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	255220	A. BUILDING _____ B. WING _____	C 08/22/2019

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F 000	INITIAL COMMENTS	F 000		

CI MS #16118, CI MS #16119 & CI M S#16120

The State Agency (SA) conducted a complaint survey at the facility, from 08/19/19 to 08/22/19, for CI MS #16118, CI MS #16119, and CI MS #16120. The SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicare, and substantiated CI MS #16120 regarding Quality of Care/Treatment, Neglect, and failure to provide assessment, notify the physician and provide foot care, which resulted in harm to Resident #1, due to the amputation of his left fourth (4th) toe. On 05/09/19, the facility identified that Resident #1's 4th toenail was detached. The toe was cleaned and wrapped by Licensed Practical Nurse (LPN) #2 at that time, however the Physician was not notified of the incident to provide treatment orders for the toe. The facility did not accurately assess and treat the 4th left toe, and on 06/04/19 (three and one half weeks later), the left 4th toe was observed swollen and discolored. LPN #2 assessed the toe and described it to be cyanotic, one plus (1+) edema, with moderate bleeding and pus. Resident #1 was transferred to the local hospital for evaluation, then transferred to a regional hospital for surgical treatment. Diagnoses included Cellulitis and Wound Infection. On 06/04/19, Resident #1 was admitted to the hospital with diagnoses of Multiple Fractures of the Left Fourth Toe (confirmed by x-ray on 06/04/19), Left Foot Cellulitis, and Left 4th Toe Cellulitis. Resident #1 received treatment for left foot infections and underwent amputation of his 4th toe on the left foot. Resident #1 was discharged back to the facility on 06/13/19. The

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

Electronically Signed | 09/20/2019

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F 000	Continued From page 1 SA cited F580, F600, F656, F687, at harm levels and F842 at a non-harm level, related to the complaint CI MS #16120. The SA did not substantiate CI MS #16118, an anonymous complaint, regarding Abuse and Neglect related to an unwitnessed fall. No deficiencies were cited related to MS 16118. The SA did not substantiate CI MS #16119, a complaint regarding Quality of Care/Treatment, Activities of Daily Living (ADL) care, Weight Loss and Hydration. No deficiencies were cited related to MS #16119.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		10/1/19

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F 580	Continued From page 2 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the physician of a change in condition for one (1) of five (5) residents observed for foot care, Resident #1. On 05/09/19, Resident #1 was observed with a detached toenail of the left 4th toe. As a result of the facility's failure to notify the MD, no orders were received for the treatment of the toe, and no assessments of the foot were performed, which resulted in harm to Resident #1. Resident #1 required hospitalization, on 06/04/19, due to the	F 580	1. Resident□s physician was notified of the change in condition on 6/4/2019. On 6/4/2019 Resident received order to transfer to Local Hospital for evaluation. Resident record reflected the notification of change on 6/4/2019. 2. All residents have the potential to be affected. On 8/27/2019, an audit was conducted of wound care related documentation and wound care orders to	

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F 580	Continued From page 3 development of redness, swelling, bleeding, and pus to the 4th left toe. On 06/04/19, Resident #1 was transferred to the local hospital for evaluation, and diagnosed with severe Cellulitis and Infection of the Left 4th toe, and then transferred to a regional hospital for surgical intervention. During the hospitalization, Resident #1 required an amputation of his 4th left toe, due to Infection, Multiple Fractures to the Left 4th Toe, and Cellulitis. Findings include: Review of the facility policy titled, "Change in Resident Medical Status", Resident Care-MS-06/94, revised 06/02/99, revealed, "A change in medical status is defined as any physical, psychological and/or medical deviation as compared to the resident's status as noted in the initial assessment. A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: 1. An accident involving the resident which results in injury and has the potential for requiring physician intervention; 2. A significant change in the resident's physical, mental or psychological status". An observation of Resident #1's feet, on 8/20/19 at 3:44 PM, with the Director of Nursing (DON), revealed the absence of the 4th toe on the left foot. Skin was intact with no swelling. Review of the Departmental Notes-Charge Nurse, dated 05/09/19 at 10 :45 AM, documented by LPN #2, revealed, "Resident pulled toenail bed on left foot. Area cleaned and wrapped". There was no documentation the Physician or Nurse	F 580	ensure Resident Physician and Resident Representatives were notified of results. No new issues noted. (injury/Decline/Room). 3. On 8/23/2019 the facility altered its Clinical Workup Meeting template to include notification of change verification to include phone and fax confirmations. In-service conducted by Staff Development Nurse to Nursing Staff Licensed Practical Nurse and Registered Nurse of notification of change policy as listed in Resident Care Manual performed on 08/23/2019. In-service conducted by Staff Development Nurse to Administrative Nursing Staff to monitor for fax confirmations when Team Members state that a facsimile was sent to the physician as notification, the new clinical workup meeting template, to ensure that documentation is saved in the facsimile book. If no facsimile may be found that the Administrative Nursing Staff to call to ensure notification occurred and a departmental note is completed. Performed on 08/23/2019. 4. Evidence of notifications to be collected and monitored daily for six weeks initiated on 8/27/2019. Director of Nurses will monitor notification of change daily in Clinical Workup meeting. All findings will be reported monthly to Quality Assurance by Director of Nurses. Quality Assurance Committee will: Monitor effectiveness of the plan of correction monthly x 3 months, and quarterly thereafter. The Quality Assurance	

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F 580	Continued From page 4 Practitioner (NP) were notified. Further review of the Departmental Notes-Charge Nurse, dated 05/31/19 at 10:52 AM,documented by LPN #1/Treatment Nurse, revealed, "(Name of Physician) made rounds today. No new orders at this time". The Department Note-Charge Nurse, dated 06/04/19 at 4:48 PM, documented by LPN #2, revealed: "+1 (Plus One) pitting edema noted to left foot. Nurse removes bandage wrapped around 4th toe next to pinky toe. Cyanosis. Moderate bleeding, and pus noted. 4:45 PM resident transferred to (Initials For Local Hospital) ER. Transported from w/c (wheelchair) to stretcher safely by EMT (Emergency Medical Technicians). RP (Responsible Person) notified". There was no documentation of MD notification. In an interview with LPN #1/Treatment Nurse, on 08/20/19, at 1:30 PM, she confirmed she was called into the Whirlpool Room on 05/09/19, and that Resident #1's left fourth toenail was "hanging by a little piece". She stated she did not observe any blood to the toenail bed. LPN #1 said she asked Resident #1 if the toe hurt, and he said "no". She stated she cleaned the nail bed with normal saline, and thought she put antibiotic ointment on it and a band aid. LPN #1 said she told the NP, that Resident #1 had pulled his toenail off and what she had done to dress it. LPN #1 stated the NP said that was fine and gave no further orders. LPN #1 said she did not document this in the medical record, or write an order for the treatment and the following day, she took the band aid off and cleaned it again and it was fine. LPN #1 stated that no further treatment was needed, it really wasn't an open area and there was no swelling or deformity noted to the left 4th toe that day. LPN #1 confirmed she did not notify the physician or receive further orders	F 580	Committee will make further recommendations on training or modification to the Clinical Workup Meeting as necessary. The Director of Nurses is responsible for on-going monitoring and compliance.	

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when the resident's toenail was pulled off.

The SA called the name of the medical clinic where the NP worked, on 8/22/19 at 10:21 AM, but was not able to speak to the NP at that time. The SA left a message with the Receptionist to have the NP return the call. The SA did not get a return call from the NP.

An interview, on 08/20/19 at 1:08 AM, with LPN #2 revealed she was aware of a prior incident, on 05/09/19, in which she was called into the Whirlpool Room by CNA #1 and CNA #4/Whirlpool CNA. LPN #2 said the CNAs reported Resident #1 was picking at the toenail and pulled it off. LPN #2 said she observed the toenail of the left fourth toe was detached and there was blood over the nail bed. LPN #2 said she did not observe any swelling or redness to the left 4th toe that day. LPN #2 said she called LPN #1, the Treatment Nurse, into the Whirlpool Room and LPN#1 actually dressed the toe that day. LPN #2 said she documented the incident in the nurse's note that the resident had pulled his toenail off per report by the CNAs on 05/09/19, but did not perform the dressing change, or notify the resident's Physician.

