Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Maine Veterans' Home – Bangor

Location: 44 Hogan Road, Bangor, ME 04401

Onsite / Virtual: Onsite

Dates of Survey: 8/8/22 – 8/11/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 84

VA Regulation Deficiency	Findings
	A VA Annual Survey was conducted from 8/8/22, through 8/11/22, at the Maine Veterans' Home - Bangor. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.100 (b) Self-determination and participation. (b) Self-determination and participation. The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on record review, resident and staff interviews, clinical record review, and review of the facility policy titled, "Resident Rights," the facility failed, for two (2) of 18 sampled residents (Resident #14 and Resident #6), to promote a resident's right to make choices regarding aspects of his/her life. The findings include: 1. Review of the facility policy titled, "Residents' Rights," revealed: "Procedure: 5.1 Resident' Rights: MVH residents have a right to dignified existence, self-determination, and communication with and access to persons and services inside and outside of the MVH facility at which they reside including 5.1.1 The right to be treated by MVH's facility with respect and dignity, and to be cared for in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality." 2. Resident #14 Review of the resident's face sheet revealed Resident #14 was admitted to the facility in [DATE] and readmitted in [DATE] with

	diagnoses including, but not limited to, Paraplegia, Chronic Obstructive Pulmonary Disease (COPD), Cirrhosis of Liver, and Adjustment Disorder. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #14 had a Brief Interview of Mental Status (BIMS) score of 15, indicating he/she was cognitively intact. Further review of the MDS revealed Resident #14 was totally dependent on staff, requiring extensive assistance with activities of daily living (ADLs) including, but not limited to, dressing, bathing, hygiene, transfers, and bed mobility. On 8/9/22, at 12:20 p.m., an interview was conducted with Resident #14 to address any concerns with his/her care at the facility. The resident stated that two (2) nights ago (before the survey), they were the last resident to be put to bed. Resident #14 stated that they preferred to be in bed by 7:00 p.m. The resident stated the next morning, they did not receive their medication at the scheduled time and that staff did not wake them at their preferred time, which was 5:00 a.m. Resident #14 stated that they were unhappy and had "had enough" with staff not honoring their wishes. Resident #14 was asked to explain how staff did not honor their wishes and they revealed they had requested multiple times for staff to put them in bed at 7:00 p.m. Resident #14 stated that they liked to get up at 5:00 a.m., take their medications, and get dressed for that specific day. Resident #14 stated they did not get up at their requested time and was always last when it was time to go to bed. Resident #14 stated they had been at the facility for almost 10 years and did not have this problem before. Resident #14 stated it made them feel like they were not important, and that staff did not care about their preferences. Resident #14 stated it made them feel down and that other residents' preferences were acknowledged while theirs were not. Resident #14 stated they had complained to staff and filed grievances, but nothing had been resolved. On 8/9/22, at 2:37 p.m., an interview with Licensed Nurse A revealed on [DATE], during the morning shift, Resident #14 was agitated because they had not received their 5:00 a.m. medication on time. Licensed Nurse A stated Resident #14 had requested to get up at 5:00 a.m., and be put to bed at 7:00 p.m. Licensed Nurse A stated that they were unsure why staff did not honor Resident #14's preferences, however, it seemed to be a reoccurring thing. Licensed Nurse A stated they were a charge nurse, and this was not the first time this had happened. Licensed Nurse A stated that they knew Resident #14 had specific preferences and they should be honored by staff. On 8/9/22, at 2:55 p.m., an interview with Administrative Nurse A revealed on [DATE], that they received a phone call from Administrative Nurse B about Resident #14's behavior.

	Administrative Nurse A stated that they were not in the building at that time, but that they were the on-call nurse. They stated that the Administrative Nurse B revealed that Resident #14 was agitated and upset about the events that occurred over the weekend. Administrative Nurse A stated that Resident #14 was very particular when it came to how they wanted things, and that staff should honor their wishes. Administrative Nurse A stated that it was their expectation that staff honored the residents' wishes and preferences. Administrative Nurse A was asked by the survey team to provide Resident #14's individual Care Plan, grievances filed by the resident, and any documentation regarding their preferences. Administrative Nurse A did not have any supporting documentation indicating Resident #14's preferences. Review of Resident #14 Care Plan, with a start date of [DATE], did not address any of their current preferences or choices regarding waking up at 5:00 a.m., to take medication and get dressed. Further review of the Care Plan did not address any of their preferences for going to bed at 7:00 p.m. 3. Resident #6 Observation of respiratory treatment administration to Resident #6 by Consultant Staff A began at 8:30 a.m., on 8/10/22. Resident #6 was to receive DuoNeb (Ipratropium-Albuterol) 0.5 milligrams (mg) / 3 milliliters (ml) - 2.5 (3mg/3ml) via oral inhalation using a nebulizer. (Nebulizers are machines that turn liquid medications into a fine mist, allowing for easy absorption into the lungs.) During the observation, Consultant Staff A placed a 3ml vial of DuoNeb in a nebulizer cup, handed Resident #6 the nebulizer's mouthpiece, and turned on the nebulizer's compressor to deliver the medication. Upon completion of the nebulizer treatment, Consultant Staff A handed Resident #6 a mask, which was connected by large bore tubing to a cough assist machine and turned on the machine. [A cough assist machine uses a facemask to deliver gradual positive air pressure to the airway (inflation), followed by a rapid shift to negative air pressure (deflation), in an attempt to simulate a natural cough.] Resident #6 completed five (5) repetitions of breathing exercises using the cough assist machine and handed the mask back to Consultant Staff A. Consultant Staff A then handed Resident #6 an incentive spirometer. Resident #6 completed five (5) repetitions of breathing exercises using the incentive spirometer and handed the device back to Consultant Staff A. Consultant Staff A then handed Resident #6 an Acapella device. [The Acapella is a handheld airway clearance device with a

