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	165245	A. BUILDING _____ B. WING _____	11/16/2017

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F 000	INITIAL COMMENTS Correction Date:_____ The following deficiency is the result of the recertification survey and investigation of complaint #72040-C, and #70294-C, completed on 11/13/17 - 11/16/2017. #72040-C, unsubstantiated #70294-C, unsubstantiated (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to prevent the development of heel pressure sores and failed to	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/29/2017

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promote healing with timely dietary intervention (Resident #1). The facility reported a census of 47 residents and the sample consisted of 4 residents with pressure ulcers.

Findings include:

The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:

Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

Unstageable Ulcer: inability to see the wound bed.

1. Resident #1 had an initial MDS (Minimum Data Set) assessment with a reference date of 6/9/17. The MDS identified the resident had diagnosis including anemia (low red blood count),

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hypertension (elevated blood pressure), diabetes mellitus, anxiety disorder, depression, vascular dementia without behavioral disturbance, osteoarthritis, gastro-esophageal reflux disease with esophagitis, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease and type 2 diabetes mellitus without complications. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 3. A score of 3 identified the resident had a severe cognitive impairment.
The MDS identified the resident required extensive assistance of 2 or more staff members for bed mobility and transfers. The resident did not walk in the corridor and only walked in room once or twice with the assist of 2 or more staff. The MDS identified the resident to be at risk for pressure ulcers and had no pressure, atrial or venous ulcers at this time. The resident only had a pressure reducing device in the chair.

The Care Plan, initiated on 6/1/17, identified the resident had the potential/actual impairment of skin integrity regards to decreased mobility and the need for assistance with activities of daily living. The interventions directed the staff to assist the resident with repositioning as needed (6/2/17), apply Calmoseptine to buttocks twice a day (6/2/17), encourage good nutrition and hydration in order to promote healthier skin (6/1/17), apply pressure reducing mattress on bed (6/1/17), observe skin with cares (6/2/17), use caution during transfers and bed mobility to prevent striking arms, legs, and hands against sharp or hard surfaces and use assistive devices for bed mobility (6/1/17). The Care Plan indicated the resident used a wheelchair for mobility.

A quarterly MDS assessment with reference date

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of 10/24/2017, indicated the resident still required extensive assist of 2 staff for bed mobility. The resident walked in the corridor and in room once or twice with the assistance of 2 staff members. The MDS identified active diagnosis of an unstageable pressure ulcers of the right and left heels.

A Braden Scale (for predicting pressure sore risk) dated 10/23/2017, identified a score of 17. A score of 17 represented a mild risk for the development of pressures.

The document titled LN-Skin Pressure Ulcer Weekly dated 6/21/17 identified the development of a right heel ulcer that measured 2 cm (centimeters) by 1 cm. on 6/19/17. A cushion placed on the resident's bed to float the heels off the bed. The left heel measured 3 cm by 5 cm, appeared dark purplish, soft and tender to touch. A Treatment Administration Record (TAR) dated 6/19/17-8/23/17 identified the treatment as to apply Betadine to bilateral heels BID (twice daily) until healed.

The physician clinic note dated 6/20/17, identified the resident had pressure points on his heels and the physician recommended he wear a soft slipper when he tries to be mobile in a wheelchair. The resident had been using his heels (to propel).

The Care Plan indicated the following interventions following the development of the pressure ulcers: Monitor areas to right and left heel (6/19/17).

A nurse sent a fax to the physician about a concern with applying Betadine twice a day since 6/19/17 and the wound needed debrided. The

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nurse asked if physical therapy could evaluate and treat. The physician gave approval with an order on 7/28/17. The therapy note dated 7/31/17 identified the resident had 75-100 percent wound bed covered on the right heel and 100 percent coverage on the left heel.

On 9/26/17, the physician ordered heel lift boots on each foot at all times (to suspend the heels and promote healing). A physician phone order dated 9/11/17 directed staff to give Arginaid packet (nutritional supplement) 1 packet by mouth 3 times a day for wound healing related to the pressure ulcer of the right heel and left heel.

The skin Committee IDT notes dated 6/23/17 identified both heels reveal pressure type areas. The left [heel area] measured 3 cm by 5 cm and the right heel measured 2 cm by 1cm. The nurse notified the PCP (Primary Care Physician) and family and treatment begun. The nurse updated the Care Plan.

The Weekly Wound Documentation form dated 6/21/17 indicated the right heel as a dark purple area and measured 2 cm by 1 cm. A cushion on the bed to float heels and Betadine applied to the dark purple area. The left heel identified as dark purple to outer edge and measured 2 cm by 2.5 cm. A cushion was placed on the resident's bed to float heels off bed and Betadine applied to the dark purple area.

The Weekly Wound Documentation form dated 6/28/17 identified the right heel s dark purple area measured 2.5 cm by 1.4 cm. Float heels, cleanse with wound cleaner and paint with Betadine. The left heel measured 4.6 cm by 3.0 cm. Cleanse with wound cleaner and apply

