STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275140	A. BUILDING _____ B. WING _____	C 08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A complaint survey was completed on 8/22/18. Deficiencies were cited for the complaint, with the Event ID 41702. Glossary ADL Activities of Daily Living BM Bowel Movement CM Centimeters CNA Certified Nurses Aide C&S Culture and Sensitivity DON Director of Nursing ER Extended Release GM Grams IDT Interdisciplinary Team IR Immediate Release MAR Medication Administration Record MG Milligrams PM Evening PRN As Needed Q Every S/S Signs and Symptoms TAR Treatment Administration Record UA Urinary Analysis UTI Urinary Tract Infection	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		10/3/18

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

Electronically Signed | 09/07/2018

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide the necessary services and staffing to prevent the development and worsening of pressure ulcers for 3 (#s, 1, 2, and 3); failed to provide necessary services to prevent isolation and neglect for 1 (#1); failed to provide catheter care to prevent the potential for a UTI for 1 (#1); failed to provide routine care to a suprapubic catheter for 1 (#3); and failed to ensure necessary staffing to provide regularly scheduled showers for 4 (#s 1, 2, 3, and 4) of 6 sampled residents. The accumulative effect of this deficient practice resulted in harm with the development of pressure ulcers for resident #s 1, 2, and 3; and alternate negative outcomes identified included: pain for #2; resident #4 felt dirty, gross, and unclean; and resident #3 felt bad, unclean, and that no one cared about the resident. Findings include: 1. Pressure Ulcers A. During an observation on 8/20/18 at 11:15 a.m., resident #3 was laying on his back, with his head propped up, watching his computer, which was placed on his over the bed table. The resident had a strong musky odor, and his hair was oily with flakes of dandruff. During an interview on 8/20/18 at 11:15 a.m.,	F 600	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Aspen Meadows Rehabilitation and Wellness does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F 600 1. A. Resident #3 received a full skin evaluation wounds to sacrum, scrotum and penis were immediately assessed for staging, appropriate treatment, RD evaluation for nutritional support. His air mattress was upgraded to a higher level of pressure reduction capability. Routine care orders were also obtained for his	

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F 600	Continued From page 2 resident #3 stated he had been in his bed for approximately one and half months, since his electric wheelchair quit working. He said he was told it would be fixed, but no one has come by to check on repairing his electric wheelchair. He stated he owns a manual wheelchair, but he did not know where it was. He stated he had asked staff to find his manual wheelchair for him, but nobody had brought it in for him. He stated he had difficulty moving and repositioning himself in his bed because of his upper extremity weakness, and his bilateral lower extremity amputation. He said he lays in the same position most of the day, because staff did not come in and help him reposition. He said had many skin impairments when he was admitted to the facility, and they had been improving when he had a "Sand" mattress. He stated since the facility changed him from the "Sand" mattress to his current mattress (air mattress), he had developed more skin problems. He stated his doctor had ordered for him to have wound care once a day, and that was not happening. He stated he also did not get regular showers, he preferred to be showered at least twice a week, but he was lucky to get one once a week. He stated he felt there was not enough staff to care for everyone. During an interview on 8/20/18 at 11:29 a.m., staff member O stated she was the only nurse to manage two medication carts. She stated she was expected to manage the care for 27 or more residents every shift. She stated there were days when she physically could not provide wound care for her assigned residents. She stated she felt she needed to prioritize her day, and passing medications came first, then if she still had time she would provide wound care. She stated she was not always able to get to the assigned skin	F 600	suprapubic catheter. His physician was notified of all wounds, suprapubic catheter needs/evaluation and new orders received. He was provided a loaner electric wheelchair until his wheelchair could be fixed. A shower was provided to him on 8/24/18. B. Resident #1 received a full skin evaluation for any skin integrity breakdown on 8/21/18. All wounds identified had orders received for treatment with MD notification, appropriate staging determined, RD evaluation for nutritional support and current air mattress evaluated for function and pressure reduction on 8/22/18. Catheter care was immediately provided upon finding and orders reviewed to ensure catheter care every shift are in place. Resident received a shower on 8/23/18. Activities and Social Services Directors evaluated resident for individualized care and support to prevent isolation, as well as ordering a geri chair to allow resident more time outside of her room. Education was provided to staff on frequent rounding and repositioning on 8/21/18, 8/22/18, 9/5/2018 and 9/6/2018. The allegation of neglect was also reported to the state department of health. C. Resident #2 received a full skin evaluation for any skin integrity breakdown on 8/21/18. All wounds identified had orders received with MD notification, appropriate staging determined, RD evaluation for nutritional support and air mattress put into place as well as his wheel chair cushion evaluated for possible replacement needed. He	

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assessments as well. The staff member stated she did not feel she had enough time to manage the care for all her assigned residents and was afraid she was going to hurt a resident because of the exaggerated workload.

During an interview on 8/21/18 at 9:00 a.m., staff member O stated she did not have time to assess resident #3's skin the day before, and she would not be able to complete a skin assessment on the resident until 11:00 a.m.

During an observation on 8/21/18 at 11:00 a.m., resident #3 was lying in bed on his back, with his head supported with pillows. He smelled of musk, his hair was oily with flakes of dandruff. While the resident was laying on his back, staff members O and R removed the front of the resident's brief. The brief had a foul odor and was saturated with a thick yellow and green drainage. The suprapubic site had a thick white and yellow string which pulled out of the suprapubic site when the brief was pulled back. The brief had a large amount of thick yellow, green and brown colored exudate build up, which came from the suprapubic site. The posterior side of the resident's penis appeared to have had a previous surgical repair, which showed the penis flayed open from the tip of urinary meatus down the shaft. The interior of the penis was exposed. The interior of the penis was bright red. Below the surgical opening, there was an approximately 12 cm by 5 cm oval shaped area of bright red, inflamed, macerated skin which was open and had sanguineous and purulent drainage which saturated the front of the resident's brief. The resident was then turned to his left side and his brief was removed entirely exposing his buttocks. The brief had a large amount of thick brown,

received a shower on 8/25/18. A new pain evaluation was completed on 9/6/18 to ensure his current pain regime is adequate per his interview.

2. All residents are identified to be at risk. A 100% skin evaluation audit was conducted by the DNS/designee on 8/30/18 and skin integrity issues were addressed per policy and procedure. A 100% audit was conducted on all showers for residents with any discrepancies found fixed by ensuring a shower was received on 8/31/18. A 100% audit was conducted on any resident with a urinary catheter to ensure catheter care orders are in place on 8/31/18. Resident interviews conducted by the IDT for their satisfaction of care being received and observation of their environment weekly starts 9/3/18.

3. An in-service was held with all staff by the DDCO and RVP on 8/21/18, 8/22/18, 9/5/18 and 9/6/18 regarding ensuring wound treatments are done, catheter care completion, weekly skin evaluations are completed as scheduled, showers are completed, and efforts being made regarding staffing, retention, and recruitment. Additional systematic changes for improvement include the hiring of a dedicated wound certified nurse, designated bath aides for both units, and new structured shower schedule. Peri care and catheter competencies will be completed for all CNA□s by the SDC or Designee. Wound treatments and weekly evaluations have been moved from the TAR to the MAR for

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F 600	Continued From page 4 green, and yellow, purulent drainage, which pulled away in thick strings from his buttocks, as the brief was removed. The wound had a strong odor. Two dressings were present, one on the right sacrum and one on the left sacrum, both dated 8/19/18. The resident's buttocks showed a large football sized area of discolored skin. On the resident's right sacrum were 2-3 open areas approximately 1 cm by 1 cm, round, the wound bed was filled with slough, and was unstageable. On the right sacrum were 2 open wounds, both approximately 1 cm by 1 cm, round, one covered with eschar and one covered with slough, both were unstageable. The resident also had a bright red, open area approximately 1.5 cm by 1 cm, round, on puckered skin on the sacrum. He also had an area of bright red macerated skin on is scrotum, which measured approximately 5 cm by 4 cm, oval shaped. The area on his scrotum was draining a sanguineous red fluid. The resident was covered with a bed sheet for privacy and offered a bath, which he accepted. On the resident's right shoulder was a patch of scaled skin, which had a 2.5 cm scratch, which was open and actively bleeding bright red blood. During an interview on 8/21/18 at 11:30 a.m., resident #3 stated he could not reposition himself and would lay for long periods on his back. He stated staff did not offer to come in and reposition him. He stated he felt his skin has had substantial breakdown since his mattresses were changed. He stated he had told the staff his concern regarding his mattress, and they did not follow up on his concerns for skin breakdown related to his new mattress. Review of resident #3's Braden Scale Assessment for Predicting Pressure Sore Risk,	F 600	better adherence and notification as well. In addition a 3rd nurse in the form of a unit manager will be hired and available to support additional needs/concerns of residents and staff on Timbers. TLC will also include hiring of an additional nurse as a unit manager to support additional needs/concerns of the unit nurses and residents. 4. Audits will be conducted by the DNS or designee on wound treatments in place as ordered, weekly skin evaluations, and showers being completed routinely weekly X 12 weeks then monthly X 2 months. An audit will be conducted by the social services director or designee on any bed ridden patient for isolation concerns and appropriate interventions in place to prevent isolation weekly X 8 weeks then monthly X 2 months. Results of the initial corrections, audits and education were submitted to an AdHoc QAPI meeting on 8/23/18 for review and recommendations. Results of the Audits will be taken to QAPI x 3 months or until resolved. 5. Corrective action will be completed by 10/3/18.	