	mouthpiece on one (1) end into which a person exhales. It is used to help mobilize mucus from the airways for people with lung conditions that produce a large amount of mucus.] Resident #6 completed 10 repetitions of breathing exercises using the Acapella and handed the device back to Consultant Staff A. Consultant Staff A then handed Resident #6 the mask for the cough assist machine, and Resident #6 repeated a second cycle of breathing exercises using, in the same sequence as stated above, the cough assist machine, the incentive spirometer, and the Acapella. Between breathing treatments, Consultant Staff A and Resident #6 spoke about their preferences regarding the sequence of breathing exercises and performing a second full cycle of those exercises. Consultant Staff A commented to Resident #6 that, when the nurses do the nebulizer treatment and breathing exercises with them when Consultant Staff A is off-duty, they had to "set them straight" regarding those preferences. Review of Resident #6's clinical record revealed a MDS assessment with an ARD of [DATE]. In Section C: Cognitive Patterns, BIMS, Resident #6 scored 14 out of a possible 15, indicating that they were cognitively intact. In Section I: Active Diagnoses, the MDS indicated Resident #6 had the following diagnoses that compromised their respiratory system: Chronic Obstructive Pulmonary Disease, Respiratory Failure, Sleep Apnea, Asthma, and Hypoxemia. Review of Resident #6's Physician Order found the following: - "DuoNeb (Ipratropium-Albuterol) 0.5mg/3ml-2.5 (3) mg/3ml soln (solution) 3ml vial oral inhalation QID [four (4) times daily] 0800 1200 1600 2000. RT to administer 0800 and 1200 nebs (nebulizer treatments) M-F (Monday through Friday)." - "Nebs and cough machine x 5 reps (repetitions). Lungs diminished and slight improvement in inspiration with tx (treatment). Tx for 15 min (minutes)." - "Incentive spirometer four times a day. RT to do IS (incentive spirometer) with residents 0800 and 1200 M-F." - "Cough Assist adjust, RT to adjust per patient comfort and therapeutic result … 3 to 5 cycles as tolerated three times daily. RT to do cough assist weekday mornings." The above orders, when displayed on the Electronic Medication Administration Record (e-MAR), listed the breathing exercises at the top and the DuoNeb medication order at the bottom. There were no

	instructions directing staff to administer the DuoNeb medication before assisting the resident with their breathing exercises. Review of Resident #6's active Care Plan found no mention of the resident's preference with respect to performing two (2) cycles of breathing exercises using the cough assist machine, the incentive spirometer, and the Acapella device in that sequence. During an interview at 12:50 p.m., on 8/10/22, Administrative Nurse A was asked how the nurses knew which sequence to perform Resident #6's breathing treatments, since Consultant Staff A performed them in a specific sequence and the Physician Order did not specify that sequence. Administrative Nurse A stated that they probably did not know what order to perform them in if the sequence was not specified in the orders. During an interview on 8/10/22, at 1:17 p.m., Administrative Nurse A and Consultant Staff A reported that Consultant Staff A did Resident #6's breathing exercises in a specific sequence per the resident's preference and these exercises did not have to be performed in that sequence to achieve the desired therapeutic outcome. Administrative Nurse A and Consultant Staff A did acknowledge there were no special instructions given to the nurses regarding the resident's preferred sequencing of breathing exercises. When asked if the DuoNeb had to be administered before the breathing exercises in order to achieve the desired therapeutic outcome, they did acknowledge that the nebulizer treatment did need to be given first, and Consultant Staff A did acknowledge that the order for the DuoNeb did display on the e-MAR after the orders for the breathing exercises. During an interview on 8/11/22m at 2:06 p.m., Resident #6 explained their preferred sequencing of the respiratory treatment and exercises as follows, pointing to each device as they spoke: First the nebulizer device, followed by the cough assist machine for five (5) repetitions, incentive spirometer for five (5) repetitions, Acapella for 10 repetitions, then a second set of exercises using the cough assist machine for five (5) repetitions, incentive spirometer for five (5) repetitions, and Acapella for 10 repetitions. Resident #6 further stated the nurses had not been doing the exercises the way the resident liked, but now they were. Review of the resident's clinical record on 8/11/22, at 2:45 p.m., found the following orders that had been entered on [DATE]: - "Ipratropium-Albuterol 0.5mg/3ml – 2.5 (3) mg/3ml solution (3ml) inhalation four times a day 0800 1200 1600 2000 for COPD."

	- "Administration Instructions: [Consultant Staff] to administer 08:00 and noon time nebs M-F. When [Consultant Staff] not available, nursing to give duoneb [sic] prior to cough assist, IS, accapella [*sic*]." - "LIFE ACTIVITY: Resident prefers the following order for respiratory treatment deliveries: Neb treatment, cough assist, IS, and acapella. FYI (for your information) TAR (Treatment Administration Record) first date: [DATE]."
§ 51.110 (b) (3) Review of assessments. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on record review, observations, and staff interviews, the facility failed to ensure resident assessments were completed no less than once every three (3) months and revised as appropriate to ensure the continued accuracy of the assessments. Specifically, the facility failed to ensure one (1) resident (Resident #9) out of 26 sampled residents was assessed accurately for: status of vascular and pressure wounds; rejection of care; and ability to be interviewed about pain. The findings include: Resident #9 was admitted in [DATE] with diagnoses including Alzheimer's Disease, Memory Deficit Following Cerebral Infarction, Hypertensive Heart disease with Heart Failure, Dysphagia, Aphasia, Vascular Dementia, Congestive Heart Failure, and Peripheral Vascular Disease. Additional diagnoses, according to record review, included Non-Pressure Chronic Ulcer of Other Part of Left Foot with Unspecified Severity, Pressure Ulcer of Sacral Region Stage 3, Diabetes Mellitus, and Osteoarthritis. The [Date] Quarterly Minimum Data Set (MDS) indicated the resident had a Brief Interview for Mental Status (BIMS) of zero (0) out of 15, indicating severe cognitive impairment. They were documented with no current pressure ulcers or injuries, no unstageable or deep tissue injury (DTI) or venous/arterial ulcers. The resident was not documented as rejecting care. The [DATE] Significant Change MDS indicated the resident had a BIMS of zero (0) out of 15, indicating severe cognitive impairment. They received a scheduled pain medication regimen during the last five (5) days of the assessment period, but did not receive as needed (PRN) pain medications or was offered and declined. They were asked if they had pain or hurting at any time in the last five (5) days, and they responded "no." They were documented with no current pressure ulcers or injuries, no unstageable or DTI, or venous/arterial ulcers. They were noted to have one (1) non-pressure chronic ulcer of other part of left foot on their diagnosis section, not skin section. There was no noted rejection of care.

