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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	R-C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Surveyor: 32332 An onsite COVID-19 Focused Infection Control revisit survey and an extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted by the South Dakota Department of Health Licensure and Certification Office on 2/17/21 through 2/19/21 and on 2/22/21 through 2/23/21. Areas surveyed included pressure injuries, pain, unexpected deaths, and quality of care/treatment. Firesteel Heathcare Center was found not in compliance with the following requirements: F678, F684, F686, F697, F835, and F837. On 2/19/21 at 6:00 p.m. an Immediate Jeopardy was identified for: *Pressure injuries at F686 when the facility failed to have ongoing monitoring, assessments, and documentation of pressure injuries for twenty-two of seventy-four residents. The facility identified residents with pressure injuries. They put a plan in place to monitor and assess the identified injuries. They failed to follow their plan of weekly wound assessments, weekly wound audits, and to notify providers. *CPR at F678 when the facility failed to start cardiopulmonary resuscitation (CPR) for one of one resident who was a full code status that required emergency response procedures. Documentation revealed CPR started fourteen minutes after the Code Blue was initiated. *Quality of Care at F684 when the facility failed to follow physician's orders regarding one of one	{F 000}		

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

Petar Mirkovic | Executive Director | 03/21/2021

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

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{F 000}	Continued From page 1 resident who was receiving an anti-coagulant medication including monitoring of therapeutic levels and dosing. *Pain at F697 when the provider failed to maintain ongoing communication regarding pain management between the facility, the hospice provider, and the physician. A removal plan was accepted on 2/24/21 at 10:30 a.m. The resident census was 76.	{F 000}	**Directed Plan of Correction** **Firesteel Healthcare Center, Mitchell** **F678** **Corrective Action:** 1. *Time cannot turn back the clock to the date resident 5 was found by RN L without a pulse or not breathing. Director of Nurses (DON) and administrator were provided re-education on 3/18/2021 by Divisional Director of Clinical Operations. The provider in consultation with the Divisional Director of Clinical Operations and the medical director will review and revise as necessary the plan prepared for removal of immediate jeopardy. Reviewed the facility Code Blue policy on 3/18/2021. Staff have capability of announcing a code or call for assistance without the need to leave the resident bedside per a walkie.	03/19/21
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Surveyor: 42477 Based on interviews, closed record review, policy review, and the unexpected death report submitted to the South Dakota Department of Health (SD DOH), revealed the provider failed to ensure one of one closed sampled resident record (5) who was a full code, with no pulse or respirations received emergency services for cardiopulmonary resuscitation (CPR). Surveyor: 32332: All residents who are full code status have the	F 678		

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F 678	Continued From page 2 potential to be affected by this deficient practice. NOTICE: Verbal notice of immediate jeopardy and the template was given on 2/19/21 at 6:00 p.m. An immediate jeopardy was identified when the facility failed to start CPR immediately for one of one resident who was a full code status. Notice of Immediate Jeopardy was given verbally to the director of nursing services (DNS) E, divisional director of clinical operations (DDCO) A, and registered nurse (RN) F. For specific immediate jeopardy noncompliance, see above finding in the base statement. At the above time DDCO A and DNS E were asked for an immediate plan of removal to ensure all staff working in the facility received education and competencies for CPR. PLAN: "1. Educate all licensed nursing on recognizing change of condition using einteract Change of Condition handouts. Education to all CNA's [certified nursing assistant] and NA's [nursing assistant] on recognizing and reporting change in condition. Education to also include that if the situation is emergent to call 911 and send to ER, not to delay waiting for a provider response. Education to all licensed and unlicensed nursing staff to include how to deflate an air mattress in the need for CPR, where the on call calendar is located and to call the primary on call for urgent needs and if no response, call eLTC. Education includes the process for CPR, how to record a CPR event when it is occurring. All licensed nurses and CNA's and unlicensed NA's will be educated to be able to record a full code. Education to all CNA's and nurses that they are to	F 678	Currently we have 30 staff certified in CPR. We offer CPR class monthly. Education and training with documented competency to include resident assessment process was completed for all nursing staff (licensed and unlicensed) of active participation in a code response and understanding of their assigned role by DNS, SDC, RCM or Designee by 3/19/2021. All staff not in attendance will be educated prior to their next working shift. To further educate staff Code Blue will be reviewed with Avera eLTC on 3/ 22/2021 to review emergent situations and change in condition. **Identification of Others:** 1. *ALL residents have the potential to be affected. 2. *ALL licensed and unlicensed staff completing their assigned tasks have potential to be affected. 3. Policy education/re-education about appropriate response to code will be provided by 3/19/2021 by DNS, SDC, RCM or designee. 4. All staff not in attendance will be educated prior to their next working shift.	

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F 678	Continued From page 3 have a walkie with them to call for help. All nurses deemed competent though BLS [Basic Life Support] training and certification. A full audit of current certification was conducted. There has since been an order placed to have adequate walkies for all managers and a reserve should some be missing or malfunctioning. ED, DNS or designee will be responsible for updating the on-call calendar and ensuring each station has one daily. Divisional Director of Clinical Operations will educate nursing management who will in turn educate all licensed and unlicensed staff prior to their next working shifts starting immediately. All education emailed to all staff not educated on 2/22/21. Education started on 2/20/21 and completed 2/22/21. 2. An audit will be done by ED, DNS or designee of licensed nursing staff on knowledge of recognizing a change of condition and actions to take if there is an acute change in condition. Audit licensed and nursing staff on the process of CPR, licensed and unlicensed nursing staff on the recording of CPR events, if staff have a walkie with them to call for assistance, where the on call calendar is located at each nursing unit, and how to deflate an air mattress in emergent situations. 3. Compliance date 2/22/2021" An onsite revisit was completed on 2/24/21 at 12:35 p.m. to verify the immediate jeopardy removal plan. Immediate Jeopardy was determined removed on 2/22/21 at 2:56 p.m. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "G." Surveyor: 42477: Findings include: 1. Review of the provider's unexpected death	F 678	**System Changes:** 1. Root cause analysis answered the 5 Whys. Problem: Nursing personnel failed to follow correct CPR procedure. 5 Whys: 1. Nursing personnel were unaware of what steps to follow during a code blue/CPR situation 2. Nursing staff were not trained appropriately on the procedure 3. Nursing management team failed to train staff on the procedure 4. Nursing management team was not held accountable to ensure CPR training was provided to staff. 5. There was not an active leadership plan on ensuring that there was a clear understanding of their roles and responsibilities. Root Cause Analysis: The DNS was out on a medical leave of absence and the facility did not properly train those appointed to fill the position in her absence to ensure above training is provided.	

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F 678	Continued From page 4 report submitted to the SD DOH involving resident 5 revealed: *At 4:10 a.m. on 2/1/21 RN L went into resident 5's room and he was verbally non-responsive. *He was on oxygen (O2) at 4 liters (L) and his oxygen saturation (sat) level was 90%. -RN L stated that was normal for him. *He had a low-grade temperature of 99.8 F (Farenheit). *Abdominal and chest retractions. *Registered nurse (RN) L called the [hospital name] telehealth line to try to get an order to transfer him to the hospital. *Certified nurse practitioner (CNP) O from the telehealth line stated it was "risky" to send him to the ED (emergency department). *CNP O ordered lab work and wanted RN L to contact an outside company to get a chest x-ray for him. *Lab work was ordered and drawn from resident 5, then taken to the hospital. *At 5:00 a.m. RN L returned to resident 5's room and he was grey, had no pulse, and his chest was not rising which would indicate breathing. *CPR was started at 5:11 a.m. *Emergency services were called at 5:14 a.m. *Emergency services arrived at the facility at 5:18 a.m. *At 5:41 a.m. medical technicians pronounced resident 5 deceased. Review of resident 5's electronic medical record (EMR) revealed: *He was admitted to the facility on 1/13/21. *He had multiple co-morbidities which included: -Chronic venous hypertension with ulcer. -Chronic kidney disease, stage 3. -Type 2 diabetes. -Morbid (severe) obesity.	F 678	Administrator and or DON will ensure ALL facility staff responsible for or who may respond to a resident without pulse or not breathing are educated and aware of the policy and procedures about Code Blue and their role and assigned tasks. DDCO, ED and DNS contacted the South Dakota Quality Improvement Organization (QIN) on 3/19/2021 and the QIN the discussion surrounded the 2567, use of eInteract tools, review of root cause analysis and other resources available.	

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F 678	Continued From page 5 *He was a full total lift of four people. Review of RN L's 2/1/21 documentation on his EMR revealed, "0500[5:00 a.m.] returned to residents room to assess resident and color is grey, no pulse no chest rise. Sputum all around lips. Code blue initiated. CPR started at 0514 [5:14 a.m.]. AED [automated external defibrillator] applied and analyzed x3. No shock advised x3. CPR continued, 911 called at 0511 [5:11 a.m.]. CPR continued. [Name of city] ambulance services arrived at 0518 [5:18 a.m.]. They applied their AED and analyzed the rhythm and continued CPR. Pronounced TOD [time of death] by EMT's [emergency medical technician] at 0541 [5:41 a.m.]." Review of resident 5's daily task record on 2/1/21 revealed: *Resident 5 was monitored for the following at 2:38 a.m.: -Bowel and bladder. -Dressing, bed mobility, locomotion on and off the unit. -Personal hygiene and toilet use. -Transferring, walkin in corridor, walk in room. -He was turned and repositioned at 2:36 a.m., and 3:17 a.m. *Resident 5 also had the following tasks marked at 9:49 a.m, after he was deceased: -Bed mobility and dressing. -Locomotion on and off the unit. -Personal hygiene and toilet use. -Turning and repositioning. *As far as nutrition, swallowing, and meal monitoring: -That was also marked at 9:49 a.m. for the 8:00 a.m. and 12:00 p.m. time.	F 678	**Monitoring:** 1. Administrator and or DON or designee will conduct at minimum two times per week on alternating shifts, for 4 weeks, a review of staff response in code scenarios. 2. After 4 weeks of successful monitoring, then will monitor 1 X per month for 3 months. 3. Monitoring results will be reported by administrator and or DON to the QAPI committee and continued as determined by the committee and medical director.	

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Review of resident 5's prescribed physician medical orders revealed he was to receive 2 L of oxygen at sleep and PRN (as needed) during the day as needed.

Interview on 2/18/21 at 1:35 p.m. with RN F regarding contacting physicians on call revealed:
*Each wing had an on call calendar located at each desk.
*The on call calendar was a month view and had:
-About nine names listed each day.
-There were no times listed.
-There were no specialities listed.
*The surveyor asked RN F how new staff knew who to call.
*RN F said she believed they went over it in orientation.
*It was up to each nurse to decide whether to call the physician on call or electronic long term care (eLTC) telehealth.
*She said the on call calendar was for the hospital doctors.
*In order to reach the clinic on call doctors the nurse would need to call the clinic.
*The surveyor pointed out that the clinic doctors were also listed on the on call calendar.
*She stated "well, that makes it easier", she did not realize that the clinic doctors were also listed on the calendar.

Interview on 2/18/21 at 11:00 a.m. with medical director G revealed he thought that it was up to the physician whether they wanted to be called or if the facility should call eLTC telehealth.

Interview on 2/18/21 at 5:10 p.m. with DNS E regarding the on call schedule for physicians.
*When surveyors asked how new nurses would

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F 678	Continued From page 7 know how to read the on call calendar, she replied "that is a good question." *DNS E said she would not know who to call either. *She said she would look in the computer and see who the physician was if she needed to find out. Interview on 2/19/21 at 8:50 a.m. with medical doctor (MD) J revealed he: *Was resident 5's physician. *Never saw resident 5 in person since it was his belief that physicians were not allowed in the building. *Believed it was facility policy that eLTC telehealth was called instead of physicians on call. *Did not recall being asked what his preference was regarding being called after hours. *He was on call on 2/1/21 but wasn't sure what time his call started that day. *Had not been told that CPR for resident 5 started 11 to 14 minutes after a code blue was called. Record review revealed the facility called MD J at 9:00 a.m. on 2/1/21 to inform his office of resident 5's death. Surveyor: 29354 Interview on 2/19/21 at 3:14 p.m. with RN/MDS coordinator D regarding CPR revealed: *When a code blue was called all the nurses that were working were expected to respond. -There were more nurses working on the day shifts so there were more nurses that could respond. -There were three nurses on the evening/overnight shift. *The process for CPR was: -The nurse made a call overhead.	F 678		

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F 678	Continued From page 8 -The nurse would get a crash cart and go to the location of the code. *There were four AEDs in the building. *There were three code carts in the clean linen or clean utility rooms. *They did not need to have an order to send a resident to the emergency department at the hospital. * For emergencies they went through eLTC because they were always available. Interview on 2/19/21 at 4:01 p.m. with RN/wound nurse C regarding on call physicians revealed: *She knew there was a list of who was on call at each nurses station. *The nurses could call the acute care hospital for emergencies. *They used eLTC which she considered a nice resource. *She confirmed the night shift started at 6:00 p.m. for the nurses. Interview on 2/19/21 at 4:45 p.m. with RN L regarding the CPR incident with resident 5 revealed: *She worked the 6:00 p.m. to 6:30 a.m. shift. *Resident 5 had needed to go to the ED. *She: -Had called eLTC. -Felt that would have been the easiest way to transfer him. -Did not know she did not need an order to send him to the ED. *The hospital ED was across the road. *She had drawn his blood. -She had another nurse take the blood sample to the hospital. *When she found resident 5 in his room: -He was gray.	F 678		

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F 678	Continued From page 9 -She had gone in at 4:00 a.m. to reposition him. -He was not responding verbally. -She decided to call eLTC knowing he required further medical care. -She could not remember what time it was. *He was fine when she went in to draw his blood. -He had looked the same as earlier. *She was concerned because he was not himself. *He was gray and had a difficult time breathing. *She could not find the aide. *She called code blue. *She had pushed his call light. -There was one aide on her unit. -That aide working on her unit was pretty quick to get to his room. *She went to the 200 unit wing nurses station to call the code blue overhead. *The aide had a walkie talkie but she did not have one. *The nurses came from the other two units. *She got the crash cart. *The nurses were there. -They started CPR and hooked him up to the AED. --The AED had monitored to continue with CPR. *The aide let the ambulance people in to the facility. -The ambulance crew hooked him up to their AED. *The nursing home staff had left the air mattress on the current setting and had not deflated it during CPR. *She was not sure what time CPR was started. *The two nurses were very fast at getting to his room and starting CPR. *She didn't believe that it took them fourteen minutes to start CPR. *She thought CNA P was recording times during the code blue.	F 678		

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F 678	Continued From page 10 *CNA P had: -Never been involved in a code before so she didn't know how to record times. -A clip board in her hand, but didn't know what she had recorded. *They didn't know what happened to the sheet of paper CNA P was documenting on. *She stated she did re-read her documentation and it was accurate as far as she could tell. -The documentation could have been off a few hours. *For the notification of the on call physician she would go by eLTC. *There was a folder with names of physicians on call kept at the nurses station. *There was not a folder with names of physicians on call at the 200 wing nurses station. *The on call calendars were done ahead of time. *RN B and LPN K were the nurses who had started CPR on him. Surveyor 42477: Interview on 2/19/21 at 4:00 p.m. with RN C regarding the physician on call schedule revealed it is not "clear cut" when to call eLTC versus calling the physician on call. Further interview on 2/19/21 at 4:45 p.m. with RN L regarding the CPR event for resident 5 revealed she: *Found out "after the fact" that she did not need an order to transport a resident to the ED. *Had remembered why she called eLTC instead of the physician on call it was because the calendar had not been updated. *Had remembered being "so mad" because she tried to find the on call calendar but was unable to so she contacted eLTC. *Did not fill out any documentation after the code	F 678		

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other than what was documented in the electronic medical record.
*Did not know how effective compressions were due to the resident's size and since he was on an air mattress."

Interview on 2/19/21 at 6:00 p.m. with DNS E, RN F, and DDCO A revealed:
*DDCO A did not believe that the medical record stated that CPR was started fourteen minutes after code blue was called:
*DNS E felt like there was nothing that they could have done differently.

Interview with LPN K regarding the CPR event for resident 5 revealed she:
*Worked the night of 1/31/21-2/1/21.
*Had worked on the 300 & 400 wing, which was the memory care unit.
*RN L was going to get an order to transfer resident 5 to the ED.
*Stated each unit had 1 nurse and 1 aide during the night shift.
*Stated resident 5 needed 4 to 6 people to reposition every 1 to 2 hours.
*Had walked down to the 100 unit to check on RN L, because she did not feel they had enough staff.
*Thought maybe an hour later she heard RN L calling a code blue over the intercom.
*Stated when she arrived to resident 5's room RN B was doing CPR on the resident.

Interview on 2/22/21 at 3:30 p.m. with CNA P revealed she:
*Was working on the 100 hallway the night of 1/31-2/1/21.
*Was doing her rounds around 3 a.m. and noticed that resident 5 was very lethargic, not

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FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE MITCHELL, SD 57301

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F 678	Continued From page 12	F 678		

responding.
*Stated resident 5's vital signs were declining rapidly.
*Informed RN L of resident 5's condition.
*Stated she had heard the code blue when she was coming back from taking resident 5's labs to the hospital.
*Stated she had a walkie talkie that night.
*Stated the facility does not have enough walkie talkies for everyone.
*Stated she was not writing anything down during the code.

Interview on 2/22/21 at 12:30 p.m. with DDCO A revealed she:
*Stated that she completed a "100% audit" as part of their facility investigation.
*Audited the three code carts to ensure nothing was missing.
*Interviewed staff.
*Educated staff about sending to the ED.
*Did not have documentation of this audit.

Surveyor 29354:
Review of provided undated nursing education revealed:
*There were 6 topics on the education.
*One of those topics was regarding CPR/ change of condition, it stated:
"Change in condition-notify MD, family, send to ER-do not need a physician order to send if resident"
-It proceeds with handwriting stating, "needs evaluation/change in condition."
*Four licensed nurses signed the education.
*The facility currently has 19 licensed nurses working in the facility.

Review of the provider's November 2019 Code

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F 678	Continued From page 13 Blue policy revealed: *"The 1st responder calls for help by announcing a Code Blue." *"The Code Blue is announced with the exact location on the overhead page system. 9-1-1 is called immediately. *The resident's code status is established immediately by the nearest Licensed Nurse (LN) using the POLST/POST/Advance Directives." *"A code team leader is clearly established and necessary duties assigned." *"The Emergency cart is promptly brought to the scene." *"Oxygen management is promptly brought to the scene." "Physician and family are notified," "CPR is continued if indicated until EMT arrival and take over." *"Completion of the post event evaluation and code event minutes is done by the LN and support team during the Code Blue event." Surveyor 29354 Review of the provider's [Name] eCare Senior Care Services Agreement signed on 1/31/19 revealed: *Article III [name] Senior Care Telemedicine Services: -"Urgent Care Services 24/7/365. [Name] agrees to be available to provide the following urgent care Telemedicine Services: --a. twenty-four hour access to a team comprised of APPs, RNs, and physicians led by a board-certified geriatrician to allow for rapid access to care to help prevent re-hospitalization of Residents and promote reduction in length of stay at hospitals. --b. phone-call based assessments of the Residents with the Facility to determine the need	F 678		

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F 678	Continued From page 14 for a video encounter." -"Facility and Customer each agree to take all actions which may be necessary to ensure [Name] is able to effectively provide urgent care Telemedicine Services, such actions will include without limitation: --u. contacting [Name] at the earliest sign of change in condition in order to expedite clinical intervention in an effort to see the greatest impact on a reduction of unplanned transfers, emergency department visits, re-hospitalization, and length of stay. --y. ensure orders from [Name] are implemented once received." Review of the provider's undated document entitled When to Call [Name] eCare Senior Care? revealed: *Any clinical questions. *Support during medical emergencies. *Assessment of resident over video. *Address urgent lab results. *Change in condition concerns. *Pharmacy consults. *Any concerns about a resident. *Pain management. *Skin Concerns."	F 678		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684	See next page.	