During an interview with Licensed Practical Nurse (LPN) #2, on 08/20/19, at 1:53 PM, she stated she was assigned to Resident #1 on 06/04/19, but had not been assigned to Resident #1 that month. LPN #2 said she was called into the Whirlpool Room by the Certified Nursing Assistants (CNAs), but unable to recall the CNAs' names. LPN #2 reported Resident #1's left foot was very swollen, and what alarmed her was the swelling seemed to be coming from the left fourth toe. LPN #2 stated the other toes were not

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swollen. LPN #2 said she took a blue bandage off the left fourth toe carefully because Resident #1 was hollering out in pain. LPN #2 said she observed pus and a little blood on the bandage, and the toe appeared deformed and blue. LPN #2 said she had no knowledge of any treatment ordered for the left fourth toe.

An interview with the Medical Doctor (MD) for Resident #1, on 08/21/19, at 9:09 AM, revealed he was not notified of the detached toenail on 05/09/19, and the NP should have notified him. The MD stated he had seen the resident on 05/31/19, and he looked at his ankles for edema, but did not remove his shoes. The MD stated the staff did not report any problems to him and he had not given any orders for a bandage to the left 4th toe. He recalled being surprised when he was told of the amputation, and stated that the staff should notify him of any incidents and he had concerns he was not being notified. The MD stated that he recently held a meeting with the facility staff about reporting and was trying to come up with better procedures and protocols for reporting.

Record review of the second receiving hospital Emergency Department (ED) History and Physical, dated 6/4/19, at 9:00 PM, revealed Resident #1 was brought into the ED with severe swelling and redness of the left foot, and severe swelling and redness of the left fourth toe, a foul smell to the left foot and a laceration of the plantar surface of the left fourth digit. and, suspected fracture of the left fourth toe. X-ray of the left foot, on 06/04/19, revealed, "Fourth toe fractures with widened distal interphalangeal joint (DIP). The resident required multiple antibiotics in the ED and the wound was aggressively washed

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out. It was unable to be closed due to MD documentation that the wound was old and would require additional evaluation and wash out. The resident was admitted to the hospital with diagnoses of Phalanx Fracture Left Fourth Toe-Open, Infected MTP (Metatarsophalangeal Joint) to the Fourth Toe Left, and Cellulitis. Orthopedic was consulted.

Review of the (Name of Regional Hospital) Discharge Summary, dated 06/16/19, revealed Resident #1 was admitted to the hospital from a local nursing home for left foot infections. The resident was successfully treated and underwent amputation of 3rd-4th left toes. (Observation of Resident #1's feet during the survey revealed only the 4th left toe was amputated). Record review of Ultra Sound Lower Extremity Arterial Duplex Bilateral, performed on 06/11/19, revealed only mild atherosclerotic changes. Left ankle pressure was unobtainable. No other evidence of hemodynamically significant stenosis in either lower extremity was found. Resident #1 was discharged back to the nursing home on 06/13/19.

Record review of a Resident Incident Report, dated 06/04/19 at 4:15 PM, revealed, "Type of Injury: Localized tissue edema". The Narrative of incident and description of injuries: "Nurse summoned to shower room. Edema noted to left foot leading to fourth toe with bandage wrapped around. Pus and blood noted to bandage. Nurse carefully removed bandage. Cyanosis and moderate bleeding noted. Pain scale of 9. (Name of local hospital's Emergency Room) nurse called". The Incident Report was signed and dated 06/06/19, by Licensed Practical Nurse (LPN) #2. The Incident Report documented the

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resident's family was notified on 06/04/19 at 5:00 PM, but no documentation that the physician was notified.

Review of Resident #1's Physician's Orders and Electronic Treatment Administration Records (ETARs) for May, June, July, and August 2019 revealed no orders or treatment for the left 4th toe.

An interview with the Director of Nursing (DON) on 8/21/19, at 2:06 PM, revealed it is the facility policy that the MD should be notified of any changes in the resident's condition and the policy was not followed for Resident #1's toenail. She stated LPN #1 should have followed up on it, and also should have reported it to the RN and MD. The DON stated she was not in the building, on 05/09/19, when Resident #1's toenail was detached, or on 06/04/19, when the worsening condition of the toe was discovered. The DON stated RN #1 was the supervisor while she was out, and would have been responsible for following up on the incident.

An interview with the Administrator, on 08/21/19, at 3:30 PM, revealed Resident #1 was self-propelled in his wheelchair and it was reported to him by staff that earlier in the day on 06/04/19, the resident had been going about his normal routine with no complaints of pain until the left foot was noted to be swollen in the shower room. He stated an incident report should have been done for the detached toenail on 05/09/19, the MD should have been notified, and a doctor's order obtained for treatment of the left 4th toe. The Administrator stated the staff should have followed up on the toe from 05/09/19.

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F 580	Continued From page 9 Record review of the Face Sheet revealed Resident #1 was admitted by the facility, on 01/25/18, with a diagnosis of Pain in Left Leg. Review of the Physician Orders for the month of August 2019, revealed current diagnoses of Pain in Left Leg, Acquired Absence of Other Left Toe(s), Encounter for Other Specified Surgical Aftercare, Major Depressive Disorder. Record review of the 30 Day Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/11/19, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognitive skills for daily decision making. Section G of the assessment revealed that the resident required extensive assistance of two (2) persons for bed mobility, dressing, and toileting and that he was totally dependent for bathing.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		10/1/19

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F 600	Continued From page 10 by: Based on record review, staff interview, and facility policy review, the facility failed to provide necessary care and services to prevent neglect for one (1) of five (5) residents reviewed for wounds/skin alterations, Resident #1. The facility identified a detached toenail to Resident #1's left 4th toe, on 05/09/19, and failed to perform assessments and provide treatments to the toenail to prevent further skin alteration. On, 06/04/09, the facility identified a wound to the left 4th toe with redness, swelling, moderate bleeding, and pus. Resident #1 was sent to the local hospital for evaluation, and then transferred to the regional hospital for surgical intervention. Resident #1 was diagnosed with Severe Cellulitis to the Left Foot and Left 4th toe, and Multiple Fractures to the 4th left toe. Resident #1 was admitted to the hospital and received intravenous (IV) antibiotics for infection. Resident #1 required an amputation to the Left 4th toe during the hospitalization. Resident #1 returned to the facility on 06/13/19. Findings include: Review of the facility's policy titled, "Abuse and Neglect", revised 12/31/17, revealed, POLICY: It is the policy of the facility to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property. Definitions-Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Prevention: The facility will identify, perform ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors	F 600	1. Resident received wound care services on 6/4/2019 and transferred to Sharkey Issaquena Community Hospital for emergency services on 6/4/2019. Resident received counseling by Social Service Director on 6/4/2019 while at Sharkey Issaquena Community Hospital. Resident did not show signs of psychosocial harm. 2. There are twelve residents currently receiving wound care on 8/27/2019. The facility will ensure that residents are provided services as ordered by the physician, and changes of condition are reported to physician. Body audits performed of all Residents by Director of Nurses on 8/25/2019. No new injuries found by audit on 8/25/2019. 3. In-service performed by Staff Development Coordinator on neglect and abuse with all staff performed on 08/22/2019. In-service performed by Staff Development Coordinator for Licensed Practical Nurses and Registered Nurses performed on 8/23/19 consisting of attaining doctors orders to ensure follow up of necessary services to prevent potential of neglect. Social Service Director will interview cognitive Residents weekly for six weeks to ensure Residents have no complaints of abuse or neglect performed on 8/29/2019. High Risk Meeting template altered to review body audits of Residents for the purpose to have Director of Nurses inspect the completion of body audits performed by	

