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	495380	A. BUILDING _____ B. WING _____	C 08/11/2021

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 08/10/2021 through 08/11/2021. Two complaints were investigated during the survey. Complaint VA00052672 was substantiated with deficiencies. Complaint VA00052598 was substantiated with a deficiency. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of nine current resident reviews identified as Resident #1 through Resident #9.	F 000		
F 600 SS=E	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 by: Based on observation, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to	F 600	1. The PEG tube for Resident #1 has been re-assessed and the area is clean and dry without any complications noted.	9/9/21

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

Electronically Signed | 08/31/2021

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

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F 600	Continued From page 1 ensure one of nine residents was free from neglect, Resident #1. No care or dressing changes were provided to Resident #1's PEG (percutaneous endoscopic gastrostomy) tube site for ten days following an assessment of bleeding and prolapsed skin around the tube. A physician's order for topical treatment and dressing changes following the assessed bleeding was not implemented. Resident #1 had no treatment orders or evidence of routine, daily care provided to the gastrostomy site for at least three months. The findings include: Resident #1 was admitted to the facility on 1/26/19 with a re-admission on 12/21/20. Diagnoses for Resident #1 included non-traumatic brain dysfunction, anemia, hypertension, obstructive uropathy, urinary tract infection, alcohol-related dementia, dysphagia, adult failure-to-thrive, malnutrition, COPD (chronic obstructive pulmonary disease), anxiety and depression. The minimum data set (MDS) dated 7/13/21 assessed Resident #1 with moderately impaired cognitive skills and as receiving over 51% of nutritional calories through a gastric tube. Resident #1's clinical record documented a late entry nursing note (dated 7/30/21) stating, "On 7/14/21 approx. [approximately] 2200 pm [10:00 p.m.] writer called to resident room by floor nurse advising peg site with moderate amount of bright red blood, upon assessment observed bright red blood at site with surrounding skin prolapsed, area cleaned by writer with NS [normal saline] pat dry, dry gauze with applied pressure to stop bleeding successful, dressing placed, writer	F 600	An order for routine daily care for his PEG tube site has been implemented. The Physician Assistant has been notified that the treatment she ordered on 7/14/21 was not implemented, no new orders given. All nurses currently working in the Center will be re-educated by the Director of Nursing on the Center□s protocol for care and management of PEG tube site including but not limited to routine daily care and dressing changes and on the Center□s policy on Abuse Prevention. 2. Any resident with a PEG tube has the potential for harm if the PEG tube is not assessed and cared for properly. An audit will be completed by Director of nursing or designee of current residents who have a PEG tube to ensure PEG tube sites are assessed, proper care being performed and following physician orders for the care of the PEG tube site. 3. All nurses currently working in the Center will be re-educated by the Director of Nursing on the Center□s protocol for care and management of PEG tube site including but not limited to routine daily care and dressing changes and the Center□s Policy on Abuse Prevention. 4. An audit of all residents with PEG tubes will be conducted weekly x 4 weeks then monthly x 2 months to ensure an order is in place for routine daily care of the PEG tube site and no complications noted at the site. An audit will be conducted by the Unit Manager or designee weekly x 4 weeks then monthly x 2 months to verify orders written by Medical Professionals have been implemented. The Director of Nursing or	

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F 600	Continued From page 2 advised floor nurse to place on list to be seen by NP [nurse practitioner] for evaluation d/t [due to] resident with HX [history] of recurrent prolapsed skin surrounding peg site." A physician's assistant (PA, other staff #4) assessed Resident #1's PEG site on 7/14/21. A PA note dated 7/14/21 documented, "...The patient is seen today per nurse request due to noticing some blood around the PEG insertion site. The patient denies any pain, very mild drainage from the site. We will continue to monitor, place gauze and steroid cream..." The PA documented under the plan for treatment for the PEG site, "...Attention to gastrostomy - Continue current site care, gentle with hyper granulation tissue - Nursing to continue to monitor site, notify provider of any worsening or developing symptoms...Continue monitoring PEG site. Cover with gauze and apply steroid cream." The treatment orders for steroid cream and dressing ordered by the PA on 7/14/21 in response to the bleeding PEG site were not implemented. There was no physician's order entered and no entry on Resident #1's treatment administration record (TAR) or medication administration record (MAR) regarding steroid cream or dressing applications. There were no other orders or entries on the July 2021 TAR regarding cleaning and/or monitoring of the PEG site. Licensed practical nurse (LPN) #9 documented a nursing note stating the resident was found on 7/24/21 with a 10-day old dressing in place on the PEG tube site. A nursing note dated 7/24/21 at 1:57 a.m. documented, "Pt [patient] observed lying in bed during med pass with PEG dressing	F 600	designee will review the audits and report findings to the QAPI committee monthly x 3 for any further recommendations. 5. Date of compliance: September 9, 2021	

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in place dated 7/14/21. Upon removal of dressing, a thick, hard, black substance was observed with pus and serosanguinous [serosanguineous] fluid. PEG site was excoriated and tender to touch. Site was cleaned and dressing removed. Dressing reported to DON [director of nursing]...attempted to begin pt tube feeding. PEG was not patent, unable to pull residual or flush...upon viewing PEG, thick sediment observed in line...attempted to flush PEG with water and was unsuccessful...attempted to pull residual and was unsuccessful. De-clogger was used...and was successful. Tube was able to be flushed...MD [physician]...contacted and assessed pt via video and gave order to send pt to ER [emergency room]..."

Another nurse (LPN #8) also documented an assessment of the 10-day old PEG site dressing. A nursing note dated 7/24/21 at 3:26 a.m. documented, "...This nurse assessed patient's peg tube and upon initial observation seen the dressing around the peg tube was dated '07/14/21' [nurse initials] and had a black ring on the dressing around the tube. Upon removal of dressing, dressing had moderate amount of hard black substance and pus on the bottom of the dressing touching the skin. Skin was bright red and excoriated underneath the dressing at the peg insertion site. Cleaned and dried wound area. Peg tube was not patent... [physician] assessed patient via video consult and ordered patient be transferred to local ER for further evaluation..."

The emergency room report dated 7/24/21 documented the resident's gastric tube was not clogged upon arrival. The ER note dated 7/24/21

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documented, "...upon pt arrival PEG tube flushed well with 60 ml [milliliters] water. no blockage or resistance noted...evaluation of G-tube no abnormalities were found..." The resident was diagnosed with a urinary tract infection and returned to the nursing facility with an order for an antibiotic.

Further review of Resident #1's clinical record from 5/1/21 through 7/31/21 revealed no orders for care and/or treatment the resident's PEG site. The treatment administration records for May 2021, June 2021 and July 2021 made no mention of the resident's PEG. Prior to the assessment of the bleeding PEG site on 7/14/21, nursing notes from 5/1/21 through 7/13/21 documented notes about the patency and use of the tube for feedings and included only six notes listing an assessment and/or cleansing of the PEG site. These notes did not list what the site was cleaned with or if a dressing was in place. The PEG site was cleaned without any active physician's order for care of the site.