	The [DATE] Significant Change MDS indicated the resident had a BIMS of zero (0) out of 15, indicating severe cognitive impairment. They received a scheduled pain medication regimen during the last five (5) days of the assessment period but did not receive PRN pain medications or was offered and declined. They were asked if they had pain or hurting at any time in the last five (5) days, and they said "yes." They indicated the pain was frequent and had limited their day-to-day activities. They were documented as "unable to answer" when asked to rate their pain. A Care Plan, dated [DATE], identified a new care area pressure ulcer with impaired skin integrity related to cognitive impairment, limited mobility, and urinary incontinence. A vascular wound was noted to the left heel. It included approaches to administer medications/treatments as ordered and evaluate for effectiveness, elevate heels in bed, and minimize pressure on bony prominence. A Care Plan, dated [DATE], identified a pressure ulcer. Impaired skin integrity for vascular wound to the left heel and an excoriated area on the coccyx were also noted. This was discontinued on [DATE]. This was not captured on the [DATE] MDS. A skin note on [DATE] documented the presence, on the back of the resident's left heel, of a vascular wound described as a dark colored, fluid filled blister, cyanotic and edema was present at the site. Tenderness was present and with an onset of [DATE]. The length of the wound was 7 centimeters (cm), width of 8 cm, depth 0 cm. On 8/11/22, at 1:37 p.m., Consultant Staff B was interviewed. They said Resident #9 had been at the facility awhile and had more recently decompensated and was less mobile and eating less. They had a slow, progressive decline and went back onto hospice. They said that they remembered initially seeing the resident for excoriation on their buttocks. Consultant Staff B stated it was very superficial, and pinkish red. They said on [DATE] they noticed the excoriation to the resident's buttock, and then on [DATE] the resident had an open medial area that had opened more. Consultant Staff B stated that on [DATE] the left medial buttock opened more, and so they reached back out to hospice, since the resident was so immobile. They said that the resident was resistive to care and yelled out a lot during care. They said Resident #9 seemed to be in pain with care. They said that was when they increased the scheduled morphine from every six (6) hours to every four (4) hours. Consultant Staff B stated that they did not know when the facility scheduled the administration of the morphine, but they were aware of the need for the resident to receive the pain medication about an hour before treatment. They stated that the resident also had an "as needed" pain medication order. Consultant Staff B said that Resident #9 was nonverbal and to assess their pain level with nonverbal cues because it would be difficult for the resident to express their pain level with their cognition. The resident would not be able to speak with them about their pain

	levels. Consultant Staff B stated that when they had assisted to roll the resident onto their side to look at their wound, Resident #9 was yelling and moaning. They were not sure if it was from pain or a fear of pain. The wound had rapidly deteriorated with the resident's current physical decline with mobility, nutritional status, and cognition; they stated that the resident had reasons to be having true pain. Consultant Staff B said the resident could not give a direct answer to anything. On 8/11/22, at 2:58 p.m., Administrative Nurse C C was interviewed. They said that they expected to see Resident #9's heels floated, as the resident allowed. They were able to move the resident's legs significantly. They try to keep the boot on the left heel as the resident allows. Resident #9 had a history of being resistive to care in the past but had been better in the last year. Administrative Nurse C said the resident could reposition themself, although that was not observed during the investigation. They said the left vascular heel wound started out as what appeared to be a blister. Consultant Staff B saw the wound and called it a vascular wound. The blister had been there for quite a bit of time. They stated that when they started charting it a few months ago or so, it was just a blister. With the resident's decline and chronic kidney disease, they did not think they would heal the ulcer. The pressure wound on the coccyx developed the end of [DATE]. Administrative Nurse C stated the resident had a history of having incontinence dermatitis. It resolved with treatment, then reoccurred. Then excoriation developed. Administrative Nurse C further stated that one day the excoriation had no depth and was blanchable, and the next day was open with slough, not blanchable and a Stage Three (3). They said that since then, they had changed the wound orders a few times. They did not recall when the resident started on morphine, but knew it was as soon as they expressed any discomfort when any pressure was on their bottom. Administrative Nurse C stated that it took a long time to get Resident #9 comfortable with care. They said that the morphine was scheduled every six (6) hours with a PRN order, to better manage their pain level. They stated that if the resident needed the PRN pain medication they could increase their timing, and that they had not used it every day. Administrative Nurse C said that the resident received it before wound care. Administrative Nurse C said that the resident was not a reliable source to be interviewed. On 8/11/22, at 3:22 p.m., Administrative Nurse D was interviewed. They said that each department did their own section of the MDS assessment. They said that this included the nutrition, nursing, and therapy departments. They said Resident #9 had the [DATE] Significant Change MDS completed for weight loss and activities of daily living (ADL). A new [DATE] Significant Change MDS was completed to include hospice. They stated that they did not chart the wound care on the MDS assessments, and the charge nurse would chart BIMs, which Resident #9 had a score of zero (0) out of fifteen (15).

	The [DATE] and [DATE] MDS documented that the resident did not have stated pain, or had an identified vascular left heel wound or coccyx pressure wound. Skin notes, Care Plan history, and interviews identified that the resident had developed and been receiving care to skin breakdown during these assessment periods. The resident was identified with significant cognitive impairment, but was interviewed and stated that they had no pain. They were identified by staff as rejecting care, yet that was not noted on the MDS as rejecting care.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on record review, staff interviews, and observations, the facility failed to provide or arrange services that met the professional standards of quality for one (1) of three (3) residents (Resident #10) reviewed for nutrition and weight loss out of 26 sample residents. Specifically, the facility failed to ensure that Resident #10 was offered an appropriate, well-balanced meal of choice prior to being served an alternative dietary supplement in accordance with the resident's written Plan of Care and professional standards. The facility also failed to administer a medication in the dose prescribed by the provider for one (1) of six (6) residents observed during medication administration (Resident #25). The findings include: 1. Resident #10 Resident #10 was admitted in [DATE] with diagnoses including Diabetes Mellitus, Urinary Tract Infection, Agnosia, Muscle Weakness, Unspecified Sequelae of Unspecified Cerebrovascular Disease, Hypertensive Chronic Kidney Disease, and Atherosclerotic Heart Disease. According to the five (5) day Minimum Data Set (MDS) the resident had a Brief Interview for Mental Status (BIMS) score of two (2) out of 15, indicating severe cognitive impairment. The resident was noted to have a poor appetite for two to six (2 to 6) days during the assessment period and had a nutritional approach of a mechanically altered diet. A [DATE] Care Plan, in pertinent part, was identified for a self-care deficit related to decreased mobility and dementia, manifested by decreased ADL (activities of daily living) participation. A revised approach on [DATE] stated that the nurse aide would provide setup and supervision for eating. A [DATE] Care Plan, in pertinent part, was identified for the potential for unintended weight loss related to inadequate food intake, inadequate fluid intake, functional decline, confusion, and periods of