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F 600	Continued From page 11 which might lead to conflict or neglect. An observation of Resident #1, with the Director of Nursing (DON), on 08/20/19 at 3:44 PM, revealed the absence of the 4th toe on Resident #1's left foot. The skin was intact with no swelling. Treatment Administration Records (ETARs) for May, June, July, and August 2019, revealed no orders or treatment for the left 4th toe. The ETARs did address toenail care by the Registered Nurse (RN) as needed (PRN), and the last date it was documented was on, March 3, 2019, by an agency RN. Review of Resident #1's Physician's Orders revealed an order dated, 05/21/18, for Weekly Body Audits, and on 01/25/18, for toenail care by RN PRN. Review of the Departmental Notes-Charge Nurse, dated 05/09/19 at 10 :45 AM, documented by LPN #2, revealed, "Resident pulled toenail bed on left foot. Area cleaned and wrapped". There was no documentation the Physician or NP were notified. Record review of the Departmental Notes, from 05/09/19 until 06/04/19, revealed no documentation of any concerns regarding Resident #1's left 4th toe. The documentation of skin assessments reflected that Resident #1's skin was intact, with the exception, on 05/21/19, when a skin tear was noted on an unspecified arm. Review of the Departmental Notes-Charge Nurse, dated 05/31/19 at 10:52 AM, documented by LPN #1/Treatment Nurse, revealed, "(Name of	F 600	Wound Care Nurse on 9/04/2019. 4. High Risk Meetings will be reviewed monthly to Quality Assurance by Director of Nurses. Quality Assurance Committee will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly. The Quality Assurance Committee will make further recommendations as needed.	

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Physician) made rounds today. No new orders at this time".

The Department Note-Charge Nurse, dated 06/04/19 at 4:48 PM, documented by LPN #2, revealed: "+1 (Plus One) pitting edema noted to left foot. Nurse removes bandage wrapped around 4th toe next to pinky toe. Cyanosis. Moderate bleeding, and pus noted. 4:45 PM resident transferred to (Initials For Local Hospital) ER. Transported from w/c (wheelchair) to stretcher safely by EMT (Emergency Medical Technicians).

Record review of a Resident Incident Report, dated 06/04/19 at 4:15 PM, revealed localized tissue edema to Resident #1's left toe. The report documented: "Nurse summoned to shower room. Edema noted to left foot leading to fourth toe with bandage wrapped around. Pus and blood noted to bandage. Nurse carefully removed bandage. Cyanosis and moderate bleeding noted. Pain scale of 9. (Initials of Local Hospital Emergency Room) nurse called". The Incident Report was signed and dated 06/06/19, by Licensed Practical Nurse (LPN) #2. The Incident Report documented the resident's family was notified on 06/04/19 at 5:00 PM. Further review of the Incident Report revealed Transportation by: (local) Emergency Medical Technician to local ER. Review of the Resident Incident Followup, no name or date on the form, revealed the 24 Hour Followup for the condition and injury appearance stated the left 4th toe was amputated due to pathological fracture. Additional Followup stated the resident returned from the hospital on 06/13/19, with orders to clean the left 4th toe with sterile water and cover with 2 x 2 and Kling.

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Review of the facility's Investigation, dated 06/04/19, revealed Certified Nursing Assistant (CNA) #3 noted Resident #1's 3rd left toe was red and warm, bleeding was noted under the third toe, and there was an open area under the 3rd left toe. (An interview, on 08/20/19 at 1:13 PM, with the Administrator revealed he had documented the wrong toe, should have been the 4th toe). The report documented: Small chip fracture through the base of the distal phalanx (end of toe) of the third toe. The report revealed Resident #1 propelled himself in a wheelchair. The Nurse Practitioner (NP) assessed the wound on 06/04/19, and stated he believed it could be due to trauma or athlete's foot. The NP also noted the resident had poor circulation. The last Body Audit was done on 05/28/19 by LPN #1, and she noted skin was intact. Body Audits were performed on all residents between 06/03/19 and 06/07/19. (Record review after this report, revealed Resident #1's Body Audit on 06/04/19 by LPN #1/Treatment Nurse revealed his skin was intact. LPN #1 documented a Body Audit,on 06/12/19, that documented Resident #1's skin was intact, and the resident was in the hospital at this time).

Record review of the (local hospital) Emergency Room Note, dated 06/04/19, at 5:03 PM, revealed upon physical exam by the Medical Doctor, "Extremities remarkable for swelling of the left foot and calf. There is erythema primarily of the distal foot, and the toes. There is an open wound on the plantar surface, at the proximal joint of the left forth toe. Wound goes all the way across the joint, and it is deep, possibly extending to bone. Impression: Cellulitis, wound infection, Plan: Transfer for surgical attention. Start antibiotics prior to transfer, unless he can be moved

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quickly". Record review revealed that Resident #1 was transferred to a regional hospital by ambulance on 06/04/19, at 5:43 PM.

Record review of the regional/second receiving hospital Emergency Department (ED) History and Physical, dated 06/04/19, at 9:00 PM, revealed Resident #1 was brought into the ED with severe swelling and redness of the left fourth toe, with suspected fracture of the left fourth toe. X-ray of the left foot on 06/04/19, revealed, "Fourth toe fractures with widened distal interphalangeal joint (DIP). Physical examination revealed, "Foul smell from the left foot. Laceration of the plantar surface at the left fourth digit at the metatarsophalangeal joint (MTP) Musculoskeletal: Ankle/foot: Diffuse swelling of the left fourth digit, foot, erythematous, laceration as above. Foul smell area of erythema to that digit and diffusely over the dorsal aspect of the left foot". Multiple antibiotics were given in the ED on 06/04/19.

Review of the hospital's Discharge Summary, dated 06/13/19, revealed Resident #1 was admitted to the hospital, on 06/04/19, with diagnoses of Phalanx Fracture Left Fourth Toe-Open, Infected MTP Fourth Toe Left, and Cellulitis. Orthopedic was consulted and the resident underwent an amputation of the left fourth toe.

Record review of Ultra Sound Lower Extremity Arterial Duplex Bilateral, performed on 06/11/19, revealed only mild atherosclerotic changes. Left ankle pressure was unobtainable. No other evidence of hemodynamically significant stenosis in either lower extremity was found. Resident #1 was discharged back to the nursing home on

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06/13/19.

An interview, with Certified Nursing Assistant (CNA) #2, on 08/21/19 at 1:06 PM, revealed on 06/04/19, she was in the Whirlpool Room, and she said to CNA #3, "Look at that man's toe, how did they miss that". CNA #2 said when she saw it, "it was just hanging by a thread". She stated Resident #1 had been refusing baths, and that was why she hadn't seen it until that day. CNA #2 said Resident #1 did not act like the toe hurt him. CNA #2 reported Resident #1 usually got his baths in the evening due to he attended a daytime activity usually till 2:00 PM.

An interview, with CNA #3, on 08/21/19, at 1:15 PM, revealed she did not remember Resident #1's toenail falling off. CNA #3 said they were bathing Resident #1 on 06/04/19, and noticed his left foot was swollen, and they (CNAs) reported it to the nurse. CNA #3 said the toe was "reddish looking and that the toe didn't look good at all. It kinda (sic) scared me, it was something like I'd never seen before. It looked like it was going to pop or something". CNA #3 stated there was a blue bandage wrapped around the 4th toe of the left foot. CNA #3 reported Resident #1 would pick at his toenails and he would sometimes have a bandage on the toe he was picking at the time. CNA #3 said Resident #1 had refused baths a couple of times and that was why she had not seen his feet. She stated he never complained of anything and always had socks on when she put him to bed.

An interview, on 08/20/19 at 1:22 PM, revealed CNA #1/Whirlpool CNA stated she remembered Resident #1's toe was bleeding, and she called the nurse. She thinks it was LPN#2. CNA #1 said

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she could not remember the date of the incident. CNA #1 said she did not recall seeing Resident #1's feet because he refused a tub bath and preferred to keep his socks on.

Record review of Resident #1's Completed Care Tasks, revealed the resident received a shower bath on 05/09/19, 05/11/19, 05/18/19, 05/21/19, and 05/25/19. A sponge bath on 5/14/19, 05/28/19 and 6/01/19. Skip baths due to medical condition on, 05/17/19, 05/31/19, and 06/05/19. A whirlpool bath on 05/23/19.