5/6/21 - "...writer noted that Resident's PEG tube site had slight bloody drainage..."
5/29/21 - "...Redness noted to peg site. Cleaned area..."
5/31/21 - "...Redness not to peg site. Cleaned area..."
6/11/21 - "Resident peg site has reddish drainage around site. Area was cleaned..."
6/24/21 - "...Resident peg tube area is cleaned..."

Nursing notes after the assessed bleeding on 7/14/21, dated 7/15/21 through 7/23/21, documented the PEG was patent and "in place" but made no mention of the dressing placed on 7/14/21. There was no follow up assessment of

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the bleeding at the PEG site after 7/14/21 until the nursing note on 7/24/21. The nurse's note about the bleeding PEG site and dressing placement on 7/14/21 was not documented in the clinical record until 7/30/21.

There were no care orders entered or documented for Resident #1's PEG site until 8/1/21. A physician's order with start date of 8/2/21 documented, "Clean feeding tube site daily with soap and water apply drain sponge every day shift."

The resident's plan of care regarding the PEG tube (revised 7/14/21) documented the resident required tube feedings due to dysphagia and a failed swallow study. Care plan goals for PEG included, "...insertion site will be free of s/sx [signs/symptoms] of infection...free of aspiration...will maintain adequate nutrition..." Interventions to meet care plan goals included, "...Check for tube placement and gastric contents/residual volume per facility protocol or MD orders. See orders...Provide stoma site care per MD order or facility policy; see TAR..."

On 8/10/21 at 11:20 a.m., with the resident's permission and accompanied by LPN #3, Resident #1's PEG site was observed. A clean, dry dressing was in place around the tube. There was a small amount of dark, brown drainage on the gauze dressing next to the tube. The tube site was clean, dry and without signs of infection. The resident expressed no pain at the tube site. The dressing in place on the PEG site was not dated. An access port on the gastric tubing and the attached cap were covered with a dried brown substance. LPN #3 stated at the time of the observation that the port and cap needed to be

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cleaned or replaced.

On 8/10/21 at 11:25 a.m., LPN #3 was interviewed about cleaning and care of Resident #1's PEG site. LPN #3 stated care orders were started on 8/2/21. LPN #3 stated this was her second day working in the facility and she did not know about previous care to the PEG site.

On 8/10/21 at 2:15 p.m., the unit manager (LPN #2) was interviewed about Resident #1's PEG site care and no assessment, dressing change or cleansing for 10 days in July 2021. LPN #2 stated she was told about the nurse finding the PEG site on 7/24/21 with a 10-day old dressing. LPN #2 stated she assessed the PEG site on Monday 7/26/21 and the site had no dressing, no excoriation and a small amount of drainage. LPN #2 stated the site had been cleaned prior to her assessment on 7/26/21. When asked about what care was provided to the PEG site prior to the 7/14/21 assessment of bleeding, LPN #2 reviewed the clinical record and stated she did not see any orders for care and no entries on the July TAR regarding PEG site care. LPN #2 stated the nurse applied the dressing on 7/14/21 after finding bleeding at the PEG site. LPN #2 stated she did not know why there were no further assessments or dressing changes to the PEG site until 7/24/21. LPN #2 stated she did not know why the order for the steroid cream and gauze was not implemented.

On 8/10/21 at 3:50 p.m., LPN #5 responsible for wound care in the facility was interviewed about Resident #1's PEG site. LPN #5 stated the resident was known to "pick and pull" at the PEG tube. LPN #5 stated the nurse on 7/14/21 assessed the PEG site with bleeding and applied

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a dressing. LPN #5 stated she did not see an order for that dressing and the nurse placed the resident's name on the list for a PA visit the next day. LPN #5 stated the PA saw the resident on 7/14/21 and documented treatment with steroid cream and a dressing. LPN #5 stated she found no order entered or implemented for the steroid cream and dressing. LPN #5 stated she was asked to assess Resident #1's PEG site on 7/24/21 and she found the site open to air, with no swelling or drainage and with a small amount of blood noted. LPN #5 stated it was expected that PEG tube sites be cleaned daily with soap and water and care was supposed to be documented on the treatment administration record. LPN #5 stated dressings were applied to PEG sites if ordered by the physician.

On 8/11/21 at 8:00 a.m., LPN #5 was interviewed again about any policy or protocols for care of PEG sites. LPN #5 stated the facility had no policy about PEG tube feedings or site care but the electronic health record had care options, when selected, that made entries on the treatment administration record for implementation by nurses. LPN #5 stated the care options included flushes, intake monitoring, cleaning of tube site daily with soap and water and checking residuals. LPN #5 stated the options for site cleansing were not selected for Resident #1 until a physician's order for the care was entered on 8/1/21. LPN #5 stated the order for the steroid cream and dressing were not entered into the record.

On 8/11/21 at 8:50 a.m., the PA (other staff #4) caring for Resident #1 was interviewed about the PEG site care. The PA stated she assessed Resident #1 on 7/14/21 after nursing reported

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bleeding from the PEG site and she ordered steroid cream and a dressing daily as treatment. The PA stated she was not aware the steroid cream/dressing were not implemented until this morning (8/11/21). The PA did not know why the order was never entered or implemented. The PA stated PEG sites typically required daily cleansing with soap/water or normal saline but did not always need a dressing unless there was drainage.

On 8/11/21 at 10:40 a.m., the director of nursing (DON) was interviewed about Resident #1's lack of PEG site care. The DON stated nurses go by the physician orders for care and the appropriate menu options for care were selected from the electronic health record options based upon orders. The DON stated there were no orders for care prior to 8/1/21. The DON stated in general, PEG sites required daily cleansing and this was part of their bath. Concerning the assessed bleeding and dressing applied on 7/14/21, the DON stated there should have been a physician's order for the dressing/care. When asked about no orders from May 2021 through 7/14/21 for routine cleansing/care of the PEG site, the DON stated, "It is part of general skin care and part of the bath." The DON stated there should be a physician's order if a dressing was applied to the site.

The nurse that applied the PEG dressing on 7/14/21 was not available for interview during the survey. LPN #8 and LPN #9 that found the 10-day old dressing in place on 7/24/21 were temporary agency staff and no longer worked at the facility.

