

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6989		Date: June 13, 2019		
Facility Name: Trinity Center at Luther Park		Survey Dates: May 13-16, 2019		
Facility Address/City/State/Zip 1555 Hull Avenue Des Moines, IA 50136				
		MW/DC		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.19(2)b	<p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(2) Medication and treatment.</p> <p><i>b.</i> Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II)</p> <p>DESCRIPTION:</p> <p>Based on clinical record review, observation, family interview, and staff interviews, the facility failed to prevent the development of pressure sores, failed to complete wound assessments, failed to communicate decline in residents condition and deterioration of sacrum wound that developed osteomyelitis and failed to complete wound treatments as ordered for 2 of 4 residents reviewed for pressure sores, (Resident #97 and Resident #9). The facility reported a census of 115 residents.</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:</p>		\$6250	UPON RECEIPT

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	<p>Stage I is 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Unstageable Ulcer: inability to see the wound bed.</p> <p>Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and</p>			

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	<p>discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p>1. The Minimum Data Set (MDS) assessment dated 1/13/19 for Resident # 97 identified a Brief Interview for Mental Status (BIMS) score of 12 without signs/symptoms of delirium. A score of 12 indicated moderate cognitive impairment. The MDS documented the resident displayed no behaviors during the 7 day look-back period which included no rejection of cares. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, personal hygiene, 2 persons for toilet use, and independent with set up help only with eating. The MDS revealed the resident walked once or twice with the assistance of 1 person in the room and corridor. The MDS documented diagnoses that included Diabetes Mellitus, Alzheimer's disease, moderate recurrent Major Depressive Disorder, Morbid (severe) Obesity, Chronic Kidney Disease, stage 3 (moderate), and other skin changes. The MDS recorded a weight of 329 pounds. The MDS recorded the resident at risk of pressure ulcers/injuries but did not have any unhealed pressure sores.</p> <p>The Discharge Return Anticipated (DRA) MDS assessment dated 3/25/19 documented the resident went to the hospital on 3/25/19. The MDS documented the resident displayed verbal behaviors directed toward others on 1 to 3 days of the 7 day</p>				

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	<p>look-back period but did not display rejection of cares. The MDS revealed the presence of unhealed pressure ulcers/injuries but failed to document the number or types.</p> <p>The Significant Change MDS assessment dated 4/21/19 documented the resident returned from the hospital on 3/29/19. The MDS identified a BIMS score of 09 without signs/symptoms of delirium which indicated moderate cognitive impairment. The MDS documented the resident rejected cares on 1 to 3 days of the 7 day look-back period. The MDS revealed the resident required the extensive physical assistance of 1 person for personal hygiene, 2 persons for bed mobility, dressing, toilet use, and supervision of 1 person for eating. The MDS revealed the resident totally dependent upon 2 persons for transfers and did not walk in room or corridor during the assessment period. The MDS record the presence of 1 Stage II, 2 Stage III, and 1 Unstageable Deep Tissue Injury pressure ulcers.</p> <p>The care plan revealed the following:</p> <p>a. On 1/23/19 a new problem onset identified a potential for altered skin integrity due to history of irritation of skin and resident scratched, picked her skin. A blister present on the coccyx upon admit and excoriation to the perineal area. The resident chooses to lay in recliner most of the day, eating meals in room and watching TV. The interventions included: the nurse to assess skin twice weekly and notify the doctor as needed; treat skin issues as ordered; NIP (nutritional supplement) due to pressure areas; peri-</p>			

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	<p>care per staff; gel cushion and dicem (anti-slip mat) in recliner; moisture barrier cream twice a day and as needed as resident allows; and standard pressure reducing mattress.</p> <p>b. On 2/11/19 a new intervention started for an alternating air mattress.</p> <p>c. On 2/11/19, a focus area identified the resident sometimes resistive to care and staff direction related to adjustment to nursing home and dementia. Another focus area identified an ADL (Activities of Daily Living) self-care performance deficit related to Alzheimer's disease.</p> <p>d. On 2/22/19 staff directed to provide assistance of 1 staff for dressing, 1 staff with gait belt for transfers, the use of the wheelchair to go to meals and back per resident preference, and to complete the restorative nursing program as ordered.</p> <p>e. On 3/25/19 a new focus area identified an Unstageable pressure sore at the sacrum (located at the base of the lumbar vertebrae and connected to the pelvis) related to incontinent of bowel (diarrhea/bladder, resistive to peri-care/repositioning, and poor nutritional intake. The new interventions directed staff to: apply treatment per order; encourage good nutrition and hydration in order to promote healthier skin; and keep the skin clean and dry.</p> <p>f. On 3/26/19 the care plan documented the resident non-complaint with cares, repositioning, and incontinence cares.</p> <p>g. On 4/1/19 new interventions directed staff to frequently turn and reposition the resident and to provide NIP supplement to promote wound healing.</p>				

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	<p>h. On 4/1/19 and revised 5/3/19 an entry directed staff to monitor and document location, size, and treatment reporting abnormalities, failure to heal, signs/symptoms of infection, maceration (softening skin) etc. to the doctor.</p> <p>i. On 4/9/19 staff directed to use the hoyer (mechanical) lift with 2 staff for transfers starting 4/8/19.</p> <p>j. On 4/11/19 the care plan again informed staff the resident non-compliant with repositioning and turns.</p> <p>k. On 4/12/19 new focus areas identified an Unstageable pressure sore at the left gluteal fold, an Unstageable pressure sore at the right gluteal fold, and a Stage II pressure sore at the right buttock (fluid filled blister); all related to incontinent with bowel (diarrhea/bladder, resistive to peri-care/repositioning, and poor nutritional intake.</p> <p>l. On 5/2/19 staff advised the resident could sit up in the Broda chair (a type of reclining wheelchair) with Roho (pressure relief) cushion for meals up to 1 hour at a time as tolerated.</p> <p>The January, February, and March 2019 Treatment Administration Records (TARs) documented an entry for the administration of Calmoseptine ointment to be applied topically to the coccyx every shift as a preventative treatment to maintain skin integrity. The TARs documented the Calmoseptine treatment routinely completed 3 times a day at 5:30 a.m., 1:30 p.m., and 9:30 p.m., every day of the month with only 2 exceptions. The staff visualized the resident's buttocks approximately every 8 hours.</p>			

