin/bathing orders, no fragrance/colored lotions, use Cetaphil body wash on shower days, Cetaphil body lotion daily to trunk and extremities and Triamcinolone cream to rash on chest/arms twice a day for one</p>	F 309			

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F 309	Continued From page 137 (1) week. However, review of the Physician's Orders and Medication Administration Record revealed no documented evidence of the orders received from the PA on 09/25/14 were implemented. Review of the "Nursing" Note dated 09/29/14, revealed Resident #4 had experienced a fall, and when the nurse assessed the resident she noted he/she was observed to "actively pick at existing scarbous lesions on arms, causing them to bleed sullenly". Review of the "Nursing" Note dated 10/17/14, revealed the Lotrisone cream ordered by the Physician on 09/19/14 for a rash on Resident #4's trunk was discontinued as the rash was "resolved". Review of the "Nursing" Note dated 11/09/14, revealed Resident #4 was observed to "pick at skin", partially "picked tiny, existing scab off one site, of many present on left upper extremity, with no frank bleed noted". Further review of the Note revealed no documented evidence the Physician was notified to obtain treatment for the areas. However, further review of the "Nursing" Notes revealed no documented evidence of continued monitoring of the scabbed areas on Resident #4's left upper extremity, or of the Physician ever being notified of the areas for treatment orders. Further review of the "Nursing" Notes revealed Resident #4 was sent to the hospital and admitted with a diagnosis of Pneumonia on 01/22/15, and was re-admitted to the facility on 01/27/15. However, review of Resident #4's "Skin Inspection Report" from 09/28/14 to 01/18/15, revealed the nurses noted the resident's "skin not intact-existing". Review of the "Wound	F 309			

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Assessment Report" from 08/05/14 through 01/22/15, revealed no documented evidence Resident #4 had a rash other than Resident #4 was a chronic "picker" during the timeframe. Further review of the "Wound Assessment Report" revealed no documented evidence Resident #4 experienced a rash during the time frame of 08/05/14 through 01/18/15, even though the Physician had been ordering treatment for a rash.

Further review of the Physician's Orders revealed on 01/27/15, after Resident #4 was re-admitted to the facility, an order for Permethrin cream to be applied topically from the neck down, leave on for eight (8) to fourteen (14) hours, then wash off.

Observation, on 01/28/15 at 4:51 PM, of a skin assessment performed by RN #1, revealed Resident #4 was actively scratching his/her arms. Further observation revealed numerous reddened areas and scabs to both legs and left arm.

14. Record review revealed Resident #13 was admitted to the facility on 06/13/13, with diagnoses which included Dementia, Chronic Kidney Disease, Subdural Hemorrhage and Insomnia. Review of the Quarterly MDS Assessment dated 11/05/14, revealed the facility assessed Resident #13 to have a BIMS score of five (5) out of fifteen (15), indicating the resident was severely cognitively impaired. Review of Resident #13's Comprehensive Care Plan revealed the facility had care planned the resident to be at risk for impaired skin integrity with an intervention for weekly skin assessments.

Review of the facility's EMR "Skin Inspection Report" for the dates of 08/25/14, 09/01/14,

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F 309	<p>Continued From page 139</p> <p>09/08/14, 09/15/14, 09/29/14, 10/07/14, 10/14/14, 10/21/14, 10/28/14 revealed the nurses documented Resident #13's "skin intact". Review of the date 10/30/14 revealed the nurse documented Resident #13's "skin not intact-existing". The "Wound Assessment Report" for the assessment date of 10/30/14 was requested; however, no documented evidence was provided, even though per interview this was the facility's process.</p> <p>Continued review of the facility's EMR "Skin Inspection Report" for the dates of 11/04/14, 11/11/14, 11/18/14, 11/25/14 and 12/02/14, revealed the nurses documented Resident #13's "skin intact". However, review of the "Wound Assessment Report" dated 12/02/14 revealed Resident #13 had a "rash" on his/her "entire abdomen" and "entire chest" area, with the "cause" noted as "unknown". Continued review of the "Wound Assessment Report" revealed the "rash" on Resident #13's abdomen measured 45 cm by 45 cm and the "rash" on his/her chest area measured 45 cm by 45 cm, with a note stating treatment in progress of Triamcinolone cream mixed with Cetaphil lotion applied to the rash every shift for one (1) week. Review of the telephone order dated 12/02/14, revealed orders for Prednisone in a tapered dose, and the Triamcinolone cream mixed with Cetaphil lotion to be applied to the rash.</p> <p>Review of the PA's Note and Physician's Order dated 12/05/14 revealed Resident #13 had a "pruritic" maculopapular rash to his/her anterior chest with orders to continue the Prednisone, discontinue any "outside lotion to skin" and use a hypoallergenic laundry detergent. Review of the "Nursing" Note dated 12/06/14 at 10:19 PM</p>	F 309		

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revealed Resident #13 was observed by a State Registered Nursing Assistant (SRNA) to be "scratching" his/her left arm causing an 1 cm by 1 cm "skin tear". Continued review of the "Nursing" Note revealed Resident #14 was "still scratching at area" when he entered the resident's room to assess the area. Further review revealed the Physician was notified and orders received for treatment of the skin tear.