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F 684	Continued From page 15 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Surveyor: 42477 Based on observation, interview, record review, closed record review, policy review, and South Dakota Department of Health (SD DOH) online report, the provider failed to ensure residents received treatment and care in accordance with professional standards of practice for: A. Ensuring monitoring and dosing for one of one newly admitted sampled (6) resident receiving monitoring of anti-coagulant therapy for signs and symptoms of bleeding. B. Resident call lights were answered in a timely manner for two of two sampled residents (7 and 8). C. Resident's received a bath every seven days for seven of seven sampled residents (11, 12, 13, 14, 15, 16, and 22). D. Facility having enough walkie talkies for staff to be able to meet each resident needs (non-IJ finding). E. Ensuring one of one sampled resident (20) with multiple recurring self-inflicted wounds received nail care to prevent skin breakdown (non-IJ finding). Surveyor 29354 Failure to monitor lab values and follow physician dosing orders have a potential to affect all residents who receive anti-coagulant medications. NOTICE:	F 684	**Directed Plan of Correction** **Firesteel Healthcare Center, Mitchell** **F684 (IJ)** **Corrective Action:** 1. Time cannot turn back the clock to the dates and event surrounding resident 6 and anticoagulant therapy.Director of Nurses (DON) and administrator were provided re-education on 3/18/2021 by DDCO. The provider in consultation with the Divisional Director of Clinical Operations, medical director, and pharmacy consultant will review and revise as necessary the plan prepared for removal of immediate jeopardy by 3/19/2021. Reviewed the facility Anticoagulant Therapy policy. Provided education and training with documented understanding for those staff responsible for monitoring anticoagulant therapy by 3/19/2021. All staff not in attendance will be educated prior to their next working shift. Provided education and training with documented understanding to all staff. (licensed and unlicensed including housekeeping, dietary, and maintenance) to report signs and symptoms of bleeding. All staff who are responsible for monitoring or overseeing those who may encounter the resident on anticoagulant therapy will be educated by DNS, SDC, RCM or designee by 3/19/2021.	03/19/21

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F 684	Continued From page 16 Verbal notice of immediate jeopardy and the IJ template was given on 2/19/21 at 6:00 p.m. An Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare & Medicaid Services (CMS) monitoring of lab values and physician dosing for a newly admitted resident that had received anti-coagulant therapy. Notice of Immediate Jeopardy was given verbally to the Divisional Director of Clinical Operations A, director of nursing services E, and registered nurse/staff development coordinator F. At the above time the Divisional Director of Clinical Operations A was asked for an immediate plan of removal to ensure a plan to follow physician's orders regarding one of one resident who was receiving an anti-coagulant medication had included monitoring of therapeutic levels and dosing. PLAN: The administrator submitted an email that included the final written removal plan. That removal plan was approved by the South Dakota Department of Health on 2/24/21 at 10:30 a.m. the following plan was approved: "1. Educate all licensed nursing staff on the anticoagulation therapy policy. Education provided to the nursing management team by the Divisional Director of Clinical Operations. Education in turn will be delivered to the licensed nursing staff by nursing management prior to their next working shift. Education provided to therapy, CNA's and NA's staff to report signs or symptoms of bleeding to LN's. Education to begin immediately. Education provided by nursing management team. Education started on 2/20/2021. Education will be completed by	F 684	**Identification of Others:** 1. All residents on anticoagulant therapy have the potential to be affected.All licensed and unlicensed staff completing their assigned tasks have potential to be affected. Policy education/re-education about monitoring oversight and response to active bleeding will be provided by DNS, SDC, RCM or designee by 3/19/2021. All staff not in attendance will be educated prior to their next working shift. **System Changes:** Root cause analysis answered the 5 Whys. Problem: Resident receiving anticoagulant therapy was not monitored for signs and symptoms of bleeding. 5 whys: 1. Facility staff were not educated to report any signs and symptoms of bleeding to the charge nurse 2. nursing leadership failed to educate staff on reporting signs and symptoms of bleeding to the charge nurse 3. nursing management team was not held accountable to ensure the training above was provided to staff. Root cause analysis: DNS was out on medical leave and the facility did not properly train those appointed to fill the position in her absence to ensure above training is provided.	

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F 684	Continued From page 17 2/22/2021. Nurse management team will ensure that physician's orders are implemented when a resident is admitted. Communication with physician will occur on day of admission in regards to Coumadin and PT/INR orders in regards to what current orders should be in place and who will be doing the doing of coumadin and PT/INR. Physicians with patients on Coumadin will be educated on the new process immediately by 2/24/2021 via fax/phone communication. 2. An audit will be conducted by ED, DNS or designee on all residents receiving Coumadin to ensure accurate dosing and scheduling of PT/INRs by 2/21/2021. 3. Compliance date 2/24/21." An onsite revisit was conducted on 2/24/21 at 12:35 p.m. Immediate Jeopardy was removed on 2/24/21 at 10:45 a.m. after the removal plan implementation was verified during an onsite visit by the surveyor. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "G". Surveyor 42477 Findings include: 1. Observation and interview on 2/17/21 at 3:00 p.m. with RN F revealed: *This surveyor asked why there was not any precautions signs on the door of a quarantined residents door. *RN F said that was resident 6's room. -She had passed away that morning. *RN F said it was a very: -Unexpected death. -Traumatic death for the new nurse on duty. --The new nurse had to go home because she was so upset.	F 684	Administrator and or DON will ensure ALL facility staff responsible for monitoring or overseeing those staff who may encounter the resident on anticoagulant therapy will be educated and aware of the policy and procedure about Anticoagulant Therapy and their responsibility for monitoring or their role in an emergency because of the therapy. DDCO, ED and DNS contacted the South Dakota Quality Improvement Organization (QIN) on 3/19/2021 and the discussion surrounded the details of the 2567 and root cause analysis. **Monitoring:** 1. Administrator and or DON will conduct at minimum 2 X per week on alternating shifts, for 4 weeks, a review of staff response in scenarios of appropriate monitoring or response in an emergency related to the anticoagulant therapy. 2. After 4 weeks of successful monitoring, then will monitor 1 X per month for 3 months. Monitoring results will be reported by administrator and or DON to the QAPI committee and continued as determined by the committee and medical director.	

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F 684	Continued From page 18 Review of the SD DOH online report submitted by the provider on 2/17/21 at 5:29 p.m. revealed: *The director of nursing services (DNS) E submitted the online report, which stated: *"0430 [4:30 a.m.] The nurse was walking down the hall when she was summoned to the resident's room by two CNA's. The nurse entered the residents room to find the resident in bed with many bloody tissues on the bed. Resident was laying on her right side with blood coming out of her nose and mouth. Resident had dried blood on her right hand. Resident was pale in color, respirations absent and no palpable pulse present..." *"...Oral suctioning done during this time with bright red blood returning..." *"...No change in condition and Code Blue was stopped 0500 [5:00 a.m.] per EMS [emergency medical staff]." Review of resident 6's admission documentation revealed she: *Had been admitted on 2/10/21. *Received outpatient hemodialysis therapy. *Had been on anti-coagulation therapy. Review of resident 6's electronic medical record (EMR) revealed: *On 2/11/21 the facility had certified nurse practioner (CNP) I sign an order to "Please have eLTC adjust/monitor and order PT/INR [prothrombin time and international normalized ratio] for coumadin." *The order was noted by a licensed nurse (LN) on 2/11/21. *On 2/13/21 at 2:38 p.m. a progress note stated: -"During assessment residents BP [blood pressure] was low. 79/45 with automatic BP	F 684	**Directed Plan of Correction** **Firesteel Healthcare Center, Mitchell** **F684** **Corrective Action:** 1. Time cannot turn back the clock to the dates and event surrounding: -Timely response to call lights for residents 7 and 8. =Sufficient staff to meet the needs of individual care plan. -"Walkie talkie" or mechanism for adequate communication between all care staff. -Timely bathing that meets resident preferences for residents 11, 12, 13, 14, 15, 16, and 22. -Timely nail care for any resident so lack there of is not a contributing factor to skin injury. Resident 20. Director of Nurses (DON) and administrator were provided re-education on 3/18/2021 by the DDCO. The provider in consultation with the Divisional Director of Clinical Operations, medical director, and governing board reviewed and will continue to follow standards of practice per the SOM for (cont)	03/19/21

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F 684	Continued From page 19 machine; I took it manually and got a reading of 62/34; resident does not appear to be in any distress; I reached out to family and asked if resident would like to be evaluated by ER [emergency room] or continue to be monitored here and both family [family member's name] and resident stated to continue monitoring here; I also reached out to eLTC for anything further we can do and the CNP on shift stated to give her the 0800 [8:00 a.m.] dose of 10 mg midodrine now and continue to evaluate BP; if it drops call back." *On 2/13/21 at 11:32 p.m. a progress note stated: -"Resident laying in bed on her right side, CNA enters to assist with a bloody nose. Resident became limp, eyes rolled back in her head, then developed a full body shaking. Resident is not responding verbally at this time. Episode lasted <2 minutes. Resident recovers and is verbally responsive, following commands. She denies any aura prior to event. She has a gash to the right side of her tongue and is bleeding. BP 133/88, P [pulse] 47, R [respirations] 18, blood glucose is 118. Denies any pain. [Family member's name] informed of the event. States she has had these in the past, and quickly recovers. She and resident decline going to the hospital. [Doctor's name] phoned and updated. Orders to monitor her status and if a repeated event send to [hospital's name] ED [emergency department]." Review of resident 6's pharmacy documentation revealed: *LPN T sent a fax to the eLTC pharmacy on 2/15/21. *On 2/15/21 the pharmacy returned communication stating to draw the resident's PT/INR on 2/17/21. *Resident 6 passed away the morning of 2/17/21 and they were not able to draw the PT/INR.	F 684	for adequate staffing and response for identified areas of call light response, sufficient equipment for adequate communication link between staff, timely bathing per resident preference, and timely nail care so lack of it does not contribute to skin injury by 3/18/2021. The facility has adequate staffing for the resident assessment process and care plan to meet the needs of the individual resident(s). All staff licensed and unlicensed who are responsible for oversight of care or direct care will be educated about their roles and responsibilities by DNS, SDC, RCM or designee by 3/19/2021. All those not in attendance will be educated prior to their next working shift. **Identification of Others:** 1. ALL residents have the potential to be affected. *ALL licensed and unlicensed staff completing their assigned tasks have potential to be affected.	

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F 684	Continued From page 20 Interview on 2/18/21 at 2:00 p.m. with CNP I regarding resident 6 revealed: *She was not familiar with resident 6. *The order to have eLTC pharmacy monitor Coumadin was the standard for residents being admitted. *Her expectation would have been for staff to contact eLTC the day the order was written on 2/11/21. *She was not sure why staff had not called eLTC pharmacy until 2/15/21. Interview on 2/19/21 at 8:50 a.m. with MD J revealed he: *Believed having eLTC pharmacy to dose Coumadin and monitoring PT/INRs was a standing order for the facility. *Was called about resident 6's seizure activity on 2/13/21. *Did not feel like it was a seizure due to what staff described. *Stated resident 6 was coherent during the entire event so it did not seem like a typical event. *Was not aware of any issues of bloody noses or other bleeding. Interview on 2/25/21 at 2:15 p.m. with RN F regarding resident 6 revealed: *She stated that she would never forget the smell in her room the day she passed. *The surveyor asked what was the smell and she had replied "the blood." *All of the bleeding from her had caused a strong odor in the room that staff would never forget. Review of provider's July 2014 Anticoagulation Therapy policy revealed: *"Residents who are on anticoagulation therapy	F 684	Policy education/re-education about roles and responsibilities will be provided by DNS, SDC, RCM or designee by 3/19/2021. All staff not in attendance will be educated prior to their next working shift. **System Changes:** Root cause analysis answered the 5 Whys. Problem: Call lights not answered timely due to facility not having enough walkies for staff to address residents needs 5 whys: 1. Facility failed to ensure and audit appropriate equipment for nursing staff to fulfill duties 2. Previous leadership team failed to ensure staff had walkies to hear call light alarms Root cause analysis answered the 5 Whys. Problem: Bath audits not being completed timely on scheduled baths, resulting in residents not having a bath within 7 days 5 whys: 1. Bathing supervisor was not educated prior to receiving supervisory role of policy and procedure in relation to baths 2. Leadership failed to ensure employee was educated on policy/procedure for bathing	

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F 684	Continued From page 21 are monitored to deliver proper care and treatments. This includes monitoring lab levels to validate they are within therapeutic range, as well as monitoring resident for any signs or symptoms of complications from the medication(s) utilized." Surveyor: 29354 2. Interview and observation on 2/18/21 at the following times with resident 7 regarding her admission on 2/3/21 revealed at: *4:00 p.m.: -She had been admitted to the facility due to having hip surgery. -She was going to be at the facility for a short time to get physical therapy so she could return to her own home. -The facility had explained to her about being on quarantine status. -She did not like it but was dealing with it. -Her call light was not always answered and had not worked. -She had told staff multiple times her call light had not worked. -The last time her call light had not worked was over the "past weekend being Valentine's weekend." -She had reported to the staff her call light had not worked on the Friday before Valentine's weekend. --Staff had told her she would have to wait until the following Monday to let maintenance know. -A certified nursing assistant (CNA) had given her a different call light cord on Saturday night. -They had plugged her call light cord into her roommates call light unit located on the wall. --During the interview her call light was plugged into her roommates wall call light system.	F 684	Continued 3. DNS was out on medical leave of absence and the facility did not properly train those appointed to fill the position in her absence to ensure above training was provided. The DDCO, ED, DNS contacted the South Dakota Quality Improvement Organization (QIN) on 3/19/2021 and the discussion surrounded the details of the 2567 and review of root cause analysis/5 whys and other resources available. **Monitoring:** 1. Administrator and or DON or designee will conduct at minimum 3 X per week on alternating shifts, for 4 weeks, a review of staff response in scenarios of appropriate monitoring or response call lights, sufficient availability of communication devices, resident bathing per their preference, and nail care for any resident needing it. 2. After 4 weeks of successful monitoring, then will monitor 1 X per month for 3 months. Monitoring results will be re ported by administrator and or DON to the QAPI committee and continued as determined by the committee and medical director.	

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*4:05 p.m.:
-She put on her call light.
-The light on the call light unit was blinking from her roommates wall unit.
*4:08 p.m.:
-Nurse aide Q brought in a container of water for her.
-Interview at that time with nurse aide Q revealed:
--She had not noticed the call light was on.
--She had not asked resident 7 if she had needed anything.
--She was going to come into the room anyway with the water.
--It was her fourth day "working solo."
*4:15 p.m. continued interview with resident 7 revealed:
-She had chronic pain which usually was scored at a four out of ten.
--A score of four was tolerable and a ten was untolerable.
-She had to wait long periods of time for the staff to get her pain medication.
-She had not gotten pain medication on February 4, 5, and 8.
-On February 8th she put her call light on at 6:30 a.m.
-She had not gotten her pain medication by 9:00 a.m. so she put her call light on again.
-No one had stopped by to confirm they had seen her call light on or were getting her pain medication.
-Her pain level was between a six or a seven out of ten.
-She had a fentanyl patch and could have PRN (when necessary) hydrocodone.
*4:20 p.m.: She had put on her call light.
*4:37 p.m.:
-No staff had stopped in her room to answer the call light.

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F 684	Continued From page 23 --The surveyor went out to the nurses station. --Behind the nurses station was a computer monitor. ---On the monitor screen were different rooms listed and the amount of time the call lights had been on. ----Room 121 had been on for 23:20 minutes and room 125 had been on for 23:30 minutes. *4:40 p.m.: -Licensed practical nurse (LPN) T came behind the nurse station. Interview at that time with LPN T regarding call lights revealed: --The call lights came across the "walkies." --CNAs had the walkies with them at all times. --Nurses and medication aides did not always have a walkie with them because they were "dead" and not had not been recharged. ---They did not have enough walkies for all the staff. -She confirmed the time listed on the computer monitor was the amount of time the call lights had been on. Review of resident 7's medical record revealed: *An admission date of 2/3/21. *Diagnoses of: dislocation of left hip subsequent encounter, chronic pain syndrome, myalgia, gout, and Parkinson's disease. *She had orders for Celebrex, fentanyl patch, gabapentin, hydrocodone-acetaminophen PRN and tramadol PRN for pain. *Order to "shower only." *The 2/9/21 admission Minimum Data Set (MDS) assessment review period was coded: -Brief Interview for Mental Status (BIMS) examination score of fifteen indicating she was cognitive. -She received scheduled and PRN pain medication.	F 684		

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F 684	Continued From page 24 -She had pain or was hurting in the last five days. -The severity of the pain was coded mild in the last five days. -She had received scheduled narcotics in the last seven days. -The care area assessment (CAA) summary triggered the care plan for ADL (activities of daily living) and falls. It had not triggered for pain. Review of resident 7's 2/3/21 admission pain evaluation revealed she was immobile, was interviewable, pain type was achy, worse with movement, site was the left leg/hip, pain scale was coded seven indicating severe pain, sudden onset, pain effects was coded for changes in activities, ADL function, independence, and mobility. Rest and medication improved the pain. Review of resident 7's February 3 through February 18, 2021 medication administration record (MAR) for resident 7 revealed: *She had received pain medication on February 4 and 5. *On February 8th she received hydrocodone-acetaminophen at 11:11 a.m. for pain level score of seven out of ten. Review of resident 7's 2/3/21 admission care plan revealed there was no information on it for pain. Interview on 2/22/21 at 2:50 p.m. with DDCO A regarding resident 7's pain management and the length of time to answer her call light revealed she would need to check into it before she would be able to answer the question. -By 2/23/21 at 2:00 p.m at exit she had not replied regarding the above. 3. Review of resident 8's (resident 7's roommate)	F 684		

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F 684	Continued From page 25 bathing task flow sheet from February 5 through 24, 2021 revealed: *She had received a: -Bed bath on 2/5/21, 2/8/21 and 2/24/21. -Whirlpool bath on 2/17/21. *She had gone nine days without a bed bath or whirlpool. Review of the call alarm report from 2/1/21 through 2/17/21 for resident's 7 and 8 regarding call light response time revealed: *On 2/8/21 resident 7 had put her call light on at 6:38 a.m., 9:14 a.m., 9:40 a.m., and 10:58 a.m. *From 2/1/21 through 2/17/21 resident 7 had: -Fifty-two occasions it took over eight minutes to have her call light answered. -Three occasions it took over sixty minutes to have her call light answered. -Two occasions it took forty to fifty-nine minutes to have her call light answered. -Twenty occasions it took twenty to thirty-nine minutes to have her call light answered. *The last documented call light for her was on 2/13/21 at 4:55 a.m. *From 2/1/21 through 2/17/21 for resident 8 had: -27 occasions it took over eight minutes to have her call light answered. -One occasion took fifty-six minutes. 4. Interview on 2/22/21 at 12:50 p.m. with resident 9 revealed she: *"Sometimes did not get a bath." *Would like to get a bath weekly. Review of resident 9's medical record revealed: *A 12/7/20 admission date. *The 12/10/20 admission five day MDS assessment revealed: -A BIMS examination score of fourteen indicating	F 684		

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F 684	Continued From page 26 she was cognitive. -It was somewhat important to choose between a tub bath, shower, bed bath, or sponge bath. Review of resident 9's January 27 through 31, 2021 and February 1 through 17, 2021 bathing task flow sheet revealed she: *Had received a bath on 1/27/21, 1/28/21, 2/3/21, 2/9/21, and 2/17/21. *She had gone eight days without a bath from 2/9/21 through 2/17/21. Surveyor 42477 Review of bath records from 2/1/21 to 2/21/21 for 8 randomly sampled resident's (11, 12, 13, 14, 15, 16, and 22) with documented skin concerns revealed: *Resident 11 had documentation that revealed: -From 2/1/21 to 2/21/21 resident 11 had 1 documented bath. -On 2/18/21 she refused a bath. -On 2/19/21 she had a whirlpool bath. *Resident 12 had documentation that revealed: -On 2/4/21, 2/5/21, and 2/8/21 she refused baths. -On 2/10/21 and 2/18/21 she received baths. -There was 8 days in between documented baths. *Resident 13 had documentation that revealed: -On 2/10/21 and 2/16/21 he had a bed bath. -There was not any documentation of refusals. -There was 10 days without a documented bed bath. *Resident 14 had documentation that revealed: -On 2/2/21 and 2/9/21 he had a whirlpool bath. -On 2/19/21 he had a shower. -There was 10 days without a documented bath. -There was not any documented refusals. *Resident 15 had documentation that revealed: -On 2/5/21, 2/9/21, and 2/18/21 she received a	F 684		

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bath.
-There was a 9 days gap between baths for resident 15.
*Resident 16 had documentation that revealed:
-On 2/2/21, 2/9/21 she received a whirlpool bath.
-On 2/18/21 she received a bed bath.
-There was a 9 day gap between baths for resident 16.
*Resident 22 had documentation that revealed:
-On 2/1/21 he received assistance with a bath.
-On 2/9/21 and 2/17/21 he had total dependence.
-There were eight days between baths for him.