Review of Resident #1's Daily Care Guide revealed the resident was as risk for skin problems. Bath assistance was two (2) person physical assist. Whirlpool bath on Tuesdays, Thursday, and Saturdays, and offer sponge bath on opposite days. Mobile via wheelchair.

During an interview with LPN #2, on 08/20/19 at 1:08 PM, LPN #2 stated she was aware of the prior incident, on 05/09/19, in which she was called into the Whirlpool Room by the CNAs due to Resident #1's toenail of the left fourth toe was detached and that there was blood over the nail bed. LPN #2 said there was no swelling or redness to the left 4th toe that day, and she called LPN #1, the Treatment Nurse, into the Whirlpool Room. LPN #2 reported LPN #1 dressed the toe that day. LPN #2 said she documented in the nurses note Resident #1 had pulled his toenail off per report by the CNAs, on 05/09/19, and she did not perform the dressing change. LPN #2 said she did not notify the Medical Doctor of the detached toenail or get an order for the treatment to the toenail.

Interview with Licensed Practical Nurse (LPN) #2,

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on 08/20/19, at 1:53 PM, revealed she was the nurse assigned to Resident #1 on 06/04/19, and was called into the Whirlpool Room by the CNAs. LPN #2 reported Resident #1's left foot was very swollen, and what alarmed her was that the swelling seemed to be coming from the left 4th toe. LPN #2 said the other toes were not swollen. LPN #2 said there was a blue bandage on the left 4th toe, and she removed the blue bandage carefully. LPN #2 said she observed pus and a little blood on the bandage, and the toe appeared deformed and blue. LPN #2 said she had no knowledge of any treatment ordered for the left 4th toe.

On 08/20/19 at 1:30 PM, an interview with LPN #1/Treatment Nurse, revealed she was called to the Whirlpool Room, on 05/09/19, by a CNA and observed Resident #1's left fourth toenail was "hanging by a little piece". LPN #1 stated she did not observe any blood to the toenail bed. LPN #1 stated she cleaned the nail bed with normal saline, and she thought she put antibiotic ointment on it and a band aid. LPN #1 stated she told the Nurse Practitioner (NP) that Resident #1 had pulled his toenail off and what she had done to dress it. LPN #1 stated the NP said that was fine and gave no further orders, but she did not document this in the medical record. LPN #1 said the following day, she took the band aid off and cleaned the nail bed again and it was fine. LPN #1 confirmed no further treatment was needed, due to it really wasn't an open area and there was no swelling or deformity noted to the left 4th toe that day. LPN #1 stated in regards to the incident, on 06/04/19, she was already gone for the day when the Social Worker called her reporting that Resident #1 was taken to the Emergency Room (ER). LPN #1 stated she had performed body

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audits on Resident #1 weekly while he was in the Whirlpool Room, and she documented a body audit in the medical record, on 06/04/19, that Resident #1's skin was intact. LPN #1 said she had heard the left foot was wrapped and LPN #2 or a Whirlpool CNA had removed the dressing. LPN #1 revealed she did not know who had applied a dressing to the foot. LPN #1 said someone had to have seen it before that day, wrapped it, and not told her. LPN #1 stated she went to talk to the NP to ask how it got that bad that fast and the NP said he could have hit it on something or it could have been athletes foot fungus, but she thought it was determined a fracture. LPN #1 stated she was responsible for skin audits and she usually does them in the Whirlpool Room. LPN #1 said she looks at the resident's face, front and back, and the feet. LPN #1 stated, "I wouldn't have missed that".

Review of Resident #1's Skin Inspection Reports, dated 05/07/19, 05/14/19, 05/21/19, and 06/04/19 revealed the skin was intact. The skin inspections were documented by LPN #1/Treatment Nurse. LPN #1 documented a Skin Inspection Report on 06/12/19, that stated the skin was intact. Resident #1 was in the hospital on 06/12/19.

In an interview, on 08/21/19 at 1:45 PM, LPN #1 confirmed she documented a skin audit for Resident #1, on 06/04/19, but she actually did not do a skin inspection. LPN #1 said sometimes she would write the body audits down, and then go the the computer and log them in. LPN #1 said she thinks she may have clicked the wrong name. LPN #1 said these skin reports were done on Tuesdays, even though the Physician's Orders were for Thursdays.

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An interview, with LPN #3 on 08/21/19, revealed she was not aware that Resident #1's left 4th toe nail had come off. LPN #3 recalled LPN #2 called her into the Whirlpool Room on 06/04/19. LPN #3 said Resident #1's left 4th toe was "big and red", and his whole left foot was red and swollen. LPN #3 said she looked at the foot and toe, and said, "you need to send him out".

An interview with the Medical Doctor (MD) for Resident #1, on 08/21/19, at 9:09 AM, revealed he was not notified of the detached toenail on 05/09/19, and he recalled being surprised when he was told of the amputation. The MD confirmed he had not given any orders for a bandage to the left 4th toe. The MD stated he had seen the resident on 05/31/19, and he looked at his ankles for edema, but did not remove his shoes. The MD stated there was a concern regarding notification of changes.

Review of the MD's Nursing Home Visit note, dated 05/31/19 at 9:36 AM, revealed no swelling to the right or left foot. Nursing staff was present during the visit and all concerns were reviewed. Will continue current plan of care and treatment.

During an interview with the Director of Nursing (DON), on 08/21/19 at 2:06 PM, she revealed the facility's policy was not followed for Resident #1's toenail injury, due to the MD should be notified of any changes in the resident's condition. The DON stated LPN #1 should have followed up on the injury and should have reported it to the Registered Nurse (RN) and MD. The DON stated she was not in the building, on 05/09/19, when Resident #1's toenail detached, or on 06/04/19, when the worsening condition of the toe was discovered. The DON stated RN #1 was the

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supervisor while she was out, and would have been responsible for following up on the incidents.

During the interview with Registered Nurse (RN) #1, on 08/21/19, at 9:57 AM, she stated, "I didn't know about the toenail. I remember discussing it after he went to the hospital on 06/04/19". Further interview, on 8/21/19, at 3:16 PM, and record review of the Electronic Treatment Administration Records (ETARs), with RN #1, revealed no toenail care was documented on the May 2019, June 2019, July 2019, and August 2019 eTARs. RN #1 stated, "Just whatever RN is doing toenail care would do it. Usually on the weekends. I guess it wasn't done. If it's not documented, it's not done".

The interview with the Administrator, on 08/20/19 at 1:13 PM, revealed the facility did not do an Accident/Incident Report, on 05/09/19, regarding Resident #1's left 4th toe nail. The Administrator confirmed there was no Physician's Orders for the left 4th toe wound care. Further interview with the Administrator, on 08/21/19 at 3:30 PM, revealed an incident report should have been done on 05/09/19, the MD should have been notified, and a doctor's order obtained for treatment of the left 4th toe. The Administrator also said the staff should have followed up on the toe from 05/09/19, after the nail was detached. The Administrator revealed in-services were began, on 06/05/19, with Nursing Services for treatments, orders, and reporting injuries when they were found, and the Quality Assurance Team met to review this incident on 06/07/19.