Review of the "Skin Inspection Report" for the dates of 12/09/14, revealed Resident #13's "skin not intact-existing". Review of the "Wound Assessment Report" dated 12/09/14 revealed Resident #13 had a "rash" on his/her "entire abdomen" and "entire chest" area, with the "cause" noted as "self-inflicted scratching/picking" which continued to measure 45 cm by 45 cm on the abdomen and 45 cm by 45 cm on the chest area. The "Wound Assessment Report" noted treatment in progress of Triamcinolone cream mixed with Cetaphil lotion applied to the rash every shift for one (1) week, which was ordered on 12/02/14.

Review of the "Skin Inspection Report" for 12/15/14, revealed Resident #13's "skin not intact-existing". Review of the "Wound Assessment Report" dated 12/15/14 revealed Resident #13 now had an "abrasion" noted to his/her right buttock, with the "cause" documented as "self-inflicted scratching/picking" which measured 2 cm by 2 cm. Continued review of the "Wound Assessment Report" revealed an order dated 12/15/14, which noted to cleanse the abrasion with normal saline, pat dry and cover with a non-adherent pad and change everyday until healed.

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Review of the "Skin Inspection Report" for the date of 12/16/14, revealed the nurse documented Resident #13's "skin not intact-existing". Review of the "Wound Assessment Report" dated 12/16/14, revealed Resident #13 continued to have the "rash" on his/her "entire abdomen" and "entire chest" area and an abrasion on the right buttock. Continued review of the "Wound Assessment Report" revealed the nurse documented the "cause" of the rash on the abdomen as "unknown", and the "cause" for the rash on the resident's chest, and abrasion on the right buttock as "self-inflicted scratching/picking". Further review of the "Wound Assessment Report" revealed the "rash" on Resident #13's abdomen now measured 30 cm by 30 cm, the "rash" on his/her chest area now measured 30 cm by 30 cm and the abrasion on the right buttock continued to measure 2 cm by 2 cm. Additionally, review of the "Wound Assessment Report" revealed for the chest and abdomen rash the nurse's narrative note stated "scabs noted to entire abdomen and upper chest" with "healed rash" and "no evidence of rash noted", even though the nurse documented the rash with measurements on the Report. Further review revealed the nurse documented "no treatment required" for the rash on Resident #13's chest and abdomen, and noted the treatment ordered on 12/15/14 for the right buttock abrasion.

Review of the "Skin Inspection Report" for 12/23/14 and 12/30/14, revealed the nurse documented Resident #13's "skin not intact-existing". Review of the "Wound Assessment Report" dated 12/23/14 and 12/30/14, revealed Resident #13 continued to have the "rash" on his/her "entire abdomen" and "entire chest" area and an abrasion on the right

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F 309	Continued From page 142 buttock. Continued review of the "Wound Assessment Report" revealed the nurse continued to document the "cause" of the rash on the abdomen as "unknown", and the "cause" for the rash on the resident's chest, and abrasion on the right buttock as "self-inflicted scratching/picking". Further review of the "Wound Assessment Report" revealed the "rash" on Resident #13's abdomen now measured 25 cm by 25 cm, the "rash" on his/her chest area now measured 25 cm by 25 cm and the abrasion on the right buttock now measured 0.8 cm by 1 cm. Additionally, review of the "Wound Assessment Report" revealed for the chest and abdomen rash the nurse's narrative note stated "scabs noted to entire abdomen and upper chest" with "healed rash" and "no evidence of rash noted", even though the nurse documented the rash with measurements on the Report. Further review revealed the nurse documented the right buttock abrasion had "improved" and the resident was "cooperative with treatment", no new orders noted. Review of the "Nursing" Note dated 01/05/15, revealed the abrasion to Resident #13's right buttock was "resolved" and the order for treatment was discontinued. Review of the "Skin Inspection Report" for 01/06/15, revealed the nurse documented Resident #13's "skin not intact-existing". Review of the "Wound Assessment Report" dated 01/06/15, revealed Resident #13 continued to have the "rash" on his/her "entire abdomen" and "entire chest" area. Continued review of the "Wound Assessment Report" revealed the nurse continued to document the "cause" of the rash on the abdomen as "unknown", and the "cause" for	F 309			

