STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676215	A. BUILDING _____ B. WING _____	**02/19/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION & WELLNESS CENTRE OF DALLAS LLC	**4200 LIVE OAK ST DALLAS, TX 75204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0285 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Coordinate assessments with the pre-admission screening and resident review program for mentally-ill and mentally-retarded patients.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinator assessments with the pre-admission screening and resident review (PASRR) program for one (Resident #10) of four residents reviews for preadmission screening for mentally ill individuals and/or mental [MEDICAL CONDITION]. Residents #11 did not receive an evaluation and screening for specialized services that she may have qualified for with the Local Intellectual/Development Disability Authority (LIDDA). This failure could affect four residents in the facility, including Resident #10, who had mental illness, developmental disability, or intellectual disability for not being properly assessed for specialized services. Findings included: Review of Resident #10's admission MDS Resident Assessment reflected she was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Her MDS Resident Assessment indicated she was moderately cognitively impaired, had no mood or behavior issues, was independent in eating, was always incontinent and had unclear speech but was usually understood and could understand others. The assessment reflected the resident expected to be discharged to the community. Review of Resident #10's PASRR Level I Screening dated 01/15/16 reflected a case manager at a local hospital had completed the screening. Review of the PASRR Level 1 revealed the screening question for Mental Illness was coded Yes. Review of Resident #11's clinical record and e-chart revealed no evidence of discussions regarding the PASRR Level II follow up with the LIDDA. Interview with Resident #10 on 02/17/16 revealed she had been at the facility for three months. She stated she wanted to go back to the group home she had come from. She stated she came to the facility because she got pneumonia while at the group home, she could not eat regular food, so was sent to the hospital where they put in a [DEVICE] in her. She stated she was feeling better. Resident #10 said speech and physical therapy had worked with her and when she first came, she could not eat anything by mouth and all her food was through the tube. She was eating by mouth again and hoped to get the tube removed soon so she could go back to the group home. She stated no one had talked to her yet about discharging back to the group home or discussed what the plan was. An interview on 02/18/16 at 4:00 PM with the DON, ADM and LVN N revealed Resident #10 had not received a Level II PASRR, which meant Resident #10 had not been evaluated to determine if she required specialized services. Interview with the ADM on 02/19/16 at 12:06 PM revealed the facility was going to revamp their system to where the DON and Admissions staff could have access to the PASRR system as well as the MDS Coordinator. She stated there was a problem in the follow up on the Level II PASRR's in the facility. She stated the social worker also had the ability to call the local authority of they were delayed in coming to the facility to do the evaluation, but that had only happened once. The ADM stated the LIDDA was fairly consistent in coming out for the Level II ' s on time. The ADM stated a new system would be put in place and the facility census would be audited to see if there were any more positive Level I PASRRs that may have been missed. Interview with the LVN N on 02/19/16 at 1:13 PM revealed she had recently started to track PASRRs in the facility. She stated she did not know Resident #10 needed an additional PASRR II evaluation. She said the admissions staff would start entering the Level I PASRRs as well as herself. She stated the social worker knew how to contact the LIDDA to follow up on getting evaluations done. Review of the facility ' s PASRR-Screening and Referral Responsibility Policy (undated) was provided by the ADM who stated it reflected California in it, but it was a corporate document and was used for Texas as well. It reflected, .Policy. IV. If the Level I screening results indicate the individual should receive the Level 2 screening, the Social Services Department will contact the appropriate State agency. The State agency will arrange for Level 2 screening and determine whether the individual should be admitted to the Facility and, if so, what services the individual will need. The Level 2 screening must be completed prior to admission, Procedure. C. If, based on the Level I screening, the applicant is suspected of having a serious mental illness, the Facility ' s Social Services Department will forward the form to the California Department of Mental Health, ., Documentation. B. If the applicant is admitted is referred to the State agency for Level 2 screening, the completed screening form will be kept on file in the office of the Director of Nursing Services. An interview on 02/18/16 at 4:00 PM with the DON, ADM and LVN N revealed there were three residents at the facility who were positive for a Level II PASRR evaluation; however, Resident #11 was not included on that list.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview it was determined the facility failed to ensure one (Resident #3) of four resident's reviewed who were unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. The facility failed to ensure Resident # 3 was turned and repositioned every two hours to maintain comfort and prevent the possibility of pressure ulcers. 2. The facility failed to ensure Resident #3, received the necessary oral hygiene, to keep the residents mouth fresh, and moist, and to provide nail care to keep her clean prevent infections and unnecessary scratches. 3. The Facility failed to ensure Resident #3 had positioning devices to decrease the severity of contractures and the prevention of pressure sores. These failures could affect the 75 residents who required assistance with provision of everyday health hygiene, eye-care, oral hygiene, turning and repositioning, contracture management, bathing , dressing, grooming, and incontinent care put the residents at risk for the spread of infections, skin breakdown, decrease in self-esteem, including Resident #3. Findings included: 1) A review of Resident #3's most current MDS assessment dated [DATE], revealed she was a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with Diagnoses: [REDACTED]. Additional [DIAGNOSES REDACTED]. The assessment also reflected Resident #3 had moderately impaired cognitive skills for daily decision making, inattention,

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