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	<p>The April 2019 TAR contained an entry to apply metahoney to the pressure sacrum, bilateral gluteal fold, right buttock, and cover with mepilex daily until healed. The TAR reflected 4/17 and 4/22 left blank indicating the treatment not completed. The progress notes lacked documentation of any refusals to complete the treatment on those days.</p> <p>The Progress Notes revealed the following:</p> <ul style="list-style-type: none"> a. On 1/11/19 at 9:48 p.m. a care plan charting note revealed the resident alert to self, transferred with assist of 1, mobility via wheelchair with frequently asking staff to propel but self-propelling encouraged, and the resident out in the dining room and able to feed self. b. On 3/22/19 at 9:23 a.m. the resident's blood sugar reading high at 516 and staff updated the primary ARNP (Advance Registered Nurse Practitioner). At 1:43 p.m., the resident noted to continue with some watery loose stools but none since 9:30 a.m. that day. The resident complained she didn't feel good, and orders to obtain specimen for C Diff test (type of infection that causes diarrhea). c. On 3/23/19 at 1:27 p.m. the resident refused to get out of bed so given a bed bath and the resident on contact precautions for loose stools and emesis. d. On 3/23/19 at 8:27 p.m., the nurse observed a pre-existing bloody blister to the left side of the resident's buttock getting bigger and tender. Peri care provided, barrier cream applied, and fax sent out to physician 			

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	<p>about condition as resident refusing to lay in bed on her side to reduce pressure to her bottom.</p> <p>e. On 3/23/19 at 8:46 p.m. the C Diff test results reported as negative and a fax request sent to the physician to discontinue the Miralax order due to diarrhea.</p> <p>f. On 3/24/19 at 3:50 a.m. the resident's temperature 98.2 degrees, had a small amount of loose stool, Calmoseptine (a protective barrier) applied to buttock to prevent excoriation, and the resident remained on a pressure relief mattress with HOB (head of bed) elevated 30 degrees. At 12:28 p.m. the resident had a small amount of diarrhea, refused to get up, refused cares, bed bath given, and the resident ate in room while in bed. At 6:25 p.m. the resident continued with diarrhea, refused cares including per-care. Resident assisted by 4 staff and a gait belt to transfer to the wheelchair so the resident could get clean and the bed changed.</p> <p>g. On 3/25/19 at 2:00 a.m. dry excoriation observed on the left buttock with Calmoseptine documented as placed on the resident's buttock. At 12:03 p.m. the resident refused to get out of bed to check weight and at times refusing cares. At 1:46 p.m. the resident had generalized body weakness and found to have pressure sores to her bottom. The resident received cares and took all meds during that shift. A new order received to send the resident to the hospital and the ambulance service contacted. At 3:26 p.m. Staff P, Registered Nurse (RN)/facility wound nurse, documented a detailed Skin/Wound Note. Staff P recorded the resident had 4 areas of Unstageable pressure. The sacrum area measured 5.5 cm</p>			

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	<p>(centimeters) by 11.9 cm, the left gluteal fold measured 1.6 cm by 2.2 cm, the right gluteal fold measured 2.7 cm by 8.2 cm, and a Stage II pressure at the right buttock measured 2.7 cm by 8.2 cm. Staff P wrote the resident with impaired skin integrity related to incontinent of bowel due to diarrhea for 2 to 3 days, incontinent of bladder, and noted the C Diff test negative. Staff P documented the resident had generalized body weakness due to diarrhea, refused to be out of bed, was non-compliant with cares, refused/resistive during peri-care and repositioning/turns while in bed. Staff P documented the resident had poor nutritional intake related to current illness and diagnosis of Diabetes Mellitus. Staff P wrote the nurse called the primary ARNP and received an order to send to the hospital for further evaluation and treatment.</p> <p>h. On 3/26/19 at 11:06 a.m. a call was made to the hospital and informed the resident admitted for UTI (Urinary Tract Infection) and general body weakness.</p> <p>i. On 3/29/19 at 10:09 p.m. the resident arrived back from the hospital at 5:25 p.m. The resident was alert and oriented times 2 (person/place), assist of 1 with ADL's but uncooperative during care. The resident was started on an antibiotic for UTI.</p> <p>j. On 3/30/19 at 2:39 a.m., the presence of open sores and eschar (dead tissue) to sacral area, area cleansed and Calmoseptine applied. The resident was on a pressure relief mattress. At 1:05 p.m. the resident noted to be very uncooperative during cares, wound to buttock cleaned, treatment applied. The resident refused to get out of the bed during the shift. At 9:02 p.m. documented the treatment continued to the</p>			

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	<p>buttock and the resident refused to get up that evening.</p> <p>k. On 4/1/19 at 1:56 p.m. the resident noted to spend time in room, refused to get up. The resident had been turned and changed as the resident was incontinent of both bowel and urine. At 10:18 p.m. the staff documented the resident needed fed during the shift.</p> <p>l. On 4/4/19 at 3:33 a.m. the resident on a pressure relief mattress. At 12:32 p.m. the resident refused to get up from bed, cares were provided, treatment to wounds completed, and the resident turned to sides to reduce pressure from her buttock. At 9:27 p.m. documented the resident stayed in bed all shift, checked, changed, and turned as needed.</p> <p>m. On 4/5/19 at 12:18 p.m. documented the resident stayed in bed all day and reposition on side at least every 2 hours.</p> <p>n. On 4/7/19 at 6:30 p.m. a post fall evaluation was documented for a witnessed fall. The fall occurred in the resident's room while peri-care being done. The evaluation documented yes to change in mental status, change in behaviors, and change in mobility status. The evaluation documented a Stage I pressure issue on buttock with non-blanchable erythema. At 9:31 p.m. the incident note documented the resident lowered to the floor as she was unable to bear weight when being cleaned up and the bedding being changed. The incident note recorded a scant amount of blood noted from the existing wound on buttock, the wounds cleaned, treatment completed, and weekend supervisor made aware.</p>			