	not eating. Approaches included to avoid mealtime interruptions, to offer snacks, and to assess for signs and symptoms of dysphagia. A [DATE] Nutrition Note stated to discontinue a Physician Order for protein shake, and to start eight (8) ounce (oz.) Ensure three (3) times a day per Physician Order. A [DATE] Physician Order stated for a Certified Nurse Aide (CNA) to administer a supplement, eight (8) oz. Ensure Plus a.m. [morning] intake afternoon, p.m.. (administration for both a.m. and p.m.) An [DATE] Physician Order stated for a CNA to administer eight (8) oz. Ensure Plus as needed. An [DATE] Dietary Progress Note stated to add an eight (8) oz. Ensure Plus as needed (PRN) per Physician Order. On 8/8/22, at 12:48 p.m. Resident #10 was observed sitting in the dining room for lunch. They were observed with one (1) cup of strawberry supplement and one (1) cup of chocolate supplement in front of them. The meal was not yet served. The chocolate supplement was 1/3 empty and the strawberry supplement was half empty. At 12:57 p.m., Dietary Staff A was observed asking Resident #10 if they wanted their lunch, and Resident #10 stated “no.” Certified Nurse Aide A was heard to tell the other staff member to bring the resident their meal anyway because they would often eat it later. The staff member brought the plate of food to the resident, who then put their hand out and refused the meal.Resident #10 continued to drink their supplements and the plate was taken away. On 8/10/22, at 4:50 p.m., Dietary Staff B was observed preparing meal service on [LOCATION]. Trays were observed with prelabeled Ensure Plus, and other additional drinks. They said that all of the residents that needed extra protein or nutrients received an Ensure with each meal. They said those residents who received the Ensure would get it with their meals three (3) times a day. On 8/10/22, at 5:00 p.m., Resident #10 was observed in the dining room, prior to meal service, with a cup of supplement in front of them. No meal was yet served. On 8/11/22, at 8:41 a.m., Resident #10 was observed receiving one (1) eight (8) oz. supplement of Ensure Plus by Dietary Staff C. On 8/11/22, at 8:50 a.m., Certified Nurse Aide B said that if there was a Physician Order for a dietary supplement, they would give it to the resident with their meals, not usually in between the meals or after a resident had refused the meal. They were not aware of Resident #10 having a PRN supplement order.

	On 8/11/22, at 8:58 a.m., Resident #10 was served their breakfast. They had consumed 90% of their supplement and did not want the food. Dietary Staff C left the food on the table in case the resident changed their mind. On 8/11/22, at 9:08 a.m., Resident #10 was observed snacking on their breakfast. On 8/11/22, at 9:11 a.m., Certified Nurse Aide A said that if a resident had a supplement on their order, and it was on the meal tray, then it was served to the resident. They were not aware of Resident #10 having a PRN supplement order. If the supplement was brought for the meal service, it was given with the meals. They said that on 8/8/22, after they had told Dietary Staff A to bring and leave the meal for the resident, the other staff member had thrown the food out anyway. They said that they went ahead and made the resident a peanut butter and jelly sandwich a bit later, and that the resident had eaten some, much like the resident was now snacking on their breakfast after consuming a supplement. On 8/11/22, at 9:22 a.m., Consultant Staff C was interviewed. They said that Resident #10 had been recently upgraded on their meal texture, and that they were able to eat with cueing, for the most part. They were not involved in physician supplement orders. On 8/11/22, at 9:36 a.m., Licensed Nurse B and Administrative Nurse C were interviewed. They said that the Dietary Staff and the Certified Nurse Aides worked together for meal service. The education for the meal service process was done during orientation. They said that the Dietary Staff and Consultant Staff C were involved with resident diet orders. Consultant Staff would educate the charge nurse of any diet order changes and put a copy in the kitchen and in the diet book. They were not aware of any recent dietary changes for Resident #10. They said most supplements were scheduled, and the residents would get them regardless of their meal intakes. They were not familiar with any PRN supplement orders, as they were not frequently ordered that way. Therefore, the residents would get them with their drinks and before each meal. They said that residents on the [LOCATION] usually needed them for weight maintenance. They said that they were aware that Resident #10 had originally been scheduled a supplement due to their family's concern. On 8/11/22, at 10:30 a.m., Dietary Staff D was interviewed. They said that they expected the facility staff that worked with the residents to communicate with the Dietary Department if there were any nutritional concerns. Dietary Staff D said that they had no concern if residents were ordered supplements during or between meals. They said that it would depend on the resident's needs, and what the right approach was. They said that it would involve communication with the Dietary Department to know what the right