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) disorganized thinking and psychomotor [MEDICAL CONDITION]. She required total assistance with the physical help of two staff for bed mobility, two staff for transfers, dressing, eating, toilet use; and dependent assistance with the physical help of one staff for mobility in the room, locomotion on and off the unit, and personal hygiene. Resident #3 was incontinent of bowel and bladder, weighed 170 pounds, was on an enteral feeding for nutritional support, and was at risk of developing a pressure ulcer. The Care Area Assessment portion of the Resident Assessment Instrument associated with this MDS assessment reflected the facility decided to proceed to care planning of the triggered area of pressure ulcers. A review of Resident #3's Plan of Care dated as initiated on 07/31/14, reflected this resident was at high risk for pressure ulcers, was dependent on the staff for all activities of daily living and generally required two staff to provide care, had contractures and required positioning devices and was at risk for skin breakdown. The plan was to provide care, and turn and reposition the resident every two hours. Resident #3 was observed during initial tour with LVN ¿¿G on 02/17/16 at 10:20 AM. Resident #3 was up in her bed lying flat on her back with the head of the bed elevated. The surveyor noted Resident #3's eyes had a yellow sticky matter on them and in the coroner of the eyes, contracted right hand without a hand-roll, dirty nails on the left hand which the nails were jagged. The residents' hair was uncombed, her lips were dry and yellow crusty substance on them, her teeth had a film on them and her tongue had a thick white coat of a mucus type substance on it. On 02/17/16 at 12:19 PM, 2:10 PM, 3:15 PM, and 3:50 PM, Resident #3 was observed to be lying on her back, with the knees of the bed flexed, and the head of the bed elevated. Her eyes continued to have a yellow matter stuck to them. Resident #3's teeth had a film covering them, her tongue continued to have a white substance on it. Resident #3's right hand was contracted without a hand roll; her finger nails were dirty and jagged. Bed sheet and blanket were on the floor by the bed on the left side of the bed. Observation on 02/17/16 at 4:00 PM, RN H went to assess Resident #3 at the request of the surveyor. He observed the resident. He then put gloves on each hand and went and wet a wash cloth in the bathroom, and came out to cleanse Resident#3's eyes. RN H picked the linen off the floor and put it in the chair. He then left the room to get a CNA to assist him. RN H returned to the room and put on another clean pair of gloves and CNA G entered the room and glove. Neither staff member washed their hands. Observation on 02/17/16 at 4:20 PM during the incontinent care process Resident #3's brief was removed and she was very wet with urine and some feces. During the incontinent process the surveyor noticed Resident # 3 had an open area next to her left buttock and coccyx area which measured approximately 0.2cm x0.2cm Stage 2 area. At this time RN H stated the area was open but would not comment on the stage stating. RN H stated I don't like to stage areas. RN H also revealed he was unaware of Resident #3 having an open area. Observation on 02/18/16 at 9:30 AM, revealed Resident #3 lying in bed, the head of the bed was elevated, it was obvious the resident had a shower, and appeared neat and clean, there was no positioning devise in the right hand and the nails remained long and jagged. On 02/18/16 at approximately 10:40 AM, the surveyor made rounds with LVN L (wound treatment nurse) informed the surveyor she was unaware of Resident #3 having a pressure ulcer until 02/17/16 at 5:30 PM when her the DON and the ADON looked at the resident that evening after a surveyor had made rounds. Observation on 02/18/16 at 12:00 PM, revealed Resident #3 was lying on her back, lips dry, mouth with white substance on her tongue.Both eyes have yellow crusty matter on them and in the coroner of the eyes there is a buildup of matter. Observation on 02/18/16 at 2:15 PM, revealed Resident #3 was lying on her back, lips dry, mouth with white substance on her tongue.Both eyes have yellow crusty matter on them and in the corner of the eyes there is some drainage. The sheets are wrinkled under the resident. Observation on 02/18/16 at 3:15 PM Resident #3 was lying on her back, lips dry, mouth with white substance on her tongue. Both eyes have yellow crusty matter on them and in the corner of the eyes there is a yellowish liquid substance. No hand roll in the right hand the nails are dirty. Sheets wrinkled and resident has slid down in bed. Observation on 02/18/16 at 4:10 PM, revealed Resident #3 was lying on her back, lips dry, mouth with white substance on her tongue.Both eyes have yellow crusty matter on them and in the corner of the eyes there is a buildup of matter, the teeth have a film on them. No hand roll in right hand and the nails are dirty and elongated and jagged. Observation on 02/18/16 at 5:00 PM, revealed Resident #3 was lying on her back, lips dry, mouth with white substance on her tongue.Both eyes have yellow crusty matter on them and in the coroner of the eyes there is a buildup of liquid substance, the right hand still does not have a hand roll and the nails are dirty and the nails are jagged on both hands. The sheets are still wrinkled under the resident. Observation on 02/19/16 at 9:10 AM revealed Resident #3 was lying on her back in bed. The head of the bed was elevated; she had foot pillows on both feet. Resident #3's hair was not combed, her mouth was dry looking, a whit substance on her tongue. her eyes still have yellow substance on them. The resident's nails continue to be elongated, she does not have a positioning devise in her contracted right hand and her fingernails are dirty on both hands. The sheets are dirty and have spilled formula on them and are wrinkled under the resident. On 02/19/16 at 10:00 AM, Resident #3, did not have heel protectors on at this time, still laying on her back. On 02/19/16 at 11:00 AM, Resident # 3 had heel protectors on however she remained lying on her back with no change in her position. On 02/19/16 at 12:00 PM Resident #3 continued to lie on her back and there is no appearance her position had changed any. On 02/19/16 at 2:35 PM observed Resident #3 again she still has yellow matter on her eyes, her mouth is dry looking with a crusty looking substance and there is still not a positioning devise in the residents ' contracted right hand. On 02/19/16 at 2:40 PM during a conversation with the DON Resident #3's care was discussed, the matted eyes, not turning and positioning her, contracted right hand, oral hygiene, and nail care. On 02/19/16 at 2:50 PM, CNA M was observed as she was completing oral care on Resident #3. CNA M took the pink toothette and swabbed Resident #3's mouth two times. The CNA M stated she had just finished cleaning the resident up. The surveyor observed the eyes were matted, tongue was white substance on it and the resident did not have a hand roll in her right hand. The surveyor queried as to why she did not clean the residents' eyes, nails, mouth, and tongue and put a hand roll in her right hand. CNA M replied I clean her eyes every time I go in there and I turn her every two hours. Had an in service on turning and repositioning a few weeks ago. I didn ' t know she was supposed to have splints on I just use wash cloths. Interview on 02/19/16 at 4:00 PM with the DON, revelaed that The DON expected her staff to follow the policies of the facility and practice good nuring care. DON expected them to bath, dress groom, provide incontinent care, turn and reposition the residents according to their plan of care, to use props and positioning devices as needed. She also revealed the nurse aides did nail care except on diabetics, and they did oral care.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure a resident who entered the facility without pressure ulcers did not develop pressure ulcers unless the individual's clinical condition demonstrated they were unavoidable for two (Resident's #3 and Resident # 12) of 6 residents and one (Resident #18) of one resident who was discharged with two unidentified pressure ulcers were reviewed for pressure ulcers. 1) The facility failed to follow the plan of care and implement interventions to prevent Resident # 3, who was at high risk for developing pressure ulcers, from developing a pressure ulcer that was was a pinpoint open area. 2) The facility failed to assess Resident #12 who developed an unstageable pressure ulcer on her left heel. 3) The facility was not aware that Resident # 18 had two pressure ulcers one behind each ear. These were found by the hospital staff upon her admittance to the emergency roiagnom on [DATE]. The failure of staff not being aware of the wounds behind Resident #18 ' s ears created a delay in the treatment of [REDACTED]. These failures could place 60 residents who required extensive assistance or who were totally dependent on staff and in the chair all or most of the time, and the 8 residents in the facility with existing pressure ulcers, which included Resident