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showed the resident was a very high risk for skin breakdown, with a score of 9.

Review of resident #3's Physician Orders, dated 6/26/18, showed, "Wound Treatment: Apply Hydroguard silicone cream, cover with gauze dressing Q-day. No tape necessary can be open to air when the gauze falls off." The wound order fails to identify the site for wound care.

Review of resident #3's Physician Orders, dated 7/14/18, showed, "Meplix dressing on both sacral sores Q 24 hours and PRN."

The physician orders failed to address the wounds to the penis, the rest of the sacrum, the distal side of his scrotum, and the open area on the resident's right shoulder. A review of the resident's MAR/TAR's for July and August of 2018, failed to show an order for weekly skin checks.

Review of resident #3's Weekly Skin Evaluations showed the resident had a weekly skin assessment on the following dates, for the following wounds:

- 7/19/18: showed:

"1. left buttock pressure ulcer to left buttock scabbed over, no drainage. Measured 0.7 by 0.3 by 0, circular wound.
2. The right buttock pressure ulcer is scabbed over and no drainage noted, no pain. Measures 1 x 0.5 by 0, circular wound.
3. The pressure ulcer to the right buttock scabbed over no drainage noted, no pain. Measured 1.2 by 1.4 by 0, circular wound."

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F 600	Continued From page 6 - 7/25/18: showed: "1. Left buttock, small pressure ulcer to left buttock now resolved. 2. Left buttock, pressure ulcer to left buttock decreasing in size, scabbed over, minimal serous drainage noted, no odor, no complaint of pain. Measured 0.9 by 0.8 by 0, circular shaped wound. 3. Right buttock, pressure ulcer to right buttock decreasing in size, scabbed over, no drainage noted, no complaints of pain. Measured 1.2 by 0.5 by 0, circular shaped wound." -8/1/18: showed: "1. Left buttock, stage 2 pressure ulcer to left buttock red in color, moderate serous drainage noted, no complaints of pain. Measured 1.0 by 0.2 by 0, oblong wound shape. 2. Left buttock, stage 2 pressure ulcer to left buttock wound bed is light pink in color, minimal serous drainage noted. Measured 1.0 by 1.0 by 0, wound circular in shape. 3. Left buttock, stage 2 pressure ulcer to left buttock wound bed is light pink in color, minimal serous drainage noted. Measured 1.0 by 1.0 by 0, with a circular wound bed." -8/8/18: showed: "1. Left buttock, pressure ulcer to left buttock now resolved. 2. Left buttock, pressure ulcer to left buttock now resolved." Review of resident #8's Nutrition Hydration Skin Committee Review Form, dated 8/8/18, showed, "Skin issue healed 8-8-18."	F 600		

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The Skin Evaluation Notes and Nutrition Hydration Skin Committee Review Forms, failed to identify any skin breakdown on the resident's penis and scrotum.

Review of resident #3's Skin Evaluation Notes, MAR/TAR, IDT Notes, Nutrition Notes, and Progress Notes, failed to show continued management and assessments for skin breakdown after 8/8/18. On 8/21/18, the resident was observed to have had open areas of skin breakdown to his penis, distal side of his scrotum, buttocks, and right shoulder.

The facility failed to provide weekly skin assessments, daily wound care, and regular position changes for resident #3, which resulted in the development of sacral and coccyx pressure ulcers, open areas of maceration on his penis and distal scrotum.

B. During an observation on 8/20/18 at 11:13 a.m., a strong odor of urine and BM could be smelled in the hallway, outside of resident #1's room. The resident was lying in bed on her right side. She was contracted into a semi-fetal position and was very rigid, with limited mobility.

During an observation on 8/20/18 at 12:37 p.m., resident #1 was lying in the same position in her bed. The room had a strong odor of urine and BM.

During an observation on 8/20/18 at 2:15 p.m., resident #1 was lying in the same position, on her right side. The room had a strong odor of urine and BM.

During an interview on 8/20/18 at 2:20 p.m., staff

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member K stated she "honestly had not had time to check on resident #1 since around 9:00 a.m." She stated it was the expectation to check on resident #1 every two hours or more, because she was completely bed ridden, and was close to death. She stated she thought the resident had a small wound on her back. She said she was not sure if it was supposed to be covered or not, because sometimes it did not have a dressing covering it, so she believed it was to be open to air. She stated she was the only CNA on resident #1's hall, and she had not even had time for a break or lunch since she came into work that morning at 6:00 a.m. She stated she frequently felt the facility was understaffed, and had to work without help on many different shifts. She stated she was afraid of hurting herself and the residents, because she has had to make many challenging transfers without assistance. Staff member K stated she would get another CNA, and go in and check resident #1.

During an observation on 8/20/18 at 2:30 p.m., staff member K and H assisted resident #1, to change her soiled brief. When the staff pulled back the resident's top sheet, the resident was wearing a hospital gown, and brief. The bottom sheet was saturated with yellow, brown fluid from her thighs up her back. The BM had seeped out around her brief and was saturated into the sheep skin blanket which was wrapped around the resident's feet. When the staff removed the resident's brief, the resident had BM which extended from the top of her pubis around her back and up past her sacrum. The resident's catheter tube was saturated in BM up to the catheter hubs. After the staff had cleaned off the majority of the BM from the resident, there was a sacral pressure ulcer, which was open to the air,

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and it measured approximately 1.5 cm by 1.5 cm, it was open and the wound bed was cavernous, and was impacted with BM and slough. The pressure ulcer was not able to be staged. When the wound was wiped clean of the majority of BM, there remained a brown/yellow dried circle of BM around the wound.

During an interview on 8/20/18 at 2:45 p.m., staff member Q stated the resident should be checked on at least every two hours to change her brief and change her positioning. She stated many times there was not enough staff to complete all the required cares for residents. She stated she did not get time for breaks. She stated she was not sure if the resident's wound should be covered with a dressing, because it doesn't have one most of the time.

During an interview and observation on 8/20/18 at 2:40 p.m., staff member J stated she was not aware of resident #1's sacrum wound. She reviewed the MAR/TAR for resident #1 and stated there was no wound care orders for her to complete on the resident during her shift. She reviewed the MAR further and determined the wound care was to be provided by the night shift. She stated she would go in and assess resident #1's sacrum and place a dressing over the wound. She stated she felt overwhelmed many times with not having enough staff to complete all resident cares. She stated they used to have three nurses on the unit, two to pass meds, and one to provide treatments. She stated there has only been two nurses for about four months, and she wants to quit, because she can no longer put her license at risk.

Review of resident #1's Braden Scale

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Assessment for Predicting Pressure Sore Risk, showed the resident was a very high risk for skin breakdown, with a score of 9.

Review of resident #1's Physician Recapitulation Orders, dated 8/1/18 to 8/31/18, stated, "Restrictions: (1) Turn every 2 hours to prevent skin breakdown... "

Review of resident #1's Physician Recapitulation Orders, dated 8/1/18 to 8/31/18, stated, "Weekly skin audit one time a day every Thursday. Wound Care: Turn every 2 hours from side to side... (4) Sacral Breakdown, wach [sic] daily, opti foam." Review of the resident's MAR, dated August 2018, showed the resident did not receive a weekly skin audit on the following date:

- 8/16/18

Review of resident #1's MAR, dated August 2018, stated, "Santyl Ointment 250 units/gm (Collagenase). Apply to Sacrum topically one time a day related to pressure ulcer of sacral region, unspecified stage." Review of the dates of administration the resident did not receive the ordered ointment on the following dates for the month of August, 2018:

- 8/6/18, 8/17/18, and 8/21/18.

