

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

PRINTED: 11/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 11/25/2014
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NAME OF PROVIDER OR SUPPLIER PIONEER TRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041
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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 11/08/14.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00022306 was initiated on 10/17/14 and concluded on 10/15/14. KY00022306 was substantiated with related deficiencies cited with the highest Scope and Severity of an "E".	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	Facility notified MD for Resident #1 of bedbug exposure and interventions related to bedbug exposure on 10/14/14. MD did not give any new orders. Facility notified MD for Residents #3 and #4 of bedbug exposure and related interventions on 10/2/14. MD did not give any new orders. Facility notified responsible parties for Residents #1, and #3 of bedbug exposure and related interventions on 10/2/14. Rhonda Clark, LPN, Bobbi Noland, RN, Amanda McClanahan, LPN, and Carrie Rice, LPN performed skin assessments on all residents in facility on 10/1/14. No evidence of bedbug bites noted to other residents. Susan Fulton, LPN, QA/Staff Development conducted education for all nursing staff on policy regarding Notification of Resident, MD, and Responsible Party on 10/24/14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Cox TITLE: ADMINISTRATOR (X6) DATE: 11/25/14

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

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F 157 Continued From page 1
legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to notify the Physician of a significant change in a resident's condition or need to alter treatment significantly for three (3) of six (6) sampled residents (Residents #1, #3 and #4) regarding changes in their skin condition and itching after exposure to bedbugs.

Additionally, the facility failed to notify residents' family or responsible party when there was a change in their room for two (2) of six (6) sampled residents (Residents #1 and #3) when their rooms were temporarily changed on 09/28/14, while their assigned rooms were being treated for bedbugs.

The findings include:

Review of the facility's policy titled, "RE: Concerning calling Physician, Family etc.", revised 1994, revealed the Physician and residents' family or legal representative were to be notified of significant changes in a resident's condition or need to significantly alter his/her treatment.

Review of the facility's policy titled, "Skin Care Prevention Program", revised January 2011, revealed the Physician and resident's family or responsible party were to be informed of significant changes in a resident's condition and documented in the resident's medical record.

F 157 10/27/14, 10/28/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14 and 11/7/14.

Michelle Marshall, RN, Unit Coordinator and Kim Breeze, RN Unit Coordinator will monitor the 24 Hour Summary Report and MD orders daily, Monday through Friday as part of job description, for compliance to facility policy regarding notification of resident, MD, and responsible party. The 24 Hour Summary Report is a report generated from facility EHR, which includes nurse's notes, progress notes, vitals, admissions, and discharges. Results will be given to QA Committee for review of compliance.

The Quality Assurance (QA) Committee will monitor for compliance weekly for 120 days then quarterly thereafter. The QA Committee consists of Administrator, DON, Unit Coordinators, QA/Staff Development Nurse, MDS Coordinator, Maintenance Manager, Housekeeping Supervisor, Dietary Manager, Activities Director, Social Services Director and Medical Director.

Completed 11/08/14

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F 157	<p>Continued From page 2</p> <p>The Administrator provided an untitled and undated document on 10/10/14 to the Surveyor. Review of this document revealed the Administrator was informed by Registered Nurse (RN) #1 on 09/28/14 of possible bedbugs in room 43 (Resident #3's and #4's room) and one (1) of the residents in that room (Resident #3) had an "area" appearing to be "bite marks". The document revealed staff also had found two (2) bugs, one (1) in room 43 and one (1) in room 42, which had been placed in a plastic bag. The document revealed the Administrator gave instructions for staff on what to do for the residents in rooms 42 and 43, which included moving the residents to another room and quarantining their assigned rooms. According to the document, the Administrator called the facility's pest control service to have a technician (tech) come to treat rooms 42 and 43 for "bedbugs". Per the document, on 09/30/14 the pest control service called to schedule a time to come treat the affected rooms, requested pictures of the "questionable bugs" in the bag and confirmed the bugs to be "bedbugs".</p> <p>Interview, on 10/13/14 at 2:15 PM, with RN #1 revealed she had worked the 7:00 AM to 7:00 PM shift on 09/27/14 and 09/28/14 and had cared for the residents in room 42 and 43. She stated Resident #4's spouse had been sleeping on the couch in the facility's sunroom while his/her apartment complex was being treated for bedbugs. Continued interview with RN #1 revealed on 09/27/14 staff reported observing "insect bites" on three (3) residents, Resident #1, Resident #3 and Resident #4. RN #1 stated she did not notify those residents' Physicians of this information, but indicated she should have.</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>Additionally, RN #1 stated on 09/28/14, during morning shift report Licensed Practical Nurse (LPN) #2 reported finding two (2) "bugs" on a resident in room 43 which she had placed in a bag. RN #1 revealed the Administrator told her on 09/28/14, to move the residents in rooms 42 and 43 temporarily to other rooms, until their assigned rooms could be treated by the pest control service. She stated this was done; however, two (2) of the four (4) residents residing in those rooms, Resident #1 and Resident #3, families or responsible parties were not notified of the temporary room changes for those residents, but indicated they should have been. She stated the residents were returned to their assigned rooms, rooms 42 and 43 on 10/01/14, after bedbug treatment by the pest control service.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/22/14, with diagnoses which included Congestive Heart Failure, Generalized Muscle Weakness and Chronic Kidney Disease with Dialysis, and he/she resided in room 42. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment dated 09/04/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated he/she was moderately cognitively impaired. Review of Resident #1's Comprehensive Care Plan, dated 09/09/14, revealed a care plan for potential/actual impairment to the resident's skin integrity with a goal of his/her "itching" to be resolved by the next review date.</p> <p>Review of the Nurse's Note revealed Resident #1 had complained of "itching all over" on 09/19/14, and had a "rash" on his/her "upper right shoulder", and on 9/20/14, the resident had</p>	F 157		
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F 157	<p>Continued From page 4</p> <p>"scratched" the area on his/her right shoulder until it was "open", the Physician was notified and an order for Benadryl cream (anti-itch cream) was received. However, review revealed no documented evidence the resident's Physician was notified of the "bedbugs", found in his/her room on 09/27/14 and 09/28/14 in order to see if he wanted Resident #1's nurses to increase monitoring and assessment of him/her for signs and symptoms of bedbug bites or possible infection to the area on the right upper shoulder.</p> <p>Interview with Resident #1 on 10/10/14 at 11:15 AM, during a skin assessment revealed the resident had told staff he/she had been itching; however, nothing had been done. Observation at the time of interview revealed Resident #1 was actively scratching his/her right lower arm and right shoulder areas.</p> <p>Interview with Resident #1's Primary Care Physician (PCP) on 10/14/14 at 5:00 PM, who was also the facility's Medical Director, revealed he had not been notified of changes in the resident's skin condition related to possible bedbug exposure on 09/28/14. However, Resident #1's PCP stated he expected to be notified; however, the facility had not notified him until 10/02/14.</p> <p>2. Record review revealed the facility admitted Resident #3 on 09/24/12, with diagnoses which included Peripheral Vascular Disease and Alzheimer's Disease and Peripheral Vascular Disease, and he/she resided in room 43, bed 1. Review of the 08/11/14, Annual MDS Assessment revealed the facility assessed Resident #3 as having a BIMS score of eleven (11) indicating the resident was moderately cognitively impaired.</p>	F 157		
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F 157	<p>Continued From page 5</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 08/12/14, revealed care plans for potential skin impairment and for actual skin impairment with goals for the resident to have no complications. Further review of the care plans revealed interventions included reporting abnormalities, failure to heal, signs and symptoms of infection to the Physician.</p> <p>However, continued record review revealed no documented evidence Resident #3's Physician was notified regarding the "area" observed by RN #1 that "appeared to be bite marks" or notified of the bedbugs found in the resident's room to determine if he wanted to order treatment for this "area" or have nurses increase monitoring and assessment. In addition, there was no documented evidence Resident #3's family or responsible party was notified of the temporary room change which took place on 09/28/14. Continued review revealed the Physician was notified on 10/02/14 Resident #3 now had "multiple scabs" on his/her bilateral lower extremities which he/she continued to "pick at".</p> <p>3. Record review revealed the facility admitted Resident #4 on 05/06/12, with diagnoses which included Muscle Weakness, Abnormality of Gait and Alzheimer's Disease, Abnormality of Gait and Muscle Weakness, and resided in room 43, bed 2. Review of the 09/24/14 Quarterly MDS Assessment revealed the facility assessed Resident #4 as having a BIMS score of three (3) indicating the resident was severely cognitively impaired. Review of Resident #4's Comprehensive Care Plan, dated 09/29/14, revealed a care plan for potential for skin impairment related to fragile skin with a goal for the resident to have no skin related problems.</p>	F 157	