The facility's policy titled Abuse Prevention

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F 600	Continued From page 9 (revised 1/2017) documented, "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse...Neglect is 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...A comprehensive assessment and individualized care plan will be developed for each resident to assist staff in providing effective interventions to prevent abuse and meet the resident's need..." These findings were reviewed with the administrator, DON and corporate consultant during a meeting on 8/10/21 at 5:00 p.m. and on 8/11/21 at 4:20 p.m.	F 600		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and complaint investigation, the facility staff failed to provide assessment, monitoring and implement a plan of care regarding a penile split for one of nine residents	F 684	1. Resident #1 penis has been re-assessed and will be monitored weekly by the Center's Wound Care Nurse or designee related to his penile erosion due to chronic indwelling catheter use.	9/9/21

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F 684	Continued From page 10 in the survey sample. Resident #1, assessed with split/filleted penis due to chronic catheter use, had no ongoing assessments and/or monitoring of the size or status of the split. The findings include: Resident #1 was admitted to the facility on 1/26/19 with a re-admission on 12/21/20. Diagnoses for Resident #1 included non-traumatic brain dysfunction, anemia, hypertension, obstructive uropathy, urinary tract infection, alcohol-related dementia, dysphagia, adult failure-to-thrive, malnutrition, COPD (chronic obstructive pulmonary disease), anxiety and depression. The minimum data set (MDS) dated 7/13/21 assessed Resident #1 with moderately impaired cognitive skills and as receiving over 51% of nutritional calories through a gastric tube. Resident #1's clinical record documented the resident had a Foley urinary catheter since his admission due to obstructive uropathy with urine retention. Resident #1's clinical record documented a nursing note by licensed practical nurse (LPN) #9 dated 7/24/21 at 1:57 a.m. stating, "...further assessment of the patient, urine in foley bag was reddish brown with sediment and pus observed. Following the catheter from foley bag to insertion point this nurse observed pt [patient's] tip of penis to be slightly blue and penis shaft split horizontally with a penny sized hole at the base of penis that foley could be observed through. Pt c/o [complained of] pain during assessment and asked to speak with a doctor. Attempted to retrieve documentation regarding this issue being	F 684	Resident #1 will continue follow up appointments with his urologist. 2. Any resident with an indwelling catheter has the potential to be affected if chronic use of indwelling catheter. An audit of all residents with indwelling catheters will be completed by the Director of Nursing or designee to ensure there is no erosion occurring and staff is monitoring care. 3. All RN's and LPN's will be educated on catheter care and management to include but not limited to assessing and reporting of any abnormal findings to ensure proper follow up care. 4. An audit of 2 residents (where applicable) with indwelling urinary catheters will be conducted by the Unit Manager or designee to ensure there is no catheter associated erosion and staff is providing routine catheter care weekly x 4 weeks then monthly 2 months. The Director of Nursing or designee will report findings in QAPI for any further recommendations x 3 months. 5. Date of Compliance: September 9, 2021	

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chronic or new and this writer was unable to find any documentation that this was a chronic issue that had been previously addressed. MD [physician]...contacted and assessed pt via video and gave order to send pt to ER [emergency room]...Upon receiving pt ER nurse...called to ask if pt was currently being treated for UTI [urinary tract infection]...[ER nurse] stated...that penis being split was a chronic issue because it is in healing process and 'looks good' This nurse asked [ER nurse] if penile split and penny sized hole at base of penis was observed and she responded that it was observed and that it was a 'chronic issue'..." (Sic)

LPN #8 also documented assessment of the resident's penis on 7/24/21. A nursing note dated 7/24/21 at 3:26 a.m. documented, "...reddish tea colored urine in the foley bag and moderate amount of sediment down the side of the foley bag. Further inspection of catheter led to observation of pus discharging out of head of penis...found the penis was horizontally split side to side and down the middle of penis shaft...catheter visible at the base of penis and testicles through a penny size hole that was red and excoriated... [physician] assessed patient via video consult and ordered patient be transferred to the local ER...Patient's groin had a foul odor and excoriated..."

A telemedicine assessment dated 7/24/21 documented, "On nursing rounds pt noted to have dark urine in foley bag. on initial assessment purulent drainage seen at head of penis. On closer examination with brief removed, the catheter seems to have torn from urinary meatus down to almost base of penis...No obvious distress. Tip of penis seems slightly

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cyanotic as well...Large nonbleeding laceration down lateral aspect of penis with catheter seeming to be inserted at the base...Catheter associated trauma...pt needs assessment sooner as opposed to delayed...Will therefore send to ER for evaluation..."

The ER report dated 7/24/21 documented the reason for the visit included, "Nurse also reports pt penis is split and is unsure if the issue is chronic. Pt does have long term foley in place..." The ER physician assessment documented, "...he has a Foley catheter in place. It looks like the penis has been split in half and easily falls back but this looks chronic there was no bleeding and there is granulation tissue present testes were nontender is no drainage around the site..." (Sic) The resident was diagnosed with a urinary tract infection and returned to the facility with orders for an antibiotic.

A physician's progress note dated 7/27/21 documented, "...seen today at the request of the administration nursing staff for evaluation of the patient's chronic Foley catheter...There have been concerns brought up by one of agency nurses regarding the patient's Foley catheter and the changes to his penis because of this...Foley catheter in place. The penis if filleted from the urethral meatus down approximately an inch down the shaft. There is no erythema or drainage from the penis...patient's penis has chronic changes associated with chronic Foley catheter placement including filleting of the penis down to approximately mid shaft. This is something that is seen with patients who have Foley catheters placed for a long period of time. There is no infectious process occurring..." (Sic)

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Resident #1's clinical record documented the resident had a Foley catheter in place since his admission due to urinary retention. Further review of Resident #1's clinical record documented no ongoing assessments or monitoring of the penile split/erosion prior to the nursing note on 7/14/21. The resident's care plan prior to 7/30/21 made no mention the resident had a filleted/split penis.

The first mention of the penile erosion in the clinical record was from a urologist consultation report dated 2/26/20 performed during a hospitalization. This report documented,"...longstanding indwelling Foley catheter for years...No lesions...On the ventral aspect of the penis there is a urethral resection from a contact necrosis from his indwelling Foley catheter. It extends approximately 2 cm [centimeters] proximally. There is no surrounding cellulitis discharge stenosis or other pathology..."

A facility readmission assessment and body audit dated 2/26/20 documented no assessment of the penile split identified by the urologist.

Body audits/skin assessments documented no ongoing assessments of the resident's penile split prior to the 7/24/21 nursing note. Body audits dated 9/24/20, 10/1/20 and 10/22/20 documented, "penial erosion" due to catheter use but included no description, exact location or size of the erosion/split.

A skin/wound evaluation dated 7/24/21 documented a healed penis wound measuring 4.6 cm x 3.8 cm by 0.3 cm (length by width by depth in centimeters) with notification to the physician's assistant (PA).

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Resident #1's plan of care made no mention of the resident's penile split or erosion prior to 7/30/21. The plan of care documented the resident had a catheter due to obstructive uropathy and was noted to pull on the catheter tubing at times. Interventions to prevent complications from catheter use included, changing tubing/bag as ordered, urologist as needed, ensure tubing was kink-free, observe for changes in urine output, color, odor, pain and report, ensure bag was below level of bladder and catheter care as ordered. The problem, "Noted with filleting of shaft due to chronic foley" was added on 7/30/21 but there were no interventions regarding monitoring of the penile split for changes.

On 8/10/21 at 11:20 a.m., with the resident's permission and accompanied by licensed practical nurse (LPN) #3, Resident #1's Foley catheter and penis were observed. The resident had a healed split along the underside of the penis from the head to the base approximately 2 inches in length. The split was deep red in color with no open areas observed. LPN #3 was interviewed at this time about the penile split. LPN #3 stated this was her second day in the facility and she was not familiar with the resident's history.