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	<p>o. On 4/8/19 at 9:15 p.m. a new order received from the primary ARNP to evaluate the resident to be a hooyer transfer and documented family notified.</p> <p>p. On 4/10/19 at 11:29 p.m. a new order received from the primary ARNP to apply metahoney (treatment designed for wounds that have difficulty healing on their own) to the pressure area on the sacrum and cover with mepilex (self-adherent, soft silicone foam dressing) daily until healed; documented family notified.</p> <p>q. On 4/15/19 at 1:11 p.m. the resident repositioned but refused getting out of bed throughout the shift.</p> <p>r. On 4/20/19 at 3:05 p.m. the resident's son gave verbal authorization to see the wound doctor that week.</p> <p>s. On 4/22/19 at 11:05 a.m. an Activity Significant Change MDS progress note documented the resident recently laid in bed often.</p> <p>t. On 4/30/19 at 8:20 a.m. the resident's blood sugar level high at 530 and the primary ARNP and family notified.</p> <p>u. On 5/3/19 at 8:47 p.m. a Life Enrichment Note documented the resident now on a 1 to 1 program but at times refusing visits and spending a lot more time in room.</p> <p>v. On 5/8/19 at 10:57 p.m. a new order received from the ARNP Wound Nurse to cleanse the coccyx with Vashe (intended for use in cleansing, irrigating, moistening and debriding acute and chronic wounds), a nickel thick layer of Santyl (a debriding agent) to the wound bed to slough covered area (have a layer of skin come off), loosely pack with fluff gauze to fill cavity, sprinkle collagen (a protein) powder to red</p>			

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	<p>granulation tissue (new growth of connective tissue associated with wound healing), cover with border gauze, and change daily.</p> <p>w. On 5/10/19 at 9:17 a.m. a Communication with Family note, documented by the Social Worker (SW), recorded the resident's son came to discuss the resident's current state after being told by the nurses the resident refused a lot of cares and chose to stay in bed all day. He stated he felt like his mom may be giving up. The SW wrote she educated the son about hospice and palliative care and the son expressed interest in information on palliative care. The SW wrote she would discuss options for the resident with the clinical team and would follow up with the son early the next week. At 12:27 p.m. the son went to Staff U, Licensed Practical Nurse (LPN), to request a UA (urinalysis) test. Staff U wrote the resident had been down, refusing to do things, incontinent of bowel and urine, and changed per staff. At 12:33 p.m. Staff U documented she sent a fax out to the physician requesting a UA per family request.</p> <p>x. On 5/13/19 at 3:45 p.m., the son came to visit the resident and complained of the resident not able to stay awake, engage in conversation, or eat a meal. Staff A, LPN, wrote she tried to explain that aides help with the feeding in the room and the resident refused getting up. The son requested a UA and palliative care evaluation. Staff A documented a fax had been sent to the primary ARNP and staff still waiting for a response.</p> <p>y. On 5/14/19 at 5:53 a.m. orders received for palliative care and UA with dysuria (painful urination); UA obtained without difficulty with cloudy yellow urine</p>			

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	<p>output. At 2:36 p.m. a fax was sent to the primary ARNP with the UA results and son notified. The wound doctor saw the resident and treatment done.</p> <p>z. On 5/15/19 at 7:45 a.m. the resident was red and flushed, her temperature was 99.4 degrees. The resident had a High FBS (fasting blood sugar reading), the on-call doctor was notified. At 7:58 a.m. the son updated on the resident's status and the daughter-in-law to be in the facility that day.</p> <p>At 8:40 a.m. a Communication with Family, documented by the SW, noted the daughter-in-law visibly upset and wanted to see the primary ARNP when she arrived to do rounds and wanted to ensure the resident on the list to be seen. The SW explained to the daughter-in-law she does not communicate directly with the ARNP but assured the resident would be seen and she referred the daughter-in-law to the ADON (Assistant Director of Nursing) who would be better equipped to answer nursing related questions. The SW apologized to the daughter-in-law that the family not aware of the resident's health decline. The SW recorded the daughter-in-law and son very upset the resident may be hospice appropriate and the SW immediately notified the DON of the interaction.</p> <p>At 8:57 a.m. Staff U documented the resident was very sleepy during the shift, barely opening her eyes. Staff put the resident's dentures in her mouth and tried to feed her but she spit out the food. The resident refused medications. Staff U documented the physician was aware and would be in to see the resident. The resident had been repositioned in bed.</p> <p>At 9:19 a.m. Staff P documented she tried to talk to the son to give update related to the wound as the ARNP</p>			

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	<p>Wound Nurse would like to know if family wanted aggressive treatment to the wound, and if they did, a referral to infectious specialist would be given. The son did not answer the call so she spoke to the daughter-in-law and gave updates of wound care plan. Staff P documented the daughter-in-law got a hold of the son and reported he wanted to be as aggressive as possible with treatment.</p> <p>At 11:20 a.m. Staff U documented the ambulance arrived and the resident transferred by 3 persons and a hooyer. The daughter-in-law wanted to know how long the resident had been refusing meds and Staff U informed her just that morning and the resident was fed in her room with very poor appetite.</p> <p>At 12:09 p.m., Staff U documented the daughter-in-law spoke to the physician regarding the residents decline. A recheck of the blood sugar had been done at 10:00 a.m., BS 597. The physician was notified of vital signs abnormal for the resident. The Physician stated the resident will be sent to the hospital per family request. The facility still waiting on the C&S (Culture & Sensitivity) report from the UA test. Staff called for ambulance transport.</p> <p>The Facility Skin & Wound Evaluations revealed the following:</p> <p>The clinical record lacked documentation of pressure sore Skin & Wound Evaluations for any areas dated prior to 3/25/19. The care plan identified a blister to the coccyx 1/23/19 and the Progress Notes identified a pre-existing bloody blister to the left side of the resident's buttock getting bigger and tender on 3/23/19.</p>			