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F 309	Continued From page 143 the rash on the resident's chest as "self-inflicted scratching/picking". Further review of the "Wound Assessment Report" revealed the "rash" on Resident #13's abdomen continued to measure 25 cm by 25 cm and the "rash" on his/her chest area continued to measure 25 cm by 25 cm. Additionally, review of the "Wound Assessment Report" revealed for the nurse's narrative note stated "scabs noted to entire abdomen and upper chest due to previously documented body rash, rash healed, scabs in place", and "no treatment required" was noted. Review of the "Skin Inspection Report" for 01/13/15 revealed the nurse documented Resident #13's "skin intact". However, review of the "Wound Assessment Report" dated 01/13/15, revealed Resident #13 continued to have a "rash" on his/her "entire abdomen" and "entire chest", with the "cause" noted as "unknown" for the abdomen rash and as "self-inflicted scratching/picking" for the chest rash. Further review of the "Wound Assessment Report" revealed the "rash" on Resident #13's abdomen continued to measure 25 cm by 25 cm and the "rash" on his/her chest area continued to measure 25 cm by 25 cm. Additionally, review of the "Wound Assessment Report" revealed for the nurse's narrative note stated "scabs noted to entire abdomen and upper chest due to previously documented body rash, rash healed, scabs in place", and "no treatment required" was noted. Review of the PA's Note and Physician's Order dated 01/20/15 revealed Resident #13 had a "pruritic" rash in the "shirt area", with orders received for Triamcinolone cream to be mixed with Cetaphil lotion and applied to the rash on the	F 309			

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F 309	Continued From page 144 resident's "trunk and arms". Review of the "Skin Assessment Report" dated 01/20/15 revealed the nurse documented Resident #13's "skin not intact-existing". Review of the "Wound Assessment Report" dated 01/20/15 revealed Resident #13 continued to have the "rash" on his/her "entire abdomen" and "entire chest" area, with the "cause" for the abdomen rash noted as "unknown", and the "cause" for the chest rash documented to be "self-inflicted scratching/picking". Continued review of the "Wound Assessment Report" revealed the "rash" on Resident #13's abdomen measured 25 cm by 25 cm and the "rash" on his/her chest area measured 25 cm by 25 cm, with a note stating treatment in progress, and the PA's order for the Triamcinolone cream mixed with Cetaphil lotion to be applied to the trunk and arms every day. Review of the Physician's Orders dated 01/28/15, revealed Permethrin Cream, for Scabies treatment, and Contact Isolation Precautions were ordered. Observation, on 01/28/15 at 4:26 PM, of Resident #13's skin assessment performed by LPN #1, revealed scabbed areas to the resident's back, shoulders, neck, buttocks, lower left leg, chest, abdomen and both arms. 15. Record review revealed, Resident #16 was admitted to the facility on 01/16/15, with diagnoses which included Rehabilitation, Pneumonia, Encephalopathy, Muscle Weakness, Difficulty Walking, Paralysis Agitans (a shaking palsy) and a personal history of falls. Review of the BIMS, dated 01/23/15, revealed the facility assessed Resident #16 to have a score of fifteen (15) which indicated the resident was cognitively	F 309			

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intact and interviewable. Review of Resident #16's Comprehensive Care Plan dated 01/16/15, revealed the facility had care planned the resident to be at risk for impaired skin integrity related to an "ulcer type area/corn on bottom of" left foot with interventions which included to "observe any impaired areas" for signs/symptoms of infection.

Review of the facility's EMR "Skin Inspection Reports" dated 01/16/15, revealed the nurse documented Resident #16's "skin not intact-existing". Review of the "Wound Assessment Report" dated 01/16/15, revealed the nurse documented a "bruise" to the resident's left upper forearm area, with the "cause" noted as "accident/other trauma"; a surgical incision to his/her left cheek; left and right inner shin abrasion, with the "cause" documented to be "accident/other trauma"; and an abrasion to the resident's right rear forearm, with the "cause" identified as "accident/other trauma". Further review of the "Wound Assessment Report" revealed the nurse noted "pending treatment orders" for everything but the "bruise" which she noted "no treatment required". However, review of the Physician's Orders revealed no documented evidence of orders received for treatment of the areas dated 01/16/15.