On 8/10/21 at 2:15 p.m., the unit manager (LPN #2) was interviewed about assessment of Resident #1's penile split prior to 7/24/21. LPN #2 stated the wound nurse advised her the split "had been there awhile." LPN #2 stated she did not find a prior assessment of the penile erosion/split, did not know when the erosion started and did not understand why that condition

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was not noted in the clinical record. LPN #2 stated she was not aware of the penile split until the nursing assessment/note of 7/24/21 when the resident was sent to the emergency room for evaluation. LPN #2 stated the wound nurse assessed the resident's penis following the ER visit on 7/24/21.

On 8/10/21 at 3:50 p.m., LPN #5 responsible for wound care in the facility was interviewed about Resident #1's penile split. LPN #5 stated she was not sure when the resident acquired the penile split but she thought the status was followed by urology. LPN #5 reviewed the record and stated the resident was last seen by urology in September 2020. LPN #5 stated she reviewed the weekly body audits since September 2020 and stated the audits were done as required but only several of the audits mentioned penile erosion. LPN #5 stated the penile split was healed and did not required current treatment but she was not sure why there were no assessments or monitoring of the split.

On 8/10/21 at 4:10 p.m., the certified nurses' aide (CNA #4) that routinely cared for Resident #1 was interviewed about the split penis. CNA #4 stated the night shift staff usually bathed Resident #1 and she was not aware the penis was split. CNA #4 stated the resident pulled on his catheter tubing at times but she had not noticed a split penis when providing care.

On 8/11/21 at 8:00 a.m., LPN #5 stated she reviewed the body audit history and did not find any record of measurements or description of Resident #1's penile split prior to 7/24/21. LPN #5 stated because the split was healed and did not require treatment, she did not think nurses

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F 684	Continued From page 16 included it on the body audits. On 8/11/21 at 8:40 a.m., the registered nurse responsible for care plans (RN #1) was interviewed about any plan of care prior to the 7/24/21 assessment of the penile split. RN #1 stated she did not recall any discussion about the penile split in care plan meetings. RN #1 reviewed the care plan history and stated she did not find anything in the plan about the penile split/erosion prior to 7/30/21. On 8/11/21 at 8:50 a.m., the PA (other staff #4) caring for Resident #1 was interviewed about the penile split/erosion. The PA stated she had cared for the resident only for a couple of months and was not sure when the split originated. The PA stated the erosion and split was due to chronic Foley catheter placement. On 8/11/21 at 9:30 a.m., LPN #5 stated she reassessed Resident #1's penile split and presented a documented assessment. The assessment dated 8/11/21 documented the resident had a split measuring 5.5 cm x 2.4 cm x 0.3 cm (length by width by depth) with no signs of infection. These findings were reviewed with the administrator and director of nursing during a meeting on 8/10/21 at 5:00 p.m. and on 8/11/21 at 4:20 p.m.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		8/31/21

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F 689	Continued From page 17 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and during a complaint investigation, the facility staff failed to provide supervision to prevent accidents for one of nine in the survey sample, Resident #9. Resident #9 sustained a second degree burn while eating tomato soup unsupervised. The findings include: Resident #9 was originally admitted to the facility on 01/16/2012 and readmitted on 11/27/2019 with diagnoses that included gastro-esophageal reflux disease (GERD), congestive heart failure, dysphasia, depression, anxiety, anemia, hyperlipidemia, osteoarthritis, hypothyroidism, stage 4 chronic kidney disease, and type 2 diabetes. The most recent minimum data set (MDS) dated 06/02/2021 was a quarterly assessment and assessed Resident #9 as moderately impaired for daily decision making with a score of 9 out of 15. Under Section G - Functional Status the MDS assessed Resident #9 as requiring extensive assistance for dressing, eating, personal hygiene, and bed mobility, each requiring one person physical assistance and total dependent for toileting and bathing with one person physical assistance. The MDS dated 04/22/2021 was a quarterly	F 689	Past noncompliance: no plan of correction required.	

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assessment and assessed Resident #9 as severely impaired for daily decision making with a score of 7 out of 15. Under Section G - Functional Status the MDS assessed Resident #9 as requiring set-up with one person physical assistance for eating; extensive assistance for dressing, personal hygiene, and bed mobility each requiring one personal physical assistance, and total dependent for toileting and bathing with one personal physical assistance.

A review of Resident #9's care plans documented the following.

"Focus [Resident #9] requires assistance with ADLS (activities of daily living) r/t (related to) weakness, pain.... Dated Initiated: 12/22/2012. Created on: 12/22/2012. Interventions/Tasks.... [Resident #9] prefers to eat meals in her bed. Staff offer to get her up to chair but she refuses. Date Initiated 05/25/2021. Created on: 05/26/2021... Provide clothing protector for meals. Date Initiated: 05/26/2021. Created on 05/26/2021.... Requires supervision to limited one staff assistance with meals. She sometimes becomes fatigued when feeding herself and requires staff assistance to complete her meal. Date Initiated: 05/28/2021. Created on: 05/28/2021...."

"Focus Resident with burn to chest and right elbow from spilled hot soup. Revision on: 05/28/2021. Interventions/Tasks.... May use 2 handled cup with lid for hot liquids. Date Initiated: 11/14/2019. Created on: 11/14/2019. Revision on 08/11/2021....."

The care plans did not document Resident #9 requiring one person physical assistance with

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eating prior to 05/28/2021 despite the 04/22/2021 MDS assessment documenting Resident #9 required set up with one person physical assistance for eating.

Observed in the progress notes were the following:

"5/18/2021 18:16 Note Text: Writer walked into room to give scheduled insulin and noted resident to have spilled the entire bowl of tomato soup that came with dinner tray on self. Writer immediately called CNA (certified nursing assistant) to room to assist in getting resident cleaned up. Assessment of body was done by the writer, noted to have burn to upper right chest and right elbow noted to be red and skin blistered. Resident is c/o (complain of) pain and discomfort at this time. Resident gets scheduled Tylenol per order. [Medical Director] was called and made aware of situation. Gave the okay to apply in house Sooth and Cool Barrier moisture barrier ointment with aloe to affected areas. To monitor areas closely and will see resident tomorrow.... No signs of SOB (shortness of breath) or dyspnea noted. RP (responsible party) made aware. Will continue to monitor."

"5/18/2021 18:34 Note Text: F/u (follow-up) with resident on incident. Resident states she is okay. She does not remember what happen. Area to upper right chest and right elbow noted to still be red and blistered. C/o (complain of) minimal pain at this time. Will continue to monitor and pass on to night shift to monitor and document."

05/18/2021 22:50 Note Text: Writer in room to assess burns as CNA called writer into room. Burn noted to right arm just about the elbow,

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blisters and about an inch and a half in circumference. Resident complaining of mild pain at this time. Barrier cream applied. Will continue to monitor. Burn to right clavicle area, red and peeling, barrier cream also applied here. Wound 2.5 inches in length. No drainage noted at this time."