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	<p>Pressure sore Right Buttock</p> <p>a. On 3/25/19 the resident had a new intact serum filled blister that measured 2.7 cm by 8.2 cm. The surrounding tissue had erythema (redness of the skin), was excoriated and fragile. The blister was in-house acquired.</p> <p>b. On 4/1/19 the blister measured 1.6 cm by 1.5 cm with 100% granulation and light serosanguinous exudate (bloody, watery fluid drainage), progress improving. The resident had been sent to the hospital with a Stage II pressure at the right buttock (blister) and the resident readmitted with the blister broke open. Staff were directed to cleanse the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas and apply Calmoseptine to the reddened areas on the buttocks and coccyx. Education included; alternating air mattress in place, NIP supplement to promote wound healing, frequent turn and repositions, keep skin dry and clean, and wheelchair cushion in place.</p> <p>c. On 4/9/19, the area to the right buttock was marked a Stage III pressure area. The area measured 1.5 cm by 1.4 cm with 100% granulation tissue and light serosanguineous exudate. The surrounding tissue was eczematous. The area was deteriorating. The resident was seen by the primary ARNP on 4/10/19 and the treatment changed to cleanse site with normal saline, apply/pack with metahoney, cover with mepilex daily until healed. Continue all previous interventions. Education included; the resident non-compliant for turning and repositioning, encourage to turn frequently, appetite poor and diagnosed with Diabetes Mellitus</p>			

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Health Facilities Division
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	<p>type 2 with blood sugar uncontrolled despite medications, all the factors affect wound healing process.</p> <p>d. On 4/15/19 the area measured 1.5 cm by 1.6 cm with 100% epithelial tissue (thin tissues that cover all the exposed surfaces of the body) and light sanguineous exudate (bloody drainage). Noted wound healing well.</p> <p>e. On 4/22/19 the area measured 1.1 cm by 1.4 cm and was resolved.</p> <p><u>Pressure sore Right Thigh (Rear) a.k.a. Right Gluteal Fold</u></p> <p>a. On 3/25/19 a new Unstageable pressure area measured 1.8 cm by 2.3 cm with 100% eschar (dead tissue). The surrounding tissue had erythema was excoriated and fragile.</p> <p>b. On 4/1/19 the area measured 1.4 cm by 2.4 cm, 80% epithelial tissue and 20% slough (a layer or mass of dead tissue separated from surrounding living tissue in a wound), light serosanguineous exudate. The resident sent to hospital with Unstageable pressure due to suspected deep tissue injury at the right rear thigh and readmitted with Stage II at the right rear thigh. Staff directed to cleanse the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas and apply Calmoseptine to the reddened areas on the buttocks and coccyx.</p> <p>c. On 4/9/19 the area measured 2.1 cm by 1.7 cm with 100% granulation tissue. Had light serosanguineous exudate and the surrounding tissue had erythema. The area was deteriorating. The resident was seen by primary ARNP 4/10/19 and</p>			

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	<p>treatment changed to cleanse site with normal saline, apply/pack with metahoney, covered with mepilex daily until healed. Continue all previous interventions.</p> <p>d. On 4/15/19 the area measured 1.6 cm by 1.0 cm with 100% epithelial tissue.</p> <p><u>Pressure sore Left Thigh (Rear) a.k.a. Left Gluteal Fold</u></p> <p>a. On 3/25/19 a new Unstageable pressure area measured 1.6 cm by 2.2 cm with 100% eschar. The surrounding tissue with erythema, excoriated and fragile.</p> <p>b. On 4/1/19 area measured 1.8 cm by 1.6 cm with 20% epithelial tissue and 80% slough. The area had serosanguineous exudate. Resident #97 sent to hospital with Unstageable pressure due to suspected deep tissue injury at the left rear thigh and readmitted with Stage II at the left rear thigh.</p> <p>c. The clinical record lacked an assessment completed on 4/9/19.</p> <p>d. On 4/15/19 area measured 1.4 cm by 1.4 cm with 100% epithelial tissue. It had light sanguineous exudate.</p> <p>e. On 4/22/19 area measured 0.9 cm by 0.1 cm and was resolved.</p> <p><u>Pressure sore Sacrum</u></p> <p>a. On 3/25/19 a new Unstageable pressure area measured 5.5 cm by 11.9 cm, with 100% eschar. The surrounding tissue had erythema and was excoriated and fragile. The pressure area was in house acquired.</p> <p>b. On 4/1/19 the area measured 8.9 cm by 6.4 cm with 90% slough and 10% eschar. It had light</p>			

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	<p>serosanguineous exudate with a faint odor. The resident was sent to hospital with Unstageable pressure due to suspected deep tissue injury at the left rear thigh and readmitted with Stage II at the sacrum. Treatment to the area included to cleanse the wound with cleansing spray or soap and water, apply Z-guard paste to cover all open areas, apply Calmoseptine to the reddened areas on the buttocks and coccyx.</p> <p>c. On 4/9/19 the area measured 6.9 cm by 4.4 cm with 50% granulation tissue and 50% slough. It had light purulent exudate (type of liquid that oozes from a wound that can be a sign of infection), progress deteriorating. The area had a depth of 0.5 cm. The resident was seen by the primary ARNP with treatment changed to cleanse site with normal saline, apply/pack with metahoney, cover with mepilex daily until healed, and continue all previous interventions.</p> <p>d. On 4/15/19 the area measured 10.0 cm by 6.6 cm with 40% granulation tissue and 60% slough. It had moderate purulent exudate, progress deteriorating. Noted resident seen by the primary ARNP, noted a depth of 0.5 cm, treatment changed the previous week, would continue to apply and re-evaluate treatment effectiveness, and continue all previous interventions.</p> <p>e. The resident's clinical record lacked an assessment of the wound for the week of 4/22/19.</p> <p>f. The residents clinical record lacked an assessment of the wound for the week 4/29/19.</p> <p>g. On 5/7/19 the area measured 7.8 cm by 4.3 cm with 30% epithelial tissue, 40% granulation tissue and 30% slough. It had light serous exudate. The area was deteriorating. The resident was seen by ARNP Wound</p>			

