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	165294	A. BUILDING _____ B. WING _____	C 11/21/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 12/7/18 Complaint # 78561-C was substantiated. Complaint # 77249-C was not substantiated. Investigation of facility-reported incident # 77933-I did not result in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and family, Nurse Practitioner and staff interviews, the facility failed to follow the standards of practice to prevent the development of a pressure ulcer for 1 of 3 sampled residents (Resident #1). The facility reported a census of 35 residents.	F 686		

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

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.

POC accepted 12/14/18 NS

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F 686	Continued From page 1 Findings include: Review of the Minimum Data Set (MDS) assessment dated 8/6/18 revealed Resident #1 admitted on 7/30/18 with diagnoses that included prostate cancer, high blood pressure, diabetes, dementia, sepsis (blood infection), Parkinson's disease, muscle weakness and a pressure ulcer on an unspecified buttock. The assessment documented he required the assistance of two for most ADLs (activities of daily living), including being repositioned in bed. Resident #1 did not walk during the assessment period and depended on staff to push his wheelchair for mobility. The BIMS (brief interview for mental status) assessment noted Resident #1 scored 5 out of 15, indicating severely impaired cognition. Resident #1 had limited range of motion (ROM) on both sides of the upper and lower extremities. According to the MDS, Resident #1 had a urinary catheter and always had episodes of bowel incontinence. The MDS documented Resident #1 had one stage 2 pressure ulcer, the risk of developing further ulcers and a weight of 284 pounds. The MDS assessment identifies the following definitions of pressure ulcer staging: Stage 1 Pressure Ulcer: An observable, pressure-related alteration of intact skin, whose indicators as compared to adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in	F 686		

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F 686	Continued From page 2 darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. Stage 2 Pressure Ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister. Stage 3 Pressure Ulcer: 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 or tunneling. Stage 4 Pressure Ulcer: 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 due to Suspected Deep Tissue Injury: Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Resident #1's Baseline Care Plan dated 7/30/18 documented his cognition as confused and that he had advanced dementia. The Care Plan noted a current ulcer on his buttocks and frequent turning and repositioning as interventions. An 8/13/18 revision identified a left heel pressure ulcer with direction for heel float boots at all times and Allevyn (a type of dressing) as interventions for the new wound. The January 2015 Prevention of Pressure Ulcers guideline noted its purpose as:	F 686		

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F 686	Continued From page 3 1. To promote good skin integrity. 2. To relieve pressure, restore circulation and promote skin protection. Possible choices of equipment: - Skin lotion. - Elbow protector. - Heel protector. - Pressure reduction mattress. - Pressure reduction wheelchair cushion. - Foot or bed cradle. - Positioning pillows/wedges. Guidelines: Point # 6. Utilize pressure-reduction devices on bed and chair as necessary. Point # 7. Reposition resident routinely and position with pads and pillows to protect bony prominences and maintain proper alignment. Point # 11. Use bed cradle to prevent pressure from as needed. Resident #1's Discharge Summary dated 7/30/18 at 7:55 a.m. documented Resident #1's discharge diagnoses included a decubitus ulcer on his right buttock and pedal edema (swollen feet and/or ankles). Nurse's Note dated 7/30/18 at 11:15 a.m. documented Resident #1 admitted to the facility. Staff documented he was alert and oriented to himself only and required the use of a Hoyer lift (mechanical lift) with assistance of 2 staff for transfers. The nurse also assessed Resident #1 with 2+ pedal edema (slight indentation) to both lower extremities. Fax correspondence to Resident #1's primary care provider dated 7/30/18 at 9:00 p.m. noted all the skin issues identified during admission which included 6 bruises in various places and 1	F 686		

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F 686	Continued From page 4 pressure ulcer on Resident #1's left buttock. According to a Nurse's Note dated 7/31/18 at 2:35 p.m. Resident #1 continued to be alert and oriented to himself only and to require the use of a Hoyer lift (mechanical lift) with assistance of 2 staff for transfers. The nurse assessed Resident #1 with 2+ edema to both lower extremities. Resident #1 he needed staff to push him back and forth to the dining room in the wheelchair and did not attempt to propel his wheelchair by himself. According to the 8/6/18 Braden Scale For Predicting Pressure Sore Risk, Resident #1's score of 13 indicated a moderate risk for developing pressure sores. A Nurse's Note dated 8/8/18 at 8:45 a.m. noted Resident #1 needed staff assistance with ADLs, transferred with an EZ stand (mechanical sit to stand device) and used a wheel chair for mobility. The nurse assessed Resident #1 with 2 to 3+ edema to both lower extremities. A Progress Note by Primary Care Provider (PCP) on 8/9/18 documented the resident's family requested to leave Resident #1's catheter in for a while longer to enable his buttocks to heal more. The PCP assessed Resident #1's skin as warm, dry and swollen. The PCP ordered to leave the resident's catheter in and apply Calmoseptine (skin barrier ointment) to the healed areas on his buttocks. The ED (emergency department) Provider Notes dated 8/12/18 at 6:05 p.m. indicated Resident #1 presented with concerns about low urine output. According to the Physician's Assistant (PA),	F 686		