Surveyor 29354
5. Interview on 2/18/21 at 5:09 p.m. with DNS E regarding call lights revealed:
*The staff were alerted to call lights over the walkies.
*The call lights showed up on the computer monitors behind each nurses station.
*Each staff member was to have a walkie with them.
*There were times when the staff did not have a walkie. Those times had included:
-If the prior shift had not plugged them in to be recharged.
-If the walkies had been misplaced.
-The staff had taken the walkies home with them.
*It was not acceptable for a call light response time of twenty-three to twenty-four minutes.
*The response time should be eight minutes or less.
*She was out on the floor every day and if she observed a staff member without a walkie she would ask where it was and remind them to have one with.
*There was no walkie or call light policy or procedure.

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F 684	Continued From page 28 Further interview on 2/18/21 at 6:10 p.m. with DNS E regarding call lights and the walkies revealed: *They had thirteen walkies available for staff who were working the floor. *There were not enough walkies for each staff member who was working the floor. *She had collected all the managers walkies for the staff to use on the floor for the evening/night shift on 2/18/21. *Her expectations would have been for call lights to be answered within eight minutes. *She confirmed twenty-one to twenty-four minutes was too long for residents to wait for a response to a call light. *They did not have a bathing policy or a resident personal care/nail care policy. -They were considered standards of practice. 6. Review of an undated and unsigned post-it note attached to the Facility Risk Assessment received on 2/19/21 revealed "Standard of practice to meet residents needs and per regulation for each resident to have a call light." Telephone interview on 2/19/21 at 5:18 p.m. with LPN R regarding resident 6's INR's revealed: *She had worked at the facility since August 2020. *She had taken care of resident 6. *Labs were done routinely. --They did whatever the physician had ordered. *She worked the night shift. *Confirmed resident 6 was on Coumadin. *The order usually came from the eLTC. -She could not remember who gave the order for the PT INR the day she had passed away. -She had not talked to CNP I. -She had not had any interaction with eLTC for	F 684		

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her.
--They would fax orders over.
--She had noted it was to be done on the 17th.
--The standard was to draw a PT INR every two weeks.
--She did not deal with new admissions.
--If things needed to be followed up on she would do it but it was usually done on the day shift.
--She did not know how to deal with getting information back from eLTC pharmacy.
--She had been working when resident 6 coded.
--Resident 6 had:
---A bloody nose a day or two prior to the incident.
---Seizure activity over the weekend, had bit her tongue, had bleeding.
---No one had reported a bloody nose on Tuesday.
--Two CNAs came into resident 6's room.
---CNA EE had been in resident 6's room but had not reported any bloody nose.
-She did not know why lab had not been drawn earlier than the 17th.

Surveyor: 32332
7. Review of resident 20's medical record revealed:
*He was admitted on 11/22/19.
*His diagnoses had included:
-Persistent vegetative state, encephalopathy, unspecified.
-Hemiplegia affecting right dominant side.
*His nursing progress notes revealed:
-On 11/22/20 LPN Z documented he had open areas to his coccyx that were starting to weep and bleed. He had drainage on his hands from itching the site. She applied a dressing and planned to notify the physician of his status.
-On 11/28/20 the dietitian documented he had been receiving protein powder for his skin

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F 684	Continued From page 30 integrity. -On 12/6/20 LPN AA had applied a foam dressing to his "bottom due to sores and drainage." -On 1/14/21 his physician made virtual visit. There was no documentation of skin concerns in the progress notes. *Section M (skin) of the 1/21/21 Minimum Data Set assessment indicated skin tears and moisture associated skin damage (MASD) were present. -A 2/2/21 progress note by RN C indicated a "Stage 2 open area to on buttocks, scar tissue surrounding area, history of skin breakdown in this area. Moisture barrier cream twice daily and PRN [as needed] until healed." *An initial skin and wound evaluation was completed on 2/2/21 for an abrasion to the coccyx. -The wound area was described as 0.41 centimeters (cm) long by (x) 0.35 cm wide. *On 2/4/21 resident 20's physician ordered a referral to the wound clinic. *On 2/4/21 the resident returned from the wound clinic with physician's orders for Medihoney and cover with a foam dressing. *On 2/8/21 RN contacted the wound clinic for a diagnosis of the wounds. The diagnosis was for abrasions and scratches. *A 2/8/21 progress note progress note by RN indicated the resident had a "red bottom." He also had scratches to his right lower abdominal area and had "the draining area to left abdomen, area cleaned and new bandage applied. Large amount of yellow drainage noted." * 2/9/21 skin and wound evaluation was completed for the coccyx abrasion. -The wound was identified as "Deteriorating - Age unknown." -Measurements described as 1.7 cm long x 2.99 cm wide, with an area of 4.51 cm2 (total	F 684		

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F 684	Continued From page 31 measurement of the entire wound). *The resident was seen again on 2/12/21 at the wound clinic, with no new orders. *A 2/16/21 skin and wound evaluation for the coccyx abrasion revealed: -The area was 7.91 cm long x 10.44 cm wide, making the total area 44.96 cm2. -A photo of the resident's buttocks revealed heavy scarring across both sides of the buttocks from self-scratching and other areas of skin gouges with some bits of skin hanging off. *A 2/18/21 nursing progress note by LPN CC indicated "Picking at buttock and abdomen. Tearing up brief." -The nurse had not indicated what interventions might have been used to prevent the resident from picking at his skin. *A 2/20/21 progress note by LPN CC indicated "Buttocks skin is broken down. Right buttock is open. Medihoney and optifoam applied." Review of resident 20's revised 2/2/21 care plan revealed: *He had open areas on his coccyx. *Interventions had included: -"Keep fingernails clean and trimmed." -Medihoney to coccyx." Observation on 2/22/21 at 2:25 p.m. of resident 20 revealed: *He was laying in bed. *He had no clothing or incontinent brief on from the waist down. *His blankets had been pulled off. *Observation of his hands revealed his fingernails and thumbnails had grown beyond the tips of his fingers and thumbs. Interview at that time with unlicensed assistive	F 684		

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F 684	Continued From page 32 personnel DD regarding resident 20's fingernails revealed: *The residents get their nails trimmed on their bath day. *She was not sure when resident 20 had his bath last. *She was not sure where a bath list was kept. Interview with health unit coordinator N at 2:35 p.m. regarding resident 20's bath revealed: *All residents were to have their nails trimmed with every bath. *His last bath was on 2/16/21. *The resident was a diabetic so he required a nurse to trim his nails. *Regarding the resident scratching his skin off the health unit coordinator stated: -He was admitted in May of 2019. -"He has been doing that since the day he came in." -"He takes his brief off and scratches and scratches." Interview at the same time with LPN CC regarding resident 20's long fingernails revealed: *She confirmed that resident 20 required a nurse to trim his nails. *She usually had RN B trim resident 20's nails. *When questioned she confirmed that RN B no longer worked in the facility. Review of resident 20's February 2021 medication, treatment, and aide task records revealed none of those documents had included documentation indicating the resident was to have his nails trimmed to reduce skin problems. Review of resident 20's nursing progress notes on 2/23/21 revealed that his nails were finally	F 684		

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F 684	Continued From page 33 trimmed on 2/22/21 at 7:30 p.m. Surveyor 29354 8. Interview on 2/22/21 at 11:55 a.m. with maintenance director S regarding the call light system revealed: *There should be one call light per resident. -Each room had a wall unit for the call light to be plugged into. -One side of the wall unit indicated falls and the other side indicated need for assistance. -There should not have been two separate call cords plugged into one wall unit. -He has had to switch the call cords back when staff plugged two call cords into one wall unit. -He was informed of call lights needing maintenance through their internal system called TELS, a maintenance work order, or the staff informed him of the issues. -The TELS system could be entered as a work order on the computer. --He printd out the work orders. --He tried to check the best he could for call light orders. --No one had let him know they were having call light issues in resident 7's room over the past few days. --He had done call light audits. --He checked the call light system weekly. *If a call light was not working over a weekend there was a maintenance person on call or they should have let the director of nursing services know. 9. Review of the provider's Resident Admission Packet revealed residents have the following rights under Federal law including: *"Rights related to care and treatment: -7. The Resident has the right to be informed of ,	F 684		

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F 684	Continued From page 34 and participate in, his/her treatment, including: --f. The right to receive services and/or items included in the plan of care." *"Rights as a resident of the Center: -21. The Resident has the right to reside and receive services in the Center, with reasonable accommodation of Resident needs, except when doing so endangers the health and safety of other Residents. -22. The Resident has the right to reasonable accommodation of individual needs or preferences, except where the health or safety of the Resident or other Residents is endangered. -24. The Resident has the right to make choices about aspects of his/her life in the Center that are significant to the Resident." Review of the provider's updated March 2012 Certified Nursing Assistant (CNA) job description revealed: *"Essential Functions: -1. Answers signal lights, bells, or intercom system to determine resident needs. -2. Provides assistance with bathing, dressing, toiletry, and oral hygiene activities of daily living (ADLs). -5. Turns and repositions bedfast residents, alone or with assistance, and utilizing proper body mechanics, to prevent pressure ulcers. -7. Completes documentation (e.g. meal monitor, I&O) records, ADL, and Aide flow sheets)." Review of the provider's updated March 2012 Charge Nurse job description revealed: *Job Summary: -"Directly accountable to the Director of Nursing Services (DNS) to manage the nursing care of assigned residents to maximize independence and self-direction for residents.	F 684		

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F 684	Continued From page 35 -Responsible for safety of residents under their supervision. -Manages day-to-day compliance with Federal and State regulations, Center policies and procedures, and standard of practice with regard to resident care." *Essential Functions: -"3. Supervises and evaluates direct resident care provided within assigned unit and initiates corrective action as necessary. --d. Identifies special nursing problems and emergency situations quickly, and initiates appropriate interventions for individual residents. --e. Supervises and evaluates the implementation of Resident Bill of Rights. --g. Documents resident care provided and resident's response or lack of response to treatment provided, --h. Assesses and reports changes in resident's condition, including development of pressure ulcers, to physician, the DNS and responsible party, and takes recommendations for nursing action to be implemented. --i. Assesses resident responses to medication and treatment, and makes appropriate recommendations for nursing action to be implemented." -"4. Assesses on a weekly basis via resident rounds the condition of existing pressure ulcer by stage, size (measurements), sites depth, color, drainage, and odor. reports problems to the DNS; takes necessary follow-up action." -"7. Supervises the timely response of call-lights within assigned unit." -"9. Follows up on physician orders, lab, and x-rays." -"10. Observes resident, records significant conditions and reactions, and notifies family (responsible party) and physician of resident's	F 684		

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FIRESTEEL HEALTHCARE CENTER	1120 EAST 7TH AVENUE MITCHELL, SD 57301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36 condition, and reactions to drugs, treatment, and significant incidents. --Documents it according to Center policy and Standards of Practices." *Administrative: -"3. Provides clinical supervision to nursing assistants." Review of the provider's updated March 2012 Director of Nursing Services job description revealed: *Job Summary: -"Is directly accountable to the Executive Director (ED) for the day-to-day operations, activities, and success of the resident care staff, as governed by the Center policies, and state and federal regulations. -Validates that the Nursing Department continues to develop and maintain high standards of excellence." *Essential Functions: -"2. Manages, supervises, and develops plans of action for assigned units, providing consistent monitoring and follow-through." Review of the provider's updated November 2019 Executive Director job description revealed: *Job Summary: -"Is directly accountable to the Divisional Vice President of Operations (DVP) to provide strong overall leadership and management of a long-term care center. -Manages delivery of the highest level of health services and quality of care that is responsive to customers' needs. -Directs efforts to facilitate the overall well-being of Center." *Essential Functions: -"2. Quality Management:	F 684		

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F 684	Continued From page 37 --a. Lead the process to develop and implement programs to maintain quality of care to meet established goals. --c. Hold Department Managers accountable for departmental quality performance. --d. Verify the Center meets state and federal requirements for long-term care Centers for licensure." Review of the provider's updated January 2019 Divisional Director of Clinical Operations (DDCO) job description revealed: *Job Summary: -"Works in tandem with the DVP and Divisional Team to maximize the Centers clinical and operational performance. -Is instrumental in analyzing and identifying opportunities for clinical and operational improvement." -Is responsible for the quality of resident care services of region Centers. -Verifies region resources are adequate to meet the care and needs of the residents." *Essential Functions: -"2. Assists Center with creating a clear, useful plan of action to resolve issues. -4. Provides education, system implementation and monitoring, and development of QAPI (quality assessment process improvement) Action Plans in conjunction with Executive directors and Directors of Nursing Services to promote positive resident outcomes. -5. Communicates and confirms implementation of changes in protocol, policies, and processes. -6. Validates and audits the Center clinical systems, including the Minimum Data Set (MDS) process; verifies that a process is in place and is functioning appropriately. -7. Provides regular on-site Center visits for the	F 684		

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F 684	Continued From page 38 validation of key clinical system integrity. --Provides guidance and direction to center leadership regarding operationalization of clinical systems to support compliance with company policy, standards of practice, and regulatory requirements."	F 684	**Directed Plan of Correction** **Firesteel Healthcare Center, Mitchell** **F686** **Corrective Action:** 1. *Time cannot turn back the clock to the dates and event surrounding: -Compromised skin integrity for residents 1, 2, 3, 4, 9, 10, 11, 13, 14, 15, 16, 17, 21, 22, 24, and 25. -Timely and accurate weekly skin and wound documentation for residents 1, 2, 3, 4, 9, 10, 11, 14, 15, 17, 18, 19, 21, 22, and 25. -Not following physician orders for skin and wounds for resident 3. -Lack of notification to physician, resident, and family about skin concerns for residents 2, 3, 4, 13, 14, 15, and 23. -Repositioning programs for residents 2, 3, 4, 10, 11, 15, 22, 23, 24, and 25. Director of Nurses (DON) and administrator were provided re-education on 3/18/2021 by DDCO.	03/21/21
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, policy review, South Dakota Department of Health (SD DOH) on-line incident report, and job description review, the provider failed to follow their Skin Integrity policy for: *Accuracy of weekly skin assessments and/or wound documentation for eighteen of twenty-three sampled residents (1, 2, 3, 4, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 21, 22, 24, and 25). *Physician's orders for skin and wound management for one of twenty-three sampled residents (3).	F 686		

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F 686	Continued From page 39 *Notification to physician, resident and/or family representative of skin and wound issues in a timely manner for seven of twenty-three sampled residents (2, 3, 4, 13, 14, 15, and 23). *A turning and repositioning program for ten of twenty-three sampled residents (2, 3, 4, 10, 11, 15, 22, 23, 24, and 25) to off load pressure areas. These failures have the potential to cause serious harm up to and including death. Specifically, a resident with a pressure injury that resulted in a hospitalization. All residents have the potential to be affected by this deficient care practices. Due to the lack of ongoing monitoring, assessments, documentation prevents identification of care needs and provision of care. NOTICE: Verbal notice of immediate jeopardy and the template was given on 2/19/21 at 6:00 p.m. an Immediate Jeopardy was identified when the facility failed to ensure: *Ongoing monitoring, assessments, and documentation of pressure injuries for twenty-two of seventy-four residents. *The facility identified residents with pressure injuries. They put a plan in place to monitor and assess the identified injuries. They failed to follow their plan of weekly wound assessments, weekly wound audits, and notify providers. At the above time the Divisional Director of Clinical Operations A was asked for an immediate plan of removal. PLAN: On 2/24/21 at 10:30 a.m. the following immediate	F 686	The provider in consultation with the Divisional Director of Clinical Operations, medical director, and governing board reviewed the plan prepared for removal of the immediate jeopardy. Reviewed policies and procedures about appropriate and timely skin assessment, maintaining skin integrity, and the response to assessment and/or skin injury. Resident assessment process and care plan reviewed to meet the identified needs of the individual resident(s). There is adequate staff to meet the residents needs. All staff licensed and unlicensed who are responsible for oversight of care or direct care will be educated about their roles and responsibilities for skin assessment and maintaining skin integrity or response to skin injury by DNS, SDC, RCM or deisgnee by 3/19/2021. All staff not educated will be educated prior to their next working shift. **Identification of Others:** 1. *ALL residents have the potential to be affected.	

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

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F 686	Continued From page 40 jeopardy removal plan was accepted by the South Dakota Department of Health: "1. Educate nursing management on weekly wound assessments, on appropriate treatment and interventions, provider, dietician, and family notification. Educate all licensed nurses on performing weekly skin assessments and documenting any issues identified during the skin assessment and notifying provider and family. Educate all staff on stop and watch to alert licensed nursing staff of any abnormal skin findings. The nurse in charge of the weekly wound assessments will be in charge of changing the treatments. Educate certified nursing assistants CNA's [certified nursing assistants] and NA's [nursing assistants] on inspecting skin during ADL's [activities of daily living] and reporting abnormal findings. Education provided by Divisional Director of Clinical Operations to nursing management team. They, in turn will educate all nursing staff prior to their next working shift by 2/22/2021. 2. An audit will be conducted on ensuring preventative measures are in place to prevent skin breakdown on residents with and without wounds, Braden assessments completed per policy annually, quarterly, change in skin condition completed by licensed nursing staff, bathing preformed a minimum of weekly, peri-care completed timely and resident is clean and dry residents with incontinence are checked every one to two hours, weekly wound assessments completed every seven days, treatments done as ordered and changed if no improvement in wound noted per provider direction or every 14 days as stated in policy, family notification, physician notification, and dietician notification with assessment and knowledge of staff who has wounds on their	F 686	*ALL licensed and unlicensed staff completing their assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities in skin care will be provided by SDC, RCM, DNS or designee. Addendum PM 03/23/2021 System Changes: Root cause analysis answered the 5 Whys. Problem: Prior nurse manager who at the time was in charge of wound care failed to assess wounds in the facility per policy. 5 Whys: 1. Nurse manager responsible for wound prevention and treatment stopped performing assigned duties 2. Nurse manager stated she assumed another nurse manager was performing wound prevention duties 3. Miscommunication from leadership on what nurse manager was to complete wound prevention duties 4. Facility never validated the wound prevention duties were completed or not 5. Nursing management was not held accountable to ensure the wound prevention duties were completed. Root cause analysis: DNS was out on medical leave of absence and facility failed to ensure an individual was appointed to fulfill her job duties/responsibility in her absence.	