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	<p>Nurse on 5/7/19 with wound measurements of 8.5 cm by 3.6 cm by 1.6 cm. The area was 25% slough, 10% partial thickness, 25% epithelial and 40% red granulation. It had epithelial islands and the bone was palpable. There was moderate thin serous drainage with slight pain, managed with pain medication. Started treatment of cleanse with Vashe, nickel thick layer Santyl to wound bed to slough covered areas, loosely pack with fluff gauze fill cavity, sprinkle with collagen powder to red granulation tissue, cover with border gauze, change daily and as needed.</p> <p>Observations revealed the following:</p> <p>a. On 5/13/19 at 11:32 a.m. Resident # 97 laid in bed positioned on her back.</p> <p>b. On 5/14/19 at 9:33 a.m. Resident # 97 positioned on her right side in bed with a pillow on her left side of back to position. At 11:59 a.m. Resident # 97 laid in bed on her back, air pump in place on the bed, and functioning. Attempted conversation with the resident and she did not really respond.</p> <p>c. On 5/14/19 at 1:32 p.m. the ARNP Wound Nurse, Staff P, and Staff A, entered the room to provide cares. Staff A and Staff P assisted the resident to roll onto her right side. The ARNP Wound Nurse unpacked the sacral wound, measured 5.5 cm by 5.3 cm by 2.4 cm straight depth, and stated some necrotic tissue present in the wound that needed removed. The ARNP Wound Nurse stated the wound bed was 30% slough/necrotic tissue, 10% epithelial tissue, the rest granulation tissue. The ARNP Wound Nurse reported the wound areas were pressure related. Noted a foul odor coming from the unpacked wound. The ARNP</p>			

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	<p>Wound Nurse stated they were treating the wound with Santyl (a debriding agent) to get to the healthy tissue and that was why there was odor coming from the wound. The ARNP Wound Nurse debrided the necrotic issue then re-measured. The measurements were 5.7 cm by 5.0 cm by 2.2 cm straight depth with 3.7 cm of tunneling at 9 o'clock and 1.7 cm of undermining at 11 o'clock to noon. The ARNP Wound Nurse stated the bone was exposed and informed staff they needed to reach out to family to see how aggressive they wanted with treatment as bone exposure could mean possible osteomyelitis (bone infection). The ARNP Wound Nurse said if the family wanted aggressive treatment then infection control gets involved otherwise they would focus on keeping it from getting worse in the facility. Staff A washed hands, donned gloves, then cleansed the wound with normal saline, repacked the wound with Santyl gauze, then collagen powder on the outer skin areas where granulation tissue present, and a new foam dressing applied. Resident # 97 did moan at some points during the dressing change. Staff P stated the resident started with a decline overall, then had some loose stools, and a Stage II to III pressure area developed. Staff P stated the depth of the wound was new for the resident.</p> <p>d. On 5/15/19 at 8:35 a.m., Staff U attempted to rouse the resident to take drinks of water, drinks of Pepsi, and to attempt a bite of food. Resident # 97 was slow to respond or open eyes and moaned in response to being rubbed on the arm. Resident # 97 did take in dentures, but did not take a drink or meds. Staff U gave Resident # 97 a bite of food which the resident</p>			

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	<p>spit out. Staff U stated the resident was not going to accept anything at that time so she would just wait for the doctor who was supposed to be coming. Staff U reported she worked for the facility for a year and was familiar with Resident # 97's cares prior to going to the hospital. Staff U stated prior to going to the hospital the resident used to be up talking and walking. Staff U responded the resident came from the hospital with the pressure sores. Staff U reported the resident had 2 pressure areas on the gluteal folds that healed up and the other pressure area remained on the sacrum. Staff U stated when the resident went to the hospital her bottom just red and the wound nurse saw the resident before she went to the hospital. Staff U again clarified she had never seen the pressure areas on the resident's bottom before the hospitalization, the sacral area was just red.</p> <p>e. On 5/15/19 at 11:15 a.m., observed paramedics arrive to the resident's room to assess and transport the resident to the hospital. Resident # 97's daughter-in-law at the resident's bedside with Resident # 97's son on the speaker phone. The family relayed concerns the resident showed signs of dehydration with wrinkled skin and increased temperature above 100 degrees Fahrenheit. The daughter-in-law reported she spoke to the primary ARNP who had just been in the facility to assess the resident and the ARNP told her she had not been made aware the resident's condition that bad.</p> <p>Physician orders, primary ARNP visit, ARNP Wound Nurse visits, revealed the following:</p>			

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	<p>The primary ARNP Routine Visit note dated 1/16/19 recorded the resident examined for a routine visit and noted all chronic conditions stable at that time.</p> <p>The primary ARNP Routine Visit note dated 3/13/19 recorded the resident examined for a routine visit and noted no acute concerns per nursing staff or family and all chronic conditions stable at that time.</p> <p>The fax order sheet dated 3/23/19 documented the resident had 1 blood blister to her left bottom/groin that measured 6.0 by 6.0 cm, the skin intact but raw, cream applied, and requested treatment for the blister. The fax recorded the resident being turned to her side but non-compliant. A new order given for Duoderm to open area on the buttocks and change every 3 days.</p> <p>The hospital Discharge Summary dated 3/29/19 documented the resident admitted to the hospital on 3/25/19 for increased confusion, urinary tract infection, and AKI (Acute Kidney Injury). The discharge orders included treatment to coccyx/buttock of: clean with cleansing spray or soap and water; apply thick layer of Z-guard 3 times a day; cover open areas; do not wipe to skin level; specialty mattress; side to side turns only; and foam wedge pillow. The discharge instructions included to follow up with the primary care physician in 1 week.</p> <p>The clinical record lacked evidence the resident seen by the primary care physician after return from the hospital.</p>			