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F 157	<p>Continued From page 6</p> <p>Continued review of the care plan revealed the interventions included keeping the resident's fingernails short and for him/her to "avoid scratching".</p> <p>Continued review of the record revealed no documented evidence Resident #4's Physician was notified of the "bedbugs" found in the resident's room on 09/27/14 and 09/28/14. Review of the Nurse's Notes revealed a Note dated 09/28/14 which noted Resident #4 had "multiple abnormal scabs" observed his/her bilateral lower extremities. Review of the Nurse's Note dated 10/02/14 revealed the Physician was notified Resident #4 had "multiple scabs" to his/her bilateral lower extremities which he/she continued to "pick at".</p> <p>Interview, on 10/13/14 at 1:00 PM, with Licensed Practical Nurse (LPN) #2 revealed on 09/27/14 and 09/28/14, she had worked the 7:00 PM to 7:00 AM shift, and had cared for the residents residing in rooms 42 and 43. She stated on 09/27/14, she had observed "insect bites" on Resident #3 and Resident #4; however, thought since the nurses and Physician were already aware on 09/27/14 of Resident #3's and Resident #4's "self-inflicted" scratches and itching experienced by Resident #3 and Resident #4, she had not contacted the Physician. In addition, she indicated she had not notified the residents' families or responsible regarding the temporary room change made on 09/28/14.</p> <p>Interview with LPN #3 on 10/14/14 at 11:30 AM, revealed she had worked the 7:00 AM to 7:00 PM shift on 09/28/14, with RN #1 and had assisted with moving the residents in rooms 42 and 43 to different rooms until the pest control service</p>	F 157		
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F 157	<p>Continued From page 7</p> <p>came to treat their rooms for bedbugs. However, LPN #3 revealed neither she or RN #1 had notified the residents' Physicians, of "insect bites" on the residents, of the residents' scratching, or of the possible exposure to bedbugs. She stated they also had not notified the residents' families or responsible parties of the temporary room changes for the residents.</p> <p>Interview with Unit Coordinator (UC) #1 on 10/10/14 at 12:30 PM, who supervised the hall where Resident #1, Resident #2 and Resident #3 resided, revealed if Certified Nursing Assistants (CNAs) informed nurses of changes in a resident's skin, the nurse should assess the area of concern, contact the resident's Physician for treatment orders and notify the resident's family. She stated her expectations were for nurses to continually monitor and assess residents' skin condition, and notify the Physician as necessary.</p> <p>Interview with the Physician on 10/13/14 at 4:30 PM, who was the healthcare provider for Resident #3 and Resident #4, revealed he had not been notified of changes in the resident's skin condition or of their possible bedbug exposure on 09/28/14, and he was not notified of this information until 10/02/14. He stated, however, it was his expectation to be notified of changes in his residents' condition, and notified of the residents possible bedbug exposure.</p> <p>Interview with the DON on 10/14/14 at 3:30 PM, revealed she had been notified of the residents possible exposure to bedbugs on 09/28/14. She stated the Administrator told her he had instructed staff on what to do to include moving the residents residing in rooms 42 and 43 temporarily. The DON stated she was not aware</p>	F 157		
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F 157	<p>Continued From page 8</p> <p>the nurses had not contacted the residents' Physicians; however, it was her expectation for nurses to notify the Physicians. Additionally, she indicated she expected staff to notify residents' families and/or responsible parties when room changes were made.</p> <p>Interview with the Administrator on 10/14/14 at 4:00 PM, revealed he was notified on 09/28/14, of staff finding two (2) black bugs which looked like bedbugs and of a resident having possible bedbug bites. He stated he instructed staff on what they should do to include temporarily moving the residents in rooms 42 and 43 until the pest control service could treat their assigned rooms. He stated looking back he should have also told the nurses to notify the residents' Physicians and had them contact the residents' families and/or responsible parties regarding the temporary room changes for the affected residents.</p>	F 157		
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of</p>	F 280	<p>Resident #1's Comprehensive Care Plan revised to include assessment and monitoring of skin related to exposure to bedbugs on 10/13/14. Revised CCP to include continuous assessment for itching and requires use of Benadryl cream on 11/4/14</p> <p>CCP for Resident #3 revised to include assessment and monitoring of skin related to bedbug exposure on 10/13/14.</p> <p>CCP for Resident #4 revised to include assessment and monitoring of skin related to bedbug exposure on 11/4/14.</p>	

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F 280 Continued From page 9
the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy and documents, it was determined the facility failed to revise and update Comprehensive Care Plans (CCPs) for three (3) of six (6) sampled residents (Resident #1, Resident #3 and Resident #4) related to the change in their skin condition and itching after possible exposure to bedbugs.

The findings include:
Review of the facility's policy titled, "Resident Care Plan", dated 05/01/09, revealed nurses should update and revise residents' care plans when the resident's condition changed and with new Physician Orders.
Review of a document provided by the Administrator on 10/10/14, which was untitled and undated, revealed he had been notified by Registered Nurse (RN) #1 on 09/28/14, of two (2) bugs being found, one (1) in room 42 and another in room 43, and the resident in room 43, bed 1 (Resident #3) had an "area" which "appeared to be bite marks". The document noted on 09/30/14, the pest control service confirmed the bugs found by facility staff were bedbugs, and the pest control service technician (tech) treated

F 280 CCP for Resident #5 revised to include assessment and monitoring of skin related to exposure to biting bugs on 10/10/14.
CCP for Resident #6 revised to include assessment and monitoring of skin related to exposure to biting bugs on 10/10/14.