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F 686	Continued From page 41 unite. The DNS or designee will be responsible for the audits. 3. Compliance date 2/22/2021. " An onsite revisit was completed on 2/24/21 at 12:35 p.m. to verify the immediate jeopardy removal plan. Immediate Jeopardy was removed on 2/22/21 at 2:56 p.m. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "H." Findings include: 1. Review of the following report submitted to the South Dakota Department of Health (SD DOH) regarding resident 1 revealed: *The initial self-report had been completed on 2/1/21 by the director of nursing services (DNS) for allegations of physical harm/injury regarding the status of a stage four (being the most severe stage) pressure ulcer to the sacral region and sepsis (a serious infection in the bloodstream). *Resident 1 had been admitted to the provider on 11/3/20 after being hospitalized for a left hip fracture and cellulitis of the left lower leg. *On her 11/3/20 admission to the provider she had: -A reddened coccyx and perineal area. -Two open areas to her coccyx. -One open area on her left buttock. *She required staff assistance with repositioning in bed. *She had virtual visits from: -Certified nurse practitioner (CNP) I on 12/3/20. -Her primary physician on 12/24/20 to visit about her left lower leg wound. --Review of the physician's clinic documentation for this visit located in the hospital records indicated the resident was not accompanied to	F 686	Administrator and or DON will ensure ALL facility staff responsible for monitoring or overseeing those staff who provide direct care will be educated and aware of their roles and responsibilities for timely and accurate skin assessment; maintaining skin integrity; appropriate notification to physician, resident, and family; following physician orders, and maintaining repositioning programs for the individual. The DDCO, ED, and DNS contacted the South Dakota Quality Improvement Organization (QIN) on 3/19/2021 the 2567 was discussed in detail as well as the RCA/5 whys and other resources available to the facility. **Monitoring:** 1. Administrator and or DON will conduct at minimum 3 X per week on alternating shifts, for 4 weeks, a review of staff response for identified skin care areas. After 4 weeks of successful monitoring, then will monitor 1 X per month for 3 months. Monitoring results will be reported by administrator and or DON to the QAPI committee and continued as determined by the committee and medical director.	

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F 686	Continued From page 42 this appointment and had not indicated why she had been sent to the clinic. The physician had not assessed the resident's coccyx. Further physician communications had included: *On 12/29/20 her primary physician was updated on the condition of her worsening sacral wound and had requested orders for her to see the wound clinic. *On 1/21/21 her physician made another virtual visit. -Orders were received for her to consult the wound clinic for recommendations for treatment. -She went to the wound clinic on 1/26/21. On 1/28/21 at 8:30 p.m. resident 1 was noted to be lethargic. Her blood pressure was low at 72/44 and she had a low-grade fever of 99.8 degrees Fahrenheit. She was transferred to the hospital by ambulance. She was admitted for infection to her pressure ulcer wound. Review of resident 1's 1/29/21 hospital admission records requested from the SD DOH complaint department revealed: *On 1/26/21 the wound clinic had identified: -One Stage 4 pressure injury pressure ulcer measured 8.2 centimeters (cm) long by (x) 6.5 cm wide x 2.5 cm depth. --Necrotic adipose tissue was exposed. --A large amount of drainage with a strong odor. --That wound was debrided on 1/26/21. -One Stage 3 pressure injury to her left calf measured 3 cm long x 2 cm wide x 0.2 cm depth. *Review of resident 1's 1/29/21 hospital physician's History and Physical Assessment and Plan had indicated: *Sepsis.	F 686		

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F 686	Continued From page 43 *Stage 4 pressure ulcer of sacral region. *Ulcer of left calf. *Infected decubitus ulcer. *Concern for underlying osteomyelitis. *"Consulted general surgery since it appears this may benefit from a debridement." Review of resident 1's electronic medical record (EMR) from the provider revealed her 11/3/20 admission nursing evaluation from the provider revealed the following skin concerns: *An intact dressing to her left hip surgical wound with no drainage. -The area had not been measured. *A Stage 2 pressure injury to her coccyx measured 1 cm long x 1 cm wide. No depth was identified. *Another Stage 2 pressure injury to her coccyx measured 1 cm long x 1 cm wide. No depth was identified. *A Stage 2 pressure injury to her left buttock measured 1 cm long x 2 cm wide. No depth was identified. *Her coccyx/peri area was identified as "red", without documented measurements. *A left lower leg was identified as "cellulitis" without documented measurements. *Wound treatment at that time was for a foam dressing to open buttocks. *Her Braden Scale for Predicting Pressure Ulcers form revealed a score of 14, indicating a moderate risk for skin breakdown. *There was no documentation on admission of a skin concern to her left calf. *No skin/wound evaluations had been completed for the above pressure injuries. Other skin interventions located in resident 1's medical record had included on:	F 686		

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F 686	Continued From page 44 *11/30/20 a Braden Scale indicated a score of 15, indicating "At risk" (a slight improvement from 11/3/20). *11/9/20 orders were received to apply Medihoney and foam dressing to open area on buttocks. *11/15/20: Nutritional intervention for Calorie Dense Medication Pass 2 ounces after meals for wound healing. *A 12/8/20 Braden Scale indicated 15, without change. *A 12/14/20 Braden Scale indicated 15, without change. *A 1/20/21 Nutrition Hydration Skin Committee Review indicated: -The reason for the review was "Weight." -Her 11/3/20 admission weight was 125 pounds (lb). -On 12/13/20 the weight was 107.5 lb. -On 1/12/21 the weight was 102.5 lb. -Pressure ulcer stage comments: "Unstageable." -"Resident has a large open area to her bottom which has been slow to heal." -The dietitian increased her protein powder to one scoop three times daily. -The dietitian signed the committee review form (to have been used to summarize the current skin and wound status, with no other staff identified as participating. Review of resident 1's Skin and wound evaluations from 11/3/20 through 1/28/21 revealed only two skin/wound evaluations had been completed after her admission on 11/3/20: *On 12/9/20 by registered nurse (RN) B: -Stage 3 full-thickness skin loss to her sacrum. --Present on admission. --The area had been first identified "1 month" ago.	F 686		

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F 686	Continued From page 45 --Area: 2.7 cm2 (square centimeter) (The total measurement of the entire wound area). --2.6 cm long x 1.5 cm wide x 0.1 cm depth. --100 percent (%) wound filled slough (necrotic tissue). --Light, serous exudate. --No odor. --Nothing had been addressed regarding: ---Periwound edges and surrounding tissue. ---Wound pain. ---Orders. ---Infection. --Her dressing was missing. --Her treatment included a generic wound cleanser, hydrocolloid and foam dressings. --Progress had stalled. --Additional care included: ---Foam mattress. ---Incontinence management. ---Nutrition/dietary supplementation. ---Positioning wedge. ---Repositioning devices. --"Protein powder was added to promote wound health, encouraged to lay down and offload will implement a schedule, cushion placed in recliner." --Turning/repositioning program had not been checked. --There was no identified notification to the physician, resident or responsible party or dietitian. --There was no documentation on this 12/9/20 skin evaluation or in other areas of the EMR regarding the resident having gone from three areas of concern on admission to one large open area at this assessment. *On 1/25/21 by RN B: -Stage 3 full-thickness skin loss to her sacrum.	F 686		

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F 686	Continued From page 46 --Present on admission. --The area had been first identified "1 month" ago. --Area: 10.3 cm2. --7.1 cm long x 2.5 cm wide x 0.3 cm depth. --Wound bed: ---11% wound covered epithelial tissue. ---11% granulation. ---9.20 % slough. --Light, serous exudate. --No odor. --Periwound edges were non-attached. --Surrounding tissue was excoriated and fragile at 2.0 cm. --Wound pain: 1. --No orders were identified. --Infection had not been addressed. --Her dressing was intact. --Her treatment included sterile water for cleanser, autolytic debridement, automicrobial, hydrocolloid, and 'other' dressings. --Progress "Deteriorating". --Additional care included: ---Foam mattress. ---Incontinence management. ---Moisture barrier and moisture control. ---Nutrition/dietary supplementation. ---Positioning wedge. --The turning/repositioning program had not been checked. --The physician was contacted and orders received to contact the wound clinic to change the treatment. There were no Skin and Wound evaluations completed for resident 1's left calf Stage 3 pressure ulcer that had been identified at the 1/26/21 wound clinic evaluation. Review of the 11/3/20 through 1/28/21 nursing progress notes	F 686		

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F 686	Continued From page 47 revealed the left calf had only been documented on twice: *1/7/21: "Dressing removed from L [left] posterior calf. Medial side of the black scab treatment area is loosened with a dark red clot that is pulling away from the wound bed." *1/26/21: "Resident went to [hospital name] wound clinic today for an appointment. Wounds changed and dressed, orders for treatments on coccyx and L calf wound sent." Review of the provider's resident 1's revised 2/2/21 (after she had been transferred to the hospital) care plan revealed: *An 11/3/20 problem: The resident was receiving antibiotic therapy for cellulitis of left lower leg. -Interventions were added 11/15/20 for antibiotic medications and to apply lotion to the left lower leg and watch for signs of cellulitis. *A 12/23/20 problem regarding an injury to the left lower leg. Interventions had included: -Ice to the ankle four times daily. -"Betadine to keep area clean and X-rays." -An antibiotic "due to signs and symptoms of infection." *An 11/15/20 problem indicating a pressure ulcer to the coccyx and buttock. Interventions included: -A cushion to her recliner and to lay down for one hour twice daily. -Keep skin dry and lotioned. -Ointment and dressings to area as ordered. -A 12/9/20 intervention for protein supplement and 2 Cal two ounces twice daily. *An 11/3/21 baseline plan of care revised on 2/2/21 (after she went to the hospital) indicated the goal was that she would maintain safety. Interventions had included: -Providing extensive assistance of two people for bed mobility.	F 686		

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F 686	Continued From page 48 -"Keep heels up off bed with pillow or heel up pillow." -"Skin at risk: Elevate heels." -A pressure reducing mattress. -"Turn/reposition routinely." --The care plan had not indicated how often routinely was to have occurred. *There were no further interventions or updates of the pressure injuries. Resident 1's 11/3/21 through 1/28/21 progress notes indicated she had an increase in confusion and delusional hallucinations with agitation beginning around 12/1/20, but had not indicated the resident was refusing her care. Review of resident 1's medication and treatment records requested and received during the survey had been for the month of February, 2021. The resident had been transferred to the hospital on 1/28/21. Interview on 2/18/21 at 8:30 a.m. with the divisional director of clinical operations (DDCO) A regarding a 2/1/21 self-report of resident 1's identified Stage 4 ulcer provided to the SD DOH revealed she confirmed: *Resident 1 was hospitalized on 1/29/21 for a stage 4 pressure ulcer that had become infected, causing sepsis. *The provider had two nurses (RN B and C) that had been working with pressure ulcer wounds. *On 2/2/21: -RN B and C were interviewed by the former executive director (ED), DDCO A, and medical director G regarding why weekly wound assessments and measurements had not been completed.	F 686		

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F 686	Continued From page 49 -RN B and C were given a final written warning for not completing the wound assessments. -A skin sweep was conducted to review the skin status on every resident in the facility. -She stated a skin sweep had identified eleven residents with a total of eighteen pressure ulcers. *When asked for the list of residents identified on 2/2/21 with newly identified pressure ulcers, DDCO A provided a list of thirteen residents. -That list had not identified the dates they had been found or where or how many pressure injuries had been identified for each resident. *RN B no longer worked at the facility. *RN C: -Had only worked for a few months in the facility. -Did not have previous experience with wounds. *The provider had two nurses from a sister facility come to the facility on 2/16/21 and 2/17/21 to provide wound care education to RN C. *DDCO A had been working to correct the pressure injury problems, but the pressure ulcer plan was not completely up and running. *On 2/4/21 an all-staff meeting was held with DDCO A and medical director G. Wound care and skin integrity hand-outs were provided to the staff. *ED U and/or DNS E were to have been monitoring and auditing the weekly skin assessments to see that they had been completed, and the physicians had been notified and updated timely on changes in skin integrity wounds. Review of the above 2/2/21 skin and wound investigations provided by DDCO A revealed RN B confirmed: *She had taken over the wound measuring and treatments after the previous wound nurse RN V had quit her job. *She was to have trained RN C with wound	F 686		

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F 686	Continued From page 50 assessments. *RN B and C were completing a weekly wound report to give to ED U, DNS E, or DDCO A. *RN B had not looked at the residents' wounds when she filled out the wound reports. *She had copied the information the administration had put on the quality conference sheet. Continued above interview with RN B revealed the administration educated her about the need for a seven-day wound assessment, physician, family and dietitian notification of changes, and communicating with the physician for wound care changes. Continued review of the above 2/2/21 skin and wound investigation revealed: *RN C confirmed: -It had been her job to have assisted RN B with the wound measurements and treatments. -She had not completed those wound measurements or treatments. *The administration educated RN B about the need for a seven-day wound assessment, physician, family, and dietitian notification of changes, and communicating with the physician for wound care changes. Interview on 2/18/21 at 9:04 a.m. with medical director G regarding the self-report of resident 1 revealed he: *Had been the medical director for approximately three years. *Also worked for the hospital. *Assisted with interviewing RN B and C for the investigation. *Participated in the 2/4/21 education to all staff regarding pressure ulcer skin and wound care.	F 686		

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F 686	Continued From page 51 *Planned to continue as the medical director because he wanted to correct the problems for the residents. Interview on 2/19/21 at 5:10 p.m. with DDCO A revealed: *She had asked this surveyor where she received her first list because it was not accurate. -This surveyor reminded her that she had provided that list. -DDCO A then gave this surveyor a second list identifying 8 residents. -The second list also contained only names, with no identification as to the date the pressure ulcers occurred or were identified, and had not identified wound measurements or the area the pressure ulcer was located. *When asked for information on the skin sweep findings, DDCO A stated all the information from the skin sweep was located in each resident's chart. Review of the 2/1/21 plan submitted to SD DOH complaint department revealed: *"The ED [executive director] and/or DON will monitor/audit that weekly skin assessments are being completed, documented, and the physician has been updated timely on changes to skin integrity/wounds." Surveyors requested audits from DDCO A that were being conducted to ensure weekly skin assessments were being completed, documented, and the physician had been updated timely on changes to skin integrity/wounds on the following days and times: *2/18/21 at 8:30 a.m. *2/18/21 at 12:30 p.m. *2/18/21 at 5:30 p.m.	F 686		

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F 686	Continued From page 52 *2/19/21 at 4:00 p.m. Interview on 2/18/21 at 5:10 p.m. regarding pressure ulcers with DNS E revealed: *The nursing staff completed a skin sweep on 2/2/21. *Audits would be done weekly, but had not started them yet. *Quality Assurance Performance Improvement (QAPI) notes were requested from DNS E. On 2/22/21 at 5:15 p.m. this surveyor informed DDCO A the surveyors needed to review all the investigation information they had obtained from the 2/2/21 sweep. DDCO A was informed the surveyors had requested PIP [performance improvement plan] information from QAPI and had not received it. DDCO A stated QAPI and PIPs were not needed because they only had 1 pressure ulcer in the facility prior to the skin sweep. On 2/22/21 at 5:30 p.m. surveyors asked for audits again. At that time DDCO A and RN D were printing off progress notes for each affected resident to show that residents had a skin assessment completed on 2/2/21. On 2/22/21 at 5:45 p.m. DDCO A stated her statement about a 100% skin sweep was not correct because one resident was at dialysis. Interview on 2/18/21 at 3:14 p.m. with RN/Minimum Data Set (MDS) coordinator D regarding pressure ulcer concerns identified after resident 1 was hospitalized revealed: *She helped complete the 2/2/21 skin sweep. *The sweep was completed as a leadership team.	F 686		

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F 686	Continued From page 53 *All residents were reviewed to identify skin concerns. *The team had discussed a root cause analysis for not having identified pressure ulcers. *She didn't know if it had been completed. *All staff were educated on 2/4/21. *After they completed the skin sweep and education, the leadership team began looking at notifying families of pressure ulcers, obtaining physician's orders for treatments, and visiting with the residents about their pressure ulcers and care provided. *DNS E wanted to receive a report every Thursday from every unit. *RN C would not have been able to review all the pressure ulcers weekly, so a member of the leadership team was given one unit to assist RN C with wound assessments. *The units were divided as: -RN D - 400 unit. -RN F - 300 unit. -RN C- 200 unit. -RN B - 100 unit. *RN B no longer worked in the facility, since just before the survey. *RN D was not sure who would be replacing RN B. *Physicians had not been allowed in the facility since the beginning of the pandemic. *Physicians had been allowed into the building for special reasons and it was very rare. *"They are always looking at the COVID community." Further review at the above time with RN D regarding identification of skin concerns revealed: *Before the skin sweep on 2/2/21 the nurses were expected to complete weekly skin checks on all residents.	F 686		

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F 686	Continued From page 54 -She was not sure why the weekly nursing skin checks had not identified the new skin ulcers/wounds. *There was a daily huddle the staff could communicate concerns that had been identified over the previous day. *RN C took over the skin and wound assessments approximately three weeks ago after RN unit managers V and W had quit their jobs. *Nutrition/Hydration Skin Committee reviews had been done virtually since the dietitian had not entered the building during the pandemic. *Going forward after the identification of the lack of skin assessments the leadership team members involved in skin and wound care were expected to: -Document new skin concerns and progress weekly. -Step in and complete the weekly skin assessments if it had not been done. *Prior to the pressure wound assessments concern Braden assessments were to have been completed on admission, annually, or with a significant change in status. *Going forward if there was an identified skin concern the Braden scale was to have been completed once the skin issue was identified. -She was not sure why the provider would wait until the skin had breakdown to begin a Braden skin scale. Interview on 2/19/21 at 4:00 p.m. with RN/wound nurse C revealed: *She started working in September. *RN V had planned to train RN C in wound care but she abruptly quit in November. *She had not received any skin or wound training until 2/16/21 and 2/17/21.	F 686		

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F 686	Continued From page 55 *At that time the sister facility sent two nurses to help her learn about skin and wound issues. *"To say stuff didn't fall through the cracks I would be lying." *She was not aware the skin and wound assessments were required to be completed every seven days. *The skin sweep done on 2/2/21 had identified somewhere between ten and fifteen unidentified pressure areas. *After the skin sweep, the nurses had been educated about notifying the physician of pressure injuries, notifying the family of skin changes, and getting documentation in place. *"It had been chaos since [DNS E] was gone." *When asked if the wound care was her only job, she stated she got pulled to the floor to work if there had been a sick call or if a temporary staff person was not working out. *When asked if the team had completed a root cause analysis for pressure ulcers she stated "yes and no" but had not provided any reasoning for that response. *She stated four new pressure ulcers had been identified on 2/18/21 for residents 11, 13, 16, and 17. *Audits were to have been completed to monitor if weekly wound assessments were being done correctly. -She was not sure who was to have completed those audits. *DNS E was to have received a pressure ulcer skin report every Wednesday. 2. Review of resident 15's medical record revealed: *She was admitted on 12/5/18. *A 2/2/21 progress note by RN D indicated -"Resident noted to have area on right heel.	F 686		