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F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) #3 and Resident #12, who were at risk for the development of new sites due to the lack of assessment, delayed healing, and infection. Findings included: 1) A review of Resident #3's most current MDS assessment dated [DATE], revealed she was a [AGE] year old female admitted to the facility on [DATE] and re-admitted on [DATE] with Diagnoses: [REDACTED]. Additional [DIAGNOSES REDACTED]. The assessment also reflected Resident #3 had moderately impaired cognitive skills for daily decision making, inattention, disorganized thinking and psychomotor [MEDICAL CONDITION]. She required total assistance with the physical help of two staff for bed mobility, two staff for transfers, dressing, eating, toilet use; and dependent assistance with the physical help of one staff for mobility in the room, locomotion on and off the unit, and personal hygiene. Resident #3 was incontinent of bowel and bladder, weighed 170 pounds, was on an enteral feeding for nutritional support, and was at risk of developing a pressure ulcer. The Care Area Assessment portion of the Resident Assessment Instrument associated with this MDS assessment reflected the facility decided to proceed to care planning of the triggered area of pressure ulcers. A review of Resident #3's Plan of Care dated as initiated on 07/31/14, reflected this resident was at high risk for pressure ulcers, would not develop skin breakdown and the staff would turn her every two hours. Review of Resident #3's Licensed Nurse Weekly Skin assessment dated [DATE] reflected Resident #3 had a pinpoint open area on her sacrum. On 02/17/16 at 12:19 PM, 2:10 PM., 3:15 PM., and 3:50 PM., Resident #3 was observed to be lying on her back, with the knees of the bed flexed, and the head of the bed elevated. On 02/17/16 at 4:00 PM RN H went to assess Resident #3 at the request of the surveyor. He observed the resident. He then put gloves on each hand and went and wet a wash cloth in the bathroom, and came out to cleanse Resident #3's eyes. RN H picked the linen off the floor and put it in the chair. He then left the room to get a CNA to assist him. RN H returned to the room put on another clean pair of gloves and CNA G entered the room and glove. Neither staff member washed their hands. On 02/17/16 at 4:20 PM during the incontinent care process Resident #3's brief was removed and she was saturated with urine and some feces. During the incontinent process the surveyor noticed Resident # 3 had an open area next to her left buttock and coccyx area which measured approximately 0.2cm x0.2cm Stage 2 area. At this time RN H stated the area was open but would not comment on the stage stating I don ' t like to stage areas. RN H also revealed he was unaware of Resident #3 having an open area. On 02/18/16 at approximately 10:40 AM the surveyor made rounds with LVN L (wound nurse) . LVN L informed the surveyor she was unaware of Resident #3 having a pressure ulcer until 02/17/16 at 5:30 PM the DON and the ADON looked at the resident that evening after a surveyor had made rounds. 2) The MDS assessment dated [DATE] reflected Resident #12 was admitted on [DATE], and was an [AGE] year old female admitted with [MEDICAL CONDITION], hypertension, [MEDICAL CONDITION] gastro-[MEDICAL CONDITIONS], [MEDICAL CONDITIONS], dementia anxiety, depression [MEDICAL CONDITION], psychotic, and [MEDICAL CONDITION]. The assessment also reflected Resident #12 cognitive skills for daily decision making were impaired. She was dependent on assistance from the staff with the help of two staff for bed mobility, two staff for transfers, two staff for dressing, eating, toilet use; and extensive assistance with the physical help of one staff for mobility in the room, locomotion on and off the unit, and personal hygiene. Resident #12 was incontinent of bladder and bowel. She weighed 138 pounds, was on a therapeutic diet, and was at risk of developing a pressure ulcer. The Care Area Assessment portion of the Resident Assessment Instrument associated with this MDS assessment reflected the facility decided to proceed to care planning of the triggered area of pressure ulcers. A review of Resident # 12's Plan of Care dated as initiated on 07/31/14, reflected this resident was at high risk for pressure ulcers, would not develop skin breakdown and the staff would turn her every two hours. Review of Licensed Progress Notes reflected on 02/05/16 at 2:00 PM Resident #12 had developed a 1cm x 1cm un-stageable necrotic pressure ulcer on her left heel. Physician order [REDACTED].>On 02/19/16 the DON brought a current list of Residents who had pressure ulcers in the facility and the list reflected Resident #12 acquired the pressure ulcer in house. Observation on 02/17/16 at 9:30 AM, during the initial tour of the facility, the surveyor was informed by LVN I, Resident #12 had a new pressure ulcer on her left heel, that Resident #12 was alert, however was cognitively impaired, was on an anti-pressure air loss mattress, lying on her back and had heel pillows on her feet. On 02/18/16 at 10:35 AM , during rounds with LVN L she revealed Resident #12 had an un-stageable pressure ulcer on her left heel which she developed in house. Observation revealed the left heel wound measured approximately 1 cm x1cmx0.2cm with yellow string eschar and the bed of the wound pink in color. Resident #12 had a heel pillow on. On 02/19/16 at 9:20 AM observed Resident #12 lying in bed on her with left heel without heel protector, her mouth was dry and crusty, finger nails long and jagged. On 02/19/16 at 10:00 AM Resident #12 did not have heel protectors on at this time, still laying on her back. On 02/19/16 at 11:00 AM Resident # 12 had heel protectors on however she remained lying on her back with no change in her position. On 02/19/16 at 12:00 PM Resident #12 continued to lay on her back and there was no appearance her position had changed any. 3) According to the admission comprehensive assessment ((MDS) dated [DATE], Resident #18 was admitted to the facility on [DATE] from the hospital with diagnoses, which included Hypertension, GERD, Pneumonia, [MEDICAL CONDITION] Arthritis and Unstageable Pressure Ulcers. Resident #18 was identified as being alert and usually understood by others and usually understood others but had some communication difficulties. Resident #18 required extensive assistance of at least one staff member for bed mobility, transfers, dressing, eating, hygiene and bathing. Resident #18 was incontinent of both urine and bowel. Under Section M, Resident #18 was identified as having three unstageable slough/eschar areas upon admission and two unstageable deep tissue areas present upon admission. These areas were on the left heel, left ankle, coccyx and right and left ischium. Review of the admission physician orders [REDACTED]. On 11/26/15, Resident #18 was transferred to the hospital with worsening wounds, [MEDICAL CONDITION] and cough. At the hospital it was found that Resident #18 had Stage 2 pressure ulcers, one behind each ear. There were no measurements for the areas but they were identified as having no dressing on, irregular in shape and no drainage or odors. Review of the clinical record for Resident #18, which included the weekly Pressure Ulcer Site Sheet completed by the wound care nurses and there were no areas noted behind her ears. Review of the nurses ' notes from 11/06/15 through 11/26/15 did not have any documentation of any pressure ulcers behind the ears of Resident #18. At 3:15 PM on 02/19/16, an interview was conducted with LVN L, who was the wound treatment nurse for the facility. LVN L stated the weekly skin assessments were done by the floor nurses. She stated she had put in a new system where she would flag the resident ' s sheets to be assessed the day before to remind the nurses to do one. LVN L stated when a new resident was admitted she did a complete head-to-toe assessment and after that she performed the treatments on the wounds as ordered by the physician. She depended on the nurses to keep her informed of any new wound areas that developed. LVN L stated no one told her that Resident #18 had developed pressure ulcers behind her ears and she had not been aware of them. At 3:30 PM on 02/19/16 an interview was conducted with the DON. She stated she had not known that Resident #18 had developed pressure ulcers behind her ears before she was transferred to the hospital. She stated due to the condition of Resident #18 and her wounds, the staff should have been keeping up with her skin and should have known about the pressure ulcers. 