Review of the facility's EMR "Skin Inspection Reports" dated 01/22/15, revealed the nurse documented Resident #16's "skin not intact-existing". Review of the "Wound Assessment Report" dated 01/22/15, revealed the nurse documented the "bruise" to the resident's left upper forearm area remained, with the "cause" noted as "accident/other trauma"; the surgical incision to his/her left cheek remained; the left and right inner shin abrasion both

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F 309	<p>Continued From page 146</p> <p>remained, with the "cause" documented to be "accident/other trauma"; and the abrasion to the resident's right rear forearm remained, with the "cause" identified as "accident/other trauma". Further review of the "Wound Assessment Report" revealed the nurse noted "pending treatment orders" for everything but the "bruise" which she noted "no treatment required". However, review of the Physician's Orders revealed no documented evidence of treatment orders on 01/22/15, six (6) days later for treatment of the areas first observed on 01/16/15.</p> <p>Review of the facility's EMR "Skin Inspection Reports" dated 01/27/15, revealed the nurse documented Resident #16's "skin not intact-existing". Review of the "Wound Assessment Report" dated 01/27/15, revealed the nurse documented Resident #16 had "self-inflicted scratches" to his/her lower back which measured 3 cm by 2 cm, with the "cause" noted to be "self-inflicted scratching/picking". Further review of the "Wound Assessment Report" revealed the nurse noted "no treatment required", even though other residents in the facility had been treated for Scabies on 01/26/15. Review of the Physician's Orders revealed no documented evidence of orders for treatment of the "self-inflicted scratches" on 01/26/15, even though the nurse documented the Physician was notified.</p> <p>Review of the "Wound Assessment Report" dated 01/29/15 and 02/02/15, revealed the nurse documented Resident #16 continued to have the "self-inflicted scratches" to his/her lower back which remained 3 cm by 2 cm, with the "cause" noted to be "self-inflicted scratching/picking". Further review of the "Wound Assessment</p>	F 309		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF NICHOLASVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(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 309	<p>Continued From page 147</p> <p>Report" revealed the nurse noted "no treatment required", even though other residents in the facility had been treated for Scabies on 01/26/15. Review of the Physician's Orders revealed no documented evidence of orders for treatment of the "self-inflicted scratches", even though the nurse documented the Physician was notified.</p> <p>Continued review of the "Wound Assessment Report" dated 01/29/15 and 02/02/15, revealed the nurses documented the "bruise" to the resident's left upper forearm area remained "unchanged"; the surgical incision to his/her left cheek was noted to be "unchanged"; the left and right inner shin abrasion were noted to be "improved"; and the abrasion to the resident's right rear forearm was also noted to be "improved". Further review of the "Wound Assessment Report" revealed the nurse noted "pending treatment orders" for all the areas, except the "bruise" on the resident's left forearm which she noted "no treatment required". However, review of the Physician's Orders revealed no documented evidence of treatment orders for the areas which the nurse noted to be "pending treatment orders" on 01/29/15 and 02/02/15, even though record review revealed the areas were first identified on 01/16/15.</p> <p>Review of the Physician's Orders revealed no documented evidence of orders for treatment of the skin issues identified from 01/16/15 through 02/02/15.</p> <p>Interview with Resident #16, on 02/04/15 at 8:05 AM, revealed the resident reported itching on his/her back for about two (2) weeks. Continued interview revealed Resident #16 did report the itching to staff, but was not aware of any new</p>	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 148</p> <p>treatment orders. Resident #16 stated the nurses put some lotion on the itching areas, but it only helped for a short time.</p> <p>Observation, on 02/04/15 at 9.58 AM, of a skin assessment performed by LPN #2, revealed a rash to Resident #16's upper back and across both shoulders. Interview with Resident #16, at the time of observation, revealed the resident stated he/she wasn't able to reach all the places that itched, so he/she had to stand against the doorway to rub it back and forth in order to scratch the itching areas. Resident #16 stated he/she had been infected with Scabies in 1957, and stated the current itching felt just like when he/she had Scabies.</p> <p>Staff interview revealed Resident #16's spouse also resided in the facility on the other wing where residents had been treated for Scabies and the resident frequently visited his/her spouse. However, the facility failed to identify the "self-inflicted scratches" to Resident #16's back first noted by the nurses on 01/27/15 as possible signs and symptoms of Scabies. Even though the nurses noted on 01/27/15 Resident #16 had "self-inflicted scratches" on his/her back, there was no documented evidence the facility continuously monitored him/her to ensure a rash had not developed until 02/04/15, during the Surveyor's observation of the resident's skin assessment.</p> <p>Further record review revealed Physician's Orders dated 02/04/15, for Permethrin cream, Benadryl by mouth every six (6) hours PRN for "itching" and Aquaphor ointment to be applied to the resident's body every day and PRN. Resident #16 was discharged home on 02/05/15.</p>	F 309		