	approach was. Dietary Staff D said that they expected that a dietary supplement would not replace a meal but be provided for those residents who maybe did not eat enough of their meal or needed extra intake after not eating enough. On 8/11/22, at 12:43 p.m., Consultant Staff D was interviewed. They said that the Dietary Staff would review and make recommendations, as would the [other] Dietary Staff. They said that generally those departments would lead that, and then they could make orders. If there was a documented weight loss or low intake, the facility could discuss suggested supplements with the family. A PRN Ensure order could be made when the resident might not have been eating or drinking well. If the resident did not eat their meal well, it would be a supplement, but not a main staple of their diet. On 8/11/22, at 2:35 p.m., Dietary Staff E was interviewed. They said that the Dietary Staff or a nurse might see a resident not eating very much. If there was poor intake there might be a dietary order for a supplement to be added for three (3) times a day, or just once a day. It could be provided either with or between meals. They said food was always the best, first approach to meeting dietary needs. 2. Medication administration to Resident #25 Observation of medication administration by Certified Nurse Aide C began at 7:47 a.m., on 8/9/22, for Resident #25. Resident #25 was to receive seven (7) medications at that time, of which four (4) were in tablet or capsule form and three (3) were in liquid form. Of the medications in liquid form, one (1) was already in a unit dose syringe. Before putting each medication in a medicine cup, Certified Nurse Aide C verified the medication's pharmacy label against the provider's orders in the electronic Medication Administration Record (e-MAR). They prepared the tablets and capsule first, set out the unit dose syringe, and then proceeded to measure the liquids – which included liquid Acetaminophen. Review of the e-MAR found Resident #25 was to receive Acetaminophen liquid 500 milligrams (mg) in 15 milliliters (ml) of solution – give 15ml (500mg) by mouth twice daily to treat pain. Observation of the bottle of Acetaminophen revealed a label stating the medication came in a concentration of 160mg per 5ml, meaning 15ml of the liquid would equal 480mg of Acetaminophen. Certified Nurse Aide C was aware of the difference in concentrations between what was ordered and what was available in the bottle. They stated that they had been instructed to administer 15ml of the liquid Acetaminophen that was on hand, even though this would not provide Resident #25 with 500mg of the medication.

	During an interview on 8/11/22, at 10:15 a.m., Administrative Nurse A verified this was a medication error, as the medication was not given at the dose ordered by the provider. Administrative Nurse A stated the order had been clarified with the provider and a new order was entered into the resident's clinical record to give Resident #25 Acetaminophen liquid 160mg/5ml give 15ml (480mg) by mouth twice daily.
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on resident record review, observations, and staff interviews the facility failed to ensure that a resident who entered a facility without pressure sores did not develop pressure sores, unless the individual's clinical condition demonstrated that they were unavoidable, and the resident received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for one (1) of two (2) residents reviewed for pressure sores out of a resident sample of 26 (Resident #9). Specifically, the facility failed to ensure a resident with risk of pressure sores had their heels properly floated according to Physician Order, was administered pain medication prior to wound care, or had a physician order or care plan for a podus boot that was observed in use during some observations. The findings include: Review of the facility's policy on "Prevention, Identification and Care of Pressure Injury," reviewed and accepted 9/7/21, revealed: "-Will establish a program to prevent the development of new pressure injuries, and to promote the rapid healing of existing pressure injuries. -Pressure Injury: a localized injury to the skin or underlying tissue usually over a bony prominence that is the result of pressure or of pressure combined with shear or friction. Pressure injuries should be distinguished from diabetic, ischemic, and venous wounds. -Suspected Deep Tissue Injury: this may present as a darkened, discolored localized area of intact skin or as a blood-filled blister, which may be due to the damage to underlying soft tissue from pressure and/or shear. -Do not reverse stage pressure injuries as they heal. -The care plan will be evaluated and revised as needed based on the status of the pressure injury. -Assess the need for and provide appropriate pain management prior to dressing changes." Resident #9 was admitted in [DATE] with diagnoses including Alzheimer's Disease, Memory Deficit Following Cerebral Infarction,

	Hypertensive Heart disease with Heart Failure, Dysphagia, Aphasia, Vascular Dementia, Congestive Heart Failure, and Peripheral Vascular Disease. Additional diagnoses, according to record review, included Non-Pressure Chronic Ulcer of Other Part of Left Foot with Unspecified Severity, Pressure Ulcer of Sacral Region Stage 3, Diabetes Mellitus, and Osteoarthritis. The [DATE] Quarterly Minimum Data Set (MDS) indicated the resident had a Brief Interview for Mental Status (BIMS) of zero (0) out of 15, indicating severe cognitive impairment. They were documented with no current pressure ulcers or injuries, no unstageable or Deep Tissue Injury (DTI) or venous/arterial ulcers. There was no rejection of care. The [DATE] Significant Change MDS indicated the resident had a BIMS of zero (0) out of 15, indicating severe cognitive impairment. They received a scheduled pain medication regimen during the last five (5) days of the assessment period but did not receive as needed (PRN) pain medications or was offered and declined. They were asked if they had pain or were hurting at any time in the last five (5) days, and they responded “no.” They were documented with no current pressure ulcers or injuries, no unstageable pressure ulcers or DTI, or venous/arterial ulcers. They were noted to have one (1) non-pressure chronic ulcer of other part of left foot on their diagnosis section, not in the skin section. There was no rejection of care. In a Care Plan initiated [DATE], and last revised [DATE], the resident was identified with self-care deficits. Approaches included repositioning every two (2) hours while in bed to ensure left heel remains floating. Equipment included a specialty chair (Carefoam) to allow for heel off-loading. A Care Plan, last revised [DATE], revealed pressure ulcer and impaired skin integrity, related to cognitive impairment, limited mobility, and urinary incontinence manifested by a vascular wound, left heel, Stage three (3) pressure wound of the left gluteal cleft. Approaches included administer medication treatments as ordered and evaluate for effectiveness, elevate heels in bed, minimize pressure on bony prominences, perform daily skin checks, minimize friction/shear, and report indicators of pain. A Care Plan initiated on [DATE] identified a pressure ulcer, with impaired skin integrity for peripheral vascular disease, Stage two (2) pressure injury. This was discontinued on [DATE]. A Care Plan initiated on [DATE] identified a new care area pressure ulcer with impaired skin integrity related to cognitive impairment, limited mobility, and urinary incontinence. There was noted a vascular wound left heel. The goal was to be met in three (3) months ([DATE]). It included approaches to administer