"05/18/2021 08:02 Note Text: Writer called (Medical Director) on clarification of wound. Described wound to MD as red with areas of closed fluid filled blisters on both right upper chest and right elbow. Per MD burn is stages as a second degree burn. Current treatment left in place. Per MD will be in the facility later today to assess the resident."

05/19/2021 10:28 Note Text: Writer in to check on resident. Resident currently sitting in bed with HOBE (head of bed elevated), call bell within reach. Writer assessed burns to right side of chest and right elbow. Areas are raised and red around the sites. Resident denies any pain/discomfort to area. Cream being applied per MD order. Phone call placed to RP to update her....."

"05/19/2021 14:57 Note Text: MD in to assess burns to chest and right elbow, new orders as follows: Silver Sulfadiazine Cream 1%. Apply to right chest/right elbow topically three times a day for Altered skin integrity. Clean with NS (normal saline) apply Silvadine cover elbow with Kerlix and Right chest with ABD (abdominal wound dressing) and tape edges leave loosely. Start Date: 05/20/2021..."

A review of the physician and physician assistant notes documented the following regarding the

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burn wounds.

"05/20/2021.... The bullous wounds from her burn is now ruptured. We will start treatment with Silvadine and keep the wounds covered with clean bandages. Patient is not having any systemic symptoms. Pain is improved.

"05/24/2021... The patient is seen today to follow-up on silver sulfadiazine for elbow and chest. Was wrapped in gauze today, did not unwrap at this time. Nurse states it is healing well.... Continue current treatment until it resolves..."

"05/25/2021.... Wound evaluation... She has been having the Silvadene cream applied daily....Wound to right upper chest is healing well. There is good granulation tissue. There is a small amount of epidermis in the lateral aspect, which we will remove. The right elbow is healing well as well. There is no induration, erthema, or purulent draining. Good granulation tissue appreciated.... Appears to be healing well without any signs of infection. We will continue Silvadene for next 3 days and then we will stop the Silvadene in order to alleviate some of the moisture. We will continue to monitor daily..."

"05/31/2021... The patient is seen today for follow-up of right chest and elbow burn. Wound care has continued to treat with silver sulfadiazine and cover with gaze. Wish to discontinue silver sulfadiazine as this point to let dry. We will consult with wound care nurse. Appears to be healing well. We will continue to follow daily..."

"06/22/2021... The patient is seen today with wound nurse for follow-up of her right chest and

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elbow wounds from burns. Wounds are now completely scabbed over. We will discontinue dry dressings and continue to monitor..."

A review of the clinical record weekly body audits documented the following:
"05/18/2021 18:09 ... Chest - right upper chest noted to be red and blistered. 1st degree burn noted. Right elbow - blistered, redness noted."

A review of the clinical record documented an "Area(s) of Care Concern" assessment completed on 05/19/2021 by the wound nurse (LPN #5) documented the following: "Identify all areas to be discussed: A10 - Other - Burns...Resident noted with burn to right upper chest and right elbow.... Recommendations/Interventions: Treatment in place as orders by MD. Monitor for s/s (signs/symptoms) of infection.

A review of the clinical record documented a "Hot Liquid Safety Evaluation" dated 05/20/2021 completed by the unit manager (LPN #10) that assessed Resident #9 has having muscle weakness in her upper extremities, and determined to be at risk for spilling hot liquids. There was no other hot liquid safety evaluations documented in the clinical record.

A review of the facility's follow-up letter to the state agency dated May 26, 2021 documented the soup was temped at 135 degrees prior to leaving the kitchen. The investigation documented Resident #9 stated she was trying to drink her soup and just dropped it. Per the follow-up letter, the meal trays were delivered to the unity shortly before 5 p.m. and a CNA delivered the tray to the room and set up the

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resident for her meal. At 5:09 p.m. the unit nurse entered the room to administer Resident #9's medication and observed Resident #9 picking up her bowl of soup to drink it and spilled it on her chest and arm. The follow-up letter documented the nurse assessed the area, rendered first aid to the burn areas and notified the physician for further orders. The physician saw Resident #9 on the next day and initiated treatment changes. On May 25, 2021, the physician reassessed and stated the second-degree burns were healing without infection.

A review of the facility's investigation working document completed by previous ADON (assistant director of nursing/RN #2) included interviews with staff on duty the day of the incident. The investigation documented the soup was temped at 135 degrees prior to leaving the kitchen with an acceptable range of 140-150 degrees Fahrenheit. The investigation documented the trays arrived on the floor shortly before 5 p.m. The investigation documented CNA#7 delivered and set up the tray in Resident #9's room. The nurse on duty, LPN #11 entered the room with her hands full to administer medication and witnessed Resident #9 pick up the bowl of soup and drink it. According to the investigation document, LPN #11 witnessed Resident #9 spilling soup on her chest and removed the soup from Resident #9 and observed her chest was red. LPN #11 then asked CNA #6 to come and clean up Resident #9 due to the spilled soup.

The ADON's investigation documented LPN #11 came to CNA #6 while she was providing care in another room. CNA #6 stated she was instructed by LPN #11 to clean up Resident #9 due to spilled

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soup. CNA #6 stated she was told Resident #9 had a red area on her chest. CNA #6 stated she informed LPN #11 that she was in the middle of providing resident care and she would go when she completed the care which would take about 10 minutes. CNA #6 stated she finished her task with the other resident and went directly to Resident #9's room. CNA #6 stated that was about 10-15 minutes elapsed from time she was instructed by LPN #11 until the time she walked into Resident #9's room. Per CNA #6 upon entering Resident #9's room, she observed the resident still had on soiled blankets, clothing, and soup was still on the resident. CNA #6 stated Resident #9 had on a normal t-shirt and upon removal she noted redness to the chest and elbow. CNA #6 stated she told LPN #11 about the blisters and placed a loose gown on the resident to avoid friction to the wound.

A review of the facility's witness statements for staff members working/involved with the incident documented that CNA #7 who was identified as delivering and setting-up Resident #9's tray stated she did not witness the incident because she was feeding during this time CNA #6 who was identified as cleaning up Resident #9 stated she did not witness the incident, but she did witness the resident had burns on her right chest and right elbow. LPN #11 who witnessed the incident stated Resident #9 spilled soup on self during supper. The ADON's (RN #2) interview with Resident #9 documented Resident #9 as stating, "I spilled my soup., I think I tried to drink it."

Additional review of the ADON's investigation documented the following: "....Clothing protector not in place.... Resident in OT (occupational

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therapy) from August to November. Findings during OT eval were resident needs mod to max assist with supervised meals. One person assist with set-up. Noted that resident fatigues easily during meals and leans to right. Needs assistance to maintain proper position for feeding. Resident expresses wishes to continue to self feed...."

A review of the OT Discharge Summary for the period of 09/01/2020 through 11/13/2020 assessed Resident #9 as requiring partial/moderate assistance for eating.