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F 686	Continued From page 56 -Resident last fall was 10/22/20." *A 2/2/21 at 5:58 p.m. indicated a skin assessment was completed with a picture taken of the right heel area. *The physician had been notified of a purple discoloration to the right heel on 2/3/21. *There was no documentation the family had been notified of the skin concern. Review of resident 15's medical record revealed two skin and wound evaluations: *On 2/9/21: -Indicated an in-house acquired deep tissue injury (DTI) to her right heel. -The injury measured 0.36 centimeters long by (x) 0.24 cm wide. The total skin area was less than (<) 0.1 cm2. -The Wound evaluation only contained wound measurements. --It had not been completed for the periwound, treatments, orders, monitoring, or notifications to the family. *On 2/16/21: -The DTI measured 1.37 cm wide x 2.08 cm long. The total skin wound area was 2.4 cm 2. -The wound was 100% epithelial wound covered. -It had indicated the resident was on a repositioning program. A 2/16/21 at 3:26 p.m. progress note by RN C indicated the resident's heel wound had healed, and the heel area would be lotioned twice daily. Review of resident 15's revised 2/3/21 Care plan indicated she: *Had a new suspected DTI. *Was to have been turned and repositioned every two hours and as needed."	F 686		

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F 686	Continued From page 57 Review of resident 15's Turning and Repositioning program was to have been completed every two hours from 2/2/21 through 2/20/21 (nineteen days) revealed of 240 opportunities in twenty days the resident had been repositioned 114 times, with 126 missed repositioning opportunities. 3. Review of resident 2's medical record revealed: *She was admitted on 2/10/2016. *She had a history of a right buttock pressure ulcer that healed approximately two years ago. *On 2/2/21 RN F had identified "excoriation to bilateral inner buttocks." Review of resident 2's 2/2/21 skin and wound evaluation revealed: *Moisture Associated Skin Damage (MASD) had been identified related to incontinence. *The evaluation had not identified the location of the area or any measurements of the area identified. *There was 100% of wound filled granulation (new tissue). *There was no exact date of the excoriation (wearing off of skin). *No treatments had been identified. *She was to have a foam mattress, seat cushion, moisture barrier nutrition supplementation. *No turning/repositioning program had been identified. *There was no documentation on notification to the physician, family, or dietitian. *Progress had been marked for "Monitoring." *Her care plan had not been updated with the 2/2/21 skin changes. Review of resident 2's February Treatment record	F 686		

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F 686	Continued From page 58 revealed: *A weekly skin check had been completed on 2/5/21 and 2/12/21. *There was no documentation in her progress notes to indicate there were skin concerns. On 2/9/21 resident 2's physician completed virtual rounds and documented the resident voiced no concerns. There was no discussion of skin concerns. On 2/15/21 LPN AA documented resident 2 had an open area to her right buttock. She applied hydrogel and optifoam to the area. -No measurements or notifications to the physician or family had been documented. On 2/16/21 for resident 2 RN C documented a skin and wound evaluation indicating: *An in-house acquired Stage 3 pressure injury was identified on her right buttock. *"No exact date" was identified. *Wound measurements: -Area of wound was 3.6 cm2. -2.4 cm long. -2.0 cm wide. -0.2 cm depth. *There was 10.0 cm area of fragile periwound. *Some bleeding was identified in the wound. *The skin and wound evaluation suggested the dressing was intact, but failed to document the identified treatment. *Additional care had been added for turning and repositioning program and incontinence management. *The nurse documented the physician and family were notified in the 2/16/21 evaluation. *On 2/16/21 RN C documented a progress note asking the physician for treatment orders.	F 686		

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F 686	Continued From page 59 Phone interview on 2/19/21 at 8:50 a.m. with resident 2's primary physician J regarding the identified Stage 3 pressure injury revealed he had been notified of a pressure injury, but had not been notified that it was at a Stage 3. On 2/23/21 a skin and wound evaluation was done for resident 2's Stage 3 pressure injury: *Wound measurements had not been documented. *The wound bed was 100% wound filled. *There was light sanguineous/bloody exudate. *Pain had not been addressed. *A foam dressing was intact. *Additional care provided included incontinence management. *The turning/repositioning program had not been addressed. Review of resident 2's updated 2/17/21 care plan revealed. *She had a Stage 3 pressure injury. *A turning and repositioning program had not been added to the care plan. Review of resident 2's Turning and Repositioning program for every two hours from 2/2/21 through 2/22/21 (twenty days) revealed of 240 opportunities in twenty days the resident was repositioned 118 times, with 122 missed repositioning opportunities. 4. Review of resident 4's medical record revealed: *She was admitted on 9/12/15. *An 11/26/20 progress note indicated that her 'bottom' was red and she had an open area on her inner buttock. The area was cleaned and a	F 686		

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F 686	Continued From page 60 barrier applied. The nurse covered the area with a foam dressing. -A skin and wound evaluation had not been located in her medical record. -There was no documentation of notification to the physician or family. *On 11/27/20 RN F added a progress note indicating: -Her left buttock had a 4 cm x 4 cm white area with a black center. -Her right buttock had a 1 cm x 0.5 cm open Stage 2 area. -A skin barrier cream was applied to the open area on the right buttock. -A foam dressing was applied to the left buttock. -"Staff reposition resident every two hours." -No skin and wound evaluations had been located in the record for these wounds on or before 11/27/20. -There was no documentation of notification to the physician or family of the wounds. *On 12/4/20 a nursing progress note by LPN R indicated the resident had "open areas to bilateral buttocks. The nurse applied a foam dressing. -There was no documentation the physician or family had been notified. -No skin and wound evaluation was located in the medical record. *Review of a 12/7/20 Nutrition Hydration Skin Committee form regarding resident 4 revealed: -She had "Unstageable pressure ulcers on bilateral buttocks." -She received protein powder for her skin. -"Continue to monitor." *There were no November 2020 skin and wound evaluations located in her medical record. *Review of RN F's 1/9/21 progress not for	F 686		

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F 686	Continued From page 61 resident 4 revealed her physician had completed virtual rounds with her and "any/all concerns addressed at this time and new orders." The nurse had not documented if the skin concerns had been reviewed with the physician. *Review of a 1/15/21 Quarterly Nursing Review form for resident 4 by RN D revealed: -Her last Braden Skin assessment dated 7/28/20 had a score of 10 indicating high risk for pressure injuries. -She had pressure injuries to bilateral buttocks. -She received protein powder routinely. -"Treatment as ordered." -There had been no devices used. -There were no care plan changes identified. *There was no further documentation of skin concerns in her progress notes until 1/29/21: "Replaced the dressing to residents coccyx with a new dressing." Review of a 12/2/20 a skin and wound evaluation for resident 4 identified: *An in-house acquired unstageable pressure injury to her right buttock. *Wound measurements were 2.2 area cm2 x 2.3 cm long x 1.1 cm wide. *The wound bed contained 90% slough. -Light serous exudate. *All evaluation areas had been complete except notification to the physician and family. *Skin and wound evaluations were completed on 12/9/20 and 12/24/20 for her right buttock, except for physician and family notification. *There were no skin and wound evaluations located between 12/9/20 and 12/24/20. *There were no skin and wound documentation's located for the last week of December 2020, and the month of January 2021.	F 686		

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F 686	Continued From page 62 Review of resident 4's right buttock skin and wound evaluations for the following dates revealed: *There was no wound evaluation the first week of February 2021. *A 2/9/21 evaluation: -Documented only the wound measurements as 0 cm x 0 cm x 0 cm. -Had not been signed. *A 2/17/21 progress note indicated the right buttock had healed on 2/17/21. Review of resident 4's left buttock skin and wound evaluations revealed: *A 12/2/20 skin evaluation for an in-house unstageable pressure injury. -Documentation indicated the wound had been present for two weeks with no exact date. -Wound measurements: --Area: 2.2 cm2 x 2.3 cm long x 1.1 cm wide. --All evaluation areas were identified except for notification to the physician and family. *A 12/9/20 skin evaluation identified the wound measurements as 4.5 cm2 area with 3.4 cm long x 1.7 cm wide, larger than the previous measurements. -All areas of the skin evaluation had been completed except notification to the physician and family. *No skin evaluation was completed between 12/9/20 and 12/24/21. *A 12/24/20 skin and wound evaluation revealed: -The wound remained unstageable. -All evaluation areas were identified except for no notification to the physician and family. *No skin and wound evaluations were located in the medical record between 12/24/20 and 1/29/21 (four missing weeks).	F 686		

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F 686	Continued From page 63 *A 1/29/21 skin and wound evaluation indicated: -The wound remained unstageable due to eschar. -It had been present for one month (no exact date). -Wound measurements were: <0.1cm2 area and 0.7 cm long x 0.1 cm wide. -All areas of the skin evaluation had been completed except notification to the physician and family. *A 2/2/21 skin and wound evaluation revealed: -The wound had been identified one month ago. -It had been identified on 11/27/20 in the nursing progress notes. -All evaluation areas were identified except for no notification to the physician and family. *A 2/9/21 skin and wound evaluation revealed: -The status of the wound bed, periwound edges, edema pain, dressings or wound treatment had not been identified. -There was not notification to the physician or family. *A 2/16/21 skin and wound evaluation of the left buttocks indicated the wound had changed to a Stage 3 pressure injury. -The evaluation had not identified when the change had taken place. -It continued to state the wound had been present, although it had been identified on 11/27/20. -The wound measurements were documented. -The status of the wound bed, progress and wound goals had not been identified. -There was no notification to the physician and family. *A 2/17/21 Braden Scale assessment indicated a score of 11 indicating she was at high risk of pressure ulcers. Review of resident 4's revised updated 2/7/21	F 686		

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F 686	Continued From page 64 care plan indicated: *She had two unstageable pressure areas to her left and right buttock. *The right buttock had healed. *She was to have been turned and repositioned every two hours and as needed." Review of resident 4's Turning and Repositioning program to have been completed every two hours from 2/5/21 through 2/17/21 (thirteen days) revealed of 156 opportunities in thirteen days the resident was repositioned 81 times, with 75 missed repositioning opportunities. 5. Review of resident 10's medical record revealed: *She was admitted on 1/13/21. *She required a total mechanical lift for transferring and assistance with repositioning. *She had been identified as having a pressure ulcer on 2/2/21 during a facility-wide skin sweep. Review of a 2/3/21 skin and wound evaluation form for resident 10 revealed: *She had one Stage 2 pressure injury. -The evaluation had not identified where the pressure ulcer was located. -The wound had been measured with an area of 0.4 cm2 and 0.9 cm long x 0.9 cm wide x 0.5 cm deep. -Her wound bed had 100% wound filled granulation. -The evaluation had been completed for skin, pain, wound treatments, and physician and family notification. On 2/4/21 a nursing progress note for resident 10 indicated the physician had been notified and skin orders were provided on 2/4/21.	F 686		

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F 686	Continued From page 65 *A progress note for resident 10 by RN L documented resident 10's left buttock pressure ulcer had small open areas. -No measurements had been documented. *A 2/9/21 skin and wound evaluation form revealed: -The wound: --Location had not been identified. -Identified for a stage 2 pressure ulcer. -Wound measurements were: Area: 1.1 cm2: 1.2 cm length x 1.2 cm wide x Depth not applicable. -There was 100% wound filled slough. -The evaluation had been complete. -The resident was to be repositioned according to the repositioning program. -Staff were educated on off-loading pressure and repositioning. Review of resident 10's 1/4/21 care plan revealed: *The care plan had not been updated to identify the left buttock Stage 2 pressure injury. *The initial care plan had included skin interventions including: -Elevating her heels of the bed. -Pressure-reducing mattress. -Turning and repositioning routinely. Review of resident 10's Turning and Repositioning program task to have been completed every two hours from 2/1/21 through 2/11/21 (eleven days) revealed of 132 opportunities in eleven days the resident was repositioned 54 times, with 78 missed repositioning opportunities. -The repositioning program had not begun until 2/5/21 three days after the pressure ulcer identification.	F 686		

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F 686	Continued From page 66 Surveyor: 42477 6. Interview on 2/18/21 at 2:00 p.m. with CNP I revealed: *She has only been back in the facility for 2 weeks. *Prior to two weeks ago they were only doing virtual visits for residents. *She was told today by RN C about resident 3's wound. -She had not been informed of her wound prior to 2/18/21. *Resident 3's physician informed the nursing staff on 2/11/21 to have CNP I assess the wound. *She saw resident 3's wound for the first time on 2/18/21. -It had not looked like it was improving. -She was putting in a referral to wound care for her. *Resident 3 stated that her wounds were because she needed a new wheelchair and had not been changed properly. *She was informed today about resident 16's wounds. Review of resident 3's EMR revealed: *She was admitted to the facility on 9/24/20. *She was admitted to the facility with pressure areas. *She has had some pressure areas close and had obtained new pressure areas. *On 2/2/21 she had a skin assessment completed by RN F that stated, "Skin assessment done-noted left lateral thigh closed, left posterior knee scabbed over, see wound app [application]." *On 2/11/21 documentation by licensed practical nurse (LPN) AA stated: -"Old left thigh pressure area is closed, but filled with fluid and slightly draining yellow fluid. Resident has new thigh high ted hose seeming to	F 686		

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F 686	Continued From page 67 push fluid out. Resident also has an open area on back of left high. Applied optifoam to both. Resident was up in chair today but continues with painful edema." *On 2/11/21 LPN AA documented she faxed resident 3's physician MD H. *On 2/11/21 MD H replied "Have [CNP I's name] CNP evaluate please 2/11/21." *On 2/12/21 RN C documented "Refusing ted hose, states they are hurting her thigh and cannot wear below the knee, it causes too much pain. Agreed to try tubigrip, put on both legs right above the knee. Says she will give it a try and let nursing know if it works for her or not." *On 2/15/21 LPN AA documented "Two open areas open on left thigh; applied two 4x4 optifoam dressings. Upper wound has lots of yellow drainage). Applied 3x3 optifoam area to area on bottom left thigh." *On 2/17/21 RN C documented "Area on left lateral thigh draining, skin tear on left upper back of thigh, abrasion right upper thigh, spoke with [CNP I's name] 2/16/21, will get give [sic] update on Thursday if improving and discuss if further treatment needed." Review of CNP I's documented visit notes regarding resident 3 for February revealed: *On 2/18/21 revealed: "[Age of resident] patient seen today in her resident as [nursing home name] for wound evaluation. Patients PCP [primary care physician] was notified on 2/11/21 of worsening appearance to left thigh wound despite wound care being performed by [name of nursing home staff]. Patient's PCP faxed the facility back on 2/11 requesting I be asked to evaluate wound. I was notified today 2/18 to see patient for evaluation of wounds. This was the first I have been notified by [RN C's name] at	F 686		

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F 686	Continued From page 68 [nursing home name] regarding wound worsening and asked to evaluate. Wound to left thigh started due to being left in a wheelchair for a prolonged period of time per her report. Area has now become open and is draining serosanguineous drainage [yellow drainage with blood]. Staff is applying Medihoney an an optifoam to the area with no improvement. She also has an open area directly below this wound that is smaller in size as well as an open area behind her left knee, extending medially around the back of her knee along the skin fold...." Review of resident 3's February 2021 "left rear thigh" wound evaluations revealed: *There was an evaluation completed on 2/9/21. *The evaluation stated the injury was a new in-house acquired pressure injury. *No goal of care listed. *There was not any treatments marked such as: -Cleansing solution. -Debridement. -Primary Dressing. -Secondary dressing. -Modalities. -Additional care, such as interventions. *Nothing was marked for provider, family, or dietician notification. *Eight days later there was another evaluation completed on the "left rear thigh." *The wound was still listed as new, in-house acquired stage II pressure ulcer. *There was no drainage noted. *No goal of care listed. *There was not any documentation of any treatments marked such as: -Dressing appearance. -Cleansing solution. -Debridement.	F 686		

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F 686	Continued From page 69 -Primary dressing. -Secondary dressing. -Modalities. -Additional care, such as interventions. *Nothing was marked for provider, family, or dietician notification. *There was an evaluation for a "left thigh (lateral)" wound completed on 2/9/21. *The wound was classified as a stage III pressure ulcer that was present on admission. *The wound was marked to be 1-3 months old. *Provider notification was not marked. *There was a wound evaluation completed on 2/17/21. *The location of the wound listed as, "Left Thigh (Rear)." Review of resident 3's 2/1/21 through 2/18/21 repositioning log revealed: *There had been 432 total hours during that time period. *She should have been repositioned every two hours. *There were 216 opportunities to reposition her in 18 days. *There were 103 missed repositioning opportunities in 18 days. 7. Review of resident 16's EMR revealed: *She was admitted to the facility on 9/22/20. *The facility completed a skin sweep on the resident residents on 2/2/21, resident 16 had been included. -She had no pressure ulcers at the time of that skin sweep. *There was documentation on 2/5/21 of an open area to her right buttock but a skin evaluation was not completed until 2/16/21. *On 2/16/21 she had wound evaluations for four	F 686		

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F 686	Continued From page 70	F 686		

new in-house acquired pressure ulcers which included:
-Stage II on right ischial tuberosity (thigh).
-Stage II on left ischial tuberosity (thigh).
-Stage III on left buttock.
-Stage III on Coccyx.
*The 2/16/21 wound evaluations had no documentation of the physician being informed.
*There was documentation that RN D had attempted to notify the family on 2/17/21.
*On 2/17/21 a fax was sent to her medical doctor (MD) GG stating:
-"Need coding diagnosis for wounds: L [left] & R [right] Ischial Tuberosity, L buttock, Coccyx. Can we have wound orders: wash with generic wound cleanser. Apply Medihoney to wound base. Cover with dry dressing (telfa Island) Large. Change q [every] 3 days and prn [as needed] when soiled or dressing saturated with drainage."

Review of resident 16's progress notes on the following dates revealed:
*On 2/2/21 documentated by RN D: "Skin assessment completed. Skin intact. Resident lower legs are discolored. Often choices not to wear her ted hose."
*Three days later on 2/5/21 documented by LPN R: "Small open area noted to right buttock. Area cleansed and hydraguard applied."
*On 2/8/21 documented by RN C: "Small open area on left upper thigh/buttock, appears to have been pinched by brief. Buttocks is red and irritated. Apply hydroguard twice daily and keep clean and dry."
*On 2/11/21 documented by LPN R: "Resident's buttocks is excoriated with several open wounds on left buttock. Area cleansed and hydraguard with optifoam applied."
*On 2/13/21 registered dietician FF documented

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F 686	Continued From page 71	F 686		

addition of protein added to residents diet due to a new stage II pressure area on left thigh.
*On 2/17/21 RN D documented, "Attempted to call husband [husband's name] to update him on resident skin concerns and going to ask doctor for new treatment. Air mattress was put on bed to replace the pressure redistributing mattress that was on bed. Left message for husband to return call for update."
*On 2/17/21 RN C documented: "Assessing pressure injury on thigh, 3 stage III pressure injuries noted, fax out to [MD GG] for treatment orders, and requested to decrease scheduled docusate due to having frequent stools."
*On 2/18/21 RN C documented: "[CNP I's name] CNP saw on rounds- ordered labs for AM and every 6 months, wound care referral for pressure injuries, decrease docusate sodium to twice daily and PRN. See NH rounds note."

Review of resident 16's February 2021 treatment administration record (TAR) revealed:
*Weekly skin checks on 2/2/21 she was documented to have:
-Abnormalities noted on feet, macerated areas on her sacrum gluteal folds, and abrasions on the tips of her toes.
*Weekly skin check on 2/9/21 she was documented to have:
--Abnormalities noted on feet, macerated areas on her sacrum gluteal folds, and abrasions on the tips of her toes, and resident wears oxygen.
*Weekly skin check on 2/16/21 she was documented to have:
-Abnormalities noted on feet and macerated areas on her sacrum gluteal folds.