4) The facility policy for Pressure Ulcer Prevention revised on January 01/2012, reflected the following: Purpose: To provide interventions for residents identified as high risk for developing pressure ulcers. Procedure: II The Nursing Staff will implement interventions identified in the care plan, which may include, but are not limited to: A. Pressure redistributing devices B. Repositioning, D. Use of pillows and linen rolls . IV. Linens will be kept clean, smooth and free of wrinkles . VI. Nursing Staff will monitor interventions for effectiveness and resident tolerance. VII. CNAs will complete body checks on Resident shower days and report unusual findings to the Licensed Nurse. VII. Licensed Nurses will document effectiveness of pressure ulcer prevention techniques in the resident ' s medical record on a weekly basis . 5) Review of the Licensed Nurse Weekly Skin Assessment sheet reflected This form was to be completed weekly on all residents

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F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) per facility policy. Any areas of skin requiring treatment should have a thorough record of documentation in addition to this form located elsewhere in the chart per facility policy . 6) LVN L (Wound Treatment Nurse) provided the team with a list of residents in the facility that had pressure ulcers at 3:40 PM on 02/19/16 and there were ten residents identified with pressure ulcers. According to the list, there were six out of the ten residents who acquired pressure sores in the facility. 7) The Resident Census and Conditions of Residents completed by the DON on 02/17/16 reflected there were 89 residents in the facility, and 60 residents who required extensive assistance or who were totally dependent on staff or in the chair all the time, and the 8 residents in the facility with existing pressure ulcers, which included Resident #3 and Resident #12,
F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents with a limited range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (Resident #11) of six residents reviewed with a limited ROM. 1. Restorative exercises/interventions were not initiated for Resident #11 after being care planned as an intervention. 2. Resident #11 had no bilateral hand splints on for contractures as was ordered by the physician. These failures could contribute to Resident #11 experiencing a decline in ROM and could affect the twelve residents identified by the facility with contractures, by placing them at risk for a further decrease in ROM, increased pain and discomfort with movement. Findings included: Resident #11's MDS Resident Assessment, dated 04/14/15, reflected she was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She had severe cognitive impairment, memory problems, inattention and disorganized thinking. The MDS assessment reflected Resident #11 used a wheelchair for mobility, was always incontinent and was rarely understood. She was on hospice services for Dementia. She was documented as having no range of motion issues, was at high risk for pressure ulcers and required extensive assistance with all activities of daily living (including transfers, bed mobility, dressing and peri-care). The MDS reflected she did not have any impairments with her range of motion. Review of Resident #11's MDS-CAA Worksheet dated 04/14/15 reflected Resident #11's assessment triggered for range of motion limits. Review of Resident #11's January and February 2016 physician's orders [REDACTED]. Review of Resident #11 ' s TAR did not reflect the splints were being put on daily. Resident #11's most recent care plan, dated 03/24/15, reflected: Problem: (Resident #11) requires extensive assistance with mobility. Goal: Obtain a PT evaluation for the resident and treat as needed; Provide Restorative Program for resident as needed. Problem: Restorative Services needed for passive ROM, grooming and feeding. Goal: Passive range of motion to all extremities 3 to 6 times a week, Restorative Care for grooming 3 to 6 times a week, and Restorative Care for eating 3 to 6 times a week. There was no care plan related to the use of any adaptive equipment for Resident #11's contractures, such as physician ordered bilateral hand splints. Review of Resident #11 ' s clinical record revealed no PT evaluation had been completed in the past year. During orientation rounds with LVN F on 02/17/16 at 10:05 AM, Resident #11 was observed in bed in her room. She had contractures of both her arms and hands. No positioning devices were being applied to her contracted hands. She had pillows around her trunk and legs. No towels or washcloths were observed in her hands for positioning. LVN F stated Resident #11 was bedfast, incontinent, total care, and was assisted with eating all meals. She had experienced weight loss, was on hospice, and was a fall risk. He did not indicate she had any contractures or required restorative therapy when asked. Observation of Resident #11 on 02/17/16 at 2:35 PM revealed she had just been brought back to her room and was asleep in bed. Resident #11 was not observed to have any hand splints on. Interview with CNA K on 02/17/16 at 2:27 PM revealed she did not do range of motion with the Resident #11, but did help her get dressed. CNA K stated she had to be delicate with Resident #11 ' s arms when putting on sleeves because they did not rise up very much. An interview with LVN C on 02/18/16 at 11:09 AM revealed she did not have any restorative notes on Resident #11 and would check with the restorative aide in the facility to see if he had any. She returned about 15 minutes later and provided one sheet titled Nursing Restorative Care Program for February 2016. LVN C was asked if there were any other restorative notes for Resident #11 and she replied no. Resident #11's Restorative Care Program sheet for February 2016 reflected the goal was to maintain ROM in the bilateral upper extremities by using both a prolonged stretch to the fingers/wrists/elbows, and ensuring proper fit and application of splints. The sheet reflected both approaches were completed five times a week for fifteen minutes since 02/01/16 through 02/17/16. The RA noted on week 1 and week 2 that Resident #11's hand splints were applied on 02/05/16 and 02/12/16. There was no other evidence provided that the other care planned restorative ROM exercises were being conducted. Observation of Resident #11 on 02/18/16 at 11:13 AM revealed she was in bed, body positioned to the left side, with rolled washcloths in both hands. No hand splints were observed. Observation of Resident #11 on 02/18/16 at 12:05 PM revealed she was asleep in her wheelchair near the nurses' station. Her