Review of resident #1's Weekly Skin Evaluations showed the resident received a skin assessment for the month of August on the following dates:

- 8/2/18, showed, "stage 3 pressure ulcer to sacrum, wound bed covered in slough, maceration noted to edges. Skin surrounding wound is red in color and blanches easily. The

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wound measured 1.0 by 1.5 by 0.6, and was circular in shape."

- 8/9/18, showed, "sacrum stage three pressure ulcer to sacrum covered in slough with red wound edges, maceration noted, minimal SS drainage noted, decreasing in size. Wound measured 0.9 by 0.8 by 0.4, and was circular in shape."

-There was no Weekly Skin Evaluation for the week of 8/16/18.

The facility failed to provide weekly skin assessments, daily wound care, and regular position changes for resident #1, which resulted in a worsening of a Stage 3 pressure ulcer to unstageable.

C. During an observation on 8/20/18 at 2:00 p.m., resident #2 was sitting in his wheelchair by the nurses station. He told staff member O that he his "backside" hurt and he wanted to lay down. Staff member O stated the CNA's were "busy right now" but would be there to lay him down before long.

During an observation on 8/20/18 at 2:56 p.m., resident #2 was asleep in his wheelchair at the nurses station.

During an observation on 8/20/18 at 5:46 p.m., resident #2 called out that he wanted to lay down in his bed.

During an interview on 8/21/18 at 9:28 a.m., staff member L stated she had not yet seen the pressure ulcer on resident #2's sacrum. She stated the resident did complain of a lot of bottom pain. She stated his bottom starts to hurt from

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sitting in his wheelchair for too long.

During an observation on 8/21/18 at 9:35 a.m., resident #2 had a new reddened area, which was non-bleachable, on his left sacrum. He had a dressing covering a wound on his right sacrum which was dated, 8/19/18. The wound to his right sacrum had an area which was approximately 3 cm by 5 cm, and it was open. The wound bed was red and raised in appearance and had about 25% slough covering the surface.

During an interview on 8/21/18 at 9:35 a.m., the resident stated his bottom hurt if he sat in his wheelchair for too long.

During an interview on 8/21/18 at 9:35 a.m., staff member L stated she was aware of the pressure ulcer on his right sacrum, but was not aware of the one on his left. She stated she would start an SBAR, measure the wound, and document the findings. She stated she would also notify the physician and family. Staff member L stated she did not know if the facility had a standing order for wound treatment until the physician can be notified. The staff member stated she was not able to get to all the wound care on her hall. She stated when she had to work two medication carts, she did not have time to complete all the wound care. She stated the facility used to have a third nurse on this wing, but not for the last four months. She stated she tried to prioritize her care provided to the resident's. She said she rarely gets a break during her 12 hour shift.

Review of resident #2's Braden Scale Assessment for Predicting Pressure Sore Risk, showed the resident was a high risk for skin breakdown, with a score of 16.

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Review of resident #2's Physician Orders, started on 7/20/18, showed, "Weekly skin audit every day shift, every Sunday."

Review of resident #2's TAR's for July 2018, and August 2018, showed the resident did not receive a weekly skin check for the following dates: 7/1/18, 7/15/18, 7/22/18, 7/29/18, 8/5/18, 8/12/18 and 8/19/18.

Review of Nursing Progress Notes, dated 8/19/18, stated, "Direct care staff reported skin breakdown on [resident #2]. He has a red area on his right buttock approximately 1 x 2 inches stage II. The center of this area is open with no drainage. This is likely caused from direct pressure as he usually lays on his back related to hip discomfort. Area cleaned and foam dressing applied. Encouraged to try to lay on his side rather than on his back."

Review of resident #2's MAR's and TAR's for July 2018, and August, 2018, failed to identify ordered wound care for the wound on the resident's right buttock, which was identified by staff on 8/19/18.

The facility failed to provide weekly skin assessments, daily wound care, and provide aid when the resident wished to lay down and relieve the pressure on his bottom. These factors resulted in a new development of a Stage I pressure ulcer on the resident's left sacrum, and a worsening Stage II pressure ulcer which became larger in diameter.

A review of the facility's policy, titled Skin Integrity, showed, "In an effort to maintain the resident's optimal level of skin integrity and promote healing

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of skin ulcers/pressure ulcer/wounds, the Center has a systematic approach and monitoring process for evaluating and documenting skin integrity. In the event that a resident is admitted with or develops a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcer/pressure ulcers/wounds...4. The resident's skin is inspected daily with completion of ADL's (unless resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN). Ongoing evaluation continues weekly with the LN completing a full body skin audit. Completion of the skin audit is documented on the Treatment Administration Record (TAR) with their initials, and either a '-' or '+'. a. '-' indicates no skin impairment present. b. '+' indicates skin impairment present. 6. New admissions are reviewed by the Nutrition Hydration Skin Committee meeting, for 4 weeks following admission. 7. For skin impairment identified with admission...a. document skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation. b. Notifies the physician and obtain a Treatment Order if needed, document on the TAR after implemented...10. Wounds are evaluated weekly by Center clinicians... ."

2. Isolation and Neglect

During an observation on 8/20/18 at 11:13 a.m., a strong odor of urine and BM could be smelled in the hallway, outside of resident #1's room. Inside the room, the room was dark, resident #1 was lying on her right side, she was contracted into a

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semi-fetal position. The resident's hair was stringy with oil, and the pillow behind her head had a green pillow case which had a ring of oil saturated around the resident's head. The resident's eyes were open and the TV was on, the volume for her TV was inaudible. Resident #1's roommate was not in the room, but the roommate's TV was on, and the volume was turned up and could be heard on resident #1's side of the room. The resident had a tube feeding pump which was continually beeping, indicating the tube feeding was complete. The resident had a catheter bag which was laying on the floor under her bed. When asked questions, the resident could blink once for yes, and twice for no, but was not consistent in responses.

During an observation on 8/20/18 at 12:37 p.m., resident #1 was lying in the same position in her bed, the tube feeding alarm was still beeping. The room was dark, and the TV was on without sound. The roommates TV was on and the volume was turned up. The room had a strong odor of urine and BM.

During an observation on 8/20/18 at 2:15 p.m., resident #1 was lying in the same position, on her right side. The room was dark and the blinds were drawn. The resident's TV was on with the volume turned down, and the roommates TV was turned up, and the roommate was not in the room. The tube feeding alarm was still beeping, and the room had a strong odor of urine and BM.

During an interview on 8/20/18 at 2:20 p.m., staff member K stated she "honestly had not had time to check on resident #1 since around 9:00 a.m." She stated it was the expectation to check on resident #1 every two hours or more, because

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she was completely bed ridden, and was close to death. She stated she was the only CNA on resident #1's hall and she had not even had time for a break or lunch since she came into work that morning at 6:00 a.m. She stated she frequently felt the facility was understaffed, and had to work without help on many different shifts. She stated she was afraid of hurting herself and the residents, because she has had to make many challenging transfers without assistance. Staff member K stated she would get another CNA, and go in and check resident #1.

During an observation on 8/20/18 at 2:30 p.m., staff member K and H changed resident #1's soiled brief. When the staff pulled back the resident's top sheet, the resident was wearing a hospital gown, and brief. The bottom sheet was saturated with yellow, brown fluid from her thighs up her back. The BM had seeped out around her brief and was saturated into the sheep skin blanket which was wrapped around the resident's feet. When the staff removed the resident's brief, the resident had BM which extended from the top of her pubis around her back and up past her sacrum. The resident's catheter tube was saturated in BM up to the Hub. After the staff had cleaned off the majority of the BM from the resident, there was a dime sized open to air pressure ulcer on coccyx. The wound was covered in BM, and there was BM in the wound bed. When the wound was wiped clean of the majority of BM, there remained a brown/yellow dried circle of BM around the wound. During this process the TV was still on with the volume off. The roommates TV was on and the volume was turned up, but the roommate was not in the room. Resident #1's tube feeding alarm was still beeping, and CNA's did not notify the nurse of the

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tube feeding alarm sounding. The alarm was still sounding when the staff finished their care of resident #1.

During an interview on 8/20/18 at 2:55 p.m., staff member H stated the resident's tube feeding alarm sounded when her tube feeding was done running, and the nurse would need to change the tube feeding. She stated the resident should be checked on at least every two hours to change her briefs and change her positioning.