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F 686	Continued From page 5 Resident #1 had a chronic indwelling catheter due to urinary incontinence causing skin breakdown issues on his buttocks. The PA's physical exam assessed a 1 cm superficial open wound on Resident #1's buttocks near his coccyx. The PA discharged Resident #1 to the facility at the same level of care. A Nurse's Note dated 8/13/18 (no time listed) recorded Resident #1 had a pressure area to his left heel with redness surrounding it. The Pressure Ulcer Healing Record documented a 5.1 cm x 8.3 cm Stage 2 left heel pressure ulcer with a small amount of drainage and bright red surrounding skin identified on 8/13/18. A Nurse's Note dated 8/13/18 at 2:00 p.m. recorded staff transferred Resident #1 with a sit/stand lift and pushed him to and from meals in a wheelchair. The nurse assessed Resident #1 with 3+ pedal edema to both lower extremities and he complained of left heel pain. Fax correspondence to Resident #1's PCP on 8/13/18 notified him of an open pressure ulcer to the resident's heel, a blister that opened, measuring 5.1 cm x 8.3 cm with a red surrounding area measuring 4 x 14.3 cm. The nurse requested the provider to authorize an order for Allevyn to be applied and changed every 3 days and PRN. A Nurse's Note dated 8/14/18 at 2:45 p.m. documented receipt of a new order to apply Allevyn and change the dressing every 3 days and as needed (PRN). The August 2018 Treatment Record recorded	F 686		

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F 686	Continued From page 6 staff applied Allevyn to Resident #1's left heel on 8/14/18, to be changed every 3 days and PRN. Review of a Nurse's Note dated 8/18/18 at 7:30 p.m. revealed Resident #1 complained of left heel pain. The Pressure Ulcer Healing Record documented the weekly assessment dated 8/19/18 as a 7 cm x 8 cm Stage 2 left heel pressure ulcer with a slightly odorous, moderate amount of drainage with a black wound bed and white surrounding skin. A Nurse's Note dated 8/19/18 at 10:45 a.m. recorded Resident #1's physician authorized a wound consultation for the left heel ulcer. The nurse recorded the wound increased in size from 5.1 cm x 8.3 cm to 7 cm x 8 cm. A Nurse's Note dated 8/19/18 at 6:30 p.m. noted a very odorous left heel dressing with red colored drainage. The nurse documented that Resident #1 complained of pain. Fax correspondence to Resident #1's PCP on 8/19/18 informed the pressure ulcer to Resident #1's heel increased in size that week from 5.1 cm x 8.3 cm to 7 cm x 8 cm with black eschar noted. The nurse requested the PCP to authorize a wound consultation. Resident #1's PCP saw the resident on 8/20/18; the resident's family requested the visit regarding a left heel ulcer identified about a week before. The PCP documented the wound as pretty large, concerning and mildly tender. The PCP assessed the wound as a 5 cm necrotic Stage 3 ulcer and noted that although Resident #1 wore protective	F 686		

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F 686	Continued From page 7 boots, the wound still hit the wheelchair and bed due to his weight. Resident #1 seemed more confused during the visit and gave inappropriate answers to questions. The PCP's ordered: - A referral to the wound nurse. - The resident must have the extremity elevated with no pressure on it. - Recommendation to have a pillow behind the calf while in the chair or bed to keep pressure off his heel. A Urology Clinic Note dated 8/20/18 at 4:49 p.m. noted that Resident #1's spouse accompanied him and reported he is less alert, his overall activity has decreased and he had difficulty with pressure ulcers due to his inability to move about in bed. The urologist assessed Resident #1 with a decreased level of consciousness from the many times he had seen him before and recorded worsening of the left heel ulcer compared to the last evaluation. The urologist indicated the ulcer may have an active infection based on its foul smell. He discussed a Hospice consultation with Resident #1 and his wife. New orders included: - Hospice consultation. - Wound nurse consultation. - Keep pressure off by putting pillow/s under the calf so his heels do not touch the mattress. The August 2018 Medication Administration Record (MAR) documented staff placed pillows under Resident #1's calf so his heel did not touch the mattress starting on 8/20/18. A Nurse's Note dated 8/20/18 recorded Resident #1 had pain when she changed his left heel dressing. She documented that both lower extremities were floated with a pillow and heel	F 686		