On 08/11/2021 at approximately 11:45 a.m., the unit manager (LPN#10) was interviewed regarding incident. LPN #10 stated she was not directly involved in the investigation; however, she did monitor Resident #9 after the incident and completed the Hot-Liquid assessment. LPN #10 was asked for any hot liquid assessments dated prior to the incident on 05/18/2021. LPN #10 stated "there isn't one. As far as I'm aware we were not doing them until this incident happened." LPN #10 was asked what type of assistance did Resident #9 require with eating. LPN #10 stated, "[Resident #9] has a fluctuating poor oral intake. She prefers to eat/feed herself, but she is weak in her upper extremities. She has had a decline and is on comfort care. She prefers to stay in the bed. I know the staff normally set-up her meal trays and they will then go back and forth to check on her to offer cueing and encouragement for her to eat more. I don't think they actually feed her." LPN # stated, "I can get one our CNA's who works with her often & has been here a long time to give you more information."

On 08/11/2021 at approximately 12:30 p.m., CNA

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#5 was interviewed regarding Resident #9's assistance with eating. CNA #5 stated, "I will set up her meal tray and get her set up in the bed. She eats very slowly and eats a little. She prefers to feed herself." CNA #5 was asked if she assisted feeding Resident #9. CNA #5 stated, "no not all the time because she wants to be independent and feed herself. I'll go in/out of the room to check on her during meal times. A lot of times she needs cueing and encouragement to take more bites or maybe to drink/eat something else on her tray, but I rarely actually feed her." CNA #5 was asked if clothing protectors were provided to all residents. CNA #5 stated, "we have always offered them but if a resident refuses then we don't use them. It seems we are using them more often now since [Resident #9] burned herself."

On 08/11/2021 at 2:25 p.m., the occupational therapist (OS #5) was interviewed regarding Resident #9's self-feeding ability. OS #5 reviewed the OT notes and discharge summary for the period of 09/01/2020 through 11/13/2020 and stated at that time Resident #9 did require partial to moderate assistance for eating.

On 02:50 p.m. the above findings were discussed with the facility's administrator, director of nursing (DON), and corporate consultant. The facility's administrative staff was advised that Resident #9 had been burned resulting in harm because the facility staff failed to provide supervision during meals. The facility's administrative team was asked if they had been completing hot liquid assessments prior to the incident with Resident #9. The DON stated, "no, we weren't unless it was indicated or observed there was a need to do so." A copy of the facility's policy on clothing

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protectors was requested. The administrator stated after the incident, the facility determined there were some areas of opportunity for improvement and implemented an action plan and would provide supporting documentation of the plan to the survey team.

On 08/11/2021 at 4:00 p.m., the MDS coordinator (RN #1) was responsible for completing the quarterly assessment dated 04/22/21 was interviewed regarding Resident #9's ADL assistance for eating. RN #1 stated the coding was determined from a variety of documentation including therapy notes, CNA documentation of ADL tasks, as well as nursing observations/notes. RN #1 stated from her understanding Resident #1 required, "supervision that including watching, not necessarily hands on for eating/feeding assistance. She stated this would include staff being able to go in/out of the room and monitor the resident during meals, but not necessarily feeding Resident #9." RN #1 stated, "[Resident #9] eating fluctuates for eating assistance, she does requires supervision with eating because she fatigues with meals and may need some assistance with cueing and feeding." RN #1 was asked to if this should have been documented on Resident #9's care plans prior to the incident. RN #1 reviewed the care plans and stated, "yes, you're right it should have been included. It's on there now, but it wasn't before she was burned." RN #1 stated she had recently completed an in-service training with all staff on how to properly identify/code residents who need ADL assistance for eating/feeding.

LPN #11 who witnessed Resident #9 spilling the soup was on vacation and unavailable for interview during the survey. CNA #6 was a PRN

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(as needed) staff; an attempt to contact CNA #6 via telephone on 08/11/2021 was unsuccessful. CNA #7 who delivered and set up Resident #9's meal tray on the day of the incident was no longer employed by the facility, therefore no interview was completed. The ADON (RN #2) who completed the investigation at the time of the incident was no longer employed by the facility, therefore no interview was completed.

On 08/11/2021 at 12:30 p.m., 2:30 p.m., and 3:30 p.m., attempts were made to interview Resident #9. At 12:30 p.m., Resident #9 was unable to communicate, her speech was unintelligible; at 2:30 p.m. and 3:30 p.m., Resident #9 was observed in her room sleeping in her bed.

A review of the facility's Dining Room Meal Service policy documented: "....5. Residents have the option of using a clothing protector at their request...."

A review of the facility's plan of correction action plan dated 05/25/21 documented the following:

1. Audit and hot liquid assessment for all residents.
2. Staff education on mealtime protocol including setting residents up, providing mealtime cueing and supervision, offering clothing protectors to all residents, and center's policy on identifying patients who require supervision/cueing., etc.
3. Staff education for nurses on center's policy on burns.
4. Mealtime observation rounds for 8 weeks.
5. Updated QA monthly for three months to assess for other recommendations.

On 08/11/2021 at 4:12 p.m., the administrator

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F 689	Continued From page 29 was asked the date of completion for the action plan. The administrator stated the plan was completed as of June 10, 2021 with continued mealtime rounds currently in place During the current survey, staff were observed providing appropriate supervision and assistance during mealtime. No other information was provided to the survey team prior to exit on 08/11/2021 at 5:15 p.m. This deficiency was cited as past non-compliance. This was a complaint deficiency.	F 689		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic	F 693		9/9/21

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F 693	Continued From page 30 abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and complaint investigation, the facility staff failed to provide proper care to gastric tube sites for two of nine residents in the survey sample. No care or dressing changes were provided to Resident #1's PEG (percutaneous endoscopic gastrostomy) tube site for ten days following an assessment of bleeding and prolapsed skin around the tube. A physician's order for topical treatment and dressing changes following the assessed bleeding was not implemented and the resident had no treatment orders or evidence of routine, daily care provided to the gastrostomy site for at least three months. Resident #4 was observed with a dressing taped over her gastrostomy site without a physician's order for care/treatment. The findings include: 1. Resident #1 was admitted to the facility on 1/26/19 with a re-admission on 12/21/20. Diagnoses for Resident #1 included non-traumatic brain dysfunction, anemia, hypertension, obstructive uropathy, urinary tract infection, alcohol-related dementia, dysphagia, adult failure-to-thrive, malnutrition, COPD (chronic obstructive pulmonary disease), anxiety and depression. The minimum data set (MDS) dated 7/13/21 assessed Resident #1 with moderately impaired cognitive skills and as receiving over 51% of nutritional calories through a gastric tube. Resident #1's clinical record documented a late entry nursing note (dated 7/30/21) stating, "On	F 693	1. The PEG tube for Resident #1 has been re-assessed and the area is clean and dry without any complications noted. An order for routine daily care for his PEG tube site has been implemented. The Physician Assistant has been notified that the treatment order she ordered on 7/14/21 was not implemented, no new orders given. Resident # 4 PEG tube site has been assessed and the area is clean, dry and without any complications noted, the dressing was removed and an order for routine daily care has been implemented. The nurse who taped a dressing to the PEG site will be re-educated on the Center's protocol for care of PEG tube and should assessment of a PEG tube site warrant a dressing then the nurse is to document his/her assessment findings and notify the medical professional for further orders. All nurses currently working in the Center will be re-educated by the Director of Nursing on the Center's protocol for care and management of PEG tube site including but not limited to routine daily care and dressing changes. 2. Any resident with a PEG tube has the potential for harm if the PEG tube is not assessed and cared for properly. An audit will be completed by Director of nursing or designee of current residents who have a PEG tube to ensure PEG tube sites are assessed, proper care being performed including but not limited to following physician orders for the care of the PEG	