During an observation on 8/21/18 at 8:45 a.m., resident #1 was lying in her bed on her left side. She had a bag of tube feeding solution hanging from the pump with a date and time of 8/20/18 at 3:30 p.m. The room had a strong odor of urine and BM, and it could be smelled in the hall outside of the resident's room. The resident's hair was oily and stringy, with dandruff. She was wearing a black neck pillow. The alarm on the resident's tube feeding was beeping. The resident's TV was on and the volume was down, and the volume of the resident's roommates TV was turned up. The roommate was not in the room.

During an observation on 8/21/18 at 9:00 a.m., staff member Q stated it was the expectation to check and change the resident every two hours. She stated she routinely did not have time to check on resident #1 until after the morning meal pass, because she was alone on the hall, and had too many resident's to get up by herself. Staff member Q said she had not checked on resident #1 since she had started her shift at 6:00 a.m. She stated she believed the resident had her brief changed and was checked on by the night shift, around 5:00 a.m. She stated she would try to find

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another CNA to help her change resident #1.

During an observation on 8/21/18 at 9:20 a.m., staff member Q and I provided resident cares to resident #1. The resident had a brief which was saturated in urine, even with a catheter in place. The urine had a strong odor. The resident had a dressing covering her coccyx wound, which was dated 8/20/18. The tube feeding had ended, and the alarm was beeping. The CNA's did not turn off the alarm while providing care or before they left the room. The resident was repositioned to her left side.

During an interview on 8/22/18 at 8:00 a.m., NF1 stated she was worried about the care of resident #1. She stated she did not feel the resident was repositioned or checked for soiled depends. NFI stated she had complained to the facility, because she was worried the resident was not receiving regular baths. She stated she was not always able to come in and visit, but thought the facility was too short staffed to provide adequate care for all the residents.

During an observation on 8/22/18 at 8:30 a.m., resident #1 was laying in bed on her right side. The alarm on her tube feeding was beeping and her TV was on, without volume. The date on the tube feeding bag indicated the bag was hung new on 8/20/18 at 3:30 p.m. The tube feeding had been hanging for over 24 hours.

Review of resident #1's Progress Note, dated 8/19/18, showed, "Daughter in to visit this pm. She is concerned that she feels like her mother has not had a shower or had her hair washed recently... ."

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The facility failed to provide the necessary services for resident #1. The facility failed to ensure the resident was free from excessive noise related to the alarm on her tube feeding, and the excess noise from the roommates TV. They failed to provide regular check and changes every two hours as ordered.

3. Lack of Catheter Care

During an observation on 8/20/18 at 2:30 p.m., resident #1's catheter bag was lying on the floor under her bed. Staff member K picked it off the floor and placed it on the bed. Staff member K and H changed resident #1's soiled brief. The resident's catheter tube was saturated in BM up to the Hub. Staff member H reminded staff member K to clean the catheter tubing away from the resident. After staff member K finished cleaning the catheter tubing, the catheter tubing remained discolored a light-yellow color.

During an interview on 8/20/18 at 2:30 p.m., staff members K and H stated they tried to clean the catheter tubing the best they could every time they changed the resident's briefs.

During an observation on 8/21/18 at 9:20 a.m., staff member Q and I provided resident cares to resident #1. The resident had a brief which was saturated in urine, even with a catheter in place. The urine had a strong odor. The staff members failed to clean the catheter tubing during peri-care.

During an interview on 8/21/18 at 9:20 a.m., staff members Q and I stated it would be important to provide catheter care during the resident cares to prevent infection.

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A review of resident #1's Physician Orders, and the MAR and TAR's for August of 2018, failed to reflect an order for the care of the catheter.

A review of resident #1's Nursing Progress Note, dated 8/19/18, showed, "[Resident's] urine has an odor and is cloudy appearing. Will ask direct care staff to obtain urine specimen in the a.m. for analysis and C&S if indicated."

A review of resident #1's Nursing Progress Notes and Physician Orders after 8/19/18, failed to show the resident had an order to obtain a UA, and failed to show a urine specimen was sent for analysis.

The facility failed to provide proper and routine catheter care to resident #1's catheter. The facility failed to establish an order on the MAR/TAR to provide services to care for the resident's catheter and prevent infection. The facility failed to obtain an order for a urine analysis and failed to send the resident's urine for analysis to check for a UTI.

4. Lack of Care to a Suprapubic Catheter

During an observation on 8/21/18 at 11:00 a.m., staff members O and R provided peri-care for resident #3. They removed the front of the resident's brief. The brief had a foul odor and was saturated with a thick yellow and green drainage. The suprapubic site had a thick white and yellow string which pulled out of the suprapubic site when the brief was pulled back. The brief had a large amount of thick yellow, green and brown colored exudate build up, which came from the suprapubic site.

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During an interview on 8/21/18 at 11:00 a.m., resident #3 stated he had his suprapubic catheter cleaned once a month. He stated it was only cleaned when it was changed. He stated the staff did not clean the site regularly between catheter changes.

A review of resident #3's Physician Orders, dated August 2018, stated, "Change suprapubic catheter Q 30 days and PRN one time a day every day(s) related to encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. A review of resident #3's physician orders, and treatment orders, failed to include regular care and cleaning procedures for the resident's catheter care.

5. Missed Showers for dependent resident's

A. During an observation on 8/20/18 at 12:03 p.m., resident #4 was sitting in his wheelchair, he smelled lightly of musk and body odor, and had short cut hair which appeared oily with small flakes of dandruff.

During an interview on 8/20/18 at 12:03 a.m., resident #4 stated he did not feel there was enough staff to provide the necessary care for all the residents. He stated it had been almost three weeks since he was given a shower. He said before he was admitted to this facility he would shower every day. He said he was told by the staff that he would not be offered a shower everyday due to staffing, and could have one twice a week. He stated when he was not provided a shower he felt "dirty and gross."

Review of resident #4's ADL-Bathing report for

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the month of August 2018, showed the resident did not received a shower since 8/10/18.

B. During an observation on 8/21/18 at 9:30 a.m., resident #3 was lying in his bed, in a hospital gown. He smelled of stale musk, his hair appeared oily with flakes of dandruff.

During an interview on 8/21/18 at 11:00 a.m., resident #3 stated he did not get a shower on a regular basis. He stated hewanted a shower at least twice a week, but there were many times when he would only get a shower once a week or not even that often. He stated when he did not get a shower regularly he felt bad. He stated he felt like the staff did not care about him, and he wanted to move to another facility as soon as he could.

Review of resident #3's ADL-Bathing Log for the month of July 2018, showed the resident was provided a shower only on 7/31/18.

Review of resident #3's ADL-Bathing Log for the month of August 2018, showed the resident had not been provided a shower since 8/14/18.

C. During an observation on 8/21/18 at 9:35 a.m., resident #2 was sitting in his wheelchair in his room. He was dressed in jeans and white shirt, and the room smelled stale. The resident had gray, short cut hair, which had flakes of dandruff.

During an interview on 8/21/18 at 9:35 a.m., resident #2 stated he could not remember the last time he had a shower, but did not mind getting them.

Review of resident #2's ADL Bathing Log, for the

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month of August 2018, showed the resident had not received a shower since 8/10/18.

D. During an observation on 8/20/18 at 11:13 a.m., a strong odor of urine and BM could be smelled in the hallway, outside of resident #1's room. Inside the room the resident was lying on her right side, she was contracted into a semi-fetal position. The resident's hair was stringy with oil, and the pillow behind her head had a green pillow case which had a ring of oil saturated around the resident's head.

During an interview on 8/22/18 at 8:30 a.m., NFI expressed concern that resident #1 was not getting bed baths, and was worried there was not enough staff to care for her mother.

Review of the resident's Progress Note, dated 8/19/18, stated, "Daughter in to visit this pm. She is concerned that she feels like her mother has not had a shower or had her hair washed recently..."

A review of resident #1's ADL Bathing Log, for the month of August 2018, showed, the resident had only received one shower, instead of two for the week of 8/10/18 to 8/18/18. Further review of the log showed the resident was not provided with a bath since 8/18/18.

During an interview on 8/20/18 at 12:30 p.m., staff member G stated she was concerned the facility was not adequately staffed to provide regular showers for the residents. She stated there were many days when a resident was scheduled to have a shower and they did not get it because the CNA's could not get to it.