Review of the Face Sheet revealed the facility admitted Resident #1 on 01/25/18, with a

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F 600	Continued From page 21 diagnosis of Pain in Left Leg. Current diagnoses include Pain in Left Leg, Acquired Absence of Other Left Toe(s), Encounter for Other Specified Surgical Aftercare, Major Depressive Disorder. Review of the 30 Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/19, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS)score of 3, indicating severely impaired cognitive skills for daily decision making.	F 600		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		10/1/19

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F 656	Continued From page 22 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to develop and implement a plan of care, which included accurate skin assessments and treatments for Resident #1's left fourth (4th) toenail detachment, identified by the facility on 05/09/19, which resulted in infection and amputation of the resident's toe. This concern was identified for one (1) of five (5) resident care plans reviewed. Findings include: Review of the facility's policy titled, "Care Plan", undated, revealed, "Policy: It is the policy of the facility that the interdisciplinary team, in accordance with the resident and his/her family and/or responsible party, as appropriate, will develop a comprehensive care plan for each resident that includes measurable goals, objective goals with specific timeframes for meeting those goals. The interventions developed	F 656	1. Resident care plan updated on 9/10/2019 to reflect Resident amputation and to address the behavior of Resident #1 picking his toenails by Administrator. 2. Director of Nurses, 100% audit on Resident foot care for any potential risk areas and needs performed on 08/28/2019. No new risk areas or wound care needed as of 08/28/2019. Minimum Data Set Registered Nurse to review Resident□s charts for one hundred percent completion of skin related care plans completed on 08/22/2019. Audit indicated that seven Residents needed care plans related to skin break down, four Resident□s Care plans were updated to reflect most recent wound care changes. Minimum Data Set Registered Nurse to update Care Plans of Residents with current skin integrity needs	

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F 656	Continued From page 23 in the care plan will be followed to meet the resident's medical, nursing, dietary, and psychosocial needs to maximize the resident's level of functioning and quality of life". Review of Resident #1's Care Plan, dated 02/05/18, revealed a potential for impaired skin integrity. The Goal included the resident would not have any skin breakdown or alterations. The most recent Target Dates were 10/26/19, 08/09/19, and 04/30/19. The Approaches included: Ensure staff observes the resident's skin daily with routine care and notifies the nurse so the nurse can notify the doctor. Ensure Body Audits are done at least once a week by a nurse. Further review of the Care Plan revealed there was no documentation for the identification of the detached toenail on 05/09/19, or the hospitalization on 06/04/19, and amputation of the Left 4th Toe. The Care Plan also did not address the behavior of Resident #1 picking his toenails. An interview, on 08/20/19 at 1:30 PM, revealed LPN #1/Treatment Nurse, confirmed she was called to the Whirlpool Room on 05/09/19, by a CNA. LPN #1 said she observed Resident #1's left 4th toenail was "hanging by a little piece". LPN #1 said she did not see any blood on the toenail bed. LPN #1 said she cleaned the nail bed and applied a band aid, but did not document in the medical record. LPN #1 stated she cleaned the toenail area the next day without any open areas noted. LPN said she did not observe any swelling or deformity to the left 4th toe at the time. LPN #1 stated she had already gone for the day, on 06/04/19, when the Social Worker called her to report Resident #1 was taken to the ER. LPN #1 stated she had performed body audits on Resident #1 weekly in the Whirlpool Room and	F 656	completed on 08/22/2019. 3. In-service conducted by Administrator on Care Planning policy and ensuring that care plan reflects current level of care for Residents. Initiated on 9/10/2019, altered of High Risk Meeting to include monitoring of care plans which include care plans related to wound care. Audit conducted by Administrator of departmental notes once weekly for six weeks to ensure Care Plans have been updated initiated on 9/10/2019. Care plans audit related to current wounds to be performed monthly by Director of Nurses each month for three months initiated on 9/18/2019. 4. High Risk Meeting will completion and effectiveness will be monitored during the Quality Assurance Meetings. All findings will be reported monthly to Quality Assurance by Registered Nurse Director of Nurses. Quality Assurance team will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly thereafter. The Quality Assurance committee will make further recommendations such as increased training, corrective action against Team Members, and care plan reflections as needed.	

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that she had documented a body audit in the medical record as "Skin Intact" on 06/04/19. LPN #1 stated she was responsible for skin audits and that she usually does them in the Whirlpool Room. LPN #1 confirmed during a body audit she would look at the resident's face, front and back side, and the feet and that she wouldn't have missed the toe (if it looked bad).

An interview conducted with LPN #2, on 08/20/19 at 1:08 PM, revealed she was not aware of any treatments at this time for Resident #1's toe. LPN #2 stated the CNA told her Resident #1 had pulled his toenail off while in the whirlpool room on 5/9/19. LPN #2 stated she assessed the toenail and found the toenail was detached, with blood over the nail bed. LPN #2 said she did not observe any swelling or redness to the left 4th toe at that time, and called LPN #1/Treatment Nurse to the Whirlpool Room, who dressed the toe. LPN #2 said she made a note in the nurse's notes regarding the resident pulling the toenail off, but did not document physician notification or get orders for treatment.

An interview, with CNA #3, on 08/21/19, at 1:15 PM, revealed they were bathing Resident #1 on 06/04/19, and noticed his left foot was swollen, and reported it to the nurse. CNA #3 said the toe was "reddish looking and that the toe didn't look good at all. It kinda (sic) scared me, it was something like I'd never seen before. It looked like it was going to pop or something". CNA #3 stated there was a blue bandage wrapped around the 4th toe of the left foot. CNA #3 reported that Resident #1 would pick at his toenails and he would sometimes have a bandage on the toe he was picking at the time. CNA #3 said Resident #1 had refused baths a couple of times and that was

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why she had not seen his feet. She stated he never complained of anything and always had socks on when she put him to bed.

Record review of the regional receiving hospital Emergency Department (ED) History and Physical, dated 06/04/19, at 9:00 PM, revealed Resident #1 was brought to the ED with severe swelling and redness of the left fourth toe, with suspected fracture. X-ray of the left foot, on 06/04/19, revealed fractures of the left 4th toe. Physical exam revealed a foul smell from the left foot, a laceration of the plantar surface of the 4th toe and diffuse swelling of the left 4th toe and foot. Multiple antibiotics were given in the ED on 06/04/19. The resident was admitted to the hospital with diagnoses of Phalanx Fracture Left Fourth Toe-Open, Infected MTP (Metatarsophalangeal Joint) Fourth Toe Left, and Cellulitis. Orthopedic was consulted and the resident underwent an amputation of the left fourth toe. Resident #1 was discharged back to the nursing home on 06/13/19.

During an interview, Licensed Practical Nurse (LPN) #2, on 08/20/19, at 1:53 PM, stated she was called into the Whirlpool Room on 06/04/19, by the Certified Nursing Assistant (CNA). LPN #2 said Resident #1's left foot was very swollen, and she was alarmed the swelling was coming from the left 4th toe. LPN #2 said there was a blue bandage on the left 4th toe, and when she removed the bandage, there was pus and a little blood on the bandage. LPN #1 said the toe looked deformed and blue.

Review of Resident #1's Skin Inspection Reports, dated 05/07/19, 05/14/19, 05/21/19, and 06/04/19 revealed the skin was intact. The skin inspections

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were documented by LPN #1/Treatment Nurse. LPN #1 documented a Skin Inspection Report on 06/12/19, that stated the skin was intact. Resident #1 was in the hospital on 06/12/19.

In an interview, on 08/21/19 at 1:45 PM, LPN #1 confirmed she documented a skin audit for Resident #1, on 06/04/19, but she actually did not do a skin inspection. LPN #1 said sometimes she would write the body audits down, and then go the the computer and log them in. LPN #1 said she thinks she may have clicked the wrong name. LPN #1 said these skin reports were done on Tuesdays, even though the Physician's Orders were for Thursdays.

There was no documented care plan in the medical record regarding the toenail detachment, assessments of the nail bed, or treatments to the nail bed.