Interview 2/18/21 at 4:00 p.m. with wound nurse/ RN C regarding resident 16's wounds revealed

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F 686	Continued From page 72 she was not sure how the stage III pressure ulcer didn't get noticed before, other than the resident had "flappy skin." Interview on 2/18/21 at 4:45 p.m. with MD H regarding resident 3 revealed: *He was resident 3's physician. *She was admitted with wounds, had been doing wound care, and had a wound vac. *By December 2020 the wounds were all doing better and/or had healed. *He had been notified on 2/11/21 about resident 3's wounds. *He informed the staff to have CNP I look at resident 3's wounds because she was allowed in the building. -As far as he was aware he and the other physicians were still not allowed in the building, that is why he asked to have CNP I look at resident 3's wounds. --That was why he had asked CNP I to look at her wounds. 8. Review of resident 18's EMR revealed: *He was admitted to the facility on 7/15/16. *From 12/31/21 through 2/19/21 there was frequent documentation regarding a red buttock and hydrogaurd being applied. *On 1/22/21 RN L documented: -"Peri [perineal] area & buttocks red. Hydrogaurd applied." *On 1/25/21 RN B documented: -"Assisted CNA [certified nursing assistant] with incontinence cares no irritation or breakdown noted. Barrier cream applied for protection." *The next documented progress note 2/2/21 RN D documented: -"Skin assessment completed today. Noted to have scratches to left outer foot and scab to left	F 686		

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F 686	Continued From page 73 shin. Hx [history] of falls. Will monitor areas until healed." *On 2/12/21 LPN CC documented: -"Open sore to coccyx. Yellow drainage noted. Opti foam dressing applied." *The next documented note about resident 18's coccyx on 2/12/21 by LPN CC revealed: -"Scar tissues over coccyx and scabs noted on LLE [left lower extremity present but healing appropriately." Review of resident 18's EMR evaluations revealed: *Since 12/31/21 resident 18 has not had any skin evaluations completed. *Resident 18's last Braden was completed on 11/24/20. Review of resident 18's February 2021 TAR revealed he had a red/macerated perineal area each week. 9. Review of resident 23's electronic medical record revealed : *He was admitted to the facility on 1/28/20. *He had a skin assessment on 2/2/21 documentated by RN D: -"Skin assessment completed today. Picture was taken of left buttock redness. Resident complained of tenderness." *On 2/3/21 RN C documented: -"Barrier cream applied twice daily, hospice notified of area, Roho cushion placed in recliner." *The next documented note about residents skin was on 2/8/21 by LPN K which stated: -"Resident would not let writer assist with night cares. Attempted to have resident change into clean clothing and resident refused. Resident did not let writer look at bottom and put cream on	F 686		

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F 686	Continued From page 74 sore buttocks." *On 2/10/21 RN D had completed a quarterly review for assessment reference date (ARD) which included "skin is intact." *On the next documented note on 2/15/21 RN HH stated: -"Resident [has] small open area to L [left] inner buttock, pink/red skin tissue surrounding the area. Barrier cream applied and non-boarderd phone [foam] placed." *On 2/15/21 documentation states that hospice, MD H, dietician, and family aware of open area. *On the night of 2/15/21 LPN K documented: -"Resident has a [an] open area on right side of abdomen under abdominal flap; area is white in middle and red around edges, not raised. Measures 10 mm long, 7 mm wide; oval in shape. Cleaned with wound cleaner, air dried, triple antibiotic cream applied and no adherent dressing. Resident has 4 small open areas on left side of buttocks; cream applied." *On 2/16/21 RN C documented: -"Stage II pressure injury on coccyx can we have an order to apply a thin hydrocolloid dressing changed every 3 days and PRN, also has a scratch on abdomen that we are covering with foam dressing and monitoring." Review of wound picture, evaluation, and progress notes for resident 23's open area on his abdomen with the following dates revealed: *Progress notes documented by LPN K on 2/15/21 at 8:52 p.m. stated: -He had a an open area on his lower right abdomen. *Review of skin and wound picture taken on 2/16/21 at 10:01 a.m. stated: -He had an open in-house acquired lesion that was "minutes old."	F 686		

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F 686	Continued From page 75 *On resident 23's wound evaluation on 2/16/21 stated: -They used soap & water to clean it, no dressing applied, no additional care or interventions and that the MD H was notified. --Progress notes stated they had cleaned it with a generic wound cleanser on 2/15 and, put a foam dressing on the wound on 2/16/21. Review of the provider's 2/16/21 notification for resident 23 revealed: -MD H had faxed back the order on 2/23/21. -RN D had noted the order on 2/21/21. Review of resident 23's care plan revealed: *Problem: "I have actual impairment to skin integrity due to needing more assistance-weakness." *Problem: "2/16 I have a pressure injusry stage II to my coccyx region." *Problem: "2-16 Open lesion to right abdomen Date initiated 2/7/21 revision on: 2/17/21" *Goal: "My pressure injusry will heal without complications through the next review date." *Interventions/tasks: -"Barrier cream to bilateral buttock. Fax out to doctor regarding wounds and possible order changes." -"Follow MD orders for treatment." -"I choose to sleep in my recliner. I had my bed taken out of my room. Roho cusion [cushion] placed in recliner. Date initiated 5/11/2020 Revision on: 2/3/21." -"Keep skin clean and dry. Use lotion on dry skin." -"Staff encourage and assist as needed to reposition every 2 hours or more as requested." -"supplements as ordered." Review of resident 23's repositioning log from	F 686		

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F 686	Continued From page 76 2/1/21 through 2/22/21 revealed: *There were 264 opportunities for repositioning resident 23. -There were 154 missed opportunities to reposition resident 23. Interview on 2/18/21 at 4:45 p.m. MD H regarding resident 23 revealed: *Resident was currently on hospice. *Had a diagnosis of lymphoma. *He was informed he had a very small stage I pressure ulcer on his bottom. -He was not aware of the stage II pressure ulcer on his coccyx. -He was not aware about the open lesion on his stomach. 10. Review resident 11's EMR revealed: *She was admitted to the facility on 8/9/2016. *She had been identified as one of the residents on the skin sweep conducted by the facility on 2/2/21. *Her skin assessment on 2/2/21 by RN D noted: "Head to toe skin assessment done today. Skin intact. No open areas or abrasions noted." *On 2/14/21 LPN AA documented: "Hydrogaurd applied to buttocks." *On 2/14/21 LPN K documented: "Resident has two dime sized open areas on inside of left buttocks. Cream applied" *On 2/16/21 RN C documented: "Pressure injury found on coccyx, stage II. Can we have an order for cleanse area with soap and water, apply skin barrier to peri wound and apply hydrocolloid dressing change every 3 days and PRN if loose or soiled." *On 2/17/21 RN D documented: "[Physician's name] was notified on 2/16/2020 [2021] of open area on coccyx and treatment	F 686		

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F 686	Continued From page 77 order received." *On 2/23/21 at 4:55 a.m. LPN K documented: "Small scab noted to the inside of right buttocks." *Later that day on 2/23/21 at 10:36 a.m. RN C documented: "Pressure injury to right buttock healed, scar tissue present, no scab noted. Will continue to monitor." Further review of resident 11's EMR revealed: *Wound evaluation on 2/23/21: the wound has an exact date of 2/15/21. -There was an open area documented on 2/14/21 in her progress note on 2/14/21. Review of resident 11's care plan revealed: *Problem: -"I have an actual pressure injury to my coccyx." *Goal: "I want my pressure injury to heal without complications through the next review date. Date initiated: 2/16/21. Target date 3/7/21." *Interventions/tasks: -"Cleanse coccyx with soap and water, apply barrier to peri wound and apply hydrocolloid dressing." -"I have a pressure redistributing mattress on my bed and redistributing cushion in my w/c [wheelchair]. Staff to encourage resident to lay down during the day as tolerated between meals." -"Nurse/Wound Care Nurse to measure and evaluate active wounds and treatment protocols weekly and as needed, and update MD with progress." -"Staff monitor [resident's name] skin folds and bony prominences during cares and baths for AS [as] signs of irritation or breakdown, and report changes for further evaluation." Review of resident 11's 2/1/21 through 2/22/21	F 686		

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repositioning log revealed:
*The staff should had repositioned her 264 times.
*They repositioned resident 11, 145 times.
-Which left 119 times that resident 11 had not been repositioned.

DDCO A was approached on 2/22/21 at 5:45 p.m. by the surveyor regarding the "100% audits that were done prior to survey entry":
*The surveyor stated that these audits were not given to surveyors when they previously asked for them on 2/18/21 and 2/19/21.
*The audits were all completed by DDCO A and there were no dates of when they had been completed.
-They mentioned the week of "2/1/21-2/6/21," "2/7/21-2/13/21,1" and "2/14/21-2/20/21"
*The surveyor asked why the audits stated "F686-Pressure Ulcers"
-DDCO A stated because she completed a "mock immediate jeopardy."
*The audits had included, "Education provided to staff" or "Education provided to nursing management team."
-There was no mention of who was specifically educated or when.
*In regards to the 100% facility skin weep that was completed and audits that were completed for that revealed:
*She had not realized she needed to have the audits documented.
*She asked the surveyor if she should not trust her nurses' documentation.

Surveyor: 29354
11. Review of resident 9's medical record revealed:
*An admission date of 12/7/21.
*She was admitted with an unstageable left foot

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F 686	Continued From page 79 ulcer, had a wound vac, and was to be seen at the wound clinic. Review of resident 9's 12/10/20 Medicare 5-day Minimum Data Set (MDS) assessment was coded as being at risk for developing pressure ulcers/injuries, had one unstageable pressure ulcer and one present on admission. Her 12/29/20 Braden score was sixteen indicating she was at risk for developing skin issues. Not every 7 days as required by facility policy. Review of resident 9's skin and wound evaluation form from 12/7/20 through 2/18/21 and confirmed by RN/MDS coordinator D revealed they had been completed on 12/7/20, 12/24/20, 2/8/21, and 2/18/21. 12. Review of resident 17's medical record revealed: *An admission date of 1/28/2020. *He had three stage four pressure ulcers present on admission. They were located on his left lower back, right lower back, and right trochanter. Review of resident 17's skin and wound evaluations from December 2, 2020 through February 16, 2021 revealed: *Skin and wound evaluations had been completed on 12/2/20, 12/9/21, 12/24/20, 1/20/21, 1/30/21, 2/9/21, and 2/16/21. *There were three areas documented with a stage four. *The 1/21/21 annual MDS assessment was coded as being at risk for developing pressure ulcers/injuries. -The 1/21/21 Braden Score for determining risk for developing skin issues was coded as seventeen indicating he was at risk.	F 686		

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F 686	Continued From page 80 Interview on 2/22/21 at 12:30 p.m. with RN/MDS coordinator D regarding resident's 9 and 17 revealed they were not consistent with weekly skin and wound assessment documentation. They were to be completed weekly. 13. Review of resident 13's medical record revealed: *An admission date of 12/29/20. *Admitting diagnosis of fracture of the right femur with closed fracture with routine healing. Review of resident 13's Braden Scale scores for Predicting Pressure Sore Risk on the following dates revealed: *1/22/21: sixteen. *1/29/21: fifteen. *12/17/21: fourteen. *A score of fifteen to eighteen indicated at risk. *A score of thirteen to fourteen indicated moderate risk. Review of resident 13's interdisciplinary notes on the following dates revealed on: *12/30/20: he did not have surgical wounds or non-surgical wounds. *1/1/21: a scab had been identified to his right inner ankle. *1/24/21: two open sores had been identified to his coccyx. Review of resident 13's Skin and Wound evaluations for three areas completed on 2/16/21 revealed: *An in-house acquired stage two pressure ulcer to his coccyx measuring an area of 1.5 cm by length of 2.6 cm by width of 0.8 cm with a depth of 0.1 cm.	F 686		

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F 686	Continued From page 81 -The pressure ulcer had been present for one week. -There was documentation the physician, resident/family, or dietician had been notified. *An in-house acquired deep tissue injury/pressure area to his lateral right foot measuring an area of 0.4 cm by length of 0.7 cm by width of 0.7 cm. -It had been coded as being new. -They had not coded the physician, resident/family, or dietician had been notified. *An in-house acquired deep tissue injury/pressure area to his right heel measuring an area of 4.0 cm by length of 2.9 cm by width of 2.1 cm. -It had been coded as being new. -They had not coded the physician, resident/family, or dietician had been notified. 14. Review of documentation provided on 2/18/21 from DDCO A regarding the facility skin sweep conducted on 2/2/21 had identified resident 14 as having pressure ulcers. Review of resident 14's medical record revealed: *An admission date of 8/5/20. *Diagnoses of: history of non pressure chronic ulcer of the left lower leg, varicose veins of left lower extremity and right lower extremity with ulcers, and lymphedema. *Was followed by the wound clinic. Review of resident 14's Braden Scale scores for Predicting Pressure Sore Risk assessment revealed on 2/17/21 his score was sixteen indicating he was at risk. Review of resident 14's Skin and Wound Evaluations from 12/2/20 through 2/17/21 revealed: *Two Skin and Wound evaluations had been	F 686		

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F 686	Continued From page 82 completed. *They had been completed on 12/2/20 and 2/17/21. *On 2/17/21: -He had a stage four pressure ulcer on his right lateral calf present on admission. -"Notes: Wound clinic treating wound, see chart for progress and measurements." *They had not documented the physician and resident/family had been notified. *On 12/2/20: -He had a stage two pressure ulcer. -There was no documentation where the pressure ulcer was located. -The pressure ulcer was acquired in house. -The wound was coded as being present for one to three months. -The area measured 7.5 cm by length 6.5 cm by width 1.9 cm. -"Notes: Returns to wound clinic after completing isolation for COVID 19." -The physician was coded as being notified. -They had not documented the resident/family had been notified. *They had not completed weekly Skin and Wound evaluations for him. Review of resident 14's interdisciplinary notes from 1/2/21 through 2/22/21 revealed: *On 2/2/21 at 9:30 a.m.: "Right leg is noted to have a new quarter sized wound on the upper back side of calf. Residents left leg is weeping." *On 2/2/21 at 5:07 p.m.: "Skin assessment done today. Buttock free of any open areas." *On 2/15/21 at 11:55 a.m.: "Small scab on toe of left foot when at wound clinic getting nails cut." *There was no further documentation in the interdisciplinary notes regarding size, color, drainage, or location of open areas.	F 686		

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15. Review of resident 19's medical record revealed:
*An admission date of 10/29/19.
*He was on Hospice.

Review of resident 19's 2/3/21 interdisciplinary notes revealed at:
*2:35 p.m.: "Skin assessment completed, left hip area is healed, right hip has open area, slight bleeding."
*4:56 p.m.: "Left hip is healed and right has opened up."

Review of resident 19's Skin and Wound evaluation for the following dates revealed on:
*2/2/21:
-He had a new facility acquired stage two pressure ulcer that measured area of 2.3 cm by length of 2.1 cm by width of 1.4 cm.
-The location of the above pressure ulcer had not been documented.
-Notes: "Had similar area on opposite him now healed."
--"Staff and resident both educated on the importance of repositioning and offloading pressure."
*2/9/21:
-He had a new facility acquired stage two pressure ulcer to his right lateral thigh that measured an area of 3.6 cm by length of 2.8 cm by width of 1.6 cm.
*Additional care, notification of the physician, and resident/family had not been addressed.
*2/16/21:
-The right lateral thigh pressure ulcer area measured 0.1 cm by length of 0.2 cm by width of 0.3 cm.

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F 686	Continued From page 84 16. Review of resident 21's medical record revealed: *An admission date of 4/13/20. *He had a history of pressure ulcers with skin grafting. Review of the annual 1/19/21 MDS assessment for resident 21 revealed he: *Required extensive assistance of two staff with bed mobility, transfer, dressing, toilet use, and personal hygiene. *Did not ambulate. *Was frequently incontinent of bowel and bladder. *Was at risk for developing pressure ulcers. *Did not have any pressure ulcers. *Was not on a turning and repositioning program. Review of the skin and wound evaluations dated 2/8/21, 2/16/21, and 2/23/21 for resident 21 revealed: *On 2/8/21 he had a new facility acquired unstageable pressure ulcer located to the left trochanter area. *There were eight days between skin and wound evaluations from 2/8/21 until 2/16/21. 17. Review of resident 22's medical record revealed: *An admission date of 6/15/20. *He was receiving hospice services. *He had pressure areas to both heels that were acquired at the facility. Review of resident 22's interdisciplinary notes from January 28, 2021 through February 20, 2021 revealed on: *1/28/21 at 12:14 p.m.: "Report from hospice aide that pressure sores started on resident's heels. Heel protectors on."	F 686		

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F 686	Continued From page 85 *1/31/21 at 9:27 a.m.: "Right outer heal is starting to turn bluish/black. Yellow and redness noted around area and bottom of heel. Outer left heel has a red scabbed area. Bottom of heel is yellow. Heel protectors on in bed and legs are elevated." *2/2/21 at 6:01 p.m.: "Skin assessment completed today-pictures were taken of left and right heel sores." *2/4/21 at 2:59 p.m.: "Applied betadine to heels. Whole right heel very mushy and purple. Yellow skin noted around area." *2/9/21 at 12:57 a.m.: "Left heel; small scab from blister. Right heel; large fluid filled blister, red and dark purple. Betadine applied; heel protectors applied." *2/11/21 at 2:17 a.m.: "Betadine applied to both heels. Left heel shows improvement with new skin noted under scabs. Right heel has large, fluid filled blister. Resident did not complain of pain when heels were pressed on." *2/12/21 at 11:23 a.m.: "See skin and wound assessment. It heel resolved-will continue to monitor area. Will continue with betadine paint to right heel-air dry then make sure heel protectors are on both feet. Updated [daughter's name]." *2/12/21 at 8:13 p.m.: "Applied betadine to both heels. Right heel is black with a fluid like behind the skin. Left heel is almost healed, dry skin appearance." *2/14/21 at 12:09 a.m.: "Right heel painted with betadine; no redness noted. Heel has small scab. Left heel painted with betadine, small amount of blood noted, wound left to open air. Heel protectors on." *2/14/21 at 8:55 a.m.: "Betadine applied to heels, left heel continues with scab; right heel large dark purple pressure area." *2/20/21 at 7:33 p.m.: "Writer applied betadine on his right heel pressure sore, which appears as a	F 686		

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F 686	Continued From page 86 large, dark purple blister." Review of resident 22's 2/2/21 Skin and Wound Evaluation received from the provider revealed: *He had a deep tissue injury (persistent non-bleachable deep red, maroon or purple discoloration) to the right heel. -It was facility acquired. -The area measured 43.3 cm by length of 8.9 cm by width of 6.4 cm. -Surrounding tissue was a blister. -Treatment was providine iodine (Betadine). *There was no Skin and Wound Evaluation for the left heel. *The right heel Skin and Wound Evaluation had been completed five days after being identified by a hospice aide. *There were no further Skin and Wound Evaluations received from the provider by the time of exit on 3/23/21. Review of the 2/17/21 Braden Scale sores for Predicting Pressure Sore Risk for resident 22 revealed a score of fifteen indicating he was at risk. Review of resident 22's 2/1/21 through 2/23/21 repositioning task flow sheet revealed: *"Monitor - Turn and Reposition. *Documentation revealed it had not been completed every two hours and prn twenty-three days out of twenty-three days. Review of resident 22's care plan with the following dates revealed: *Problem: -2/2/21: "Skin and wound eval [evaluation]: SDTI to right and left heel." -2/9/21: "Left heel resolved-will continue to	F 686		

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F 686	Continued From page 87 monitor area." *Intervention: -1/28/21: "Staff to reposition every 2 hours and prn." 18. Review of resident 24's medical record revealed: *An admission date of 8/17/20. *He passed away on 2/10/21. *He was on Hospice care. Review of resident 24's 2/2/21 Skin and Wound Evaluation revealed: *He had a new in-house acquired stage two pressure ulcer to his left ischial tuberosity measuring an area of 0.2 cm by length of 0.8 cm by width of 0.2 cm. *Education was provided to staff and resident on turning and repositioning as well as offloading pressure areas. *They had contacted Hospice for an air mattress for his bed. Review of resident 24's 12/30/20 Braden Scale scores for Predicting Pressure Sore Risk assessment score was fifteen indicating he was at risk. Review of resident 24's care plan with an 8/28/20 Interventions/Tasks revealed "Staff to reposition every 2 hours and prn." Review of resident 24's 2/1/21 through 2/11/21 repositioning task flow sheet revealed: *"Monitor - turn and reposition Q2h (every two hours)." -February 1, 2, and 3 had an X indicating it had not occurred. -February 4 through 10 was documented it had	F 686		

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not occurred every two hours.
-February 11th had three initials indicating it had occurred at 12:03 a.m., 3:24 a.m. and 3:24 a.m.
*He had passed away on 2/10/21.