Rhonda Clark, LPN, Bobbi Noland, RN, Amanda McClanahan, LPN, and Carrie Rice, LPN performed skin assessments on all residents in facility on 10/1/14. No evidence of bedbug bites noted to other residents.

Susan Fulton, LPN, QA/Staff Development conducted education for all nursing staff on creation and revision of resident careplans on 10/27/14, 10/28/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14 and 11/7/14.

Michelle Marshall, RN, Unit Coordinator and Kim Breeze, RN Unit Coordinator will monitor the careplans and MD orders daily, Monday through Friday as part of job description, to ensure staff is in compliance with revising resident careplans. Results will be reported to the QA Committee.

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F 280	<p>Continued From page 10</p> <p>rooms 42 and 43. Continued review of the facility's document revealed the Administrator had additionally been informed on 10/01/14, of staff finding a "bug" in room 16 on a resident's chair, and one (1) of the residents who resided in room 16 (Resident #6) had "bites" on him/her. The document revealed on 10/02/14 "around noon" the pest control service inspected room 16 with no evidence of "bugs" found.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/22/14, with diagnoses including Chronic Kidney Disease with Dialysis, history of Pneumonia, Congestive Heart Failure and Generalized Muscle Weakness. Review revealed Resident #1 resided in room 42 where the bedbugs were identified on 09/28/14. Review of the Admission MDS Assessment dated 09/04/14, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of eleven (11) indicating moderate cognitive impairment. Review of the Nurse's Notes revealed on 09/19/14 Resident #1 complained of "itching all over" and had a "rash" to his/her "upper right shoulder". Continued review of the Nurse's Note revealed on 09/20/14 Resident #1 had "scratched" the area on his/her right shoulder until it was "open", and an order for Benadryl cream (anti-itch cream) had been received. Review of the Physician's Orders revealed an order dated 09/19/14, for Benadryl Cream 0.1% to be applied every twelve (12) hours as needed for itching.</p> <p>Review of Resident #1's CCP, dated 09/09/14, revealed the facility care planned the resident for potential/actual impairment to his/her skin integrity with a goal of his/her "itching" to be resolved by the next review date with</p>	F 280	<p>The Quality Assurance (QA) Committee will monitor compliance weekly for 120 days then quarterly thereafter.</p> <p style="text-align: right;">Completed</p>	11/08/14

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F 280	<p>Continued From page 11</p> <p>interventions including avoiding scratching and keeping his/her fingernails short. However, continued review of the CCP revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin after the possible exposure to bedbugs on 09/27/14 and 09/28/14. Additionally, there was no documented evidence the CCP was revised to include continuous assessment of Resident #1 to identify if he/she was itching and required the use of his/her Benadryl cream.</p> <p>Interview with Resident #1 on 10/10/14 at 11:15 AM, his/her right arm and shoulder had been "itching" since being admitted and he/she had told the nurses but nothing had been done. Observation at the time of interview, revealed Resident #1's actively scratching his/her right shoulder area.</p> <p>2. Record review revealed the facility admitted Resident #3 on 09/24/12, with diagnoses including Alzheimer's Disease and Peripheral Vascular Disease. Review revealed Resident #3 resided in room 43 where the bedbugs were identified on 09/27/14 and 09/28/14. Review of the Annual MDS Assessment dated 08/11/14, revealed the facility assessed Resident #3 to have a BIMS score of eleven (11) indicating moderate cognitive impairment. Review of Resident #3's CCP, dated 08/12/14, revealed a care plan for the potential for skin impairment and actual skin impairment. However, further review of the CCP revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin after the possible exposure to bedbugs on 09/27/14 and 09/28/14.</p>	F 280		

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F 280	<p>Continued From page 12</p> <p>3. Record review revealed the facility admitted Resident #4 on 05/06/12, with diagnoses which included Alzheimer's Disease, Abnormality of Gait and Muscle Weakness. Review revealed Resident #4 resided in room 43 where the bedbugs were identified on 09/27/14 and 09/28/14. Review of the Quarterly MDS Assessment dated 09/24/14, revealed the facility assessed Resident #4 as having a BIMS score of three (3) indicating severe cognitive impairment. Review of Resident #4's CCP, dated 09/29/14, revealed a care plan for potential for skin impairment related to fragile skin. However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin after his/her possible exposure to bedbugs on 09/27/14 and 09/28/14.</p> <p>4. Record review revealed the facility admitted Resident #5 on 01/02/14 with diagnosis including Depression, Dementia and Anxiety. Review revealed Resident #5 resided in room 16 where the unidentified "bugs" were observed on 10/01/14. Review of the Quarterly MDS Assessment revealed the facility assessed Resident #5 to have a BIMS score of one (1) indicating severe cognitive impairment. Review of Resident #5's CCP, dated 09/25/14, revealed a care plan for the potential for skin impairment related to "frail skin". However, further review of the CCP revealed no documented evidence the care plan was revised to include ongoing assessment and monitoring of the resident's skin after his/her possible exposure to biting insects on 10/01/14.</p>	F 280		

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F 280 Continued From page 13

5. Record review revealed the facility admitted Residents #6 on 07/19/13, with diagnoses including Cerebrovascular Accident (CVA), Hypertension and Diabetes. Review revealed Resident #6 resided in room 16 where the unidentified "bugs" were observed on 10/01/14. Review of the 07/15/14 Annual MDS Assessment revealed the facility assessed Resident #6 to have a BIMS score of fifteen (15) indicating no cognitive impairment. Review of Resident #6's CCP, dated 07/21/14, revealed a care plan for risk for impaired skin integrity related to decreased mobility and history of CVA with right sided weakness. Review of the Nurse's Note revealed a Note dated 10/01/14, which stated Resident #6 had "areas" on his/her chest and back appearing to be "possible bites" which the resident was scratching. However, further review of the CCP revealed no documented evidence the care plan was revised to include ongoing assessment and monitoring of the resident's skin after his/her exposure to biting insects on 10/01/14.

Interview with Licensed Practical Nurse (LPN) #4 on 10/14/14 at 1:40 PM, revealed she cared for Resident #6 on 10/01/14 and she documented on the twenty-four (24) Hour Report the resident had possible bedbug bites; however, had not updated or revised Resident #6's CCP, but should have.

Interview with RN #2 on 10/14/14 at 1:20 PM, revealed if nurses were informed of a resident having a skin change or concern, the nurse should assess the resident, contact the Physician and update and revise the resident's CCP.