During an interview with Registered Nurse (RN) #1/ Minimum Data Set (MDS)/Care Plan Nurse, she revealed the toenail detachment, on 05/09/19, should have been care planned. She stated she did not know about the toenail until after Resident #1 was sent to the hospital on 06/04/19. RN #1 stated it is the policy of the facility to update care plans every three (3) months with the MDS or develop a new one anytime there is a change with a resident's plan of care, for example a fall, skin problem, change in medicine or a new diagnosis. RN #1 confirmed the cellulitis resulting in the amputation of the left 4th toe, the resulting surgical incision aftercare, his toenail picking behavior, and his potential for injury were not care planned on his re-admission to the facility on 06/13/19. RN #1 stated it is the policy of the facility to develop a new care plan for

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F 656	Continued From page 27 a new problem and that the policy was not followed. Record review of the Face Sheet revealed Resident #1 was admitted by the facility, on 01/25/18, with a diagnosis of Pain in Left Leg. Review of the Physician Orders for the month of August 2019 revealed current diagnoses of Pain in Left Leg, Acquired Absence of Other Left Toe(s), Encounter for Other Specified Surgical Aftercare, Major Depressive Disorder. Record review of the 30 Day Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 07/11/19, revealed in Section C that the resident had a Brief Interview for Mental Status score of 3, indicating severely impaired cognitive skills for daily decision making. Section G of the assessment revealed that the resident required extensive assistance of two (2) persons for bed mobility, dressing, and toileting and that he was totally dependent for bathing.	F 656		
F 687 SS=G	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687		10/1/19

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by:
Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure proper foot treatment and care to prevent complications for one (1) of five (5) residents reviewed for foot care, Resident #1. Resident #1 had a detachment/injury to the left fourth (4th) toe on 05/09/19. On 06/04/19, due to the facility's lack of foot/skin care, treatment, and accurate assessments of the left 4th Toe, Resident #1 was admitted to the hospital for Severe Cellulitis, Infection, and Multiple Fractures to the Left Toe. Resident #1 required an amputation of the Left 4th Toe during the hospitalization.

Findings include:

Review of the facility's policy titled, "Skin Care Policy & Procedure, latest revision 04/11, revealed: It is the policy of this facility that skin problems will be minimized to the greatest extent possible through an aggressive approach consisting of four components. Those are: I. Prevention, Evaluation and Screening, II. Ongoing Surveillance, III. Treatment Orders, IV. Treatment Regimen. Overseeing these efforts will be the Director of Nursing, who will have ultimate responsibility of ensuring that this policy is applied consistently. I. Prevention, Evaluation and Screening- Lesion which are present, or which develop later will be followed carefully and treated according to medical direction. This will be accomplished by making rounds weekly on all residents through weekly body audits. II. Ongoing Surveillance: A. Documentation, reporting and treatment of superficial skin injuries at each occurrence. III. Treatment Orders: A. After observation/evaluation of the affected skin area,

1. Treatment to Resident #1 completed by Nurse #2 on 06/04/2019. Resident was taken to Local Hospital on 06/04/2019. Resident returned on 06/13/2019 with a return order to continue wound care until healed and physician therapy evaluation.

2. All Residents have potential to be affected by the deficient practices. Facility will ensure that physician orders are received when wound care is needed to ensure wound and foot care is performed until healed.

3. Orders obtained by attending Physician for all Residents to have routine inspection of toe nails weekly on 09/03/2019. In-service performed by Staff Development Coordinator of Certified Nurse□s Aides to inspect and report if necessary toenail care needed during routine baths on 09/03/2019. Director of Nurses to perform 100% audit on Resident foot care for any potential risk areas performed on 08/25/2019. In-service performed by Director of Nurses of Registered Nurse Weekend Supervisor on change in Treatment Administration Record orders to reflect inspection of toe nails bi-monthly on 09/18/2019. Appropriate action taken against Licensed Practical Nurse #1 on 08/27/2019. Director of Nurses to perform weekly audits of 25 percent all Resident□s feet to assess for any necessary foot care for six weeks on 8/25/2019. Director of Nurses to inspect 100 percent of skin inspection reports

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F 687	Continued From page 29 notify physician for the treatment order. IV. Treatment Regimen: Treatment for identified skin problems will be immediate and appropriate and in collaboration with the attending physician. A. Carefully document condition. B. The physician's order is sought for both direct care to the problem by nursing personnel and for any associated treatments. C. 9. Skin problems will be incorporated in the interdisciplinary plan of care along with approaches so that the entire staff has an increased awareness of those special needs. An observation, with the Director of Nursing (DON), on 08/20/19 at 3:44 PM, of Resident #1's feet revealed the absence of the 4th toe on the left foot. The skin was intact with no swelling. Review of the Departmental Notes-Charge Nurse, dated 05/09/19 at 10 :45 AM, documented by LPN #2, revealed, "Resident pulled toenail bed on left foot. Area cleaned and wrapped". There was no documentation the Physician or NP were notified and there were no orders for treatment. The Department Note-Charge Nurse, dated 06/04/19 at 4:48 PM, documented by LPN #2, revealed: "+1 (Plus One) pitting edema noted to left foot. Nurse removes bandage wrapped around 4th toe next to pinky toe. Cyanosis. Moderate bleeding, and pus noted. 4:45 PM resident transferred to (Initials for Local Hospital) ER. There was no MD notification documented. Record review of the Departmental Notes, from 05/09/19 until 06/04/19, revealed no documentation of the left 4th toe, and that Resident #1's skin was intact, with the exception, on 05/21/19, when a skin tear was noted on an unspecified arm.	F 687	weekly during High Risk Meeting each week for eight weeks on 8/28/2019. Director of Nurses to audit skin and wound documentation from previous three months to ensure accuracy of documentation performed on 08/27/2019. Facility Podiatrist performed care on Residents on 08/28/2019. 4. All findings will be reported monthly to Quality Assurance by Registered Nurse Director of Nurses. Quality Assurance team will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly, provide increased training for foot care if necessary. The quality assurance committee will make further recommendations as needed.	

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Review of Resident #1's Physician's Orders and Electronic Treatment Administration Records (ETARs) for May, June, July, and August 2019 revealed no orders or treatment for the left 4th toe. The ETARs did address toenail care by the Registered Nurse (RN) as needed (PRN), and the last date it was documented was on, March 3, 2019, by an agency RN. The Physician's Orders revealed an order dated, 05/21/18, for Weekly Body Audits, and on 01/25/18 for toenail care by RN PRN.

On 8/21/19, at 3:16 PM, an interview and record review of the Electronic Treatment Administration Records (eTARs) with RN #1 revealed no toenail care was documented on the May 2019, June 2019, July 2019, and August 2019 eTARs. RN #1 stated, "Just whatever RN is doing toenail care would do it. Usually on the weekends. I guess it wasn't done. If it's not documented, it's not done".

Record review of the Resident Incident Report, dated 06/04/19 at 4:15 PM, revealed, the nurse was called to the shower room where Resident #1's left foot was assessed with localized tissue edema noted to left foot leading to fourth toe with bandage wrapped around. Pus and blood was noted to the bandage. Cyanosis and moderate bleeding noted. Pain scale of 9 out of 10. Resident #1 was transported to the Emergency Room. The Incident Report was signed and dated 06/06/19, by Licensed Practical Nurse (LPN) #2. Review of the Resident Incident Followup, no name or date on the form, revealed the 24 Hour Followup for the condition and injury appearance documented the left 4th toe was amputated due to pathological fracture.

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Record review of the facility's Investigation, dated 06/04/19, and signed by the Administrator, revealed: Small chip fracture through the base of the distal phalanx (end of toe) of the third toe. Resident #1's mobility was by propelling himself in a wheelchair. The Nurse Practitioner (NP) assessed the wound on 06/04/19, and stated he believed it could be due to trauma or athlete's foot. The NP also noted the resident had poor circulation. The last Body Audit was done on 05/28/19, by LPN #1, and she noted skin was intact. Body Audits were performed on all residents between 06/03/19 and 06/07/19. (Record review after this report, revealed Resident #1's Body Audit on 06/04/19 by LPN #1/Treatment Nurse revealed his skin was intact).

Record review of the (local hospital) Emergency Room Note, dated 06/04/19, at 5:03 PM, revealed upon physical exam by the Medical Doctor, "Extremities remarkable for swelling of the left foot and calf. There is erythema primarily of the distal foot, and the toes. There is an open wound on the plantar surface, at the proximal joint of the left forth toe. Wound goes all the way across the joint, and it is deep, possibly extending to bone. Impression: Cellulitis, wound infection, Plan: Transfer for surgical attention. Start antibiotics prior to transfer, unless he can be moved quickly". Record review revealed that Resident #1 was transferred to a regional hospital by ambulance on 06/04/19, at 5:43 PM.