hands were observed to be resident on a pillow with no hand splints in place. were observed. Interview with CNA E on 02/18/16 at 12:29 PM revealed he did a little range of motion during care with Resident #11. He stated said the resident did not have much strength and her family wanted her in hand splints when she was up in her wheelchair, and with towels in her hands when in bed. Meal Observation of Resident #11 on 02/18/16 at 1:23 PM in the dining room with CNA K, who was attempting to feed the resident, revealed Resident #11 was asleep in her wheelchair. Blue bilateral hand splints were observed to be on both her hands. Interview with the DON on 02/18/16 at 4:18 PM occurred wherein she was queried about the resident's lack of restorative therapy during the past year and presently. She stated Resident #11 was not on a restorative therapy program. Interview with the ADM on 02/19/16 at 9:50 AM revealed Resident #11 was not on a restorative therapy program and the care plan referencing that information was over a year old. She stated she would check into it. An interview with the RA on 02/19/16 at 12:18 PM revealed he did not see Resident #11 for restorative therapy as she was not on his caseload and he only saw her for hand splints. He said he checked on her once a week to make sure her hand splints were applied correctly. The RA said the form he received from therapy when a resident was placed on the restorative program told him what specifically he was supposed to do for each resident. For Resident #11, he said it was just to put hand splints on her every day. He said he trained the CNAs and nurses on how to apply the splints, and he checked in to do it himself once a week and documented it on the form. He stated the restorative therapy and the hand splints started about two months ago in December 2015. He said he was the only restorative aide at the facility. Observation of Resident #11 on 02/19/16 at 2:53 PM revealed she was asleep in bed. There was one washcloth rolled in her left hand only. Her right hand was resting on a pillow. Interview with the DON on 02/19/16 at 1:05 PM revealed Resident #11 was not on a restorative program and she did not know why she was care planned for it. Interview with the DOR on 02/19/16 at 11:02 AM revealed she did not have any records indicating the therapy department had seen Resident #11. She stated the therapy company was new to the facility since Fall 2015 and they did not have any notes on residents prior to that. She said when therapy discharged a resident to a restorative nursing program, the therapist would fill out a form with techniques that would need to be used. and The therapist would be the one to determine the length of time for the program. The facility's Form CMS-672, Resident Census and Conditions of Residents, signed by the DON on 02/17/16, reflected twelve residents with contractures.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly care for residents needing special services, including: injections, colostomy,**

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F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) **ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to provide proper treatment and care for a PICC line for one (Resident #19) resident of two residents observed receiving medications via a PICC line. LVN F administered 5 milliliters of [MEDICATION NAME] Flush (contains the anticoagulant [MEDICATION NAME] and is used to maintain patency of intravenous lines) to Resident #19 when only a normal saline flush was ordered to be administered. Administering [MEDICATION NAME] flush more frequently than ordered by the physician placed Resident #19 and the one other resident, with a PICC line at risk for complications to include [MEDICATION NAME]-Induced [MEDICAL CONDITION] (low platelet count) Syndrome (the development of [MEDICAL CONDITION] resulting from significant exposure to [MEDICATION NAME]). Findings included: Resident #19's Face Sheet dated 02/15/16 reflected an admission date of [DATE]. Physician admission orders [REDACTED]. A physician's telephone order dated 02/15/16 reflected an order to flush Resident #19's double lumen PICC line with 10 milliliters of normal saline before and after administering intravenous medications. The orders further reflected the second unused lumen should be flushed with [MEDICATION NAME] flush every twelve hours. A PICC line is defined as a tube inserted in the arm to help carry medicine(s) into the body per the Centers for Disease Control and Prevention's (CDC) Frequently Asked Questions About Catheters accessed on 02/23/16 at <http://www.cdc.gov/HAI/bsi/catheter_faqs.html> LVN F was observed on 02/17/16 at 2:15 p.m. administering the intravenous (IV) (through the vein) antibiotic [MEDICATION NAME] 1 gram, to Resident #19. The resident was noted with a double lumen PICC line in the right arm. One line had a red cap and one line had a purple cap. Prior to hanging the IV antibiotic, LVN F flushed the lumen with the purple cap using five milliliters of [MEDICATION NAME] flush and then ten milliliters of normal saline instead of only the normal saline as ordered by the physician. During an interview with LVN F on 02/19/16 at 3:50 p.m. the nurse stated he had not realized he had used the [MEDICATION NAME] flush. He further stated he had been nervous. The facility's policy/procedure (P/P) entitled Catheter Insertion and Care was provided by the Director of Nurses on 02/19/16 and identified as current. The P/P was dated 2009 and reflected no information related to how to flush a PICC line when administering IV medications. An interview with the SDC on 02/19/16 at 11:20 a.m. revealed the facility's policy was to follow the physician's orders [REDACTED]. The SCD further stated LVN F had been provided an in-service training related to PICC line care that included a return demonstration on 02/19/16. The CMS form 672, Resident Census and Conditions of Residents signed by the Director of Nurses on 02/17/16 reflected 3 residents received IV therapy. Communication with the Administrator on 02/22/16 revealed there were two residents with PICC lines in the facility.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the drug regimen was free from unnecessary drugs for one (Resident #11) of 11 residents reviewed for psychoactive medications. The facility failed to ensure there was clinical data as to why a Gradual Dose Reduction had not been attempted for Resident #11's [MEDICAL CONDITION] medication [MEDICATION NAME]. These failures could affect the 45 residents in the facility receiving psychoactive medications by placing them at risk for serious side effects, adverse consequences, and a decreased quality of life. Findings included: Resident #11's MDS Resident assessment dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She had severe cognitive impairment, was rarely understood, had memory problems, inattention and disorganized thinking. She had no signs of mood issues or behaviors during the assessment period. There were no behavioral symptoms identified on the MDS. Resident #11's care plan updated on 03/24/15 reflected she took antidepressant medication and was at risk for adverse reactions. Approaches to this problem were to review the continued need for the drug, and evaluate effectiveness and side effects of medications for possible decrease/elimination of [MEDICAL CONDITION] drugs. Resident #11's psychological diagnostic interview dated 12/30/15 reflected no treatment was recommended. Resident #11's February 2016 Physicians Orders reflected: [MEDICATION NAME] (anti-depressant) 100 mg once at bedtime (start date 11/18/11). Resident #11 ' s February 2016 MAR indicated [REDACTED]. Resident #11's Behavioral Monitor Record for January 2016 and February 2016 reflected she was monitored for [MEDICATION NAME] with the behavior of crying. No crying