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F 600	Continued From page 24 During an interview on 8/20/18 at 1:37 p.m., staff member N stated she did not feel there were enough aides to provide the scheduled showers for residents on this unit. She stated they work short staffed so often, that the residents did not get their showers. She stated she had asked the administration repeatedly for a bath aide to help with providing showers. A review of the facility's policy titled, Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident Property, and Exploitation, stated, "Each resident has the right to be free from abuse, including... neglect... The Center implements policies and processes so that residents are not subjected to abuse by staff... 'Willful', as used in this definition of abuse, means the individual acted deliberately, not that the individual must have intended to inflict injury or harm... Neglect: Failure of the Center, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."	F 600		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		10/3/18

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F 725	Continued From page 25 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have sufficient staffing to provide the necessary care and services, to prevent and treat residents for pressure ulcers for 3 (#s 1, 2, and 3); failed to provide showers for 4 (1, 2, 3, and 4); failed to provide assistance for a dependent resident to prevent incontinence of urine for 2 (# 7 and 8); and failed to to provide meal service in timely manner for 6 (#s 3, 4, 5, 8, 9, and 10) of 13 sampled and supplemental residents; and failed to maintain a system for adequate nursing coverage, to ensure a charge nurse was available for the provision of nursing services, when the assigned charge nurse was required to leave the designated skilled nursing area of the facility, and would be unable to provide resident care. The accumulative effect of this deficient practice, put all residents at the facility at risk for not receiving care due to the lack of staff availability. Findings include:	F 725	F725 1. Resident #3 received a full skin evaluation wounds to sacrum, scrotum and penis were immediately assessed for staging, appropriate treatment, RD evaluation for nutritional support. His air mattress was upgraded to a higher level of pressure reduction capability. Routine care orders were also obtained for his suprapubic catheter. His physician was notified of all wounds and suprapubic catheter evaluation and new orders received. A shower was provided to him on 8/24/18. B. Resident #1 received a full skin evaluation for any skin integrity breakdown on 8/21/18. All wounds identified had orders received for	

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F 725	Continued From page 26 During an interview on 8/20/18 at 11:09 a.m., staff member O stated she was the only nurse available to manage two medication carts. She stated she had 29, residents who were extensive assist, to care for by herself. She stated she had multiple residents who needed wound care, and did not have time to provide that care. She stated she also had three residents with catheter care, a resident with a colostomy and one with a tube feeding. She stated she had a resident who was on hospice and was approaching the end of life, and she had not had time to check on him. She stated there were times they did not have enough staff to get residents out of bed in the mornings, and many times residents who needed extensive assistance stayed in bed, and they would also miss meals at times. She stated on many different occasions, residents lay in soiled briefs for hours, until a CNA could help them. She stated the unit currently had two nurses, and three CNAs for 58 residents. They currently had three CNAs to provide care for 58 residents, of which approximately half of the residents required extensive 2-person assistance for their cares. She stated one of the CNAs was new that day, and was training. She said the night shift had only one nurse and one CNA, to care for 58 residents, of which, approximately half require an extensive two-person assistance. She stated when CNAs call off, their is no system in place to replace them, and many times they just work short. During an interview on 8/20/18 at 12:03 p.m., staff member J stated the staffing for the facility "was not great." She said she had to go per diem because she could no longer handle the hours. She stated on many occasions over the last year, she was asked to work two shifts in a row, over	F 725	treatment with MD notification, appropriate staging determined, RD evaluation for nutritional support and current air mattress evaluated for function and pressure reduction on 8/22/18. Catheter care was immediately provided upon finding and orders reviewed to ensure catheter care every shift are in place. Resident received a shower on 8/23/18. Activities and Social Services Directors evaluated resident for individualized care and support to prevent isolation, as well as ordering a geri chair to allow resident more time outside of her room. Education was provided to staff on frequent rounding and repositioning on 8/21/18, 8/22/18, 9/5/2018 and 9/6/2018. The allegation of neglect was also reported to the state department of health. C. Resident #2 received a full skin evaluation for any skin integrity breakdown on 8/21/18. All wounds identified had orders received with MD notification, appropriate staging determined, RD evaluation for nutritional support and air mattress put into place as well as his wheel chair cushion evaluated for possible replacement needed. He received a shower on 8/25/18. A new pain evaluation was completed on 9/6/18 to ensure his current pain regime is adequate per his interview. D. Resident #4 received a shower on 8/23/18. E. Residents #7 and #8 were assisted in toileting needs upon finding and skin	

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F 725	Continued From page 27 24 hours. She stated she was the only nurse to run two medication carts, and provide care to 27 residents. She stated she had two residents with a tube feeding, two with catheter care, and several with wound care. She stated she had a difficult time completing her assigned tasks for all 27 residents. She said she would miss wound care because she did not have time to complete it for the residents. She said there was currently three CNAs and one which was orienting, to provide care for 58 residents. She stated there was only one CNA per hall which had 2-person assist residents. She, the charge nurse, would do the best they could to replace call off's, but with all the other duties, this did not happen. She stated she was aware some residents remained soiled for long periods of time, and sometimes they did not get food delivered to their rooms. She stated she was fearful for the residents and has felt she was placed in an impossible situation. She stated on several occasions she would be pulled from her duties as a charge nurse for the unit to provide assessments or services for residents on the assisted living side of the building. She said that was frustrating because she barely had time to complete the care she was required to do for the residents of the nursing home. During an interview on 8/20/18 at 12:31 p.m., staff member G stated she was afraid for the residents. She stated the facility was understaffed and many residents were being left soiled for long periods of time, not helped out of bed, and taken to the dining room for meals. Many of the residents don't get their scheduled showers, and there are several residents who have developed new skin impairments, which have not been addressed. She stated there was only 3-4 CNAs	F 725	evaluations completed for any skin breakdown. Staff educated on the importance of meeting the residents□ needs regarding toileting upon request 8/22/18. F. Resident #□s 3, 4, 5, 8, 9 and 10 were evaluated by the RD for nutritional needs. An in-service was conducted by the DDCO and RVP on 8/21/18, 8/22/18, 9/5/18 and 9/6/18. to all nursing staff regarding timely assistance in feeding those residents unable to feed themselves as well as ensuring meals are never served and allowed to sit and get cold awaiting their assistance. G. An in-service was held by the DDCO and RVP on 8/22/18 regarding implementation of agency nursing to supplement open shifts and allow for appropriate staffing ratios to meet the resident□s needs, as well as all recruitment efforts/programs, retention efforts, and staffing review. This education also discussed no cross of services between the ALF and SNF by licensed staff, they were re-educated on ensuring they are clearly delineated from one another via clocking in codes. All license nursing staff also notified of appropriate charge nurse or DNS/designee to contact for provision of nursing services via a communication binder at each nurse station with emergency contact numbers, and current schedule for the day. 2. All residents are identified to be at risk. A 100% skin evaluation audit was	

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scheduled to work the unit, and that was not enough to care for all the residents. She stated there were many times when there were only two CNAs to provide care for 58 residents.

During an observation on 8/20/18 at 12:56 p.m., there were four CNAs working the unit, one of which was a trainee, and was being oriented by a CNA.

During an interview on 8/20/18 at 2:16 p.m., staff member K stated she was the only CNA for an entire hall, the hall had several residents which were a two-person assist. She stated she could not get those residents up and they would just stay in bed. She stated she did not feel it was safe to help many of the residents because she was the only CNA for the entire hall with 16 residents, and other staff did not want to help her.

During an interview on 8/20/18 at 2:30 p.m., staff member H stated she was afraid she was going to hurt a resident. She stated she has been the only CNA on two halls with over 20 residents, of which there are residents who are a two-person assist. She stated she did what she could, but there was many times when she could not answer call lights or change a soiled brief for over an hour. She stated she was aware there were residents who did not get their showers, or get up for meals, because there was not enough staff to help. She knew residents were developing new pressure ulcers because they are left for long periods in their chairs or in bed in the same position.

During an interview on 8/20/18 at 2:40 p.m., staff member S stated the facility had replaced their DON and the Administrator on 8/20/18. He stated

conducted by the DNS/designee on 8/30/18 and skin integrity issues were addressed per policy and procedure. A 100% audit was conducted on all showers for residents with any discrepancies found fixed by ensuring a shower was received on 8/30/18. Resident interviews conducted by the IDT for their satisfaction of care being received and observation of their environment weekly are starting 9/3/18.