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	<p>The ARNP Wound Nurse, Wound Treatment Plan dated 5/14/19, documented the resident was seen to assess the coccyx wound. The notes recorded the resident stayed in bed by choice due to sacral pain when sitting. The resident incontinent of bowel and bladder making gross contamination of wound problematic. A Broda chair with Roho cushion available for the resident however the staff report the resident no longer used the chair. An air mattress overlay in place and appropriately inflated to reflect current body weight. No concerns voiced by staff related to current wound treatment.</p> <p><u>The Skin Physical Examination section documented the following:</u> Stage 4 pressure on coccyx measured 5.5 cm by 5.3 cm by 2.4 cm. The wound tissue was 30% slough/necrotic, 10% epithelial and 60% red granulation. Bone was exposed. A moderate thin serous exudate present with slight odor.</p> <p><u>The Procedures/Services section documented the following:</u> Excisional debridement done and wound measurements after were 5.7 cm by 5.0 cm by 2.2 cm, tunnel at 9 o'clock with depth of 3.7 cm, undermining from 11 o'clock to noon with depth of 1.7 cm, bone exposed.</p> <p><u>Plan Notes section documented the following:</u> Skin nurse (Staff P) will discuss with family how aggressive they wish wound care to be and if they wish for full work up for potential osteomyelitis. If they do not wish aggressive work up, will focus wound goal at pain control, odor management, and infection prevention while continued goal to promote healing.</p>			

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	<p>The primary ARNP Routine Visit note dated 5/15/19 included the following: staff related the resident refused morning meds, would not eat breakfast, and had eaten less the last 3 weeks, but did not refuse meals. Today staff informed me the coccyx wound much worse. The wound nurse debrided it this week and it was nearly to the bone. Staff are packing the wound daily. Staff related the resident had not been getting up out of bed for about 3 weeks due to sore on coccyx and when the resident sat up in the wheelchair she scooted down. Staff concerned the resident would fall out of the wheelchair and make her wound worse due to shearing. The resident laid in bed during visit and appeared quite ill, ashen, diaphoretic (sweating heavily) and hot. A recheck of vital signs showed hypotension (low blood pressure) and febrile (elevated temperature). Discussed with family and the resident to be sent to the hospital for evaluation and treatment. The family stated in a care conference the previous week they were asked if they would like palliative care or hospice care due to the resident's coccyx wound. The ARNP wrote she was unaware this was being discussed. The ARNP felt the resident appeared septic and sent the resident to the hospital for evaluation and treatment.</p> <p>The Hospital Progress Notes dated 5/16/19 at 6:59 a.m. documented the resident presented to the ED (Emergency Department) secondary to altered mental status and found to have osteomyelitis of the sacrum, renal failure, and UTI. The note recorded after long discussion with the family, the resident to be comfort</p>			

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	<p>cares only and hospice consult placed. The Impressions/Plan recorded a diagnosis of sepsis (a life-threatening illness caused by your body's response to an infection) secondary to osteomyelitis.</p> <p>Interviews: On 5/15/19 at 9:06 a.m., the resident's daughter-in-law and son reported the resident initially went to the hospital (3/25/19) for bad pressure sores. The son reported the resident treated for UTI and high blood sugars at that time just like the resident had that morning. The son stated with the first hospitalization (3/25/19) the facility told him the day his mother went his mother had some bed sores that were going to be looked at in the hospital; the son commented prior to that day, no call. The daughter-in-law reported she observed the resident's buttocks in the hospital on the first day she went (3/25/19) and recalled the skin looked purple with no skin missing or open on the part she observed, but she did not see the skin folds. The family reported the hospital wound doctor saw the resident. The resident's blood sugar went down and the resident got better and was sent back to the facility. The son reported he went up in March and his mother appeared okay, a lot going on. The son stated his mother had a lot of fluid buildup in the legs and so started laying down to get rid of the fluid buildup and put on another medication. The son stated 2 to 3 weeks prior he was notified blood sugars high or changing meds, and usually the facility called about</p>			

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	stuff like that, but never called to say his mother not eating or sleeping all the time. The son reported he went in to visit and saw his mother asleep and staff told him she was not eating. The son stated he asked how long it had been going on and told a couple weeks of not eating as much, she would drink, but not eating much breakfast and not lunch. The son reported the last time he visited, his mother's lunch sat on the tray and she slept. The son stated the facility responded the nurse aide was in there and they go in to try to get her to eat but said the lunch tray sat untouched. The son stated the facility had a meeting with him on Friday (5/10/19) to tell him his mother should get palliative or hospice care in there. He said okay because his mom was going downhill. The family reported on 5/10/19 they visited the resident and she was sleeping and not aware of who the son was so he went to talk to the nurse. The son stated that was when the staff told him they turned her every 2 hours, he was told the sores better but still watching 1, and after 10 minutes of seeing his mother's condition, he went to talk to the SW. The family stated they asked the SW what they could do for the resident and the SW mentioned palliative or hospice to the family's surprise. The son stated he asked her to explain palliative care to which the SW explained his mother would get more care. The son stated the SW said she would have a team meeting that day and get back to them by Monday and the SW had a lot going on meeting wise. The son reported the facility told him the bed sores getting better on Friday when he called the facility to tell them to get a hold of the doctor as he wanted a UA test done to check for a UTI. The son reported on			

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	<p>Saturday (5/11/19) Staff W, LPN, told him the resident not on hospice and they thought the SW had said the resident would be hospice. The son stated he felt a UA needed because maybe the same thing going on with UTI as it had the last time his mother was hospitalized. The son repeated he asked Friday morning for a UA and he had not heard anything as of Monday. The son reported when in the facility on 5/13/19 he asked about the results and the LPN there couldn't tell him anything and he felt he got different stories from everyone. The son stated he thought his mother had a UTI when told the blood sugar reading over 600 and said he was told the preliminary report showed blood in urine, WBC (white blood cells) in urine, and showed the body fighting something. The son said he he felt his mother had an infection somewhere and something needed to be done before she turned septic. The son voiced he wanted his mom hospitalized immediately. The son responded he was not aware of anyone contacting him the day before to update him about the ARNP Wound Nurse's visit but the night nurse called that morning about the high blood sugar. The son stated he was bothered no one called yet as he would have said to get very aggressive with treatment. The daughter-in-law reported she spoke to the SW about their concerns regarding communication and not getting notified and told to go to the ADON to find out what she knew.</p> <p>On 5/15/19 at 10:25 a.m., Staff A responded she worked as PRN only on weekends. Staff A stated she worked for the facility for longer than a year and floated around the facility assigned to different halls.</p>			