episodes were indicated for those two months. Resident #11's Monthly Pharmacist Drug Regimen Reviews for the past 12 months reflected gradual dose reductions were requested by the Pharmacist for [MEDICATION NAME] and [MEDICATION NAME] on 03/31/15, 05/27/15, and 01/29/16. There was no evidence the doctor had been notified of these requests. The forms were the requests were made by the pharmacist were blank. Interview with the DR on 02/19/16 at 4:01 PM revealed the process for gradual dose reductions was the same for any doctor seeing residents in the facility. He stated that when he received a gradual dose reduction request from the Pharmacist, the form was provided to him by the DON when he was at the facility. If he agreed to the reduction request, he had to write a new order. If he didn't agree with the reduction, he documented his refusal and wrote why. Interview with the DON on 02/19/16 at 4:48 PM revealed she had a call out to Resident #11's doctor because she had not been able to locate any of the doctor's review of the gradual dose reductions requests for [MEDICATION NAME] and [MEDICATION NAME]. She stated she looked through Resident #11's thinned records and could not locate anything. Review of the facility's Pharmacy and Procedure Manual dated 04/20/13 reflected, Antidepressant- Depression assessments shall be done quarterly to assess the continued need for the current dosage or the need for this medication. A reduction is not recommended with this class of medication until a resident has been on the medication for one year. If the first dose reduction fails, then another reduction shall not be attempted for twelve months. If the second reduction fails, it shall be considered contraindicated for another attempt to occur. Review of the facility's Behavior/[MEDICAL CONDITION] Drug Management Policy (undated) reflected, .Procedure .II. B. [MEDICAL CONDITION] Drug Interventions e. Dosage reduction or re-evaluations are provided according to OBRA regulations: [MEDICAL CONDITION] medications- every 6 months of continuous use. Review of the facility's Form CMS-672, Resident Census and Conditions of Residents, dated 02/17/16, revealed 35 residents received an antidepressant and 10 residents received a hypnotic.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure the medication error rate was less than 5 percent. Thirty-eight opportunities were observed with a total of five errors, resulting in a 13 percent error rate. Two staff, Registered Nurse (RN) B and Licensed Vocational Nurse (LVN) F of eight staff observed made medication errors during the medication pass conducted on 02/17/16 and 02/18/16.Three residents (Resident #15, #19 and #20) of ten residents observed during the medication pass were affected. 1) LVN F administered 5 milliliters of [MEDICATION NAME] Flush (An anticoagulant-used to prevent blood clots) to Resident

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F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) #19 when only a normal saline flush was ordered to be administered. 2) LVN F failed to follow physician's specifically ordered holding parameters by administering [MEDICATION NAME] (diuretic) and Carvedilol (beta blocker) when Resident #15's blood pressure was below parameters. 3) RN B administered 10 milliliters of Magic Mouthwash (A solution used to treat mouth sores caused by some forms of [MEDICAL CONDITION] and [MEDICAL CONDITION] therapy), to Resident #20 instead of 15 milliliters as ordered by the physician. 4) RN B failed to administer Magic Mouthwash to Resident #20 before meals as ordered by the physician. These failures placed the eleven residents RN B was responsible for administering medications for and the twelve residents LVN F was responsible for administering medications for to include Resident #15, #19 and # 20, at risk of medications to not providing the desired effects, exacerbation of medical conditions and complications related to disease processes. Findings included: (1) On 02/17/16 at 2:15 p.m. LVN F was observed to prepare and administer medications for Resident #19. Medications included 1 gram of the intravenous (IV) (through the vein) antibiotic [MEDICATION NAME]. Prior to hanging the IV antibiotic, LVN F flushed the resident's PICC line with five units of [MEDICATION NAME] and then ten milliliters of normal saline. A PICC line is defined as a tube inserted in the arm to help carry medicine into the body per the Centers for Disease Control and Prevention (CDC) Frequently Asked Questions About Catheters accessed on 02/22/16 at <http://www.cdc.gov/HAI/bsi/catheter_faqs.html> Review of Resident #19's physician's orders [REDACTED]. During an interview with LVN F on 02/19/16 at 3:50 p.m. the nurse stated he had not realized he had used the [MEDICATION NAME] flush. He further stated he was nervous. (2) On 02/18/16 at 8:40 a.m. RN B was observed to prepare and administer medications for Resident #20. Medications included 10 milliliters of Magic Mouthwash. Resident #19's breakfast tray was at the bedside and the resident stated she had eaten all she could. Review of Resident #20's physician's orders [REDACTED]. physician's orders [REDACTED]. The resident's medication administration records reflected the Magic Mouthwash was scheduled to be administered at 6:30 a.m. on 02/18/16. During an interview with RN B on 02/18/16 at 8:43 a.m. the nurse stated he had administered the medication late and the breakfast trays had been served early. A subsequent interview with RN B on 02/18/16 at 12:00 p.m. revealed he had not compared the amount of medication to administer listed on Resident #20's medication administration records with the amount listed on the medication label to ensure they matched. (3) On 02/18/16 at 9:25 a.m. LVN F was observed to prepare oral medications for Resident #15. Medications included medications used to treat hypertension (high blood pressure). The medications included [MEDICATION NAME] 180 milligrams, [MEDICATION NAME] 10 milligrams, [MEDICATION NAME] milligrams and 20 milligrams of the diuretic [MEDICATION NAME]. The nurse obtained Resident #15's blood pressure measurements and heart rate prior to administering medications. The blood pressure results were 95/64 millimeters of mercury (mmHg) and the resident's heart rate was 74 beats per minute. LVN F stated the resident's blood pressure was below physician ordered parameters and the [MEDICATION NAME] and [MEDICATION NAME] would be held. LVN F then removed the [MEDICATION NAME] and the [MEDICATION NAME] from the medication cup and administered the remaining medications to include [MEDICATION NAME] and [MEDICATION NAME] to Resident #15. On 02/18/16 at 9:20 a.m. LVN F provided the facility's standing physician orders [REDACTED]. The orders were dated 12/21/15 and reflected the [MEDICATION NAME] should have been held if the systolic blood pressure was less than 100 mmHg and the [MEDICATION NAME] should have been held if the systolic blood pressure was less than 105 mmHg. FYI- Resident #15's blood pressure was 95/64 mmHg. An interview with LVN F on 02/19/16 at 1:45 p.m. revealed he did not understand the physician holding parameters. The Nurse Practitioner was present during the interview and explained the medications should have been held because Resident #15's blood pressure was below the ordered parameters. An interview with LVN F on 02/19/16 at 10:50 a.m. revealed the nurse was responsible for administering medications to twelve residents. An interview with RN B on 02/19/16 at 10:55 a.m. revealed the nurse was responsible for administering medications to eleven residents. The CMS form 672, Resident Census and Conditions of Residents signed by the Director of Nurses on 02/17/16 reflected 3 residents received IV therapy. Communication with the Administrator on 02/22/16 revealed there were two residents with PICC lines in the facility.