3. An in-service was held with all staff by the DDCO and RVP on 8/21/18 and 8/22/18 regarding ensuring wound treatments are done, weekly skin evaluations are completed as scheduled, showers are completed, and efforts being made regarding staffing, retention, and recruitment. Additional systematic changes for improvement include the hiring of a dedicated wound certified nurse, designated bath aides for both units, and new structured shower schedule. Wound treatments and weekly evaluations have been moved from the TAR to the MAR for better adherence and notification as well. The facility leadership team implemented a Meal Manager on Duty program with oversite of every meal with training regarding ensuring that residents are served their meals timely and assist with customer service in the dining room. In addition a 3rd nurse in the form of a unit manager will be hired and available to support additional needs/concerns of residents and staff on Timbers. TLC will also include hiring of an additional nurse as a unit manager to

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F 725	Continued From page 29 the facility was actively trying to recruit more CNAs and nurses. He stated the facility did not usually use travel nursing for staffing shortages. He stated there were employees who were certified nurses assistants, and could float over to help the floor staff when things were busy. He stated there was an activities aide, a human resource manager, a business office manager, and a receptionist, all who had their CNA license and could help when short. He stated these services were not scheduled, they were just available to help if needed. 1. Pressure Ulcers During observations, interviews, record reviews, the facility failed to ensure resident #s 1, 2, and 3, had adequate staffing to provide the required nursing services to prevent the development of, and worsening of pressure ulcers. Resident #1 developed five new Stage 2 pressure ulcers on his buttocks, and had also developed open areas of maceration on his penis and distal scrotum. Resident #2 developed a worsening pressure ulcer on her sacrum; and, resident #1 developed a new Stage 1 and a worsened Stage 2 pressure ulcer. These deficiencies were related to the insufficient staffing to provide the necessary services to prevent skin impairment (See F 600 for further detail). 2. Showers During observation, interviews, and record reviews, the facility failed to provide scheduled showers to maintain the residents highest-practicable well-being for four residents (#s 1, 2, 3, and 4) (See F 600).	F 725	support additional needs/concerns of the unit nurses and residents. 4. Audits will be conducted by the DNS or designee on wound treatments in place as ordered, weekly skin evaluations, and showers being completed routinely weekly X 12 weeks then monthly X 2 months. An audit will be conducted by the designated meal manager on duty for resident□s required extensive assistance with meals to ensure timely meal service and assistance eating. An audit will also be conducted by the DNS/designee on appropriate staffing levels daily for each shift, weekly X 8 weeks then monthly X 2 months. Results of the initial corrections, audits and education will be submitted in an AdHoc QAPI meeting was held on 8/23/18 for review and recommendations. Results of the Audits will be taken to QAPI x 3 months or until resolved. 5. Corrective action will be completed by 10/3/18.	

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F 725	Continued From page 30 3. Incontinence A. During an observation on 8/20/18 at 12:57 p.m., resident #8 was sitting in his wheelchair in the doorway of the assisted dining room. His food was sitting at his table, untouched. He told staff member P he had to go to the bathroom. The staff member told the resident he would need to wait for a CNA to come help him. During an observation on 8/20/18 at 1:15 p.m., resident #4 asked if someone was going to help resident #8 to the bathroom. Resident #8 stated, "it's too late." A CNA entered the dining room and pushed the resident up to his table and started assisting him with his meal. B. During an observation on 8/20/18 at 5:00 p.m., resident #7 explained to staff member F that he was experiencing a lot of urgency with urinating, but when he tried to go, nothing would happen. He explained to staff member F that he needed to go to the bathroom and asked if someone could help him. The staff member told him he would have to wait because the CNAs were busy, and there wasn't one available right away to help him to the bathroom. The resident stayed by the nurses station and kept reminding staff member F that he needed to use the bathroom, and it was becoming more urgent. At 5:15 p.m., staff member F assisted the resident to his room and called in two CNAs to help transfer the resident. During an interview on 8/20/18 at 5:35 p.m., staff member F stated the resident was brought to his commode, and was not able to go once he was put on his commode. She stated the CNAs did need to change the resident's brief because it was soiled with urine.	F 725		

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4. Late Meal Service

During an observation on 8/20/18 at 12:15 p.m., lunch was delivered to the assisted dining room.

During an observation and interview on 8/20/18 at 12:30 p.m., staff member P brought meal trays to the tables for the residents in the assisted dining room. Four residents, #s 4, 8, 9, and 10, had a meal tray in front of them on the table, but they could not feed themselves without assistance. Staff member P stated she could not assist in feeding the residents, she was just there to ensure the residents' meals were correct before they were given their food. During the observation, several residents did not have anything offered to drink. There was fresh salad on the counter which was not offered to any of the residents.

During an observation and interview on 8/20/18 at 1:04 staff members N entered the dining room to assist residents' 4, 8, 9, and 10, with their meal. Resident #4 stated he was hungry but wanted to make sure the older residents received their meals first. He stated he was raised to "respect his elders" and just wanted to make sure they were helped first. He stated this morning he waited over an hour and half with his food sitting on the table next to him, before someone came in to set up his meal so he could eat. He stated there were many residents that did not get their room tray either. The resident stated there was also many times when there wasn't a CNA in the assisted dining room at all, he stated we are not supposed to be left unattended, but it happed on many different occasions because they did not have enough staff.

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During an observation on 8/20/18 at 1:36 p.m., resident #s 4, 8, 9, and 10, were still seated at their tables, with food in front of them. There was no staff in the assisted dining room.

During an observation and interview on 8/20/18 at 1:44 p.m., resident #5's food was still in the meal cart at the nurses station, it had not been brought to resident #5. During an interview resident #5 stated he was not hungry and, "It's a good thing too, because no brought me my lunch."

During an observation on 8/20/18 at 6:00 p.m., residents were waiting in the assisted dining room for dinner. The food cart was outside the dining room, next to the nurses station.

During an observation on 8/20/18 at 6:15 p.m., staff member P passed out the meal trays to the residents in the dining room. Resident #4 asked for his assistive device so he could eat, and staff member P told him she could not help him, and he needed to wait for an aide. Staff member P finished passing the meal trays for the assisted dining room, several residents were able to feed themselves, but there were four residents, 4, 8, 9, and 10, who needed total assistance, their food was sitting in front of them, but there was no one available to help them eat.

During an observation on 8/20/18 at 8:46 p.m., two CNAs entered the assisted dining room and started to assist resident #s 4, 8, 9, and 10 with their meals. The residents had to wait for 46 minutes with their food in front of them, and no one was available to help them eat.

During an interview on 8/20/18 at 8:46 p.m.,

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resident #4 stated it was the normal to wait for someone to come in and help them with their meals.

During an interview on 8/21/18 at 7:30 a.m., staff member P stated she was embarrassed about how the meal services went the day before. She stated she could only pass out the food, and ensure it was the correct diet, but she could not help serve food. She stated residents will wait up to an hour at times waiting for staff to come in and help them eat. She stated the facility was understaffed.

During an observation on 8/21/18 at 8:00 a.m., the kitchen brought down the meal cart for the unit.

During an observation and interview on 8/21/18 at 8:42 a.m., resident #3 stated he had not been brought his morning meal tray yet. He stated he was hungry, but was used to waiting for the staff to bring him his meals. He stated many times he would get his food and it was cold. He stated he would not eat the food when it was cold. The resident stated he felt this was because the facility was short staffed.

During an observation at 9:56 a.m., staff member Q brought resident #3 his breakfast meal tray. The resident waited two hours for his breakfast.

5. Inadequate Nursing Coverage

During an observation and interview on 8/20/18 at 2:40 p.m., staff member J stated she was the charge nurse for the unit and was just asked to go to the assisted living center to check on a resident who was experiencing chest pain. She

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F 725	Continued From page 34 stated she was pulled from her duties as a charge nurse on the unit to complete assessments, or services for residents at the attached assisted living facility. The staff member stated she felt this put a huge strain on her to meet her already heavy workload at the nursing home, and then be pulled over to the assisted living facility in the middle of her shift to help over there. She stated it made her uncomfortable to leave her residents unattended to help over at the assisted living facility, but it was an expectation of her duties by the management. During an interview on 8/20/18 at 3:30 p.m., staff member S stated if the assisted living center needed a nurse to help with resident care, the staff from the nursing home could go over and help them. (See F 835 for more detail)	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		10/3/18

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F 755	Continued From page 35 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: During an observation, interview, and record review, the facility failed to maintain an accurate Narcotic Log Record, which reflected the medication administration count of controlled medications for 4 (#s 3, 11, 12, and 13) of 13 sampled and supplemental residents. Findings include: 1. During an observation, interview, and record review on 8/20/18 at 1:57 p.m., staff member F stated there was not a narcotic card for resident #11's Lorazepam 0.5 mg tablets in the locked drawer of the medication cart. Review of the facility's Narcotic Log Book, showed page 25, which correlated with the medication card #25 was for resident #11's Lorazepam 0.5 mg tablet. The medication distribution showed there were four pills remaining in the card. During the observation, the medication blister pack was not in the medication cart for #1. 2. During an observation, interview, and record review on 8/20/18 at 1:57 p.m., staff member F	F 755	F755 1. Resident #3, 12, 11, and 13□s controlled drugs were investigated for location verification/accuracy of count as well as all other controlled medications on all carts and in the emergency cubex supply. Any discrepancies found were reported to the DEA, Department of Health and Police Department. Nurse was suspended pending investigation upon discovery of discrepancies□. 2. All residents on controlled medications are identified to be at risk. A 100% audit was completed on all medication carts for verification and accuracy of counts for all controlled medications. Discrepancies found have been reported to the police department, Billings DEA, State Board of Nursing and	