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	Staff A stated she did not recall the resident having pressure sores prior to going to the hospital. Staff A stated the resident had loose stools and around that time she had not been taking care of the resident. Staff A responded no one had told her before the hospitalization of any pressure areas. Staff A recalled the ARNP Wound Nurse talking to Staff P the day before. Staff A stated she did call the son after the wound assessment completed the day before and notified the son the wound nurse saw the resident. Staff A stated she thought she called the son around 2:35 p.m. on 5/14/19. Staff A said she spoke to the son about palliative care and handed the phone to a hospice nurse who frequented the facility to explain to the son better what hospice care was after telling the hospice nurse the family looking in to hospice care. Staff A stated the hospice nurse talked to the son for a while and then Staff A contacted the doctor. Staff A clarified she did not talk to the son about the debridement of the wound that occurred on 5/14/19 as she felt the wound nurse Staff P more appropriate to explain what was going on. Staff A said she told the son the wound doctor there to see the resident and measured the wound and treatments done. Staff A stated the progress notes would be where the staff document family notifications. Staff A responded she did not know for sure how long the resident had been declining, not responding, or opening eyes. Staff A commented the resident did open and close eyes before when feeding the week before and would say yes but no sentences used to communicate the day before.			

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	<p>On 5/15/19 at 10:35 a.m., Staff V, LPN, reported she only worked with Resident # 97 a couple of times since starting work for the facility on 4/23/19. Staff V reported what she knew of the resident was Resident # 97 slept a lot and family would come in and ask why the resident slept a lot and in the bed. Staff V stated one time the resident said no when had meals put to her mouth and pulled away. Staff V stated she knew the son was in the day before and upset that no one got a UA done on the resident when he had asked a few days prior but she heard the order had not been received.</p> <p>On 5/15/19 at 10:40 a.m., Staff Y, CNA, reported she was familiar with Resident # 97's cares and worked for the facility for 3 years. Staff Y said sometimes the resident only up once a week. She did not recall if the resident's pressure sore present prior to going to the hospital but knew it was there after her return from the hospital. Staff Y stated after being in the hospital, Resident # 97 declined. Staff Y stated the resident may drink and still took food when it was put up to her mouth. It had been a while that she kept her eyes closed while eating. Staff Y responded she did assist the resident one day to sit up on the edge of the bed but got no further because she was too weak. Staff Y could not recall the day or how long ago that attempt to get up occurred.</p> <p>On 5/15/19 at 10:50 a.m., Staff P responded she had not yet reached out to the family regarding the ARNP Wound Nurse's directive 5/14/19 to ask about how aggressive family wanted to get with treatment. Staff</p>			

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	P stated she had waited to receive the wound nurse's progress notes and orders which she just received via fax on 5/15/19. Staff P said she wanted to make sure she had all the orders and details to discuss with the family in order to answer any questions they may have. Staff P responded the resident had not been as declined the previous week. Staff P said after the resident got back from the hospital she noticed a decline. Staff P stated mostly the resident refused to get out of bed, just said no. Staff P commented times they could convince the resident to get out of bed and times she refused. Staff P responded they had been keeping the family notified of the decline. Staff P said the skin and wound assessments in the electronic record would contain documentation when the family and the doctor notified of changes if skin getting better. Staff P reported the ARNP Wound Nurse new to the facility and prior to her coming to do wound treatment, the facility communicated with the resident's primary doctor. Staff P stated prior to the resident going to the hospital 3/25/19, the resident already identified to have pressure sores caused by moisture associated skin damage related to incontinence of bowel. Staff P stated she felt the pressure sores got worse while the resident in the hospital. Staff P said her process for skins was the nurses called her for any critical wounds. She first observed the resident's wounds on 3/25/19. Staff P reported the resident assessed on 3/25/19 to have 4 areas; 1 blister on the buttock, 1 pressure in the right gluteal crease, 1 pressure in the left gluteal crease, and 1 pressure area on the sacral area. Staff P reported the blister and left, right gluteal pressures healed and only the sacral pressure sore remained.			

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	<p>Staff P provided picture documentation of her weekly assessments and said the sacral wound did not open up until 4/19/19. The review of the picture showed a lot of yellow slough present on 4/19/19. Staff P stated the staff performed skin checks on residents every shower day, 2 times a week and documented the checks in the electronic clinical record. Staff P commented the resident had not been compliant with diet and not wanting to get repositioned. Staff P stated the resident had been on a turn and reposition program, tracked for high risk potential for skin impairment, and they had protocols in place before the development of the pressure sores preventatively. Staff P stated the information also on the Kardex and staff aware as it had been on the care plan. Staff P stated they also talked in shift huddles to keep up to date on skin changes.</p> <p>On 5/15/19 at 11:10 a.m., Staff J, LPN, stated she had worked for the facility for 15 years and only worked on Resident # 97's hall when a medication aide assigned to pass medications there. Staff J stated she was familiar with the resident's pressure on her bottom and thought it happened suddenly. Staff J responded she was not sure how long the resident bed fast but she had not seen her out of bed for a while, could be a week or weeks. Staff J said she used to see the resident up and about but not seen recently.</p> <p>On 5/15/19 at 12:05 p.m., the Director of Nursing (DON) reported the facility recently updated their skin policies and procedures in April 2019.</p>			

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	<p>On 5/15/19 at 12:43 p.m. the family reported the hospital doctor confirmed the bone exposed in the wound, the wound bad, called it nasty, and would be admitted to complete more blood testing as well as discussing possible surgery to close the wound.</p> <p>On 5/15/19 at 2:25 p.m., the primary ARNP reported she saw the resident as the primary care physician but not following the pressure sores. The primary ARNP reported the facility told her the ARNP Wound Nurse started following residents for pressure sores. The primary ARNP said she routinely examined the resident every other month and previously aware the resident had a Stage 2 pressure. The primary ARNP said she received a call 4/30/19 to inform her the resident had an elevated blood sugar reading and let her know the resident not laying down. The primary ARNP reported the on-call contacted at the end of the previous week. The primary ARNP confirmed staff to notify her with condition changes and in the evenings the staff can call the office answering service to speak to the on-call doctor. The primary ARNP confirmed she spoke with the family and told the resident not getting up for 3 weeks. The primary ARNP said she had been in the facility the previous week and heard the resident in her room during cares and asked what was going on. The primary ARNP said staff told her the resident had not been getting up for a few days due to her bottom. The primary ARNP stated the resident historically refused to get out of her chair, refused to take food in room, and cycled between eating and not eating. The primary ARNP stated the resident played possum at times during her examinations. The</p>			