Interview, on 10/10/14 at 12:30 PM, with Unit Coordinator (UC) #1, revealed nurses, UCs, MDS

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F 280	<p>Continued From page 14</p> <p>Nurses and the Director of Nursing (DON) updated and revised residents' CCPs. According to UC #1, she expected nurses to update and revise residents' care plans as needed.</p> <p>Interview, on 10/14/14 at 3:30 PM, with the DON revealed she was aware of Resident #1's, Resident #3's and Resident #4's possible exposure to the bedbugs and of Resident #5's and Resident #6's possible exposure to biting insects. The DON stated she expected nurses to have updated and revised the CCPs for those residents regarding the possible exposure to bedbugs and biting insects to ensure continued monitoring and assessing of the residents. Additionally, she stated Resident #1's CCP should have been updated and revised to ensure ongoing assessment in order to determine if the resident required the use of his/her Benadryl cream for the itching.</p>	F 280		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and documents, it was determined the facility failed to provide the</p>	F 309	<p>Facility notified Resident #1 MD related bedbug exposure and interventions taken on 10/13/14. Atarax 10mg po every 8 hours as needed for itching ordered by MD. Resident #1's Comprehensive Care Plan revised to include assessment and monitoring of skin related to exposure to bedbugs on 10/13/14. Revised CCP to include continuous assessment for itching and requires use of Atarax 10mg on 11/4/14 Facility notified Resident #3 MD on 10/2/14 related to skin issues. MD gave no new orders. Facility notified</p>	

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necessary care and services for five (5) of six (6) sampled residents (Residents #1, #3, #4, #5 and #6) to ensure ongoing assessment and monitoring of the residents' for bites after the residents experienced possible exposure to bedbugs.

The findings include:

Interview, on 10/13/14 at 3:30 PM, with the Director of Nursing (DON) revealed the facility had a nursing reference to guide nursing care provided to residents; however, no nursing reference material was provided to the Surveyor.

Review of the facility's policy titled, "RE: Concerning calling Physician, Family etc.", revised 1994, revealed the facility would consult the resident immediately and notify the resident's Physician and legal representative/family member of significant changes in the resident's condition or need to alter his/her treatment significantly.

Review of the facility's policy titled, "Skin Care Prevention Program", revised January 2011, revealed significant changes in a resident's condition would be communicated to the Physician, resident and/or responsible party with the notification documented in the medical record. Continued review revealed nurse's were to conduct head to toe skin assessments and nursing assistants were to inform the Charge Nurse of any "new red, open, bruised or other skin areas of concern.

Review of the facility's policy titled, "Resident Care Plan", 05/01/09, revealed nurses were to "update" resident care plans as the resident's

F 309

MD related to resident's exposure to bedbug exposure on 10/13/14. No new orders given. CCP for Resident #3 revised to include assessment and monitoring of skin related to bedbug exposure on 10/13/14.

Facility notified Resident #4 MD related to bedbug exposure and interventions taken on 10/13/14. No new orders were given. CCP for Resident #4 revised to include assessment and monitoring of skin related to bedbug exposure on 11/4/14.

CCP for Resident #5 revised to include interventions for ongoing assessment and monitoring of skin related to exposure to biting bugs on 10/10/14.

CCP for Resident #6 revised to include interventions for ongoing assessment and monitoring of skin related to exposure to biting bugs on 10/10/14.

Rhonda Clark, LPN, Bobbi Noland, RN, Amanda McClanahan, LPN, and Carrie Rice, LPN performed skin assessments on all residents in facility on 10/1/14. No evidence of bedbug bites noted to other residents.

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condition changed and new Physician Orders "deemed necessary" were received.

Review of the facility's untitled and undated document provided by the Administrator on 10/10/14, revealed on 09/28/14 at 9:07 AM, he had received a call from a "member of board of directors" of the facility about a "possible report of bed bug activity". The document noted the Administrator called the facility and spoke to Registered Nurse (RN) #1 who informed him the resident in room 43, bed 1 (Resident #3) had an "area" which "appeared to be bite marks" and staff had found a "bug" which she had placed in a "zip lock" bag at the nurse's station, and she had "captured" a bug from room 42, bed 1 which she had also placed in the "zip lock" bag. Continued review of the document revealed the Administrator gave RN #1 instructions on what to do for residents in rooms 42 and 43, and he called the facility's pest control service to "get a tech" (technician) to the facility "to treat for bedbugs". The document revealed on 09/30/14, the pest control service called to schedule a time for a tech to come to the facility, and requested pictures of the "questionable bugs" which were confirmed by the pest control service to be "bedbugs". It was noted a tech came to the facility and found one (1) "juvenile bedbug in room 43 on bed frame of bed 1", inspected the "sunroom furniture and found bedbugs" and treated rooms 42, 43 and a storage room on the "other side of room 43".

Review of the facility's pest control service's "Commercial Service and Inspection Report", dated 09/30/14, revealed an "extra service" visit was performed by the pest control service on that date related to bedbug treatment.

F 309 Susan Fulton, LPN, QA/Staff Development conducted education for all nursing staff on following MD orders and documentation on eTAR as appropriate on 10/27/14, 10/28/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14 and 11/7/14.

Michelle Marshall, RN, Unit Coordinator and Kim Breeze, RN Unit Coordinator will monitor all resident CCPs and MD orders daily, Monday through Friday as part of job description, to ensure staff are in compliance with revising resident careplans. Unit Coordinators will ensure documentation on eTAR is accurate to MD orders and CCPs and care rendered daily is documented, Monday through Friday. Results will be reported to QA Committee weekly by Unit Coordinators.

The Quality Assurance (QA) Committee will monitor for compliance; eTAR is accurate to MD orders and CCPs weekly for 120 days then quarterly thereafter.