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F 314	Continued From page 5 Betadine The skin Committee IDT notes dated 6/30/17 identified the bilateral heels showed unstageable ulcers. The left measured 4.6 by 3.0 and the right measured 2.5 by 1.4 cm, both are treated with Betadine paint to keep dry. No c/o (complaints of) pain with palpation The Weekly Wound Documentation form dated 7/5/17 identified the right heel as dark black/brown hard skin area that measured 2.6 cm by 2.1 cm. Cleanse with wound wash, paint with Betadine, float heels. The left heel, dark black/brown hard skin, measured 4.6 cm by 3.6 cm and cleanse with wound wash, paint with Betadine. The skin Committee IDT notes dated 7/7/17 reviewed Weekly Wound Documentation form and no recommendations added. The Weekly Wound Documentation form dated 7/12/17 indicated the right heel blackish brown area measured 2 cm by 2.5 cm. Betadine and monitor. The left heel dark blackish brown measured 3.5 cm by 3.5 cm. Apply Betadine and monitor. The Weekly Wound Documentation form dated 7/19/17 indicated the right heel blackish brown area measured 2 cm by 1.5 cm, Betadine and monitor, left heel dark blackish brown measured 3 cm by 3 cm, Apply Betadine and monitor. The skin Committee IDT notes dated 7/21/17 reviewed the Weekly Wound Documentation form and added no recommendations.	F 314		

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The Weekly Wound Documentation form dated 7/26/17 identified the outer right heel as blackish brown area measured 2.6 cm by 1.6 cm. Betadine treatment and float heels off bed, outer left heel blackish brown measured 3.2 cm by 6 cm. Betadine treatment and float heels off bed.

The skin Committee IDT notes dated 7/28/17 reviewed weekly wound documentation form, added recommendation to possibly get PT (Physical Therapy) involved for debridement

A fax to the physician dated 7/28/17 identified the resident had a pressure ulcer to both outer heels. The staff had been applying Betadine twice a day since 6/19/17 and areas are dry and need debrided. The nurse requested an order for physical therapy to evaluate and treat. The physician replied with a new order for physical therapy to evaluate and treat.

The AMT wound nurse at the facility on 11/15/17 at 2:00 PM documented the following assessment included:

Left heel: partial thickness, pressure ulcer stage II, size 2.4 by 1.8 with depth 0.2 cm. Serosanguineous drainage. Periwound/wound edges: periwound tissues: intact/uninvolved tissues flush with wound base. Wound edges/margins: Edge epithelial flush with wound base.
Clinical Rational/Wound Comments: Antimicrobial wound get to contribute moisture to the wound and to provide sustained antimicrobial action to wound. Collagen to promote angiogenesis and support healing. Semipermeable cover to sustain moist wound environment to promote autolysis and moist wound healing. Daily dressing changes

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are needed due to dressing becomes dislodged within 24 hours due to repositioning.

Heel right lateral: Full thickness pressure ulcer Stage III, size 0.7 by 0.5, depth 0.2 cm
wound bed-red 75%, pale pink/red; Hypogranulation tissue; yellow 25%, Adherent Fibrinous slough
Periwound/wound Edges: Periwound tissues; Intact/Uninvolved tissues flush with wound base. Wound edges/Margins; Irregular wound edges; additional periwound wound Edges comments; dry, tan/brown ridged wound edge. Clinical rationale/Wound Comments: collagen to promote angiogenesis and support healing. Calcium alginate AG to manage exudate and provide sustained antimicrobial action to wound. Semipermeable dressing to sustain moister wound environment to promote autolysis and moist wound healing. Daily dressing changes are needed.

Treatment Intervention: Cleanse Right later heel wound with NS (Normal Saline), Apply collagen powder, then calcium alginate AG. Cover with absorptive dressing. Change dressing daily.

An interview on 11/15/17 at 1:00 PM, the Clinical Resource Nurse clarified the wound documentation for 10/29, 11/5 and 11/13 has been corrected and should have read heels not ankles.

An observation on 11/14/2017 at 7:40 AM revealed Resident #1 used a call light to request to get out of bed. Staff A, RN (Registered Nurse) arrived to give the resident morning medication. A lift pillow noted in recliner. Staff A confirmed the lift pillow should be placed in the bed too

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when the resident laid in bed. Staff A then left the room without placing the lift pillow under Resident #1's legs to float the heels.

An observation of the pressure ulcers treatment on 11/15/2017 at 1:30 PM with Staff A, RN and Staff B LPN, (License Practical Nurse) revealed the left heel area clean, no signs and symptoms of infection and edges healing around the wound bed. Area is a straight open area with no active bleeding or drainage. The right heel, healing and area open with pink center and maturation [caused from moisture] around edges. Resident #1 skin coloring on legs from knee to feet appeared normal coloring with left foot slightly edematous (swollen with fluid in tissue).

During an interview on 7/14/17 at 2:20 PM Staff B was not aware of any policy or protocol for requesting dietary interventions when a wound has been noted. Staff B stated the nurse needs to notify the physician, get a treatment and notify the family. Staff B stated she was not aware of who or when the dietary would be notified.

During an interview on 7/14/17 at 4:20 PM the Clinical Leader stated upon reviewing the papers requested, it was noted the dietician was not notified until 9/11/17. The Leader placed a call to the dietician immediately.

During a phone interview on 7/15 at 1:17 PM the AMT Wound Nurse C, stated they are here to educate and make recommendations on treatments for wounds. The recommended treatments must be approved by the physician. The wound nurse does not assess or diagnosis and it is up to the facility and physician if the pressure ulcer is avoidable-unavoidable.

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F 314	Continued From page 9 An observation on 11/15/2017 at 2:00 PM, the DON (Director of Nursing) pulled back the dressing on Resident #1's left heel. AMT wound Nurse D looked at the ulcer and commented the area is improved and the edges were clean. The DON changed gloves and proceeded to pull back the dressing on the right heel. The Wound Nurse D looked at the ulcer and commented 2 dark callous looking areas on bottom of the wound edge in corners and the top wound edge area showed maturation, but healing nicely. The Wound Nurse D reviewed the facility documentation of the ulcers and relied on this for measurements. Wound Nurse D, confirmed skin normal color from knee to feet, and this helps increase the healing process.	F 314		