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F 755	Continued From page 36 stated there was not a narcotic card in the locked narcotic box for resident #13's Oxycodone 20 mg IR. The Narcotic Log Book, page 82, should there should be a correlating medication blister packet number 82, with 15 tablets remaining. During observation, this medication blister pack was not in medication cart for #2. 3. During an observation, interview, and record review on 8/20/18 at 1:57 p.m., staff member F stated there was not a narcotic card in the locked narcotic box for resident #12's Ritalin 5 mg tablets. The Narcotic Log Book, page 84, showed there should be a corresponding medication blister packet number 84, with 30 tablets. During an observation, the medication blister pack was not in medication cart for #2. 4. During an observation, interview, and record review on 8/20/18 at 1:57 p.m., staff member F stated there was not a narcotic card in the locked narcotic box for resident #12's Ritalin 5 mg tablets. The Narcotic Log Book, page 102, showed there should be a corresponding medication blister packet number 102, with 30 tablets. During an observation, the medication blister pack was not in medication cart for #2. 5. During an observation, interview, and record review on 8/20/18 at 1:57 p.m., staff member F stated there was not a narcotic card in the locked narcotic box for resident #3's Morphine Sulfate 30 mg ER tablets. The Narcotic Log Book, page 122, showed there should be a corresponding medication blister packet number 122, with 26 tablets. During an observation, the medication blister pack was not in medication cart for #2. During an interview on 8/20/18 at 5:00 p.m., staff	F 755	Department of Health accordingly with identification and suspension of suspected nurse involved. 3. An in-service was provided on 8/21, 8/22 and 9/6/18 by the DDCO regarding correct verification/counting of controlled medications at change of shift. New processes have been implemented beginning 9/6/18 including counting total number of cards as well as the verifying the correct amount is left on each card, two nurses signature and visual validation of any fentanyl patch placed or removed, and two nurses must co-sign when pulling from the cubex emergency supply for controlled medications. 4. Audits will be conducted by the DNS/designee on verification of accurate numbers of cards of controlled medications and pill count weekly X 8 weeks then monthly X 2 months. The facility will continue to comply with any ongoing investigation of these discrepancies with the Billings DEA. Results of the initial corrections, audits and education was submitted in an AdHoc QAPI meeting on 8/23/18 for review and recommendations. Results of the Audits will be taken to QAPI x 3 months or until resolved. 5. Corrective action will be completed by 10/3/18. .	

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F 755	Continued From page 37 member F stated it was the process for two nurses to complete the narcotic count at the end and beginning of each shift. She stated one nurse stands at the locked drawer and called out the number on the medication blister packs in the drawer. The second nurse would then go to the page number which correlated with the number on the blister packets. She stated she can see how medication blister packets would not be counted for and could be missing from the cart by performing the narcotic count this way. She stated she was going to inform her DON immediately of the medication discrepancy. During an interview on 8/20/18 at 5:30 p.m., staff member A stated it was the expectation for the medication count to match the cards in the medication cart. She stated an investigation would be completed to identify the deficient practice and the missing narcotics.	F 755		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately provide oversight for the systems and processes used for the provision of resident care related to wounds, the provision of ADLs/showers, and to ensure adequate staffing was available for the provision of resident care, based on the residents care	F 835	F835 1. A. Resident #3 received a full skin evaluation wounds to sacrum, scrotum and penis were immediately assessed for staging, appropriate treatment, RD evaluation for nutritional support. His air	10/3/18

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F 835	Continued From page 38 needs (wounds, catheter care, tube feeding, and transfer requirements); and failed to ensure nursing staff was available when the charge nurse was required to leave the designated area of the facility and go to the assisted living to work. This deficient practice had the potential to affect 58 of the 58 residents who resided on the unit, and did affect 4 (#s 1, 2, 3, and 4) of 6 sampled residents, who either had wounds not treated or worsened in size and number, or showers/ADL care was not provided, and the resident felt bad related to the poor hygiene. Findings include: Staffing Concerns and Assisted Living: During an observation and interview on 8/20/18 at 2:40 p.m., staff member J stated she was the charge nurse for the unit and was just asked to go to the assisted living center to check on a resident who was experiencing chest pain. She stated she was pulled from her duties as a charge nurse on the unit to complete assessments, or services for residents at the attached assisted living facility. The staff member stated she felt this put a huge strain on her to meet her already heavy workload at the nursing home, and then be pulled over to the assisted living facility in the middle of her shift to help over there. She stated it made her uncomfortable to leave her residents unattended to help over at the assisted living facility, but it was an expectation of her duties by the management. During an interview on 8/20/18 at 3:30 p.m., staff member S stated if the assisted living center needed a nurse to help with resident care, the staff from the nursing home could go over and help them.	F 835	mattress was upgraded to a higher level of pressure reduction capability. Routine care orders were also obtained for his suprapubic catheter. His physician was notified of all wounds and suprapubic catheter evaluation and new orders received. A shower was provided to him on 8/24/18. B. Resident #1 received a full skin evaluation for any skin integrity breakdown on 8/21/18. All wounds identified had orders received for treatment with MD notification, appropriate staging determined, RD evaluation for nutritional support and current air mattress evaluated for function and pressure reduction on 8/22/18. Catheter care was immediately provided upon finding and orders reviewed to ensure catheter care every shift are in place. Resident received a shower on 8/23/18. Activities and Social Services Directors evaluated resident for individualized care and support to prevent isolation, as well as ordering a geri chair to allow resident more time outside of her room. Education was provided to staff on frequent rounding and repositioning on 8/21/18, 8/22/18, 9/5/2018 and 9/6/2018. The allegation of neglect was also reported to the state department of health. C. Resident #2 received a full skin evaluation for any skin integrity breakdown on 8/21/18. All wounds identified had orders received with MD notification, appropriate staging determined, RD evaluation for nutritional support and air mattress put into place as well as his wheel chair cushion evaluated	

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F 835	Continued From page 39 During an interview on 8/21/18 at 9:30 a.m., a staff member from the assisted living facility was looking for staff member G to help him get a resident ready for transport. During an interview on 8/21/18 at 10:00 a.m., staff member G stated it was not uncommon to be asked to help on the assisted living side of the building for various reasons. She stated when this happened she felt even more stressed out and unable to complete her daily resident cares for the residents who resided at the facility. Supervision and Oversight of Resident Care: A. During an interview on 8/20/18 at 11:15 a.m., resident #3 stated he said he lays in the same position most of the day, because staff did not come in and help him reposition. He said he had many skin impairments when he was admitted to the facility, and they had been improving when he had a "Sand" mattress. He stated since the facility changed him from the "Sand" mattress to his current mattress (air mattress), he had developed more skin problems. He stated his doctor had ordered for him to have wound care once a day, and that was not happening. He stated he also did not get regular showers, he preferred to be showered at least twice a week, but he was lucky to get one once a week. He stated he felt there was not enough staff to care for everyone. During an interview on 8/20/18 at 11:29 a.m., staff member O stated she was the only nurse to manage two medication carts. She stated she was expected to manage the care for 27 or more residents every shift. She stated there were days	F 835	for possible replacement needed. He received a shower on 8/25/18. A new pain evaluation was completed on 9/6/18 to ensure his current pain regime is adequate per his interview. D. Resident #4 received a shower on 8/23/18. E. Residents #7 and #8 were assisted in toileting needs upon finding and skin evaluations completed for any skin breakdown. Staff educated on the importance of meeting the residents□ needs regarding toileting upon request 8/22/18. E. Residents #7 and #8 were assisted in toileting needs upon finding and skin evaluations completed for any skin breakdown. Staff educated on the importance of meeting the residents□ needs regarding toileting upon request 8/22/18. F. Resident #□s 3, 4, 5, 8, 9 and 10 were evaluated by the RD for nutritional needs. An in-service was conducted by the DDCO and RVP on 8/21/18, 8/22/18, 9/5/18 and 9/6/18. to all nursing staff regarding timely assistance in feeding those residents unable to feed themselves as well as ensuring meals are never served and allowed to sit and get cold awaiting their assistance. G. An in-service was held by the DDCO and RVP on 8/22/18 regarding implementation of agency nursing to supplement open shifts and allow for appropriate staffing ratios to meet the resident□s needs, as well as all recruitment efforts/programs, retention	

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F 835	Continued From page 40	F 835		

when she physically could not provide wound care for her assigned residents. She stated she felt she needed to prioritize her day, and passing medications came first, then if she still had time she would provide wound care. She stated she was not always able to get to the assigned skin assessments as well. The staff member stated she did not feel she had enough time to manage the care for all her assigned residents and was afraid she was going to hurt a resident because of the exaggerated workload.