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F 686	Continued From page 8 boots were in place. On 8/20/18, staff sent a fax to Resident #1's PCP regarding very painful dressing changes to his heel and the PCP ordered Tramadol 50 milligrams by mouth 3 times a day for the pain. Fax correspondence dated 8/20/18 to Resident #1's PCP documented orders for a Hospice consult and a wound care consult for the left heel. The orders also directed staff to place a pillow under Resident #1's calf so his heels did not touch the mattress. The Physician's Order Sheet and Progress Note dated 8/22/18 documented a wound nurse's assessment and recommendations after she saw Resident #1. The nurse noted a 4.5 cm x 7.0 cm left heel pressure ulcer with black eschar (dead tissue) in the center of the wound. The upper edge of the eschar was soft - boggy, with a necrotic (dead) smell present. The nurse recommended: - Discontinue Allevyn. - Applying gauze dampened with a solution of ½ Betadine (antiseptic) and ½ saline and wrapped with gauze daily. - Continue bilateral heel pressure relief. - Dietary staff to evaluate Resident #1's nutritional needs for vitamins and supplements. The August 2018 MAR documented staff implemented the new wound treatment on 8/23/18. A Nurse's Note dated 8/24/18 at 8:00 p.m. recorded Resident #1 had difficulty standing with the use of the sit to stand lift. The nurse assessed Resident #1 as only oriented to person and he	F 686		

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F 686	Continued From page 9 moaned when he spoke. The nurse documented the resident's catheter drain bag contained dark brown urine. The note dated 8/25/18 at 11:15 a.m. recorded Resident #1 had been moaning and non-responsive to verbal cues. Orders were obtained to send Resident #1 to the ER. A Resident Transfer Form dated 8/25/18 noted that Resident #1 transferred to the hospital with a left heel wound after moaning, not responding, not eating and not acting like himself. The ED Provider Notes dated 8/25/18 at 12:38 p.m. documented Resident #1 had a recent episode of altered mental status secondary to urosepsis and had a left heel pressure sore. The physical exam documented Resident #1 looked frail and chronically ill. The resident had a 6 cm x 5 cm necrotic pressure sore on the left heel surrounded by redness, swelling and tenderness with purulent drainage a bad smell. Resident #1's PCP note dated 8/26/18 at 9:56 a.m. documented Resident #1 presented to ER the previous evening with a progressively worsening status. Resident #1 had not been eating, had poor mental status and had physically declined in his work with therapy since Wednesday. The PCP offered concern about infection of the malodorous and slightly reddened ulcer. She indicated Resident #1 moaned in pain, but was still poorly responsive. Resident #1 had poor ROM and very advanced Parkinson's where stiffness predominates. Resident #1's eyes opened, but he did not really respond to commands. The PCP documented that although his ulcer was dry on Tuesday when she saw him, the large black ulcer was now malodorous and draining.	F 686		

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F 686	Continued From page 10 The Certificate of Death filed on 9/4/18 documented Resident #1 died on 8/28/18 at 2:27 p.m. with an immediate cause of death as sepsis due to or as a consequence of urine and wound infection and end stage Parkinson's with immobility. An interview on 11/13/18 at 1:45 p.m. with Staff B, LPN (Licensed Practical Nurse) revealed that she changed Resident #1's left heel dressing on 8/19/18 and 8/21/18. Staff B thought the wound bed was necrotic and had an odor to it. Resident #1 depended on staff for a lot. Staff B said the resident was too weak and lacked the cognitive ability to do much of anything for himself. Staff got him up for breakfast and lunch, but otherwise they had to reposition him every 2 hours. Staff B said Resident #1's size alone should have prompted someone to implement the use of protective boots and/or floating his heals as a way of trying to prevent pressure ulcers. The LPN said they started floating his heels on 8/20/18. On 11/13/18 at 2:35 p.m. Staff A, LPN stated she assumed Resident #1 came to their facility with the pressure ulcer on his heel, but nobody identified it because of the swelling on his feet and legs. Staff A believed the sore had been there for some time before they identified it based on its severity when discovered. Staff A stated nurses have discretion to implement the use of protective boots for residents at risk. They try to do that if a resident has reddened skin, but she did not think Resident #1 had reddened skin. An interview on 11/13/18 at 3:15 p.m. with Staff C, LPN/Wound Nurse revealed she first saw Resident #1's left heel pressure ulcer when an	F 686		