	medications/treatments as ordered and evaluate for effectiveness, elevate heels in bed, and minimize pressure on bony prominences. A Care Plan initiated on [DATE] identified a pressure ulcer. Impaired skin integrity for vascular wound left heel, and excoriated area on the coccyx were noted. This was discontinued on [DATE]. There was no Care Plan approach that included a podus boot. There was no active Physician Order for a podus boot. On 8/8/22, at 11:55 a.m., Resident #9 was observed sleeping in their bed. They were observed with their right foot/heel resting directly on the mattress. The left foot was in a podus boot, and the heel was lifted off the mattress according to the Care Plan. On 8/9/22, from 2:50 p.m.-3:05 p.m., the resident was observed in bed. Resident #9 was observed with a bandage on their left heel, but no boot on either foot. The resident's calves were floating on a flat pillow, both heels were observed resting on the mattress on bony prominences. On 8/9/22, at 3:05 p.m., Certified Nurse Aide D said that the nurses monitored wounds, and the Certified Nurse Aides (CNAs) used wedges and repositioned the resident every two (2) hours. At 3:07 p.m., Administrative Nurse C and Licensed Nurse C entered the room and observed Resident #9. Administrative Nurse C said that Resident #9's heels were not floating, and that they would expect the bony prominences to be protected by elevating both of them off the mattress. They said that Resident #9 was having their heels floated for a while, for a few months. Licensed Nurse C said the resident was often wearing a boot to protect the vascular wound on the left heel. Licensed Nurse C said the vascular wound on the left heel was improved from the past. Administrative Nurse C said that they prioritized the resident's sacral wound when positioning them. Licensed Nurse C put the blue podus boot back onto the Resident's left heel and said that they were doing that because they were trying to protect the eschar on the left heel vascular wound. They were not aware if there was a Physician Order for the podus boot or not, but wanted to protect the left vascular heel wound. Wound treatment was observed on 8/10/22, beginning at 8:48 a.m., Observations included: -Licensed Nurse D entered the room, announced themself (resident was not verbally responsive), washed their hands, and donned gloves. -Licensed Nurse E stood on the right side of the resident's bed, wore gloves, assisted Licensed Nurse D with repositioning Resident #9 onto their right side, and held Resident # 9 in this position during the dressing change to the coccyx.

	-Resident #9 moaned when repositioned. Licensed Nurse D remarked that this was usual behavior for the resident. -Licensed Nurse D removed the old, covered dressing from the coccyx (dated [DATE]) and discarded it, doffed gloves, washed hands, and donned gloves. -Resident #9 moaned as the wound was cleansed. Licensed Nurse E rubbed the resident's arm/shoulder and attempted to comfort the resident during this part of the procedure. -Licensed Nurse D used a cotton tipped applicator to place the Iodoform ribbon into the resident's wound, inserting it into the undermining around the circumference of the wound, before covering the wound bed with the rest of the ribbon. -Resident #9 moaned loudly throughout the time that their wound was being packed. -Upon completion of the wound treatment, Licensed Nurse D assisted Licensed Nurse E with repositioning the resident for comfort, disassembled their barrier, removed their gloves, washed their hands, and exited the room. The wound care nurse failed to practice proper hand hygiene and gloving during the procedure. Review of the [DATE] "Treatment Administration Record," (TAR) revealed the Physician Order to document heels being floated qid (four (4) times a day), to have left heel prep done daily, and to keep left heel off-loaded daily during morning shift. Record review of the TAR revealed no documentation of floating the resident's heel from [DATE] through [DATE]. Review of the [DATE] Medication Administration Record (MAR) revealed the Physician Order to administer morphine 20 milligrams per milliliter (mg/ml) at 0200 (2:00 a.m.), 0800 (8:00 a.m.), 1400 (2:00 p.m.), 2000 (8:00 p.m.) for pain and hold dose if increased somnolence was not documented as administered at 0800 (prior to wound treatment observation) but was documented as administered at 1:53 p.m. The wound care observation was at 8:48 a.m. Moaning was observed during the wound care procedure noted above. A skin note on [DATE] documented the back of the left heel, onset [DATE] of a vascular wound; fluid filled dark blister, cyanotic, edema present at site, tenderness present. Length 7centimeters (cm), width 8 cm, depth 0 cm. On 8/11/22, at 12:43 p.m., Consultant Staff D was interviewed. They said that the facility used to have a wound surgeon who oversaw the wounds, but they left. Since then, they had a wound clinic they used, if needed, but they had the facility nurses provide regular wound care to the residents. They said that there was usually a wound nurse who did rounds every week and did wound measurements. They said that there would be a written change of condition if needed, which would then go back to the Consultant Staff B, or the medical person monitoring at that point. Consultant Staff D stated

	that there was a wound protocol that gave nursing staff the ability to begin the wound treatments, but if there was something more serious, or the wound was not improving, the facility nurse would get a telephone order if they were not there, or if they were in the building, they would go see the resident with the wound. Consultant Staff D said pain could be seen on an individual basis, and depending on the wound, they had premedicated residents before treatment in some cases, but that it was the exception. They said wound treatments were usually well tolerated by residents. Depending on the location of the wound that might cause pain, they would talk about premedicating the resident at least 30 minutes to an hour before administering treatment. If premedicating the resident was not effective, the facility staff should be in touch with Consultant Staff D. They said Consultant Staff B would be very involved during wound dressing changes, and they would try to make sure they were seeing the wounds, especially if they were not improving or were new wounds. They stated that excoriation would be some skin breakdown, like from briefs or wipes causing rubbing and leading to an excoriation; not necessarily from a scratching or digging, but more of a friction shearing force. They said they could see how shearing or friction injury that was irritated could be seen as an excoriation and open by the next set of nursing eyes. On 8/11/22, at 1:37 p.m., Consultant Staff B was interviewed. They said that Resident #9 had been at the facility a while and had more recently become decompensated and was less mobile and eating less. They had a slow, progressive decline and went back onto hospice. They said that they remembered initially seeing the resident for excoriation on their buttocks. They stated that it was very superficial, and pinkish red. They said that on [DATE] they noticed the excoriation to Resident #9's buttock, and then, on [DATE], the resident had an open medial area that had opened more. Consultant Staff B stated that on [DATE] the left medial buttock opened more, and so they reached back out to hospice, since the resident was so immobile. They said that the resident was resistive to care and yelled out a lot with care. They said that Resident #9 seemed to be in pain with care. They said that was when they increased the scheduled morphine from every six (6) hours to every four (4) hours. They stated that they did not know when the facility scheduled the administration of the morphine, but they were aware of the need for the resident to receive the pain medication about an hour before treatment. They stated the resident also had an as needed pain medication order. Consultant Staff B said that Resident #9 was nonverbal and to assess with nonverbal cues would be difficult. The resident would not be able to speak with them about their pain levels. They stated that when they had assisted to roll the resident over to look at their wound, the resident yelled and moaned and they were not sure if the resident was in actual pain or there was a fear of pain. The wound had rapidly deteriorated with Resident #9's current physical decline with mobility, nutritional status, and cognition. Consultant Staff B stated that the resident had reasons to be having