During an observation on 8/21/18 at 11:00 a.m., resident #3 was lying in bed on his back, with his head supported with pillows. He smelled of musk, his hair was oily with flakes of dandruff, and several concerns were identified related to the resident's skin, suprabupic catheter care, and hygiene (refer to F600 for further detail).

B. During an observation on 8/20/18 at 11:13 a.m., a strong odor of urine and BM could be smelled in the hallway, outside of resident #1's room. The resident was lying in bed on her right side. She was contracted into a semi-fetal position and was very rigid, with limited mobility.

During an observation on 8/20/18 at 12:37 p.m., resident #1 was lying in the same position in her bed. The room had a strong odor of urine and BM.

During an observation on 8/20/18 at 2:15 p.m., resident #1 was lying in the same position, on her right side. The room had a strong odor of urine and BM.

During an interview on 8/20/18 at 2:20 p.m., staff member K stated she "honestly had not had time

efforts, and staffing review. This education also discussed no cross of services between the ALF and SNF by licensed staff, they were re-educated on ensuring they are clearly delineated from one another via clocking in codes. All license nursing staff also notified of appropriate charge nurse or DNS/designee to contact for provision of nursing services via a communication binder at each nurse station with emergency contact numbers, and current schedule for the day.

2. All residents are identified to be at risk. A 100% skin evaluation audit was conducted by the DNS/designee on 8/30/18 and skin integrity issues were addressed per policy and procedure. A 100% audit was conducted on all showers for residents with any discrepancies found fixed by ensuring a shower was received on 8/30/18. Resident interviews conducted by the IDT for their satisfaction of care being received and observation of their environment weekly starts 8/24/18.

3. An in-service was held with all staff by the DDCO and RVP on 8/21/18 and 8/22/18 regarding ensuring wound treatments are done, weekly skin evaluations are completed as scheduled, showers are completed, and efforts being made regarding staffing, retention, and recruitment. Additional systematic changes for improvement include the hiring of a dedicated wound certified nurse, designated bath aides for both units, and new structured shower schedule. Wound treatments and weekly

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F 835	Continued From page 41 to check on resident #1 since around 9:00 a.m." She stated it was the expectation to check on resident #1 every two hours or more. She stated she frequently felt the facility was understaffed, and had to work without help on many different shifts. She stated she was afraid of hurting herself and the residents, because she has had to make many challenging transfers without assistance. Staff member K stated she would get another CNA, and go in and check resident #1. C. During an observation on 8/20/18 at 2:00 p.m., resident #2 was sitting in his wheelchair by the nurses station. He told staff member O that he his "backside" hurt and he wanted to lay down. Staff member O stated the CNA's were "busy right now" but would be there to lay him down before long. During an observation on 8/20/18 at 2:56 p.m., resident #2 was asleep in his wheelchair at the nurses station. During an observation on 8/20/18 at 5:46 p.m., resident #2 called out that he wanted to lay down in his bed. During an interview on 8/21/18 at 9:28 a.m., staff member L stated she had not yet seen the pressure ulcer on resident #2's sacrum. She stated the resident did complain of a lot of bottom pain. She stated his bottom starts to hurt from sitting in his wheelchair for too long. During an observation on 8/21/18 at 9:35 a.m., resident #2 had a new reddened area, which was non-bleachable, on his left sacrum. He had a dressing covering a wound on his right sacrum which was dated, 8/19/18. The wound to his right	F 835	evaluations have been moved from the TAR to the MAR for better adherence and notification as well. The facility leadership team implemented a Meal Manager on Duty program with oversite of every meal with training regarding ensuring that residents are served their meals timely and assist with customer service in the dining room. The ED/designee has provided education to all staff regarding no shared resources or services between the SNF and ALF. 4. Audits will be conducted by the DNS or designee on wound treatments in place as ordered, weekly skin evaluations, and showers being completed routinely weekly X 12 weeks then monthly X 2 months. An audit will be conducted by the designated meal manager on duty for resident□s requiring extensive assistance with meals to ensure timely meal service and assistance eating weekly X 12 weeks then monthly X 2 months. An audit will also be conducted by the DNS/designee on appropriate staffing levels daily for each shift, weekly X 12 weeks then monthly X 2 months. Audits will be conducted by the ED/designee on review of staff hours/scheduling to ensure no sharing of staff between the SNF and ALF unless completely scheduled out accordingly weekly X 12 weeks then monthly X 2 months. Results of the initial corrections, audits and education was submitted in an AdHoc QAPI meeting on 8/23/18 for review and recommendations. Results of the Audits will be taken to QAPI x 3	

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F 835	Continued From page 42 sacrum had an area which was approximately 3 cm by 5 cm, and it was open. The wound bed was red and raised in appearance and had about 25% slough covering the surface. During an interview on 8/21/18 at 9:35 a.m., the resident stated his bottom hurt if he sat in his wheelchair for too long. The facility failed to provide weekly skin assessments, daily wound care, and provide aid when the resident wished to lay down and relieve the pressure on his bottom. These factors resulted in a new development of a Stage I pressure ulcer on the resident's left sacrum, and a worsening Stage II pressure ulcer which became larger in diameter. D. Missed Showers for dependent resident's A. During an observation on 8/20/18 at 12:03 p.m., resident #4 was sitting in his wheelchair, he smelled lightly of musk and body odor, and had short cut hair which appeared oily with small flakes of dandruff. During an interview on 8/20/18 at 12:03 a.m., resident #4 stated he did not feel there was enough staff to provide the necessary care for all the residents. He said he was told by the staff that he would not be offered a shower everyday due to staffing, and could have one twice a week. He stated when he was not provided a shower he felt "dirty and gross." Review of resident #4's ADL-Bathing report for the month of August 2018, showed the resident did not received a shower since 8/10/18.	F 835	months or until resolved. 5. Corrective action will be completed by 10/3/18.	

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F 835	Continued From page 43	F 835		

B. During an observation on 8/21/18 at 9:30 a.m., resident #3 was lying in his bed, in a hospital gown. He smelled of stale musk, his hair appeared oily with flakes of dandruff.

During an interview on 8/21/18 at 11:00 a.m., resident #3 stated he did not get a shower on a regular basis. He stated he wanted a shower at least twice a week, but there were many times when he would only get a shower once a week or not even that often. He stated when he did not get a shower regularly he felt bad. He stated he felt like the staff did not care about him, and he wanted to move to another facility as soon as he could.

Review of resident #3's ADL-Bathing Log for the month of July 2018, showed the resident was provided a shower only on 7/31/18.

Review of resident #3's ADL-Bathing Log for the month of August 2018, showed the resident had not been provided a shower since 8/14/18.

C. During an observation on 8/21/18 at 9:35 a.m., resident #2 was sitting in his wheelchair in his room which smelled stale. The resident had gray, short cut hair, which had flakes of dandruff.

During an interview on 8/21/18 at 9:35 a.m., resident #2 stated he could not remember the last time he had a shower.

Review of resident #2's ADL Bathing Log, for the month of August 2018, showed the resident had not received a shower since 8/10/18.

D. During an observation on 8/20/18 at 11:13 a.m., a strong odor of urine and BM could be

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F 835	Continued From page 44 smelled in the hallway, outside of resident #1's room. The resident's hair was stringy with oil, and the pillow behind her head had a green pillow case which had a ring of oil saturated around the resident's head. A review of resident #1's ADL Bathing Log, for the month of August 2018, showed, the resident had only received one shower, instead of two for the week of 8/10/18 to 8/18/18. Further review of the log showed the resident was not provided with a bath since 8/18/18. During an interview on 8/20/18 at 12:30 p.m., staff member G stated she was concerned the facility was not adequately staffed to provide regular showers for the residents. She stated there were many days when a resident was scheduled to have a shower and they did not get it because the CNAs could not get to it.	F 835		