Review of resident 24's interdisciplinary notes with the following dates revealed:
*2/11/21 at 10:43 a.m.: "Notified [name] at the [hospital name] on resident passing last evening."
*2/8/21 at 9:39 a.m.: "Hospice informed recorder that resident heals are red. Hospice is getting him booties to wear in bed."
-There was no Skin and Wound evaluation for the above.
*1/28/21 at 2:05 a.m.: "Has a blanchable red area the size of a quarter above his coccyx."
-The Skin and Wound evaluation had been completed five days later on 2/2/21.

19. Review of resident 25's medical record revealed:
*An admission date of 12/8/17.
*Diagnoses of: dependence on wheelchair, diabetes mellitus type 2, hemiplegia, hemiparesis, obesity, chronic kidney disease, peripheral vascular disease, and rheumatoid arthritis.
*She had been in the hospital from February 4 through 7, 2021.

Review of resident 25's interdisciplinary notes from 2/2/21 through 2/21/21 revealed:
*2/2/21 at 5:43 p.m.: "Skin assessment done-noted small open area to left buttock-see wound app [wound form]."
*2/4/21 at 10:26 a.m.: "Admitted to [hospital name]."
*2/4/21 at 11:30 a.m.: "Discussed with CNP [name] resident's condition this am and currently in ER. Also update on new stage II to buttock."

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F 686	Continued From page 89 *2/7/21 at 10:20 a.m.: "Resident returns to facility from [hospital name]. -Has two stage II pressure injury to left buttock." *They had identified she had a small open area to her left buttock on 2/2/21. *The CNP (certified nurse practitioner) had been made aware of the new stage II to the unidentified location of the buttock sixty-four minutes after being admitted to the hospital. Review of resident 25's skin and wound evaluations with the following dates revealed: *2/2/21 had an in-house stage two acquired pressure ulcer that measured an area of 0.5 cm by length of 0.8 cm by width of 0.8 cm by depth of 0.1 cm. -They had not indicated where the pressure ulcer was located. *2/7/21 readmission identified two pressure ulcers to her left buttock. -They were both staged as a two. --The first one measured 1 cm by 1 cm. -The second one measured 1.5 cm by 0.8 cm. *2/12/21 present on admission stage two pressure ulcer that measured an area of 7.6 cm by length of 4.0 cm by width of 2.6 cm. -It had been present for one week. -She had been admitted five days earlier. -Under the notes section was "Area is now closed. Will continue with hydroguard for protection." -It had not indicated where the pressure ulcer was located. *2/23/21 had been present on admission stage two pressure ulcer to the right buttock that measured an area of 1.4 cm by length of 1.6 cm by width of 0.7 cm. -It was marked as being present for one week. -She had been readmitted to the facility sixteen	F 686		

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F 686	Continued From page 90 days earlier. Review of resident 25's 2/1/21 through 2/22/21 repositioning task flow sheet revealed: *"Monitor - Turn and Reposition Q2h. -February 1, 2, and 3 had an X indicating it had not occurred. -February 4 had one signature at 10:46 p.m. indicating it had occurred once. -February 5 had three signatures indicating it had occurred three times. -February 6 through 22 was documented it had not occurred every two hours. *Documentation on the repositioning log for February 4, 5, 6, and 7 had indicated she had been turned and repositioned. -She had been in the hospital on those dates. 20. Interview on 2/19/21 at 3:14 p.m. with RN/MDS coordinator D regarding resident skin issues revealed: *She had been employed for twenty-nine years. *She worked as the MDS coordinator along with another nurse. *She did MDS assessments 1/2 time. *She had helped with the "skin sweep" on 2/2/21. *They had checked all the residents from head to toe. *They had met as a leadership team and:. -Done a root-cause analysis to discuss the skin issues. --The root-cause analysis was not part of the residents medical record. -Had talked about changes to assess wounds and provide education to the staff. -Identified they had some residents with skin issues but had not provided a number. -Obtained physician changes for their treatments. -Had been working on doing weekly skin	F 686		

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assessments.
-Encouraged the charge nurses to get skin assessments done and documentation completed.
*The DNS wanted a report every Thursday from the wound nurse.
*Needed to do better at notifying family and physicians.
*Knew they needed to help the wound nurse.
*Were going to try and do this as a team.
*Asked the nurses to take a wing and be responsible for the wounds.
*Had not allowed the physicians into the building except for emergencies or a change in condition.
*Would screen the physician first for COVID-19.
*Visitation depended on the community positivity outbreak percentage for COVID-19.
*She helped with admissions.
*They had done full vital signs, skin assessments, BM checks, lung sounds, pain control, checked if there were falls from home, edema, eyes, teeth, and helped input medication orders into the computer.
*The INR was addressed by the physician or they would come with orders.
*[Name] pharmacy regulated the INR.
*They used a tablet to do the weekly skin assessments.
-The above would be pulled into an "evaluation."
-They did head to toe assessments on admit.
-Orders were sent to eLTC pharmacy.
-They would document in the progress notes.
*The process moving forward for skin issues was for RN/staff development coordinator F, RN/wound nurse C, and RN/MDS coordinator D to be responsible for skin audits.
*Prior to this they had documentation on the treatment administration record (TAR).
*The Braden scale was to be done on admission,

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F 686	Continued From page 92 nursing reviewed it quarterly, annually, and with a significant change. *They were looking at doing Braden scales with newly identified wound changes. *The skin issues were put "up in the risk management" section. *If they identified a new pressure ulcer they were going to do a Braden Scale. *They had started skin assessments on 2/2/21 on the 400 wing. -She was responsible for the 400 wing. Interview on 2/19/21 at 4:01 p.m. with RN/wound nurse C revealed: *They have had chaos. *They did not realize what needed to be done each week with wounds. *Nurses had come from a sister facility and provided education to them on pressure ulcers. *The previous wound nurse had quit in November 2020. *She had started in September 2020. *She was not aware of what happened with wounds but had gone along with the previous wound nurse on rounds. *Things "fell through the cracks" with the wounds. *It was difficult without a DNS. *She had not received any wound certification. *On 2/2/21 they had done a "skin sweep." -They had found between ten and fifteen residents with pressure ulcers. *Prior to the skin sweep and the education received from their sister facility she had not known half of what the process was from beginning to end with pressure ulcers. *The weekly wound assessments had started a few weeks ago. *They did not have the "original wound sweep" information in the residents medical charts.	F 686		

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F 686	Continued From page 93 *The electronic medical record system - point click care (PCC) had the skin/wound evaluations done weekly. *She felt the process had improved. *It had been chaos since it all began with the skin and wound issues. *She felt things had been overlooked. *She did not know how it would be set up but they had assigned a person to watch each wing. *She had worked the floor. *With the skin sweep they had not done a root cause analysis. *They had identified four new pressure ulcers this week. -They had done a root cause analysis with it. *Physical therapy (PT) and occupational therapy (OT) had been involved with some of the residents with skin and wound issues. *They had a leadership meeting each day to determine who might be in need of additional care. *They had talked about having the wound care nurse [wound clinic name] come to the facility. *They had completed a few audits for skin. *The medical director and the CNP were allowed in the building. -If they had an outbreak of COVID-19 they would not be allowed in the building. Surveyor 42477: Interview with an anonymous provider on 2/18/21 at [time withheld due to anonymity] revealed: *There was a "complete lack of care in the facility." *There was a "complete lack of accountability for the lack of care in the facility." *A group of providers had agreed to send residents to the wound care clinic to ensure their wounds were cared for and monitored.	F 686		

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F 686	Continued From page 94 Interview with an anonymous licensed nurse on 2/19/21 at [time withheld due to anonymity] revealed they: *Did not have enough staff to address the residents needs. *They felt the amount of residents they had with wounds was the result of their lack of staff. *They did not have enough staff to toilet and reposition everyone every two hours. Surveyor 29354 Review of the provider's updated May 2019 Skin Integrity policy revealed: *"In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin ulcers/pressure ulcers/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 develop a skin ulcer/pressure ulcer/wound, care is provided to treat, heal, and prevent, if possible, further development of skin ulcers/pressure ulcers/wounds." *"Procedure: - 1. The resident's skin integrity is evaluated using the Braden Scale Evaluation. -2. The nurse completes the Braden Scale/Skin Integrity Evaluation at admission, then weekly for 3 weeks, annually, and with significant change of condition. -3. The nurse establishes a Plan of Care (POC) based on risk factors in an effort to limit their potential effects. -4. The resident's skin is inspected daily with completion of ADL's [activity of daily living] (unless resident is independent in ADL completion). Changes in the resident's skin are reported to the Licensed Nurse (LN).	F 686		

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F 686	Continued From page 95 -5. 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 "+." ---"-" indicates no skin impairment present. ---"+" indicates skin impairment present. -6. For skin impairment identified with admission (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the LN completes the following: --a. Documents. --b. Notifies the Physician. --c. Notifies Responsible Party/Family Member. --d. Evaluates environment. --e. Implements interventions and documents on the resident's care plan and Care Directive." -7. If skin impairment is noted after admission (in addition to the above steps), the LN: --f. Notifies Director of Nursing Services (DNS) of skin impairment that indicate a potential significant change in condition (Stage II or greater Pressure Ulcer). --g. The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the Pressure Ulcer was avoidable or unavoidable. This evaluation is documented in the Nurses Notes. -8. Non-Healing Wounds/Pressure Ulcers are reviewed at the Nutrition Hydration Skin Committee meeting. -9. Wounds are evaluated weekly by Center clinicians. --If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Representative are notified. --If a new treatment order is obtained the LN: ---a. Re-evaluates POC and resident's condition.	F 686		

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F 686	Continued From page 96 -11. Evaluate resident's compliance with POC. When the resident chooses to not have specified treatments or interventions implemented, The Center discusses the following with the resident and documents in the medical record." *Skin Integrity Definitions: -"Avoidable/Unavoidable Pressure Ulcers: --Avoidable: The resident developed a pressure ulcer and that the Center did not do one of more of the following: ---Evaluate the resident's clinical condition and pressure ulcer risk factors. ---Define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice. ---Monitor and evaluate the impact of the interventions. ---Revise the interventions as appropriate." --Unavoidable: ---The resident developed a pressure ulcer even though the Center had evaluated the resident's clinical condition and pressure ulcer risks. ---Defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice. ---Monitored and evaluated the impact of the interventions. ---Revised the approaches as appropriate."	F 686		
F 697 SS=J	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697	See next page.	

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F 697	Continued From page 97 by: Surveyor: 42477 Based on interview, record review, policy review, and the South Dakota Department of Health (SD DOH) online report review, revealed the provider failed to ensure one of three closed record sampled residents (19) and one of one sampled resident (7) received pain management for ensuring a: *Hospice resident's pain was managed, and the provider and/or hospice agency was notified. *Resident who was receiving pain medication received her medication timely. Surveyor 29354 These failures have a potential to expose all residents not receiving effective pain management to have their quality of life to be affected. NOTICE: Verbal notice of immediate jeopardy and the template was given on 2/19/21 at 6:00 p.m. An Immediate Jeoopardy situation was identified when the facility failed to implement Centers for Medicare & Medicaid Services. Notice of Immediate Jeopardy was given verbally to the Divisional Director of Clinical Operations A, director of nursing services E, and registered nurse/staff development coordinator F. At the above time the Divisional Director of Clinical Operations A was asked for an immediate plan of removal to ensure all staff working wth residents ensured they maintaned an ongoing communication regarding pain management between the facility, Hospice Provider, and the physician.	F 697	**Directed Plan of Correction** **Firesteel Healthcare Center, Mitchell** **F697** **Corrective Action:** 1. *Time cannot turn back the clock to the dates and events surrounding: -Lack of adequate pain management for resident 19. -Timely response to calls for additional medications. Director of Nurses (DON) and administrator were provided re-education on 3/18/2021 by the DDCO. The provider in consultation with the Divisional Director of Clinical Operations and medical director reviewed the plan prepared for removal of the immediate jeopardy. Reviewed necessary policies and procedures about appropriate and adequate pain management.	3/19/21

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F 697	Continued From page 98 PLAN: The administrator submitted an email that included the final written removal plan. That removal plan was approved by the South Dakota Department of Health on 2/24/21 at 10:30 a.m. the following plan was approved: "1. Educate all licensed nurses on pain policy and notification to hospice and physician per policy, on proper documentation of pain level and communication with hospice and/or provider on residents with uncontrollable pain, recording pain scale in the medication/treatment record. Educate all licensed and unlicensed nursing staff on non-therapeutic pain interventions, and signs and symptoms of pain immediately prior to their next working shift. Education provided by Divisional Director of Clinical Operations to nursing management team who in turn will educate all nursing staff. Education will be completed by 2/22/2021. Sweep of all residents will be completed on 2/22/21 to check for pain and had pain medication administered as ordered by the physician. 2. Audits will be verified by the ED after the DNS completed/DNS or designee on proper notification and intervention on residents with uncontrollable pain to provider and hospice (if involved), recording pain scale in the medication/treatment record, and knowledge of non-therapeutic pain interventions. 3. Compliance date 2/22/2021." An onsite revisit was conducted by surveyors on 2/24/21 at 12:35 p.m. Immediate Jeopardy was removed on 2/22/21 at 2:56 p.m. after the removal plan implementation was verified during an onsite visit. After removal of the Immediate Jeopardy, the scope/severity of this citation is	F 697	Reviewed resident assessment process and care plan to meet the identified needs of the individual resident(s). There is adequate staffing to meet the needs of the residents. All staff licensed and unlicensed who are responsible for oversight of care or direct care will be educated about their roles and responsibilities for response to the resident experiencing pain by DNS, SDC, RCM or designee by 3/19/21. Staff not in attendance will be educated prior to their next working shift. **Identification of Others:** 1.*ALL residents experiencing pain have the potential to be affected. *ALL licensed and unlicensed staff completing their assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities in pain management will be provided by DNS, SDC, RCM or designee by 3/19/2021. Those not in attendance will be educated prior to their next working shift.	

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F 697	Continued From page 99 level "G". Surveyor 42477 Findings include: 1. Review of the SD DOH online report submitted on 2/16/21 revealed: *Registered nurse (RN) Y was the primary hospice nurse for resident 19. *She had been coming in the facility everyday for the last 10 days. *RN Y arrived at the facility at 11:00 a.m. on 2/16/21. *She stopped at the nurse's station to receive an update from the nursing staff for resident 19. -While at the desk she stated she could hear him "screaming and crying" from behind his closed door. *RN Y entered his room and found him screaming and crying in pain. *RN Y asked LPN X when resident 19 was last treated for pain and she replied: -Ativan Intensol 2 miligram (mg) /1 milliliter (mL) "earlier this morning." *At 11:20 a.m. RN Y administered his scheduled dose of Oxycodone 5 mg which was scheduled every 4 hours. -She also administered 20 mg of Morphine Sulfate (20 mg/1 mL) and 1mL of Ativan Intensol. *At 11:50 a.m. he was still crying in pain so RN Y notified her supervisor and the hospice medical doctor (MD) H. *He had been transferred by ambulance to the hospital to receive pain management. Review of resident 19's EMR revealed: *He was admitted to the facility on 10/29/19. *His diagnoses included: -Personal history of transient ischemic attack.	F 697	**System Changes:** 2. Root cause analysis answered the 5 Whys. Problem: Facility failed to appropriately control residents level of pain. 5 whys: 1.Facility wide staff were not educated on non-therapeutic pain interventions, signs and symptoms of pain 2.Facility failed to educate nursing staff on the pain policy, hospice and physician notification policy 3.Nursing leadership failed to appropriately educate staff on pain management policy and procedure 4.Nursing management team was not held accountable to ensure the above training was provided. Root cause analysis to problem: DNS was out on medical leave of absence and facility did not appoint or ensure the position/job responsibility of the DNS were appropriately filled.	

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F 697	Continued From page 100 -Cerebral infarction without residual deficit. -Major depressive disorder, recurrent sever without psychotic features. -Epiepsy. -Chronic obstructive pulmonary disease (COPD). -Encephalopathy. -Anxiety disorder. *Stage II pressure ulcer to his right hip. *Healed pressure ulcer to his left hip. Review of resident 19's current care plan with the following dates revealed: *On 05/05/2020 there was a problem listed as: -"The resident has the potential for discomfort" -A goal of: "The resident will not have an interruption in normal activities due to pain through the review date." --Target date 4/18/21. *The interventions and tasks that were listed were: -"Administer scheduled pain medication as ordered." -"Monitor/record/report to Nurse any s/sx [signs/symptoms] of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). *"Monitor/record/report to Nurse loss of appetite, refusal to eat and weight loss." *"Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. *"Transferred to Avera Queen of Peace for uncontrolled pain."	F 697	The administrator and or DNS are responsible for monitoring or overseeing those staff who provide direct care will be educated and aware of their roles and responsibilities for adequate and timely pain management. The ED, DNS and DDCO contacted the South Dakota Quality Improvement Organization (QIN) on 3/19/2021 the discussion surrounded the details of the 2567, the RCA/5 whys and the resources available to the center. **Monitoring:** 1. Administrator and or DON will conduct at minimum 3 X per week on alternating shifts, for 4 weeks, a review of those residents on pain medication and management, not just those on hospice, staff response and follow-up for medication administration 2. After 4 weeks of successful monitoring, then will monitor 1 X per month for 3 months. Monitoring results will be reported by administrator and or DON to the QAPI committee and continued as determined by the committee and medical director.	