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, interview and record review, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for one (Resident #3) of three residents observed during the provision of incontinent care care by one (CNA G) of one CNA observed and one (RN H) one RN observed providing care to resident G. 1. RN H failed to wash his hands before donning gloves to perform eye care, positioning a resident and assistance of incontinent care of Resident # 3. 2. CNA G failed to change her gloves or perform hand hygiene during the provision of incontinent care for Resident # 3 who had been incontinent of bowel and bladder. 3. CNA G failed to adequately cleanse the urethral meatus and labia during the provision of incontinent care. Change gloves after cleaning feces, or touching other parts of the resident when helping to position her in bed. These failures could affect the 36 residents who were incontinent of bowel and bladder, hand washing and the wearing of gloves during the provision of everyday health hygiene, eye- care, oral hygiene and incontinent care put the residents at risk for the spread of infections from CNA G and RN E by placing them at risk for the spread of infections through cross contamination. Therefore with inadequate incontinent care could result in skin breakdown, odors, urinary tract infections, and a decrease in self-esteem for the 34 residents who were incontinent of bladder, and the 36 residents who were incontinent of bowel, including Residents # 3. Findings included: 1) Obsevation on 2/17/16 at 4:00 PM revealed RN H did not wash his hand upon entering Resident #3 ' s room and preparing for care. RN H donned a pair of gloves, took a wash cloth to the wash basin in the bathroom. RN G proceeded to wet the washcloth, returned to Resident #3 ' s bed and placed the warm cloth according to him on both of her eyelids to loosen the sticky yellow matter stuck to her eye lashes and lids. RN H then gently wiped some of the matter off of Resident #3 ' s eyelids. Upon completion of wiping Resident #3 ' s eyelids RN H removed his gloves, picked up the soiled linen off the floor and put it in the chair. The surveyor followed the RN out of the room, he went to the linen room, and returned to Resident #3 ' s room with a blanket. RN H never washed his hand while he was out of the room. Upon reentering Resident #3 ' s room he donned a pair of gloves, and began to assist CNA G. 2) Obeservation on 02/17/16 at 4:09 PM revealed CNA G provided incontinent care to Resident # 3 who had been incontinent of bowel and urine. CNA G placed supplies on the over-bed table which consisted of wipes and a bag of linen. Without washing her hands, CNA G put on a pair of gloves on each hand. She then left the room, retuned with gloves on, picked up the trash can and moved it closer to the bed. CNA G had a brief conversation with Resident # 3. She then undid the brief and folded the front section and pushed it down between Resident #3's thighs. With the same contaminated gloves, she then opened the container of the wipes and pulled out multiple wipes. CNA G wiped across the mons pubis, the left groin area and the right groin area then she used her contaminated gloved hand and wiped down the center of the labia. After cleaning the Resident # 3's groin and only doing one swipe down the center of the labia. CNA G did not separate the labia to visualize the urethral meatus in order to ensure cleanliness. CNA G then had the resident to turn over onto her right side. CNA G pulled more wipes out of the container and proceeded to clean the resident's buttocks and rectal area which was soiled with feces, hence contaminating the wipes. CNA G did not change the position of her wipes or her gloves after cleaning feces. While Resident #3 was on her right side being cleansed the surveyor observed a small stage 2 open

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) areas on her buttocks. CNA G was unaware of the resident having an open area as was RN H who was also in the room at the time and acknowledge there was an open area on the buttocks area of Resident # 3. Resident # 3 continued to have a bowel movement and CNA G placed a brief back on the resident without changing her gloves, to allow her to complete the toileting process. Without changing her gloves CNA G and RN H pulled Resident # 3 up in bed and positioned her on her right side. CNA G proceeded to gather the soiled linens and trash and took it out of the room without changing her gloves or washing her hands. On 2/17/16 at 4:36 PM during an interview with CNA G she revealed staff is to wash their hands before and after coming in contact with soiled items or resident. The surveyor queried as to why she did not following procedures regarding incontinent care and she stated I just got moving too fast. On 2/17/16 at 4:40 PM during an interview with RN H he revealed staff was supose to wash hand before patient care and every time gloves are changed, if you leave the room and have contact with the patient. I did not purposfully not wash my hand I did not wash them I guess i did not think of it right then. On 2/19/16 at approximately 4:10 PM interviewed the DON regarding her expectations regarding staffs performances with infection control, hand washing, infection control, doing Activities of Daily living and incontinent care. She revealed she expected her staff to perform hand washing each and every time they were engaged in resident care, came in contact with body fluids, or infectious organisms. She expected the residents who were dependent on the staff to be turned and repositioned at least every two hours. 3) Facility Policy hand Hygiene reflected the following: Purpose: to ensure all individuals use appropriate hand hygiene while at the Facility. Policy: The Facility considers hand hygiene the primary means to prevent the spread of infection. Procedure: I Facility Staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. II Facility Staff following the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors. III Hand hygiene products and supplies (soaps, sinks, towel, alcohol-based hand rub etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy. IV Facility Staff, visitors, and volunteers must perform hand hygiene procedures in the following circumstances. A.Wash hands with soap and water: before eating, after using restroom, when soiled with visible dirt or debris: after unprotected (ungloved and damaged gloves0 contact with blood, other body fluids, wound drainage and soiled dressing: . V. hand Hygiene is always the final step after removing and disposing of personal protective equipment. VI The use of gloves does not replace hand hygiene procedures . VIII Washing Hands . B. Vigorously lather with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds under a moderate stream of running water, at a comfortable temperature . The Lippincott Manual of Nursing Practice, 7th edition, 2001, page 958, under the Heading Fundamentals of Standard Precautions, reflected the following: 1. Handwashing is the single most important measure to reduce the risks of transmitting microorganisms. 2. Washing hands as promptly and thoroughly as possible between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; and after gloves are removed is vital for infection control. 3. It may be necessary to wash hands between tasks on the same patient to prevent cross-contamination of different body sites . 5) Review of the facility's policy on Personal Protective Equipment-Using Gloves dated October 2010, reflected the following: 1. When gloves are indicated, use disposable single-use gloves . 5. Wash hands after removing gloves. Note: Gloves do not replace handwashing. When to use gloves: 1. When touching excretions. Secretions, blood, bodily fluids, mucous membranes or non-intact skin The CMS Form 672, dated 2/ 17/16 Resident Census and Conditions of Residents, revealed there were 54 residents who were incontinent of bowel and bladder or incontinent care, and 76 resident who require assistance with activities of daily living.