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F 693	Continued From page 31 7/14/21 approx. [approximately] 2200 pm [10:00 p.m.] writer called to resident room by floor nurse advising peg site with moderate amount of bright red blood, upon assessment observed bright red blood at site with surrounding skin prolapsed, area cleaned by writer with NS [normal saline] pat dry, dry gauze with applied pressure to stop bleeding successful, dressing placed, writer advised floor nurse to place on list to be seen by NP [nurse practitioner] for evaluation d/t [due to] resident with HX [history] of recurrent prolapsed skin surrounding peg site." A physician's assistant (PA, other staff #4) assessed Resident #1's PEG site on 7/14/21. A PA note dated 7/14/21 documented, "...The patient is seen today per nurse request due to noticing some blood around the PEG insertion site. The patient denies any pain, very mild drainage from the site. We will continue to monitor, place gauze and steroid cream..." The PA documented under the plan for treatment for the PEG site, "...Attention to gastrostomy - Continue current site care, gentle with hyper granulation tissue - Nursing to continue to monitor site, notify provider of any worsening or developing symptoms...Continue monitoring PEG site. Cover with gauze and apply steroid cream." The treatment orders for steroid cream and dressing ordered by the PA on 7/14/21 in response to the bleeding PEG site were not implemented. There was no physician's order entered and no entry on Resident #1's treatment administration record (TAR) or medication administration record (MAR) regarding steroid cream or dressing applications. There were no other orders or entries on the July 2021 TAR regarding cleaning and/or monitoring of the PEG	F 693	tube site. 3. All nurses currently working in the Center will be re-educated by the Director of Nursing on the Center's protocol for care and management of PEG tube site including but not limited to routine daily care and dressing changes. 4. An audit of 3 residents (where applicable) with PEG tubes will be conducted weekly x 4 weeks then monthly x 2 months to ensure an order is in place for routine daily care of the PEG tube site and no complications noted at the site. An audit will be conducted by the Unit Manager or designee weekly x 4 weeks then monthly x 2 months to verify orders written by Medical Professionals have been implemented. The Director of Nursing or designee will review the audits and report findings to the QAPI committee monthly x 3 for any further recommendations. 5. Date of compliance: September 9, 2021	

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F 693	Continued From page 32 site. Licensed practical nurse (LPN) #9 documented a nursing note stating the resident was found on 7/24/21 with a 10-day old dressing in place on the PEG tube site. A nursing note dated 7/24/21 at 1:57 a.m. documented, "Pt [patient] observed lying in bed during med pass with PEG dressing in place dated 7/14/21. Upon removal of dressing, a thick, hard, black substance was observed with pus and serosanguinous [serosanguineous] fluid. PEG site was excoriated and tender to touch. Site was cleaned and dressing removed. Dressing reported to DON [director of nursing]...attempted to begin pt tube feeding. PEG was not patent, unable to pull residual or flush...upon viewing PEG, thick sediment observed in line...attempted to flush PEG with water and was unsuccessful...attempted to pull residual and was unsuccessful. De-clogger was used...and was successful. Tube was able to be flushed...MD [physician]...contacted and assessed pt via video and gave order to send pt to ER [emergency room]..." Another nurse (LPN #8) also documented an assessment of the 10-day old PEG site dressing. A nursing note dated 7/24/21 at 3:26 a.m. documented, "...This nurse assessed patient's peg tube and upon initial observation seen the dressing around the peg tube was dated '07/14/21' [nurse initials] and had a black ring on the dressing around the tube. Upon removal of dressing, dressing had moderate amount of hard black substance and pus on the bottom of the dressing touching the skin. Skin was bright red and excoriated underneath the dressing at the peg insertion site. Cleaned and dried wound	F 693		

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area. Peg tube was not patent... [physician] assessed patient via video consult and ordered patient be transferred to local ER for further evaluation..."

The emergency room report dated 7/24/21 documented the resident's gastric tube was not clogged upon arrival. The ER note dated 7/24/21 documented, "...upon pt arrival PEG tube flushed well with 60 ml [milliliters] water. no blockage or resistance noted...evaluation of G-tube no abnormalities were found..." The resident was diagnosed with a urinary tract infection and returned to the nursing facility with an order for an antibiotic.

Further review of Resident #1's clinical record from 5/1/21 through 7/31/21 revealed no orders for care and/or treatment the resident's PEG site. The treatment administration records for May 2021, June 2021 and July 2021 made no mention of the resident's PEG. Prior to the assessment of the bleeding PEG site on 7/14/21, nursing notes from 5/1/21 through 7/13/21 documented notes about the patency and use of the tube for feedings and included only six notes listing an assessment and/or cleansing of the PEG site. These notes did not list what the site was cleaned with or if a dressing was in place. The PEG site was cleaned without any active physician's order for care of the site.

5/6/21 - "...writer noted that Resident's PEG tube site had slight bloody drainage..."
5/29/21 - "...Redness noted to peg site. Cleaned area..."
5/31/21 - "...Redness not to peg site. Cleaned area..."
6/11/21 - "Resident peg site has reddish drainage

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around site. Area was cleaned..."
6/24/21 - "...Resident peg tube area is cleaned..."

Nursing notes after the assessed bleeding on 7/14/21, dated 7/15/21 through 7/23/21, documented the PEG was patent and "in place" but made no mention of the dressing placed on 7/14/21. There was no follow up assessment of the bleeding at the PEG site after 7/14/21 until the nursing note on 7/24/21. The nurse's note about the bleeding PEG site and dressing placement on 7/14/21 was not documented in the clinical record until 7/30/21.

There were no care orders entered or documented for Resident #1's PEG site until 8/1/21. A physician's order with start date of 8/2/21 documented, "Clean feeding tube site daily with soap and water apply drain sponge every day shift."

The resident's plan of care regarding the PEG tube (revised 7/14/21) documented the resident required tube feedings due to dysphagia and a failed swallow study. Care plan goals for PEG included, "...insertion site will be free of s/sx [signs/symptoms] of infection...free of aspiration...will maintain adequate nutrition..." Interventions to meet care plan goals included, "...Check for tube placement and gastric contents/residual volume per facility protocol or MD orders. See orders...Provide stoma site care per MD order or facility policy; see TAR..."

On 8/10/21 at 11:20 a.m., with the resident's permission and accompanied by LPN #3, Resident #1's PEG site was observed. A clean, dry dressing was in place around the tube. There was a small amount of dark, brown drainage on

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the gauze dressing next to the tube. The tube site was clean, dry and without signs of infection. The resident expressed no pain at the tube site. The dressing in place on the PEG site was not dated. An access port on the gastric tubing and the attached cap were covered with a dried brown substance. LPN #3 stated at the time of the observation that the port and cap needed to be cleaned or replaced.