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F 697	Continued From page 101 Review of resident 19's current February 2021 physician's orders revealed: *"Tylenol Tablet 325 MG (Acetaminophen) Give 650 mg by mouth three times a day for general pain." *"Acetaminophen Tablet Give 325 mg by mouth every 3 hours as need for pain Give 2 tabs every 3-4 hours prn [as needed] for pain." *"IBU Tablet (Ibuprofen) Give 600 mg by mouth two times a day for Pain related to OTHER INTERVERTEBRAL DISC DEGENERATION, LUMBOSACRAL REGION." *An order with a start date of 2/15/21, "oxyCODONE HCL [hydrochloride] Tablet 5 MG Give 5 mg by mouth every 4 hours for pain." *"LORazepam Concentrate 2MG/ML Give 0.25 ml by mouth every 2 hours as needed for Anxiety AND give 0.5ml by mouth every 2 hours as needed for Anxiety AND Give 0.75 ml by mouth 2 hours as needed for Anxiety AND Give 1ml by mouth every 2 hours as needed for Anxiety." *"Morphine Sulfate (concentrate) Solution 20mg/ml *Controlled Drug* Give 0.25 ml by mouth every 1 hours as needed for Mild pain AND Give 0.5 ml by mouth every 1 hour as needed for Moderate pain AND given 0.75 ml by mouth every 1 hour as needed for Moderate/Severe pain AND given 1 ml by mouth every 1 hours as needed for Severe pain." *An order that was discontinued on 2/6/21, "oxyCONDONE HCL Tablet 5MG Give 2.5mg by mouth every 4 hours as needed for Pain-Moderate 1 tab [tablet] po [by mouth] every 4 hour[s] prn pain while awake." *An order that was discontinued on 2/12/21, "MS Contine Tablet Extended Release 15 MG (Morphine Sulfate ER) Give 15 mg by mouth at bedtime for pain." *An order, "Discontinue the Morphine 15mg	F 697		

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F 697	Continued From page 102 scheduled but still ok to give prn Morphine as needed." *An order, "Pain Monitoring: Monitor for pain every shift either verbal or non-verbal signs. Document yes if monitored and no pain was observed or verbalized, Select chart Other/see nurses notes' and enter findings in appropriate progress notes including the pain scale of 1-10. every shift." Review of resident 19's February 2021 treatment administration record revealed: *For pain monitoring, "Pain Monitoring: Monitor for pain every shift either verbal or non-verbal signs. Document yes if monitored and no pain was observed or verbalized, Select chart Other/see nurses notes' and enter findings in appropriate progress notes including the pain scale of 1-10. every shift." *There was a check mark every day shift and night shift from 2/1/21 to 2/15/21. -There was a check mark on the day shift 2/16/21. Review of resident 19's February 2021 medication administration record revealed: *He was to receive 600 mg of ibuprofen by mouth two times a day for pain. -It was on hold from 2/1/21 through 2/15/21 at 8:46 a.m. --He had not received it on 2/15/21 or the morning of 2/16/21 because it was "on order from the pharmacy." *He had an order to receive acetaminophen 325 mg by mouth every 3 hours as needed for pain. "Give 2 tabs [tablets] every 3-4 hours for prn pain. -He received PRN Tylenol once on 2/11/21 and twice on 2/12/21. --He had not received PRN Tylenol any other	F 697		

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F 697	Continued From page 103 days in February 2021. Review of resident 19's recorded pain levels revealed: *2/13/21 through 2/16/21 he had pain levels ranging from 8 to 10. -The pain scale was from 1 to 10 with 10 indicating severe pain. *Documented pain levels on: -2/13/21 at 11: 01 a..m.: 10. -2/15/21 at 3:56 a.m.: 8. -2/15 at 9:47 a.m.: 9. -2/15/21 at 12:54 p.m.: 9. -2/15/21 at 2:56 p.m.: 8. -2/15/21 at 2:57 p.m.: 8. -2/16/21 at 11:42 a.m.: 10. -2/16/21 at 2:38 p.m.: 9. *There was not follow up pain scales on 2/13/21 or 2/16/21. -There was not documented pain ratings on 2/14/21. Review of resident 19's progress notes with the following dates revealed: *On 2/13/21 at 10:06 p.m. RN BB documented: -"Hospice called and spoke with [nurse's name] was updated on continues with pain and calling out to clarify orders." *On 2/14/21 at 1:35 a.m. RN BB documented that he had not received his Oxycodone for pain because he was asleep. *On 2/15/21 at 4:19 a.m. there was documentation by RN BB stated: -"Resident fell out of bed to floor but fell onto mat on floor and bed was in low position..." --"....Resident is on Hospice and contines having pain. Will update Hospice to see if can improve pain control..." *On 2/15/21 at 4:40 a.m. RN BB documented that	F 697		

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F 697	Continued From page 104 she spoked to Hospice about fall, new abrasions, lack of pain control..." *He continued to receive PRN Morphine that was ineffective for managing his pain levels. *On 2/16/21 at 11:42 he was given Morphine. *On 2/16/21 documentation by LPN X stated: -"Resident was transferred to the Hospital per Hospice. For general admission, d/t [due to] decline in condition. Resident was moaning and s/s [signs and symptoms] for discomfort, medication was not comforting resident. Left the building at 1220 on this day Feb 16, 2021." *On 2/16/21 at 2:39 p.m. LPN X documented the given medication was not effective. Further review of resident 19's medical record revealed: *On 2/11/21 documentation stated: -At 3:00 a.m. RN II documented: "Resident has been more anxious and restless off and on from evening until present. Resident given Acetaminophen 650 mg for discomfort and Benadryl for itching, and will hold oxy at 4:00 a.m." -RN II had given him Tylenol at 3:10 a.m. -One hour later RN II held his scheduled oxycodone because he was "sleeping." -LPN AA documented on 2/11/21 at 4:35 p.m., "Resident is weak and restless..." -He was given prn Lorazepam at 5:35 p.m. -His scheduled Oxycodone was not given at 8:00 p.m. due to "drug refused." -The MS contin was also held at bedtime. -No other prn Lorazepam, Tylenol, or Morphine was given to resident 19. *On 2/12/21 documentation stated: -2/12/21 at 8:04 a.m. Hospice note regarding 2/11/21 stated: RN from facility called hospice with an update. Patient had a fall last night.	F 697		

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F 697	Continued From page 105 Patient was switching from one end of the bed to the other. Patient slipped out of bed and fell on the mat. Held the MS contin last night and patient did sleep much better. [RN II's name] has also been giving Benadryl prn for itching." -On 2/12/21 at 1:00 p.m. RN C documented, "Spoke with [hospice nurse's name] with hospice, she is working on adjusting pain medications..." -Hospice note on 2/12/21 at 1:13 p.m. stated: "...staff noted he is more aggitated [sp] after taking MS Contin 15 mg at bedtime. SN [skilled nurse] spoke with [pharmacists name] and [Doctor's name] and will change orders- d/c [discontinue] MS Contin, start Oxycodone 5 mg at bedtime and 0200 [2:00 a.m.] and cont [continue] previous order for Oxycodone 2.5 mg every 4 hours while awake." --The note continued, "...Staff heled [sic] Oxycodone during day yesterday due to agitation and gave ACM [Acetaminophen] prn and Lorazepam x 1 dose." -He was documented to have received his Oxycodone during the day on 2/11/21, he had received it at 8:00 a.m., 12:00 p.m., and 4:00 p.m. -On 2/12/21 he had not receive four of his scheduled six doses of Oxycodone. *On 2/13/21 documentation stated: -3:50 a.m. he received Tylenol. -4:00 a.m. his scheduled dose of Oxycodone was held due to resident "sleeping." -4:38 a.m. he was "restless, agitated yelling out in pain earlier in the evening." -2:43 p.m. he was "yelling out" -10:06 p.m. the facility documented that they called hospice and let them know he was calling out, continued with pain, and to clarify orders. -No prn Morphine was given on 2/13/21 which he could receive every hour.	F 697		

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F 697	Continued From page 106 -One dose of prn Lorazepam was given at 2:06 p.m. which he could receive every 2 hours. -No PRN Tylenol was given on 2/13/21. *On 2/14/21 documentation stated: -12:36 a.m.: "...Continues having quite a lot of pain. Meds given as ordered." -10:31 a.m.: "Resident occasionally restless and yells out..." -8:10 p.m.: "Resident remains very high anxiety and continues to try to get out of bed." -On 2/14/21 prn Lorazepam was given at 12:13 a.m., 3:59 a.m., 8:21 p.m., 11:36 p.m., -On 2/14/21 no PRN Tylenol or PRN Morphine was given. *On 2/15/21 documentation stated: -4:00 a.m. he had not received his scheduled Oxycodone because of "drug refused." -4:19 a.m., "Documentation of Fall. Hospice updated on pain." -On 2/15/21: PRN Morphine was given at 9:47 a.m., 1:13 p.m., 2:57 p.m. -On 2/15/21: PRN Lorazepam was given at 1:13 p.m. and 3:40 p.m. *Prior to Hospice arriving at the facility resident 19 had not received PRN pain medication. Inteview on 2/19/21 at 6:00 p.m. with divisional director of clinical operations (DDCO) A, RN E, and RN F regarding resident 19 revealed: *DDCO A felt hospice was responisble for resident 19's pain control and had been in facilty every day. *DDCO A stated that staff could not give Morphine to the resident because he was allergic to it. *DDCO A agreed the facility nurses are responsible for monitoring and treating resident 19's pain control when hospice providers were not in the building.	F 697		

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F 697	Continued From page 107 Review of resident 19's hospice notes revealed: *Morphine was discontinued because of some falls and he had and because staff felt he had been more aggitated after taking it. -He had been taking Morphine for years prior. *RN Y documented: "[nurse's name] called with an update. Patient had a fall last night. Patient was switching from one end of the bed to the other. Patient slipped out of bed and fell on the mat. Held the MS contin last night and patient did sleep much better. [nurses name] has also been giving benadryl prn for itching." Surveyor: 29354 2. Interview and observation on 2/18/21 at the following times with resident 7 regarding her admission on 2/3/21 revealed: *At 4:00 p.m.: -She had been admitted to the facility following hip surgery. -The call lights had not always worked. -She had told staff multiple times it had not worked. -The last time being the past weekend which had been Valentine's weekend. -She had reported it on a Friday and staff told her she would have to wait until Monday to let maintenance know. -A CNA had given her a different call light cord on Saturday night. -They had plugged the call light cord into the room mates call light unit located on the wall. --There was no call light cord plugged into the call light unit designated for her side of the room. *At 4:05 p.m.: -She put her call light on. -The light on the call light unit was blinking from	F 697		

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F 697	Continued From page 108 her roommates wall unit. *At 4:08 p.m.: -Nurse aide Q brought a container of water. -She had not seen the call light on. -She was going to come into the room anyway with the water. -It was her fourth day "working solo." *At 4:15 p.m. continued interview with resident 7 revealed: -She had to wait long periods of time for the staff to get her pain medication. -She had not gotten pain medication on February 4, 5, and 8. -On February 8th she had put her call light on at 6:30 a.m. -She had not gotten her pain medication by 9:00 a.m. so she put her call light on again. -No one had stopped by to confirm they had seen her call light on and were getting her the pain medication. -She stated her pain level was between a six and a seven out of ten. -She had chronic pain usually scored at a four out of ten. -She had a fentanyl patch and could have PRN hydrocodone. *At 4:40 p.m. licensed practical nurse (LPN) T came behind the nurse station. Interview at that time regarding call lights revealed: -When a call light was activated a notice came across the "walkies." -CNAs had the walkies with them at all times. -Nurses and medication aides did not always have a walkie with them because they did not have enough for all staff or they had not plugged them in so the batteries were dead. -The time listed on the computer screen monitor was the time the call lights had been on.	F 697		

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F 697	Continued From page 109 Interview on 2/18/21 at 5:09 p.m. with director of nursing services (DNS) E regarding call lights revealed: *The staff were alerted to call lights over the walkies. *The call lights showed up on the computer monitors behind each nurses station. *Each staff member was to have a walkie with them. *There were times when the staff did not have a walkie. Those times had included: -If the prior shift had not plugged them in to be recharged. -If the walkies had been misplaced. -The staff had taken the walkies home with them. *It was not acceptable for a call light response time of twenty-three to twenty-four minutes. *The response time should be eight minutes or less. *She was out on the floor every day and if she observed a staff member without a walkie she would ask where it was and remind them to have one with. *There was no walkie or call light policy or procedure. Further interview on 2/18/21 at 6:10 p.m. with DNS E regarding call lights and the walkies revealed: *They had thirteen walkies available for staff who were working the floor. *There were not enough walkies for each staff member who were working the floor. *She had collected all the managers walkies for the staff to use on the floor for the evening/night shift on 2/18/21. *Her expectations would have been for call lights to be answered within eight minutes. *She confirmed twenty-one to twenty-four	F 697		

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F 697	Continued From page 110 minutes was too long for residents to wait for a staff response to a call light. Interview on 2/22/21 at 2:50 p.m. with DDCO A regarding resident 7's call light and pain medication not documented until 11:11 a.m. for a pain score of seven with after results document "E" for effective revealed she would need to check into it before answering the question. She never returned a reply to the surveyor. Review of the provider's updated June 2016 Pain Management policy revealed: *"The Center evaluates for, and attempts to manage/minimize, pain in residents." *Procedure: -"2. Residents' pain level is evaluated every shift by the LN (licensed nurse). Noted pain is evaluated and treated accordingly by the LN. Pain is also evaluated quarterly and PRN (when needed) using the RAI (resident assessment instrument)/nursing process. --a. Pain level is monitored and documented on the MAR (medication administration record). -3. When pain is not adequately controlled by current regimen, I, or if there is newly identified pain, the LN contacts the physician for consideration of new or modified treatment orders. -6. If the resident is a hospice client or receiving palliative/comfort care, the LN and hospice personnel collaborate to develop and evaluate the pain management Plan of Care (POC)."	F 697	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. Job descriptions were reviewed with DDCO, Administrator, DNS by 3/19/2021. 3. The Administrator or designee will complete audits regarding regarding F686, F684, F697 and F678 per the 2567. The results of these audits will be taken monthly to the QAPI committee for review and recommendations to continue or discontinue the audits. 4. The governing body will work with the DDCO weekly x 4 weeks to ensure the following audits are completed appropriately. There will be continued oversight and availability of the DDCO for the next quarter. Addendum PM 03/23/2021	03/19/21
{F 835} SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that	{F 835}		

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{F 835}	Continued From page 111 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: Surveyor: 32332 Surveyor: 42477 Surveyor: 29354 Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being for all seventy-six residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the course of the survey revealed executive director U, divisional director of clinical operations A, and director of nursing services E had not ensured the safe management and overall well-being of all the residents who lived in the facility. Review of the provider's May 2018 Director of Nursing job description revealed the DON would: *Manage administrative and functional areas related to nursing services. *Manage the overall operation of the department in accordance with company policies, standards of nursing, and government regulations to maintain quality care. *Carry out, coordinate, and manage administrative functions and areas of programs related to nursing services including documentation, medical records, nursing	{F 835}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 835}	Continued From page 112 supplies, quality assurance, and the infection control program. *Manage staff scheduling, selection, training, orientation, and supervision of the nursing department. *Comply with, support, and enforce company policies involving all safety and infection control procedures. Review of the provider's February 2015 Administrator job description revealed the administrator would: *Lead and direct the overall operations of the facility in accordance with customer needs, government regulations, and company policies, with a focus on maintaining excellent care for the residents while achieving the facility's operational and business objectives. *Manage each department's activities, communicate policies, evaluate performance, provide feedback, assist, observe, and coach the disciplines as needed. *Oversee regular rounds to monitor the delivery of nursing care, operation of support departments, cleanliness and appearance of the facility and ensure the resident needs were being addressed. *Ensure equipment and work areas were clean, safe, and orderly, and any hazardous conditions were addressed. *Ensure universal precautions and infection control, isolation, safety and sanitation practices and procedures were followed. *Maintain a working knowledge of and ensure compliance with all governmental regulations and agencies. Refer to F678, F684, F686, and F697.	{F 835}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435109	A. BUILDING _____ B. WING _____	R-C 02/23/2021

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F 837	Continued From page 113	F 837		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Surveyor: 42477 Based on observations, interviews, record reviews, job description reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being for all seventy-six residents in the facility. Findings include: 1. Refer to F678, F684, F686, and F697.	F 837	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. Job descriptions were reviewed with DDCO, Administrator, DNS by 3/19/2021. 3. The Administrator or designee will complete audits regarding regarding F686, F684, F697 and F678 per the 2567. The results of these audits will be taken monthly to the QAPI committee for review and recommendations to continue or discontinue the audits. The governing board will be in attendance at these meeting to review the audits.	03/19/21

IDR Firesteel Healthcare Center, Mitchell

IDR was held with Firesteel Healthcare Center, Mitchell on 3/29/21 at 1:00 p.m. per telephone conference call. Present for the provider was Petar Mirkovic, Executive Director; Lynn Lee, DON; and Sarah Comp, Divisional Director of Clinical Operations. Patricia Brinkley, Deputy Administrator, Deb Carlson, Deputy Administrator, and Diana Weiland, RN Public Health Advisor was present for the OLC.

The disputed deficiencies were F678, F684, F686, and F697. The provider submitted 700 plus pages of documentation for review prior to the IDR. Educational documentation for annual and new hire employees was requested during IDR, but not provided as not available 24 hours following IDR.

Following introductions Diana provided a brief explanation of the IDR process for those present then turned it over to the provider.

Sarah expressed appreciation for the opportunity to have the IDR, then proceeded to discuss the submitted documentation.

F678 – she expressed the physician call calendar was irrelevant to this situation, they utilize Avera eLTC after hours. She also voiced the responding RN was working within her scope of practice and felt it had not been 11 or 14 minutes before CPR had been initiated, things just didn't get documented because the CNA wasn't familiar. As to the mattress not being deflated before staring CPR, the second nurse responding, "knew and did it." Resident 5 weighed 465 pounds.

Sarah expressed this should have been noted as "past non-compliance" as they had identified the problem and had been working on it.

F684 -Sarah expressed resident 6 had multiple comorbidities and she was dead so where was the immediacy. She discussed all Avera providers have Coumadin dosing adjusted with Avera eLTC pharmacy. Had an order for lab on 2/11/21, order sent to the eLTC on 2/15/21. Staff education as related to anticoagulant therapy was requested. She also expressed staff had responded appropriately when resident discovered.

Sarah expressed this should have been noted as "past non-compliance" as they had identified the problem. Resident 6 died 2/17/21, the survey team entered on 2/17/21 in the afternoon.

F686 – Sarah expressed they identified the pressure ulcer problem when two law enforcement officers had arrived at the facility on 2/1/21 regarding resident 1 and a pressure ulcer. They completed a "skin sweep" on the 2nd and 3rd identifying 11 residents with pressure ulcers and/or skin conditions. They had provided education to all staff by 2/4/21. She also voiced resident 18 had never had a pressure ulcer and he was a long-standing resident and expressed frustration she believed the surveyors hadn't followed the critical element pathway and documented observations

Surveyor documentation does include staff interviews that indicate an incomplete process and the DON interview noted no auditing had been started for this process. She nor the administrator made no comments during the IDR to dispute this.

F697 – Sarah expressed resident 19 had ongoing pain management issues throughout his stay due to his cancer diagnosis. She voiced they had a collaborative working relationship with hospice. They did not administer IV Dilaudid or pain meds per pump. They would need to provide the education to staff; they did administer IV antibiotics and IV push Lasix. She contended hospice made the arrangements for resident 19 to be transferred. She didn't discuss he had been screaming loudly enough that when the hospice nurse had come to the facility, he was able to be heard through a closed door down the hall. She didn't discuss resident 7's concerns for timely response to call for pain medication.
Sarah expressed this too should have been noted as "past non-compliance."

Prior to the IDR Diana discussed with Dotty Brinkmeyer CMS Denver the elements of "past non-compliance."
Provider would need to have documentation that reflects:
*Description of deficient practice – what happened.
*Plan to correct.
*In depth analysis of how it occurred – Root Cause Analysis/negative outcome
*How facility identified affected residents and those potentially to be affected.
*Corrective action taken for affected resident(s).
*Measures/systems changes made to ensure will not recur or affect others.
*Monitoring corrective action – Key to process ongoing & documentation to evaluate effectiveness of change or adjust.
*Date of completion of plan.
*Signed and dated
Facility needs to bring this to attention of surveyor(s). Surveyor(s) not required to ask for it.

The survey team [Sue Bakker, Andrea Andres, and Juli Van Engen] discussed with Diana the survey and provider assertions that many finding items were never observed but there were interviews and documents reviewed that painted a picture of a broken system.

Following review, the IDR team determined all the findings have the potential to cause residents serious harm and there were deaths.

The determination was made to:
Retain F678 as immediate jeopardy and same S/S of G following the removal plan.
Retain F684 as immediate jeopardy and same S/S of G following the removal plan.
Retain F686 as immediate jeopardy and same S/S of H following the removal plan.
Retain F697 as immediate jeopardy and same S/S of G following the removal plan.