Completed 11/08/14

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F 309	<p>Continued From page 17</p> <p>1. Review of Resident #3's medical record revealed the facility admitted the resident on 09/24/12, with diagnoses which included Alzheimer's Disease and Peripheral Vascular Disease, and he/she resided in room 43, bed 1. Review of the Annual Minimum Data Set (MDS) Assessment dated 08/11/14, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of eleven (11) which indicated moderate cognitive impairment. Continued review revealed the facility assessed Resident #3 to be at risk for Pressure Ulcers, to have a Stage II Pressure Ulcer, a Stage III Pressure Ulcer, three (3) Venous/Arterial Ulcers and a Diabetic Foot Ulcer.</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 08/12/14, revealed the facility care planned the resident for potential for skin impairment and actual skin impairment. Review of the goals revealed Resident #3 would have no complications related to Pressure Ulcers, Deep Tissue Injuries or Vascular Ulcers. Further review of the care plan revealed interventions which included monitor/document location, size and treatment of a skin injury, and report abnormalities, failure to heal, signs and symptoms of infection to the Physician. However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin.</p> <p>Further review of the record revealed no documented evidence Resident #3's Physician was notified of the "area" which "appeared to be bite marks" observed by RN #1 on 09/28/14 to determine whether he wanted to order treatment</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>for the "area" and to increase monitoring and assessment. Continued review revealed no documented evidence licensed nursing staff continually assessed and monitored the "area" for changes in size or signs and symptoms of infection, and attempted to obtain treatment for the "area". Review of the Nurse's Notes revealed on 10/02/14 the Physician was notified of Resident #3 having "multiple scabs" to his/her bilateral lower extremities and the resident continued to "pick at" these areas with no new orders received at that time.</p> <p>Observation of a skin assessment performed on 10/10/14 at 10:35 AM by LPN #1, revealed Resident #3 was scratching his/her bilateral upper thighs. Interview with Resident #1, at the time of observation, revealed the resident stated he/she had been "itching"; however, did not indicate how long the itching had been going on. Continued observation revealed Resident #3 scattered pin prick marks/rash on his/her bilateral lower extremities from knee to ankle.</p> <p>2. Review of Resident #4's medical record revealed the facility admitted the resident on 05/06/12, with diagnoses which included Alzheimer's Disease, Abnormality of Gait and Muscle Weakness, and he/she resided in room 43, bed 2. Review of the Quarterly MDS Assessment dated 09/24/14, revealed the facility assessed Resident #4 to have a BIMS score of three (3) which indicated severe cognitive impairment. Continued review revealed the facility assessed Resident #4 to be at risk for Pressure Ulcers and to require extensive assistance of two (2) staff for most Activities of Daily Living (ADLs).</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 09/29/14, revealed the facility care planned the resident for potential for skin impairment related to fragile skin. Review of the goals revealed Resident #4 would have no skin related problems with interventions which included "avoid scratching" and keep fingernails short. However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin.</p> <p>Continued review of the record revealed no documented evidence Resident #4's Physician was notified of the "bedbugs" found in the resident's room to determine whether he wanted increased monitoring and assessment of the resident. Record review revealed no documented evidence licensed nursing staff continually assessed and monitored Resident #4 for signs and symptoms of bedbug bites. Review of the Nurse's Notes revealed on 09/28/14 the nurse noted "multiple abnormal scabs" were observed on Resident #4's bilateral lower extremities. Review of the Nurse's Note on 10/02/14 the Physician was notified of Resident #4 having "multiple scabs" to his/her bilateral lower extremities and the resident continued to "pick at" these areas with no new orders received at that time.</p> <p>Observation of a skin assessment performed on 10/10/14 at 11:00 AM by LPN #1, revealed Resident #4 was scratching his/her bilateral lower legs. Continued observation revealed Resident #4 had circular open areas on his/her bilateral lower extremities and one (1) circular open area above his/her left knee.</p>	F 309		

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F 309	Continued From page 20 Interview, on 10/13/14 at 1:00 PM, with LPN #2 revealed she had worked the 7:00 PM to 7:00 AM shift on 09/27/14 and 09/28/14, and had observed "insect bites" on Resident #3 and Resident #4 on 09/27/14. Per interview, she had taken a flashlight and checked Resident #3's and Resident #4's mattresses on 09/27/14; however, had not observed any brownish/reddish spots on the mattresses to indicate bedbugs were present. She stated the nurses were already aware on 09/27/14, of the "self-inflicted" scratches and the itching experienced by Resident #3 and Resident #4. She stated the Physician was also already aware of this and therefore, she had not contacted him regarding the residents skin issues. LPN #2 revealed she had not checked room 42 or assessed Resident #1 and Resident #2 who resided in it. Interview, on 10/13/14 at 2:15 PM, with RN #1 revealed she had worked the 7:00 AM to 7:00 PM shift on 09/27/14 and 09/28/14 and had cared for Resident #4. She stated Resident #4's spouse had been sleeping on the couch in the facility's sunroom because his/her apartment complex was being treated for bedbugs and he/she had nowhere else to go. Interview, on 10/13/14 at 4:30 PM, with the Physician, who was the healthcare provider for Resident #3 and Resident #4, revealed he had received no notification regarding the change in Resident #3 and Resident #4's condition related to possible bedbug exposure on 09/28/14. He stated it would have been his expectation to have been notified of the change in his residents' condition and the possibility of both residents being exposed to bedbugs. The Physician	F 309			

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F 309	Continued From page 21 revealed the facility did not notify him until 10/02/14, of the change in his residents' skin condition and of their exposure to bed bugs. 3. Review of Resident #1's medical record revealed the facility admitted the resident on 08/22/14 with diagnoses which included Pneumonia, Chronic Kidney Disease with Dialysis, Congestive Heart Failure and Generalized Muscle Weakness, and he/she resided in room 42 bed 1. Review of the Admission MDS Assessment dated 09/04/14, revealed the facility assessed Resident #1 to have a BIMS score of eleven (11) which indicated moderate cognitive impairment. Continued review revealed the facility assessed Resident #1 to be at risk for Pressure Ulcers and to require limited assistance of one(1) staff for most Activities of Daily Living (ADLs). Review of Resident #1's Comprehensive Care Plan, dated 09/09/14, revealed the facility care planned the resident for potential for Pressure Ulcer development. Review of the goals revealed Resident #1 would have intact skin, free of redness, blisters or discoloration with interventions administer treatments as ordered and monitor for effectiveness. Continued review of the Comprehensive Care Plan revealed the resident also had a care plan for potential/actual impairment to his/her skin integrity with a goal of his/her "itching" to be resolved by the next review date. Review of the care plan revealed interventions which included "avoid scratching", keep fingernails short and educate the resident/family/caregivers regarding "measures to prevent skin injury". However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised	F 309			

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F 309 Continued From page 22
to include interventions for ongoing assessment and monitoring of the resident's skin.

Continued record review revealed Resident #1 was noted to complain of "itching all over" on 09/19/14, and to have a "rash" to his/her "upper right shoulder". Review of the Nurse's Note dated 09/20/14 revealed Resident #1 had "scratched" the area on his/her right shoulder until it had "become open", an order for Benadryl cream (anti-itch cream) had been received and the resident had been instructed not to scratch the area due to "causing infection". However, continued review of the record revealed no documented evidence Resident #1's Physician was notified of the "bedbugs", found in his/her room 42, to determine whether he wanted increased monitoring and assessment of the resident for signs and symptoms of bedbug bites. Record review revealed no documented evidence licensed nursing staff continually assessed and monitored Resident #1 for signs and symptoms of bedbug bites. Review of the Nurse's Notes revealed on 10/02/14 the Physician was notified of Resident #1 having "multiple scabs" all over his/her body with no new orders received and the Benadryl cream was continued.

Review of the Physician's Orders revealed an order dated 09/19/14, for Benadryl Cream 0.1% to be applied to area of need topically every twelve (12) hours as needed.