Record review of the regional/second receiving hospital Emergency Department (ED) History and Physical, dated 06/04/19, at 9:00 PM, revealed Resident #1 was brought into the ED with severe swelling and redness of the left fourth toe, with suspected fracture of the left fourth toe. X-ray of

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the left foot on 06/04/19, revealed, "Fourth toe fractures with widened distal interphalangeal joint (DIP). Physical examination revealed, "Foul smell from the left foot. Laceration of the plantar surface at the left fourth digit at the metatarsophalangeal joint (MTP) Musculoskeletal: Ankle/foot: Diffuse swelling of the left fourth digit, foot, erythematous, laceration as above. Foul smell area of erythema to that digit and diffusely over the dorsal aspect of the left foot". Multiple antibiotics were given in the ED on 06/04/19.

Review of the hospital's Discharge Summary, dated 06/13/19, revealed Resident #1 was admitted to the hospital, on 06/04/19, with diagnoses of Phalanx Fracture Left Fourth Toe-Open, Infected MTP Fourth Toe Left, and Cellulitis. Orthopedic was consulted and the resident underwent an amputation of the left fourth toe.

Record review of Ultra Sound Lower Extremity Arterial Duplex Bilateral, performed on 06/11/19, revealed only mild atherosclerotic changes. Left ankle pressure was unobtainable. No other evidence of hemodynamically significant stenosis in either lower extremity was found. Resident #1 was discharged back to the nursing home on 06/13/19.

An interview with LPN #2, on 08/20/19 at 1:08 PM, revealed there was an incident on 05/09/19, in which she was called into the Whirlpool Room by the CNA because the toenail of Resident #1's left fourth (4th) toe was detached and there was blood over the nail bed. LPN #2 stated she did not observe any swelling or redness to the left 4th toe that day. LPN #2 said she called the

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Treatment Nurse/LPN #1, into the Whirlpool Room and LPN#1 dressed the toe that day. LPN #2 said she documented in the nurses note Resident #1 had pulled his toenail off per report by the CNAs, on 05/09/19, but she did not perform the dressing change. LPN #2 did not document the physician was notified of the incident, or an order for the treatment provided to the toenail.

On, 08/20/19 at 1:30 PM, an interview with LPN #1/Treatment Nurse confirmed she was called to the Whirlpool Room, on 05/09/19, by the CNA due to Resident #1's left fourth toenail was "hanging by a little piece". LPN #1 stated she did not observe any blood to the toenail bed. LPN #1 said she cleaned the nail bed with normal saline, and she thought she put antibiotic ointment on it and a band aid. LPN #1 stated she told the Nurse Practitioner (NP) that Resident #1 had pulled his toenail off and what she had done to dress it. LPN #1 stated the NP said that was fine and gave no further orders. LPN #1 stated she did not document this in the medical record. LPN #1 said the following day, she took the band aid off and cleaned the area again and it was fine. LPN #1 confirmed no further treatment was needed due to it really wasn't an open area and there was no swelling or deformity noted to the left 4th toe that day. LPN #1 stated she was already gone for the day when the Social Worker called her reporting that Resident #1 was taken to the Emergency Room (ER) on 6/4/19. LPN #1 confirmed she performed weekly body audits on Resident #1 while he was in the Whirlpool Room. LPN #1 confirmed she documented a body audit in the medical record, on 06/04/19, that stated Resident #1's skin was intact. LPN #1 said she had heard the left foot was wrapped and LPN #2 or a

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Whirlpool CNA had removed the dressing. LPN #1 revealed she did not know who had applied a dressing to the foot. LPN #1 said someone had to have seen it before that day, wrapped it and not mention it to her. LPN #1 reported she went to talk to the NP to ask how it got that bad that fast and the NP said he could have hit it on something, or it could have been athletes foot fungus, but she thought it was determined it was a fracture. LPN #1 stated she was responsible for skin audits and she usually did the skin audits in the Whirlpool Room. LPN #1 said she looks at the resident's face, front and back, and the feet. LPN #1 stated, "I wouldn't have missed that".

The interview with Certified Nursing Assistant (CNA) #2, on 08/21/19 at 1:06 PM, revealed she was with Resident #1 in the Whirlpool Room, on 06/04/19, and she said to CNA #3, "Look at that man's toe, how did they miss that". CNA #2 said when she saw it, "it was just hanging by a thread". CNA #2 said Resident #1 had been refusing baths, and that was why she hadn't seen it until that day.

During an interview on 08/21/19 at 1:15 PM, CNA #3 stated Resident #1 was in the Whirlpool Room and his toe was "reddish looking" and didn't look good at all. She stated it scared her, "it was something like I'd never seen before. It looked like it was going to pop or something". CNA #3 said there was a blue bandage wrapped around the 4th toe of the left foot. CNA #3 reported Resident #1 would pick at his toenails and he would sometimes have a bandage on the toe he was picking at the time. CNA #3 said Resident #1 had refused baths a couple of times and that was why she had not seen his feet. She stated he never complained of anything and always had

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socks on when she put him to bed.

During an interview, on 08/20/19 at 1:22 PM, CNA #1/Whirlpool CNA reported she remembered Resident #1's toe was bleeding, and she called the nurse, she thought it was LPN #2. CNA #1 said she could not remember the date of the incident. CNA #1 said she did not recall seeing Resident #1's feet because he refused a tub bath and preferred to keep his socks on.

Interview on 08/20/19 at 1:53 PM, with Licensed Practical Nurse (LPN) #2, revealed she was the nurse assigned to Resident #1 on 06/04/19. LPN #2 said she was called into the Whirlpool Room by the Certified Nursing Assistant (CNA). LPN #2 reported Resident #1's left foot was very swollen, and what alarmed her was that the swelling seemed to be coming from the left fourth toe. LPN #2 reported the other toes were not swollen, and there was a blue bandage on the left 4th toe. LPN #2 said she removed the blue bandage carefully. LPN #2 said she observed pus and a little blood on the bandage, and the toe appeared deformed and blue. LPN #2 said she had no knowledge of any treatment ordered for the left fourth toe.

An interview, with LPN #3, on 08/21/19, revealed she said she was not aware Resident #1's left 4th toe nail had come off. LPN #3 said she remembered LPN #2 called her into the Whirlpool Room on 06/04/19. LPN #3 said Resident #1's left 4th toe was "big and red", and his whole left foot was red and swollen. LPN #3 said she looked at the foot and toe, and said you need to send him out.

Review of Resident #1's Daily Care Guide

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revealed the resident was as risk for skin problems. Bath assistance was two (2) person physical assist. Whirlpool bath on Tuesdays, Thursday, and Saturdays, and offer sponge bath on opposite days. Mobile via wheelchair.

Record review of Resident #1's Completed Care Tasks, revealed the resident received a shower bath on 05/09/19, 05/11/19, 05/18/19, 05/21/19, and 05/25/19. A sponge bath on 5/14/19, 05/28/19 and 6/01/19. Skip baths due to medical condition on, 05/17/19, 05/31/19, and 06/05/19. A whirlpool bath on 05/23/19. There were no documented reports of any concerns with Resident #1's feet.

Review of Resident #1's Skin Inspection Reports, dated 05/07/19, 05/14/19, 05/21/19, and 06/04/19, revealed the skin was intact. The skin inspections were documented by LPN #1/Treatment Nurse. LPN #1 also documented a Skin Inspection Report, on 06/12/19, at which time Resident #1 was in the hospital.

An interview, on 08/21/19 at 1:45 PM, revealed LPN #1 stated she documented a skin audit was done for Resident #1 on 06/04/19, but she did not actually do a skin inspection. LPN #1 said sometimes she would do the skin inspections, and go back to the computer later and log them in. LPN #1 also said she thinks she may have clicked on the wrong name. LPN #1 said she did the skin inspections on Tuesdays, even though the order is for Thursdays.

An interview with Resident #1's Medical Doctor (MD), on 8/21/19, at 9:09 AM, revealed he was not notified of the detached toenail on 05/09/19, and he had not given any orders for a bandage to

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the left 4th toe. The MD stated he recalled being surprised when he was told of the amputation. The MD stated he had seen the resident on 05/31/19, and he looked at his ankles for edema, but did not remove his shoes.