	true pain. Consultant Staff B said that the resident could not give a direct answer to anything. In [DATE], they believed there had been a previous order for a podus boot for the left heel's vascular wound, around the time the wound was identified. On 8/11/22, at 2:58 p.m., Administrative Nurse C was interviewed. They said that they expected to see Resident #9's heels floated, as the resident allowed. They were able to move the resident's legs significantly. They tried to keep the boot on the left heel as the resident allowed. Resident #9 had a history of being resistive to care but had been better in the last year. Administrative Staff C said the resident could reposition themself as they pleased. They said the heel wound started out as what appeared to be a blister. Consultant Staff B had called it a vascular wound. The edges got dried out with the skin prep, so they wrapped it so it did not get caught on anything. Administrative Nurse C said the resident used to self-propel in their wheelchair and would not keep socks on. Their feet would get black very fast. As they declined, they were able to get therapy to evaluate them and found that since they were not self-propelling anymore, they could sit in a gerichair. The blister had been there for quite a bit of time. They stated that when they started charting it, it was just a blister a few months ago or so., They did not think they would heal the ulcer, especially with the resident's decline and chronic kidney disease. The pressure wound developed the end of [DATE]. Resident #9 had a history of having incontinence dermatitis. It resolved with treatment, then came back. The excoriation to the coccyx developed again later. Then, overnight, the excoriation on one (1) day had no depth and was blanchable and the next day was open with slough, not blanchable and a Stage three (3). Administrative Nurse C said that since then, they had changed the wound orders a few times. They did not recall when the resident started on morphine, but knew it was as soon as they expressed any pain symptoms when any pressure was on their bottom. Administrative Nurse C said that with any type of resident care, such as moving them side to side, or washing them up, it took a long time to get them comfortable. Administrative Nurse C said that the morphine was scheduled every six (6) hours with an as needed order (PRN) as well, to better manage their pain level. Administrative Nurse C stated that if they needed the PRN pain medication they could increase the timing of their pain medication, and that they had not used it every day. They said the resident received it before wound care. This was not documented as administered according to record review, or resident observation, during wound care. Administrative Nurse C said the resident was not a reliable source to be interviewed. They said that the Care Plan in [DATE] for a Stage two (2) wound may have been a wound nurse identifying the heel blister as a Stage two (2) vascular wound, and then changed it to just a vascular wound after the physician saw it. They were not sure.

§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	Based on observation, staff interview, and clinical record review, the facility failed to ensure oxygen was provided continuously in accordance with Physician Order for one (1) of 18 sampled residents (Resident #6). The facility also failed to ensure oxygen tubing was dated and changed out weekly for four (4) of nine (9) sampled residents (Resident #3, Resident #6, Resident #15, and Resident #18) and four (4) residents of random opportunity (Resident #22, Resident #23, Resident #24, and Resident #26). The findings include: 1. Observation of Resident #6, beginning at 2:24 p.m., on 8/8/22, in the company of Administrative Nurse C, found them sitting on their bed wearing a nasal cannula. The end of the nasal cannula that was to connect with the oxygen concentrator unit was found on the floor under their bed. The nasal cannula's tubing was disconnected from a length of green oxygen supply extension tubing, which was attached to an oxygen concentrator running at Resident #6's bedside. This was brought to the attention of Administrative Nurse C, who obtained replacements for the nasal cannula and extension tubing. Resident #6 was not in any distress at the time of the observation. Observation of the green extension tubing connected to Resident #6's oxygen concentrator found a piece of tape had been applied to it, which was dated "[DATE]." Administrative Nurse C acknowledged that all oxygen supply tubing was to be changed out every week on Sundays. Review of Resident #6's clinical record found the following active orders: - "Oxygen 2.0 liter/min (per nasal cannula) to keep O2 sat [oxygen saturation level] > [greater than] or equal to 90% for chronic respiratory failure with hypoxia or hypercapnia. Humidify O2. Wean off O2 during the daytime." - "Change oxygen tubing and neb [nebulizer] pipe [mouthpiece] 1 x week, Sunday Shift PM [on evening shift]." - "Make sure O2 is bled into External Ventilator every night!!!! 3-4 liters O2 per RT [Respiratory Therapist] ***** NURSE TO APPLY External Ventilator daily at bedtime."

	Observation beginning at 2:24 p.m., on 8/8/22, of the oxygen tubing connected to the external ventilator and running to the oxygen concentrator (but not connected at that time), found the tubing was dated also "[DATE]." 2. Observations made with Administrative Nurse C beginning at 2:15 p.m., on 8/8/22, found the nasal cannula tubing connected to an oxygen concentrator at Resident #26's bedside, which Resident #26 was currently wearing, was not dated. The nasal cannula tubing connected to an oxygen tank stored on the back of Resident #26's wheelchair (currently not in use) was not dated. The oxygen tubing connected to the resident's continuous positive air pressure (CPAP) machine was not dated, and the tree connector that would have attached to the resident's oxygen concentrator (when the CPAP machine was in use) was on the floor. Administrative Nurse C acknowledged all of these observations, stated the oxygen tubing was to be changed out weekly on Sundays, and went to obtain replacement tubing. Review of Resident #26's clinical record found the following order: "Admin O2 Therapy (cont/daily) [continuously/daily] via nasal cannula to keep [O2] sats over 90%." Resident #26 also had an order to change oxygen tubing weekly on Sundays. 3. Observations, made with Administrative Nurse C beginning at 2:26 p.m., on 8/8/22, found the tubing from the nasal cannula attached to an oxygen tank on the back of Resident #3's wheelchair was dated "[DATE]." The nasal cannula was not applied to the resident at that time, but the oxygen tank was turned on and running. Review of Resident #3's clinical record found the following orders: - "Oxygen (per nasal cannula) to keep O2 sat > or equal to 88%." - "Change oxygen tubing and nebulizer mask 1 x wk (once weekly). Sunday Shift PM." 4. Observations made on [LOCATION] found the following: - At 3:11 p.m., on 8/8/22, Resident #24's oxygen tubing was dated "[DATE]."