However, review of Resident #1's Treatment Administration Record (TAR) from 09/19/14 through 10/10/14, revealed no documented evidence his/her Benadryl cream had been applied as ordered during this period of time, even though the nurses documented the resident

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F 309	<p>Continued From page 23</p> <p>complained of itching on 09/19/14, and noted he/she had scratched the area on his/her right shoulder until it was open on 09/20/14.</p> <p>Observation of a skin assessment performed on 10/10/14 at 11:15 AM by LPN # 1, revealed Resident #1 was scratching his/her right lower arm and right shoulder. Observation revealed Resident #1's right lower arm had erythema (redness) and a macular (circular) rash and the resident's right shoulder and left shoulder also had erythema with scratch marks. Continued observation revealed Resident #1's bilateral feet and ankles had scattered reddened pin prick rash with scabs covering the feet and ankles. Interview with Resident #1, at the time of observation, revealed the resident stated his/her right arm and shoulder had been "itching since being admitted and he/she had told the nurses but "nobody does anything".</p> <p>Interview, on 10/13/14 at 2:15 PM, with RN #1 revealed she had worked the 7:00 AM to 7:00 PM shift on 09/27/14 and 09/28/14. She stated on 09/27/14 staff observed "insect bites" on Resident #1, Resident #3 and Resident #4. RN #1 stated she did not call the residents' Physician; however, did document the information on the twenty-four (24) Hour Report. She stated during morning report on 09/28/14, LPN #2 reported finding two (2) "bugs" on Resident #3 when performing the treatment to the resident's bilateral lower extremities which she had placed in a bag. RN #1 revealed she started calling the Administrator at 8:00 AM; however, had not received a call back until approximately 3:30 PM. Per interview, the residents in room 42 and room 43 were removed from the rooms, showered, given new clothes and transferred to a different room until</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>the rooms were treated by the pest control service. She stated the residents were returned to rooms 42 and 43 on 10/01/14 after the pest control service had treated the rooms. According to RN #1, a "skin sweep" (skin assessments) was performed on all residents on the hall where Resident #1, Resident #3 and Resident #4 resided by her and LPN #3; however, she stated she and LPN #3 did not document their assessments.</p> <p>Interview, on 10/14/14 at 11:30 AM, with LPN #3 revealed on 09/28/14, she and RN #1 had performed skin assessments on all residents on the hall where Resident #1, Resident #3 and Resident #4 resided; however, they had not documented the skin assessments. She stated RN #1 called the Administrator and he called back and instructed them to take the residents out of rooms 42 and 43, shower them, change their clothing, clean and sanitize the rooms, quarantine the rooms, and told them he would call the pest control service to have them come as soon as possible. LPN #3 revealed the pest control service did not come however until 09/30/14. She stated they did not notify the Physician of the information regarding the "insect bites" or residents scratching or possible exposure to bedbugs or that the residents were being moved to other rooms.</p> <p>Interview, on 10/14/14 at 3:30 PM, with the DON revealed it was her expectation nurses should apply any necessary PRN treatments as ordered if a resident needed it. She stated Resident #1's Benadryl cream was available for use and the resident should have been assessed and asked if he/she needed the Benadryl applied. Per interview, the Benadryl cream container had been</p>	F 309			

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F 309	Continued From page 25 opened; however, after reviewing the TAR had not been documented as applied. She stated if the cream had been applied it should have been documented. Continued review of the facility's untitled and undated document provided by the Administrator on 10/10/14, revealed on 10/01/14 staff had reported finding a "bug" on a chair in room 16, and one (1) of the residents in that room had "bites" on him/her. Per the document, the resident with the "bites" on him/her spoke to the Administrator to inquire as to why the "entire facility" had not been treated if the facility "knew there was a bug problem". It was noted the Administrator informed this resident the facility did not have a "bug problem" and had "isolated the bugs" to one (1) room which had been treated by the pest control service and the "bugs eradicated". The document stated the Administrator called the pest control service for additional treatment, instructed his staff to perform "complete skin assessments on all residents that day to assess for "bug bites" with "none noted". Further review of the document revealed the room was "isolated", cleaned, sanitized, linens and residents' clothing was washed and dried on high heat. The document noted the Ombudsman spoke to the Administrator on 10/01/14 regarding "guidance" she had received which indicated the "entire facility" should be treated and the Administrator told her he would inquire from experts regarding what to do as "this was not an infestation". In addition, it was noted the pest control service came on 10/02/14 "around noon" and inspected room 16 with no evidence of "bugs" found and was questioned by the Administrator regarding treating the entire facility, with the pest control tech	F 309			

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F 309	<p>Continued From page 26</p> <p>advising not to do this as it was not an "infestation". The document noted "Health Department representatives" also came and both the Health Department representatives and pest control tech "cleared" the facility "from bedbugs".</p> <p>4. Review of Resident #5's medical record revealed the facility admitted the resident on 01/02/14, with diagnoses which included Dementia, Anxiety and Depression, and he/she resided in room 16, bed 1. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/23/14, revealed the facility assessed Resident #5 to have a BIMS score of one (1) which indicated severe cognitive impairment.</p> <p>Review of Resident #5's Comprehensive Care Plan, dated 09/25/14, revealed the facility care planned the resident for potential for skin impairment related to "frail skin" with a goal for him/her to have no complications with skin integrity through the next review date. Continued review of the care plan revealed interventions which included "avoid scratching" and keep fingernails short. However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin.</p> <p>Continued review of the record revealed a Nurse's Note dated 10/01/14, documenting Resident #5 had "areas" to his/her chest, back, abdomen and left breast which "appear" to be related to "possible bites". Continued review of the Note revealed Resident #5 was observed to be scratching the "areas" with no new orders received at that time. Continued review revealed no documented evidence licensed nursing staff</p>	F 309		

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F 309	<p>Continued From page 27</p> <p>continually assessed and monitored the "areas" for changes or signs and symptoms of infection.</p> <p>Observation of a skin assessment performed on 10/10/14 at 11:55 PM by LPN #1, revealed Resident #5 had no open or rash areas to his/her skin.</p> <p>5. Review of Resident #6's medical record revealed the facility admitted the resident on 07/19/13, with diagnoses which included Cerebrovascular Accident (CVA) with right sided weakness, Depressive Disorder and Diabetes, and he/she resided in room 16, bed 2. Review of the Annual MDS Assessment dated 07/15/14, revealed the facility assessed Resident #6 to have a BIMS score of fifteen (15) which indicated no cognitive impairment. Continued review of the MDS Assessment revealed the facility assessed Resident #6 to require extensive assistance of two (2) staff for most ADLs.</p> <p>Review of Resident #6's Comprehensive Care Plan, dated 07/21/14, revealed the facility care planned the resident for being at risk for impaired skin integrity related to decreased mobility and history of CVA with right sided weakness. Continued review revealed the goal stated Resident #6 would have no complications with skin integrity through the next review date with interventions which included turning and repositioning every two (2) hours. However, further review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include interventions for ongoing assessment and monitoring of the resident's skin.</p> <p>Continued review of the record revealed a Nurse's Note dated 10/01/14, documenting</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>Resident #6 had "areas" noted to his/her chest and back which "appear" to be related to "possible bites". Continued review of the Note revealed Resident #6 was observed to be scratching the "areas" with no new orders received at that time. Further record review revealed no documented evidence licensed nursing staff continually assessed and monitored the "areas" for changes or signs and symptoms of infection.</p> <p>Observation of a skin assessment performed on 10/10/14 at 11:40 AM by LPN #1, revealed Resident #6 was scratching his/her right shoulder area. Continued observation revealed Resident #6 had small circular reddened areas on his/her right shoulder area and two (2) small circular reddened areas on his/her jawline. Further observation revealed reddened, pin prick scabbed areas scattered on his/her left ankle and foot.</p> <p>Interview, on 10/13/14 at 1:20 PM, with Registered Nurse (RN) #2 revealed she had worked 10/01/14 on the hall where Resident #6 resided, and she and a Certified Nursing Assistant (CNA) took the resident to the shower where she observed "small bug bites" on his/her right shoulder. RN #2 reported Resident #6 and his/her roommate, Resident #5, were removed from room 16 showered, clothing changed and transferred the residents to another room. She stated room 16 was "quarantined" until the facility's pest control service came to treat the room. Per interview, no bedbugs were present she stated and the pest control tech informed them the bug found in room 16 was a "beetle". RN #2 stated a "skin sweep" (skin assessments) of all residents on the hall was performed by her</p>	F 309		