F 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the facility failed to ensure one (CNA G) of one CNA demonstrated competency in skills and techniques necessary to care for residents' needs as identified through resident assessments, and described in the plan of care to assist one (Resident# 3) during the provision of incontinent care 1. CNA G failed to change her gloves or perform hand hygiene during the provision of incontinent care for Resident # 3 who had been incontinent of bowel, failed to change the surface of the wipes each time she cleaned the resident during incontinent care. 2. CNA G failed to adequately cleanse the urethral meatus and labia during the provision of incontinent care. Change gloves after cleaning feces, or touching other parts of the resident when helping to position her in bed. Failure to provide adequate incontinent care could result in skin breakdown, odors, urinary tract infections, and a decrease in self-esteem for the 34 residents who were incontinent of bladder, and the 36 residents who were incontinent of bowel, including Residents # 3 . Findings included: Resident #3 was re-admitted to the facility on [DATE]. The Minimum Data Assessment Set dated 01/19/16 reflected this was an [AGE] year old female with the following Diagnoses: [REDACTED]. The Resident was incontinent of both bowel and bladder, aphasic, required extensive to total dependence of care from one to tow staff members. 1) At 4:09 PM on 02/17/16, CNA G was observed to provide incontinent care to Resident # 3 who had been incontinent of bowel and urine. CNA G placed supplies on the over-bed table which consisted of wipes and .a bag of linen. Without washing her hands, CNA put on a pair of gloves on each hand. She then left the room, retuned with gloves on, picked up the trash can and moved it closer to the bed. CNA G had a brief conversation with Resident # 3. She then undid the brief and folded the front section and pushed it down between Resident #3's thighs. With the same contaminated gloves, she then opened the container of wipes and pulled out multiple wipes. CNA G wiped across the mons pubis, the left groin area and the right groin area, then, she used her contaminated gloved hand wiped down the center of the labia. After cleaning the Resident #3's groin and only doing one swipe down the center of the labia. CNA G did not separate the labia to visualize the urethral meatus in order to ensure cleanliness. She then had the resident turn over onto her right side. CNA G then pulled more wipes out of the container and proceeded to clean the resident's buttocks and rectal area which was soiled with feces, hence contaminating the wipes. CNA G did not change the position of her wipes or her gloves after cleaning feces. While Resident #3 was on her right side being cleansed the surveyor observed a small stage 2 open area on her buttocks. CNA G was unaware of the resident having an open area as was RN H who was also in the room at the time and acknowledge there was an open area on the buttocks area of Resident # 3. Resident # 3 continued to have a bowel movement and CNA G placed a brief back on the resident without changing her gloves, to allow her to complete the toileting process. Without changing her gloves CNA G and RN H pulled Resident #3 up in bed and positioned her on her right side. CNA G proceeded to gather the soiled linens and trash and took it out of the room without changing her gloves or washing her hands. On 2/17/16 at 4:36 PM during an interview with CNA G she revealed staff is to wash their hands before and after coming in contact with soiled items or resident. The surveyor queried as to why she did not following procedures regarding incontinent care and she stated I just got moving too fast. On 02/19/16 at 4:00 PM during an interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676215	A. BUILDING _____ B. WING _____	**02/19/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION & WELLNESS CENTRE OF DALLAS LLC	**4200 LIVE OAK ST DALLAS, TX 75204**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) DON she was asked what she expected of her staff with regards to care issues. The DON replied she expected her staff to follow the policies of the facility and practice good nuring care. She expected them to bath, dress groom, provide incontinent care, turn and reposition the residents according to their plan of care, to use props and positioning devices as needed. She also revealed the nurse aides did nail care except on diabetics, and they did oral care. 2) Facility Policy Incontinent Care reflected the following: Purpose: to enable resident to retain their dignity by keeping residents who are incontinent or urine, feces, or both clean, dry and comfortable . I Briefs and disposable pads are used for residents who are incontinent of urine, feces, or both. A. Each resident is measured and properly sized for briefs . II Hands are washed before and after incontinent care. III Gloves are always worn when in contact with body fluids and secretions . 6) Perry and Potter's Clinical Nursing Skills and Techniques, Fifth Edition, 2004, Chapter 6, Personal Hygiene and Bed Making, pages 128-130 reflected: Female perineal care: help client flex knees and spread legs . Wash labia majora. Use nondominant hand to gently retract labia from thigh; with dominant hand wash carefully in skinfolds. Wipe in direction from perineum to rectum (front to back). Repeat on opposite side using separate section of washcloth. Rinse and dry area thoroughly . Separate labia with nondominant hand to expose urethral meatus and vaginal orifice. With dominant hand, wash downward from pubic area toward rectum in one smooth stroke. Use separate section of cloth for each stroke. Cleanse thoroughly around labia minora, clitoris, and vaginal orifice. 7) The CMS Form 672, Resident Census and Conditions of Residents, dated 06/17/16 revealed there were 36 residents who were occasionally or frequently incontinent of bowel and 34 residents who were frequently incontinent of bladder.