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F 686	Continued From page 11 aide reported it to her. Staff C described it as an unopened purple blister about 6 cm in diameter. Although some pressure sores can develop quickly, Staff C said she wondered why nobody identified it sooner based on the severity of the wound when she first saw it. Staff are supposed to report skin issues to her as soon as possible, although some do and some do not. Staff C assesses wounds on Tuesdays and Wednesdays. Nurses are supposed to start a skin sheet whenever they identify a wound and Staff C said if its in the book, she would see it although she may not realize it for up to a week. Staff C offered that other staff are pretty good about letting her know if they are not comfortable with their assessment/opinion of what should be done. Staff should use the Daily Documentation of Wound Care form to track wounds on a daily basis, but Staff C said she did not find that documentation in Resident #1's chart. Staff C stated the facility should have been floating Resident #1's heels prophylactically (preventatively) and that is just common practice unless are resident is independent. Staff C thought Resident #1's wound developed from too much pressure on his heel. An interview on 11/14/18 at 8:45 a.m. with Staff D, CNA (certified nursing assistant) revealed that she reported to the nurse the first time she saw the pressure ulcer on Resident #1's heel. Staff D said it looked like a reddish fluid filled blister that covered his whole heel. The CNA said bath aids are supposed to check everyone's skin and tell the nurse about anything they find. Staff D recalled that Resident #1 spent quite a bit of time in bed for about the first week because his family had not brought a recliner in for him yet. The got him up for meals, but that was about it for the first	F 686		

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F 686	Continued From page 12	F 686		

week. Staff D said she put pillows under his legs to float his feet, but she doubted that everyone did that. The CNA remembered sometimes seeing him without his feet floated. Staff D thought the sore developed because his heels were not always being floated and had had too much pressure on them.

An interview on 11/14/18 at 1:15 p.m. with the Physician's Assistant (PA) who assessed Resident #1 in the ER on 8/12/18 revealed she did not look at his feet during the encounter. Resident #1 presented to the ER for issues with his catheter. Unless he or his family mentioned the pressure ulcer on his heel, the PA focused primarily on the issues he presented with. The PA expected every nursing home to give a high standard of care according to each resident's needs to prevent a worsening condition.

An interview on 11/14/18 at 2:00 p.m. with the Nurse Consultant revealed the facility did not have a general pressure ulcer protocol. Staff used individualized interventions according to each resident's specific needs.

On 11/14/18 at 2:25 p.m. the Director of Nursing (DON) stated the expectation that all changes in condition of a resident's skin should be reported.

F 686

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law

This is my credible allegation of compliance to 686 . This allegation does not constitute guilt but that the facility is in compliance to 686, as of 12/7/18

Resident #1 no longer resides in the facility.

All residents are routinely assessed for their risk status for developing pressure injuries per the facility's wound care protocols. Appropriate interventions are put into place as a result of the resident assessments. Physicians are notified as needed for resident treatment needs should a skin injury be identified. Care Plans are update as needed as well as family notification.

The facility implemented a Quality Improvement Project on 8/13/18 related to increasing awareness towards Pressure Injuries along with a pro-active approach towards preventative interventions to assist in possible pressure injury prevention. This project was again reviewed and updated on 12/7/18. Staff was educated during the survey process on the Quality Improvement Project as well as where to find appropriate pressure relief measure for each resident. Staff was educated verbally during the survey process. The 12/11/18 all staff Inservice will also cover the importance of notification of resident change in condition and possible need for increased pressure relief measures. Care Plans and resident task lists will routinely be updated to reflect the most current pressure relief measure so staff knows what interventions are to be used.

The facility's QA process will review pressure relief interventions for appropriateness as well as being used as needed. Problems will be corrected as they are observed and appropriate staff will get further education related to use of proper pressure relief interventions. The facility will also continue to review pressure relief/pressure prevention as part of their weekly skin meeting and adjust pressure interventions at that time followed by appropriate staff education along with Care Plan/Tasks updates and physician notification if needed