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F 309	Continued From page 29 and another nurse; however, she reported she and the other nurse did not document their "skin sweep" findings. Interview, on 10/11/14 at 8:05 PM, with CNA #1 and on 10/12/14 at 4:20 PM with CNA #2 revealed if CNAs observed any skin issues they were to report them directly to the nurse and chart their observations in the "kiosk" (facility's computer system). Both CNAs reported they had not seen any residents with any insect bites or scratch marks/areas. They stated if they saw any insects they would tell the Maintenance Man. Interview, on 10/10/14 at 12:30 PM, with Unit Coordinator (UC) #1, who supervised the hall where Resident #1, Resident #2 and Resident #3 resided, revealed if CNAs observed any skin issues or concerns they were to verbally tell the nurse and document their observations in the "kiosk" (computer system) which nurses checked each shift. Per interview, the nurse was to go assess the area of concern reported by the CNA, contact the Physician for treatment orders, notify the family and notify the Wound Care Nurse if the area was a Pressure Ulcer. She stated the nurses, UCs, MDS Nurses and DON were responsible for updating and revising residents' care plans. UC #1 stated also, there was a daily nursing management meeting of the UCs, MDS Nurses and DON where all new Physician's Orders, laboratory results, x-rays and twenty-four (24) Hour Reports were reviewed for changes in residents' condition. She stated her expectations were for nurses to continually monitor and assess residents' skin condition, update/revise care plans as needed and assess the need for PRN (as needed) medications/treatments as ordered.	F 309			

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F 309	<p>Continued From page 30</p> <p>Interview, on 10/10/14 at 3:40 PM, with UC #2, who supervised the hall where Resident #5 and Resident #6 resided, revealed her expectation was for nurses to monitor and assess residents' skin condition every shift, apply treatments as necessary and if a PRN treatment or medication was ordered nurses should ask residents if they needed the PRN.</p> <p>Interview, on 10/14/14 at 3:30 PM, with the DON revealed the Administrator called her on 09/28/14 about a possibility of exposure to bedbugs on Resident #1's, Resident #3's and Resident #4's hall. She stated the Administrator told her he had instructed staff on what to do and he had called the pest control service. The DON stated she was not aware the nurses did not document the skin assessments performed during the "skin sweeps" on 09/28/14 and 10/01/14; however, it was her expectation they would document this information. She stated she also was not aware the nurses had not contacted the Physicians, but she expected her nurses to notify the Physicians. Per interview, it was her expectation nurses should apply any necessary PRN treatments as ordered if a resident needed it.</p> <p>Interview, on 10/14/14 at 4:00 PM, with the Administrator revealed he was notified on 09/28/14 of a resident having possible bedbug bites and staff had found two (2) black bugs that looked like bedbugs which they had placed in a bag. He stated he instructed staff on what they should do and called the pest control service's "hotline" as it was a weekend, after being notified of this information. According to the Administrator, he thought the pest control service would go to the facility on 09/28/14; however, when he came to work on Monday, 09/29/14, he</p>	F 309		
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F 309	Continued From page 31 found out the pest control service had not been there for treatment yet. Per interview, the pest control service came on Tuesday, 09/30/14, confirmed the black bugs in the bag were bedbugs and the rooms were treated by the tech who came. Additionally, he stated on 10/01/14, he was notified of a bug being found in room 16, and he had instructed staff on what to do and notified the pest control service to come. The Administrator stated in retrospect he should have directed the nurses to notify the residents' Physicians and contacted the Medical Director regarding the bedbug incident on 09/28/14, and possible bedbug incident on 10/01/14. The Administrator revealed he "wished" he had been aware Maintenance Worker #1 had the phone number for the pest control service's tech who normally inspected and treated the facility as treatment might have been completed sooner. He reported he had not been aware Resident #4's spouse had been sleeping on the couch in the facility's sunroom while his/her apartment was being treated for bedbugs; however, stated he should have been aware of this information. Interview, on 10/14/14 at 5:00 PM, with the Medical Director, who was also Resident #1's Primary Care Physician (PCP), revealed he had received no notification regarding the change in Residents #1's condition related to possible bedbug exposure on 09/28/14, and it was his expectation, as both the Medical Director and the Physician of an affected resident, to be notified of this information. He stated he was not notified by the facility regarding the occurrence until 10/02/14.	F 309	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	Facility relocated Supply Room to two storage closets on each wing in facility

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F 441 Continued From page 32

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program

The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

F 441

on 10/15/14. Prior to entering Supply Room, staff sanitized hands. Medical Supplies were placed in plastic bags in Supply Room, closed and then staff exited through dirty utility room. Medical supplies were then stored in the storage closets.

All residents have potential to be affected as a result of this practice. No actual harm to residents has occurred related to this practice.

Leanna Hunt, Supply Coordinator, removed all products from Supply Room using the above precautions and relocated them to the two storage closets. Leanna Hunt will inspect previous Supply Room (located behind Soiled Utility Room) for any unauthorized storage of medical supplies.

Susan Fulton, QA/Staff Development, instructed all clinical staff working shifts on 10/15/14 of new location of Supply Rooms on same date. Susan Fulton also wrote memo explaining new location and posted at each nurse's station and outside of previous Supply Room location. All staff educated on update to Infection Control Program and policy on 10/10/24/14, 10/27/14, 10/28/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14 and 11/7/14.

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F 441 Continued From page 33
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's Infection Control Manual, it was determined the facility failed to maintain an Infection Prevention and Control Program to recognize, control and prevent to the extent possible the onset and spread of infection within the facility as evidenced by the supply room, which contained all the facility's clean or sterile supplies, was located behind the dirty utility room. Observation revealed staff had to enter the dirty utility room, where biohazard bins, garbage cans, an open toilet (hopper) and dirty linen cart were stored, to gain access to the supply room where the clean or sterile supplies were stored.

The findings include:

Review of the facility's Infection Control Manual, revised August 2014, revealed an effective infection prevention and control program was necessary to control the spread of infections and/or outbreaks.