Review of the MD's Nursing Home Visit note, dated 05/31/19 at 9:36 AM, revealed no swelling to the right or left foot. Nursing staff was present during the visit and all concerns were reviewed. Will continue current plan of care and treatment.

The Director of Nursing (DON) revealed during an interview, on 08/21/19, at 2:06 PM, the facility's policy was not followed due to the MD should be notified of any changes in the resident's condition. The DON stated LPN #1 should have followed up on the toe after toenail detachment, and should have reported it to the Registered Nurse (RN) and MD. The DON revealed she was not in the building, on 05/09/19, when Resident #1's toenail was detached, or on 06/04/19, when the worsening condition of the toe was discovered. The DON stated RN #1 was the supervisor while she was out and would have been responsible for following up on the incident.

The interview, on 08/21/19 at 9:57 AM, with Registered Nurse (RN) #1, revealed she stated, "I didn't know about the toenail. I remember discussing it after he went to the hospital on 06/04/19".

An interview with the Administrator, on 08/20/19 at 1:13 PM, revealed the facility did not do an Accident/Incident Report, on 05/09/19, regarding Resident #1's left 4th toe nail. The Administrator confirmed there was no Physician's Orders for the left 4th toe wound care. Further interview with

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F 687	Continued From page 38 the Administrator, on 08/21/19 at 3:30 PM, revealed it was reported to him by staff that earlier in the day, on 06/04/19, the resident had been going about his normal routine with no complaints of pain until the left foot was noted to be swollen in the shower room. The Administrator said Resident #1 self-propelled himself in a wheelchair. The Administrator stated an incident report should have been done on 05/09/19, the MD should have been notified and a doctor's order obtained for treatment of the left 4th toe. The Administrator also said the staff should have followed up on the toe from the incident on 05/09/19 (until 6/4/19). Record review of the Face Sheet revealed Resident #1 was admitted by the facility, on 01/25/18, with a diagnosis of Pain in Left Leg. Review of the Physician Orders for the month of August 2019 revealed current diagnoses of Pain in Left Leg, Acquired Absence of Other Left Toe(s), Encounter for Other Specified Surgical Aftercare, Major Depressive Disorder. Record review of the 30 Day Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/11/19, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognitive skills for daily decision making. Section G of the assessment revealed that the resident required extensive assistance of two (2) persons for bed mobility, dressing, and toileting and that he was totally dependent for bathing.	F 687		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		10/1/19

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(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 40 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy statement review, the facility failed to ensure accurate medical records were documented regarding Resident #1's skin and body audits, for one (1) of five (5) medical records reviewed, Resident #1. Findings include: Review of a typed statement on the facility's letterhead, not dated, and provided by the Administrator, revealed the facility did not have a policy in regards to accuracy of medical records.	F 842	1. Addendums to the medical record of Resident #1 by Administrator reflected on 09/20/2019 to reflect the false documentation of body audits entered by Nurse #1. Resident care plan updated on 9/10/2019 to reflect resident amputation, and to address the behavior of Resident #1 picking his toenails. Appropriate action taken against Licensed Practical Nurse #1 on 08/27/2019. 2. All Residents have potential to be affected by the deficient practices. The	

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F 842	Continued From page 41 The statement included an attachment to the facility's policy for Discipline and Discharge, which is reviewed upon hire with every team member. Number 38 indicated that, "Deliberate or negligent omission or falsification of significant information on a medical record, including, but not limited to, an Employer's Application for employment, time keeping, charting, or billing form, or a mileage record", was against the facility's code of conduct. On 08/21/19 at 1:45 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed she documented she performed a skin audit for Resident #1, on 06/04/19, but she actually did not do a skin inspection. LPN #1 said she would do the skin inspections and then go log them into the computer at later times. LPN #1 said she thinks she clicked the wrong name. On 08/20/19 at 1:30 PM, an interview with LPN #1/Treatment Nurse, confirmed she was responsible for the skin audits and she usually did the skin audits while Resident #1 was in the Whirlpool Room. LPN #1 said she looks at the resident's face, front and back, and the feet. LPN #1 said she was called to the Whirlpool Room, on 05/09/19, by the CNA because Resident #1's left fourth toenail was "hanging by a little piece". LPN #1 stated she did not observe any blood to the toenail bed. LPN #1 said she cleaned the nail bed with normal saline, and she thought she put antibiotic ointment on it and a band aid. LPN #1 reported she told the Nurse Practitioner (NP) Resident #1 pulled his toenail off and she had provided the treatment to it. LPN #1 reported the NP said that was fine and gave no further orders. LPN #1 stated she did not document this in the medical record. LPN #1 said the following day,	F 842	facility will ensure that Resident records are complete, accurately documented, readily accessible, and systematically organized by addressing concerns using corrective counseling. Medical Records Coordinator will audit for incomplete or inaccurate records and report any findings will be corrected as necessary. Resident records for skin and wound inspections were audited by Administrator on 8/27/2019. Audit resulted in eleven residents resulting in no skin and wound assessments, thirteen issues related to skin inspections. Addendums to Medical records related to this audit on 9/20/2019 by Administrator. 3. In-service conducted by Staff Development Coordinator on documentation that is complete, accurately documented, readily accessible, and systematically organized, and should follow the rules and ethical standards set forth by the employee manual performed on 9/27/2019 with Nurses and Departmental Staff. Medical record quarterly audit template to be altered to include audit of weekly skin inspections of all Residents on 9/27/2019. 4. Weekly skin inspections deficiencies will be reported by Medical Records Coordinator to Quality Assurance Meeting. Quality Assurance team will: Monitor effectiveness of the plan of correction monthly x 3 months then quarterly. The Quality Assurance Committee will make further recommendations as needed.	

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she took the band aid off and cleaned it again and it was fine. LPN #1 confirmed no further treatment was needed due to it really wasn't an open area and there was no swelling or deformity noted to the left 4th toe that day. LPN #1 stated in regards to the incident, on 06/04/19, she was already gone for the day when the Social Worker called her reporting that Resident #1 was taken to the ER. LPN #1 confirmed she performed weekly body audits on Resident #1 while he was in the Whirlpool Room, and she had documented a body audit in the medical record, on 06/04/19, that stated Resident #1's skin was intact. LPN #1 said she had heard the left foot was wrapped and LPN #2 or a Whirlpool CNA had removed the dressing. LPN #1 revealed she did not know who had applied a dressing to the foot, and that someone had to have seen it before that day, wrapped it and not mention it to her. LPN #1 reported she went to talk to the NP to ask how it got that bad that fast and the NP said he could have hit it on something, or it could have been athletes foot fungus, but she thought it was determined it was a fracture. LPN #1 stated, "I wouldn't have missed that", during the skin audits.

Review of Resident #1's Skin Inspection Reports, dated 05/07/19, 05/14/19, 05/21/19, and 06/04/19 revealed the skin was intact. The skin inspections were documented by LPN #1/Treatment Nurse. LPN #1 also documented a Skin Inspection Report on 06/12/19, at which time Resident #1 was in the hospital. The report documented Resident #1's skin was intact.

An interview with the Director of Nursing (DON), on 08/21/19, at 2:06 PM, confirmed Resident #1's medical records were not accurate in regards to

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the Skin Inspection Reports in which LPN #1 documented intact skin on 06/04/19, and that she documented she had performed a body audit on 06/12/19, while the resident was hospitalized. The DON stated it was falsification of medical records. She stated "False documentation should never happen, and it is against the policy".

Record review of the Departmental Notes, from 05/09/19 until 06/04/19, revealed no documentation of the left 4th toe, and that Resident #1's skin was intact, with the exception, on 05/21/19, when a skin tear was noted on an unspecified arm.

Record review of the Face Sheet revealed Resident #1 was admitted by the facility, on 01/25/18, with a diagnosis of Pain in Left Leg. Review of the Physician Orders for the month of August 2019 revealed current diagnoses of Pain in Left Leg, Acquired Absence of Other Left Toe(s), Encounter for Other Specified Surgical Aftercare, Major Depressive Disorder.

Review of the most recent Day Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/11/19, revealed in Section C that the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognitive skills for daily decision making.