On 8/10/21 at 11:25 a.m., LPN #3 was interviewed about cleaning and care of Resident #1's PEG site. LPN #3 stated care orders were started on 8/2/21. LPN #3 stated this was her second day working in the facility and she did not know about previous care to the PEG site.

On 8/10/21 at 2:15 p.m., the unit manager (LPN #2) was interviewed about Resident #1's PEG site care and no assessment, dressing change or cleansing for 10 days in July 2021. LPN #2 stated she was told about the nurse finding the PEG site on 7/24/21 with a 10-day old dressing. LPN #2 stated she assessed the PEG site on Monday 7/26/21 and the site had no dressing, no excoriation and a small amount of drainage. LPN #2 stated the site had been cleaned prior to her assessment on 7/26/21. When asked about what care was provided to the PEG site prior to the 7/14/21 assessment of bleeding, LPN #2 reviewed the clinical record and stated she did not see any orders for care and no entries on the July TAR regarding PEG site care. LPN #2 stated the nurse applied the dressing on 7/14/21 after finding bleeding at the PEG site. LPN #2 stated she did not know why there were no further assessments or dressing changes to the PEG site until 7/24/21. LPN #2 stated she did not know why the order for the steroid cream and

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gauze was not implemented.

On 8/10/21 at 3:50 p.m., LPN #5 responsible for wound care in the facility was interviewed about Resident #1's PEG site. LPN #5 stated the resident was known to "pick and pull" at the PEG tube. LPN #5 stated the nurse on 7/14/21 assessed the PEG site with bleeding and applied a dressing. LPN #5 stated she did not see an order for that dressing and the nurse placed the resident's name on the list for a PA visit the next day. LPN #5 stated the PA saw the resident on 7/14/21 and documented treatment with steroid cream and a dressing. LPN #5 stated she found no order entered or implemented for the steroid cream and dressing. LPN #5 stated she was asked to assess Resident #1's PEG site on 7/24/21 and she found the site open to air, with no swelling or drainage and with a small amount of blood noted. LPN #5 stated it was expected that PEG tube sites be cleaned daily with soap and water and care was supposed to be documented on the treatment administration record. LPN #5 stated dressings were applied to PEG sites if ordered by the physician.

On 8/11/21 at 8:00 a.m., LPN #5 was interviewed again about any policy or protocols for care of PEG sites. LPN #5 stated the facility had no policy about PEG tube feedings or site care but the electronic health record had care options, when selected, that made entries on the treatment administration record for implementation by nurses. LPN #5 stated the care options included flushes, intake monitoring, cleaning of tube site daily with soap and water and checking residuals. LPN #5 stated the options for site cleansing were not selected for Resident #1 until a physician's order for the care

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was entered on 8/1/21. LPN #5 stated the order for the steroid cream and dressing were not entered into the record.

On 8/11/21 at 8:50 a.m., the PA (other staff #4) caring for Resident #1 was interviewed about the PEG site care. The PA stated she assessed Resident #1 on 7/14/21 after nursing reported bleeding from the PEG site and she ordered steroid cream and a dressing daily as treatment. The PA stated she was not aware the steroid cream/dressing were not implemented until this morning (8/11/21). The PA did not know why the order was never entered or implemented. The PA stated PEG sites typically required daily cleansing with soap/water or normal saline but did not always need a dressing unless there was drainage.

On 8/11/21 at 10:40 a.m., the director of nursing (DON) was interviewed about Resident #1's lack of PEG site care. The DON stated nurses go by the physician orders for care and the appropriate menu options for care were selected from the electronic health record options based upon orders. The DON stated there were no orders for care prior to 8/1/21. The DON stated in general, PEG sites required daily cleansing and this was part of their bath. Concerning the assessed bleeding and dressing applied on 7/14/21, the DON stated there should have been a physician's order for the dressing/care. When asked about no orders from May 2021 through 7/14/21 for routine cleansing/care of the PEG site, the DON stated, "It is part of general skin care and part of the bath." The DON stated there should be a physician's order if a dressing was applied to the site.

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The nurse that applied the PEG dressing on 7/14/21 was not available for interview during the survey. LPN #8 and LPN #9 that found the 10-day old dressing in place on 7/24/21 were temporary agency staff and no longer worked at the facility.

These findings were reviewed with the administrator, DON and corporate consultant during a meeting on 8/10/21 at 5:00 p.m. and on 8/11/21 at 4:20 p.m.

2. Resident #4 was admitted to the facility on 12/2/20 with a readmission on 8/9/21. Diagnoses for Resident #1 included dementia, dysphagia with gastrostomy, hypoxia, breast cancer, vertigo, deep vein thrombosis and gastroesophageal reflux disease. The minimum data set (MDS) dated 7/21/21 assessed Resident #4 with severely impaired cognitive skills and as receiving 51% or more of nutritional calories through a gastric tube.

Resident #4's clinical record documented the resident was recently hospitalized for decreased intake with vomiting and was re-admitted to the facility on 8/9/21 and had a PEG (percutaneous endoscopic gastrostomy) placement in July 2021.

On 8/10/21 at 2:45 p.m., accompanied by licensed practical nurse (LPN) #6, Resident #4's PEG tube site was observed. The resident's site was covered by two split gauze pads attached to the resident's stomach with two 1-inch wide strips of clear tape. The resident winced and moved as LPN #6 pulled the tape from the skin to view the PEG site. There was a small amount of yellow/brown drainage on the gauze and around the tube site. There was no date or initials on the

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dressing indicating who or when the dressing was applied.

On 8/10/21 at 3:00 p.m., Resident #4's clinical record was reviewed with no physician orders found for a PEG site dressing or care. There were no entries on the resident's treatment administration record for 8/9/21 or 8/10/21 indicating care/treatment to the PEG site. Nursing notes for 8/9/21 and 8/10/21 made no mention of the application of a taped dressing.

On 8/11/21 at 10:40 a.m., the director of nursing (DON) was interviewed about PEG care. The DON stated nurses were supposed to go by physician orders for PEG care. The DON stated if a dressing was in place on a PEG site, there should have been an order for it.

On 8/11/21 at 11:35 a.m., the licensed practical nurse unit manager (LPN #2) was interviewed about the Resident #4's dressing in place without an order. LPN #2 stated the admission orders were usually reviewed within 24 to 48 hours to be sure everything was entered correctly. LPN #2 stated the wound nurse entered an order today (8/11/21) for PEG site care but she did not know why PEG care was not implemented when the resident was readmitted on 8/9/21. LPN #2 reviewed the record and stated she did not know who or when the taped dressing was applied to the resident's PEG site. LPN #2 stated there should be an order for the dressing and stated tape was usually not applied as it could cause skin excoriation when removed.

This finding was reviewed with the administrator and DON during a meeting on 8/11/21 at 4:20 p.m.

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