Observation on 10/10/14 at 11:30 AM revealed the room adjoining room 42, which had been treated by the facility pest control service technician (tech) for bed bugs contained a locked door into a dirty utility room. Observation of the dirty utility room revealed: two (2) large plastic containers for trash; an open toilet (hopper) for cleansing large equipment and disposing of waste products; one (1) container of dirty linen; two (2) cartons containing twenty-four (24) cans of Jevity enteral feeding; one biohazard garbage can; and two (2) storage containers marked as "isolation" stored on the top of an equipment shelf. Continued observation revealed a door

F 441 Leanna Hunt will report weekly inspections of previous Supply Room (located behind Soil Utility Room) to QA Committee monthly for 60 days, then quarterly thereafter. QA Committee will determine whether compliance with storage of Medical Supplies in clean environment has been met after 60 days. Since Supplies are no longer stored in room behind Soiled Utility Room and staff has been educated on new location for Supply Room and Infection Control Policy, 60 days is sufficient monitoring with quarterly monitoring thereafter.

Completed 10/16/14

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F 441	<p>Continued From page 34</p> <p>located inside the dirty utility room which lead to a clean supply storage area which contained: sterile Foley (indwelling) catheters and sterile Foley catheter insertion kits; Foley catheter bags; sterile syringes; alcohol swabs; dressing supplies; colostomy supplies; Peroxide; lubricating jelly; thermometer covers; sterile saline; gloves; masks; gowns; and skin lotion.</p> <p>Observations on 10/10/14 at 11:45 AM to 12:15 PM, on 10/14/14 from 2:30 to 3:00 PM and on 10/15/14 from 10:00 AM to 10:30 AM revealed both licensed nurses and Certified Nursing Assistants passed through the dirty utility area to obtain clean equipment supplies and back through the dirty utility area after obtaining the supplies.</p> <p>Observation on 10/15/14 at 11:15 AM revealed CNA #3, was orienting and training CNA #4 on where to obtain medical supplies for residents. CNA #3 showed CNA #4 how to enter through the locked door into the dirty utility room and go into the supply room through it to obtain skin lotion and shampoo to perform resident care.</p> <p>Interview with CNA #3 on 10/15/14 at 11:20 AM revealed she went in and out of the dirty utility room "several times a day" to obtain supplies for her residents. CNA #3 stated she tried not to "touch" anything when she went through the dirty utility area.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 10/14/14 at 1:00 PM, revealed she frequently entered the dirty utility room to go into the clean supply room to obtain dressing supplies and syringes during her shift when she was caring for residents. LPN #2 stated she really did not think</p>	F 441			

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F 441	<p>Continued From page 35 about this as a problem as "everybody did it".</p> <p>Interview with LPN #3 on 10/15/14 at 11:15 AM revealed she went through the dirty utility room where the "dirty stuff" was kept to obtain supplies from the supply room.</p> <p>Interview with Registered Nurse (RN) #1 on 10/14/14 at 2:15 PM, revealed she frequently entered the dirty utility room to go into the clean supply room to obtain supplies for her residents. RN #1 stated she did see a problem with possible contamination, and had spoken with her Unit Coordinator (UC) about this; however, nothing had ever been done.</p> <p>Interview with the Director of Nursing (DON) on 10/14/14 at 3:30 PM, revealed she was aware of the potential problem with contamination of the clean supplies with staff having to go through the dirty utility room to the supply room. However, she stated at that time there was no other storage room available in the facility to store the supplies. She stated she had spoken with the Administrator, and he had submitted building plans which would change the arrangement of the storage rooms. The DON revealed then nursing staff would no longer have to obtain clean and sterile medical supplies by going through the dirty utility room to the supply room and back out through the dirty utility room.</p> <p>Interview with the Administrator on 10/14/15 at 4:15 PM, revealed he was aware of the issue and had consulted with an architect and previously submitted building plans to the Board of Directors to make the necessary changes to prevent possible contamination of the clean and sterile medical equipment supplies.</p>	F 441			

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F 514
SS=E

483.75(l)(1) RES
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents' medical records were completely and accurately documented after "skin sweeps" (skin assessments) were performed on Hall B on 09/28/14, and on Hall A on 10/01/14 of the facility's residents, and nurses failed to document the skin assessments performed in the medical record.

The findings include:

Review of the facility's policy titled, "Charting", undated, revealed residents' medical records were to be a "concise account" of all treatment, care, signs and symptoms and progress of the resident's condition. Further review of the Policy revealed all charting was to be done, noting any

F 514

Bobbi Noland, RN, Rhonda Clark, LPN, Amanda McClanahan, LPN, and Carrie Rice, LPN performed skin assessments for Residents #1, #3, #4, #5, and #6 on 11/3/14, 11/4/14, and 11/6/14; they documented findings in the residents' health records.

Staff listed above performed skin assessments on all residents in facility on 11/3/14, 11/4/14, and 11/6/14. They found no evidence that other residents had any exposure to bedbugs.

Susan Fulton, QA/Staff Development, educated all clinical staff on documentation and accurate health record keeping on 10/10/24/14, 10/27/14, 10/28/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14, and 11/7/14.

Michelle Marshall, RN Unit Coordinator and Kim Breeze, RN Unit Coordinator will monitor the "24 Hour Summary Report" daily, Monday through Friday as part of job description, to ensure proper documentation is recorded in residents' health record. Unit Coordinators will report these results to the QA Committee

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F 514	<p>Continued From page 37 changes in condition.</p> <p>Interview, with Unit Coordinator (UC) #1 on 10/10/14 at 12:30 PM, and UC #2 on 10/10/14 at 3:40 PM, revealed following the identification of bed bug exposure with Resident #1, Resident #3 and Resident #4 the Charge Nurse performed a "skin sweep" (skin assessments) on that hall, Hall B, and on 10/01/14, a skin sweep was performed on Hall A, where Resident #5 and Resident #6 resided with no further skin issues identified. UC #1 and UC #2 both stated each Charge Nurse performed an informal head to toe assessment on each resident on the halls; however, the skin assessments were not documented. Both of the UCs stated in retrospect they should have asked the Charge Nurses to document the skin assessments in the residents' medical records, but did not realize at the time the nurses had not documented the skin assessments. According to both UC #1 and UC #2, they remembered learning in nursing school if a nursing action was not documented, then it was considered not to have been done.</p> <p>Review of Resident #1's, #2's, #3's, #4's medical records revealed no documented evidence of the skin assessments performed on their hall, Hall B on 09/28/14. Additionally review of Resident #5's and #6's medical records revealed no documented evidence of the skin assessments performed on their hall, Hall A on 10/01/14.</p> <p>Interview with the DON on 10/14/14 at 3:30 PM, revealed it was her expectation every licensed nurse document all skin assessments performed on a resident. She stated she was not aware the Charge Nurses had not documented the skin assessments performed during the "skin sweeps"</p>	F 514	<p>The QA Committee will monitor for compliance of documentation practices weekly for 120 days, then quarterly thereafter.</p> <p style="text-align: right;">Completed</p>	11/8/14

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F 514	Continued From page 38 on 09/28/14 and 10/01/14. The DON revealed she would begin re-education of the nurses regarding ensuring they documented skin assessments in the medical records.	F 514		