	- At 3:14 p.m., on 8/8/22, Resident #18's oxygen tubing was dated "[DATE]." - At 3:21 p.m., on 8/8/22, Resident #23's oxygen tubing was dated "[DATE]." - At 3:27 p.m., on 8/8/22, Resident #22's oxygen tubing was dated "[DATE]." - At 3:30 p.m., on 8/8/22, Resident #15's oxygen tubing was dated "[DATE]." During a meeting beginning at 4:00 p.m., on 8/8/22, Administrative Nurse A acknowledged the facility's policy was to change out all residents' oxygen tubing every Sunday, and that oxygen tubing was to be dated when changed out.
§ 51.180 (d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, staff interview, and review of the facility's policies, the facility failed to remove from use medications that were kept past their expiration dates. This had the potential to affect one (1) resident of random opportunity with 38 residents residing in this unit. The findings include: The facility policy titled, "MEDICATION STORAGE IN THE FACILITY," with an effective date of January 2019, stated: "Procedures … H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal …, and reordered from the pharmacy …, if a current order exists." The medication refrigerator in [LOCATION] was observed on 8/11/22, beginning at 1:36 p.m., in the company of Administrative Nurse E. Observation found one (1) Humalog Kwik Pen in the medication refrigerator with an expiration date of 12/2021. Administrative Nurse E confirmed the insulin pen was kept past its expiration date.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only	Based on observation, staff interview, and review of the facility's policies, the facility failed to conduct twice daily temperature monitoring of the only medication refrigerator used in the facility to store Moderna vaccines. This had the potential to affect all residents and staff who were not up to date with vaccinations against COVID-19. The findings include:

authorized personnel to have access to the keys. Level of Harm – No Acutal Harm, with potential for more than minimal harm. Residents Affected – Some	The facility policy titled, "MEDICATION STORAGE IN THE FACILITY," with an effective date of January 2019, stated: "Temperatures … F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC [Centers for Disease Control and Prevention] Guidelines." The medication refrigerator in [LOCATION] was observed on 8/8/22, beginning at 11:24 a.m., in the company of Administrative Nurse C. Observation during the audit found five (5) multidose vials of Moderna COVID-19 vaccine being stored in a refrigerator with a temperature measuring device that did not continuously monitor for temperatures outside of the required temperature range. Observation of the temperature log for this refrigerator for the month of [DATE] found staff were only measuring and recording temperatures once daily instead of at least twice daily in accordance with current CDC Vaccine Handling and Storage Guidelines, upon which the facility's policy was based. Administrative Nurse C acknowledged at that time that the log only prompted staff to record temperatures once daily, and Administrative Nurse C reported that they were unaware of the need to measure and record temperatures at a higher frequency when vaccines were being refrigerated.
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, staff interview, and review of the facility's policies, the facility failed to ensure staff changed gloves after touching a contaminated surface and before cleansing an open wound for one (1) of two (2) residents observed during the performance of dressing changes (Resident #9). The findings include: The facility's policy titled, "INFECTION PREVENTION AND CONTROL PROGRAM," with a revision date of 11/9/21, stated: "Personal Protective Equipment … Employees using PPE must observe the following precautions: * Wash hands immediately or as soon as feasible after removal of gloves or other PPE. * Remove PPE after it becomes contaminated and before leaving work. … * Wear appropriate gloves when it can reasonably be anticipated that there may be hand contact with blood or OPIM [other potentially infectious material]), and when handling or touching contaminated items or surfaces: replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised." Observation was made of a treatment to a Stage 3 pressure ulcer to Resident #9's left buttock beginning at 8:48 a.m., on 8/10/22. The treatment was performed by Licensed Nurse D, who was assisted by Licensed Nurse E. Licensed Nurse D entered the room of Resident #9, set up a clean barrier for their supplies, assisted Licensed Nurse

	E with repositioning Resident #9 on their right side, and removed the old dressing from Resident #9's wound. At each step, Licensed Nurse D changed their gloves and performed hygiene appropriately. As Licensed Nurse D prepared to cleanse the resident's wound while wearing clean gloves, they grasped the bottle of wound cleanser (Vashe), applied the liquid to an opened package of sterile gauze, and set the bottle of Vashe back down on the clean barrier. They then used the same gloved hand to pick up the saturated gauze, squeezed the gauze to remove excess liquid, and turned toward the resident. At this time, the surveyor intervened and asked Licensed Nurse D to change their gloves. Licensed Nurse D recognized that they had contaminated their gloves when handling the bottle of Vashe (the outside of which had not been cleaned). They removed their gloves, washed their hands, and proceeded with the remainder of the treatment. Review of Resident #9's clinical record found the following order dated [DATE]: "SKIN TREATMENT: Wound care stage 3 Left buttock wound: Cleanse with Vashe, apply skin prep to peri area of wound and buttock area that dressing adhesive will touch, pack with Iodasorb packing strip, cover with gauze and Island dressing daily and prn (as needed)."
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on record review and staff interview, the facility failed to accurately document a resident's health status in the electric health record for one (1) of one (1) sampled resident reviewed for hospitalization (Resident #21). The findings include: Review of the clinical record revealed a Physician Order to transfer Resident #21 to the hospital for evaluation due to an altered mental status. Further review revealed no documentation related to Resident #21's mental status or what had changed, their symptoms, or when the change in their condition occurred. In an interview on 8/10/22, at 12:10 p.m., Administrative Nurse C confirmed it was not possible to determine that the resident was treated appropriately due to the lack of documentation of the events leading to their hospitalization. In an interview on 8/11/22, at 9:55 a.m., Administrative Nurse A stated the facility did not have a policy related to procedures for documentation of a resident's change in condition. They stated it was their expectation that staff accurately documented a resident's symptoms. In an interview on 8/11/22, at 12:55 p.m., Consultant Staff D stated they expected that when a resident was sent to the hospital there should be documentation of the resident's condition. They stated

	that when they were notified of a resident with a change of condition, they expected to be told what kind of changes had occurred and what measures had already been taken.