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	primary ARNP stated when she assessed the resident earlier in the day 5/15/19, she had to instruct the resident to speak up to let her know if she was sick and needed to go to the hospital. The primary ARNP said the resident answered her and said okay to go to hospital. The primary ARNP reported the resident sometimes yelled at her to leave her alone during examinations. The primary ARNP stated the facility had not made her aware the pressure sore opened or got worse after return from the hospital. The primary ARNP stated she is usually made aware of changes from the facility but she had not been made aware of this resident's changes in conditions. The primary ARNP stated she would have wanted updated about the wound deterioration, the resident not eating as well, and the resident not getting out of bed for 3 weeks. Discussion of the measurements documented on 3/25/19 and The primary ARNP responded the pressure areas could show up quickly within 10 to 12 hours in the elderly. The primary ARNP said she had been aware at that time in March the resident scooching in wheelchair, sliding down, and the facility got a bigger wheelchair. The primary ARNP stated the facility notified her on 3/23/19 the resident had 1 blood blister to her bottom that measured 6.0 cm by 6.0 cm, skin intact, raw, and resident turned side to side. The facility asked to be advised and a Duoderm treatment ordered and to change every 3 days. The primary ARNP stated after that she was not updated and then the resident went out to the hospital. The primary ARNP stated she was next notified in April the resident lowered to the floor and the staff asked if they could make the resident a hooyer transfer which she did			

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	<p>order. The primary ARNP stated if a wound progressed or got worse she would have wanted the wound center brought in. The primary ARNP stated there was a note on 5/10/19 from the on-call doctor the resident incontinent, refused to get out of bed, and the doctor advised to get a UA. The primary ARNP stated the UA documented as not collected till 5/13/19 and she knew of no reason why there should have been a delay in collecting the UA. The primary ARNP confirmed the delay in getting the UA may have changed the course of treatment decisions. The primary ARNP stated the bigger question she had that day when she assessed the resident was whether or not urine the issue or the wound. The primary ARNP said the urine results not horrific, the WBC 11 to 25,000, responded to the facility that afternoon, the results abnormal and would not treat with antibiotics but would take a look at the resident when she returned from the hospital. The primary ARNP stated the wound nurse debridement could have caused the blood sugars to elevate. The primary ARNP responded she was unaware that Staff A had the hospice nurse speak to the family the day before and said that would not be the proper technique for getting a hospice evaluation. The primary ARNP again stated she was not aware the pressure had gotten as big as it was. The primary ARNP stated there was no excuse for not getting the UA Friday. The primary ARNP reported March 2019 the last time she had seen the resident for a physical examination.</p> <p>On 5/15/19 at 4:36 p.m. Staff W, LPN, reported he worked in the facility for a year. Staff W stated he was</p>			

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	familiar with Resident # 97's care. Staff W stated since the resident returned from the hospital at the end of March, not get up from the bed. Staff W said therapy tried to work with the resident but it had been hard for them. Staff W stated when getting up, the resident became dead weight not want to do anything so she didn't want up. Staff W commented they had to bribe the resident with Diet Pepsi to try. Staff W responded the last time he recalled the resident out of bed, not that week or the week before. Staff W stated the thought the primary ARNP knew but then said wait, not sure if she knew. Staff W stated the son came to check on the resident and upset his mom not getting up, but he saw she wasn't cooperating. Staff W said the resident didn't want to do anything. The son wanted to get a UA test, a fax sent but he needed to wait for an okay. Staff W commented most times they had to wait 3 days to push fluids to wait to see if a resident complains before get UA; can't get UA have to push fluids first. Staff W stated the family requested it and he explained he needed to follow protocol first. Staff W confirmed if a doctor gave the order then they would need to follow the order. Staff W confirmed the son did want treatment for his mom as of 5/10/19 when he talked to him about it. Staff W reported on Saturday (5/11/19) the son's wife called again to ask about hospice option and not happy about it. Staff W stated he explained just because offered the option they didn't have to take it; said the wife wanted treatment for the resident and upset the UA test not done. Staff W said he informed the wife they had to wait for the fax to come back for an order. Staff W responded he did not call the on-call doctor after			

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	<p>speaking to the family; commented he waited for the fax to come back 5/13/19 for order for the UA. Staff W first recalled the resident having pressures before she went to the hospital (3/25/19). Staff W could not recall the sores or when they started but stated they were not open and on the sacral area. Staff W stated he thought he recalled the area looking like a red spot. Staff W recalled a treatment to Calmoseptine on it. Staff W recalled the treatment of putting Calmoseptine on the buttocks 3 times a day and responded he was not sure how he would not have seen the sores. Staff W said he did know of a blister the resident had in January 2019. Staff W confirmed before hospitalization the resident went to the bathroom, went to the dining room, but after came back, not wanting to do anything. Staff W could not recall if he ever notified the family or the primary ARNP about the resident's decline or change post hospital.</p> <p>On 5/15/19 at 5:19 p.m., Staff AA, Certified Medication Aide (CMA), worked for the facility for 3 years and familiar with Resident #97's cares. Staff AA responded she thought the resident had been in bed about 2 months. Staff AA said the resident had been up before the hospital and acknowledged the resident had declined a lot. Staff AA commented she seen the pressure sore the day before but did not recall if the sores present before the hospital. Staff AA stated prior to hospitalization the resident fed herself and now ate only a little bit.</p> <p>On 5/15/19 at 5:21 p.m., Staff X, CNA, reported she worked for 2 years at the facility and familiar with</p>			

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	<p>Resident # 97. Staff X responded staff got the resident up when she came back from the hospital for a couple of days but after that the bottom very bad so always made her lay down because of her bottom. Staff X stated sometimes they put the resident in her wheelchair, however, the resident still sat on her butt so they would lay her down in bed. Staff X recalled the resident used to stand up with walker to transfer, wouldn't stand up, so they began to use the hooyer.</p> <p>On 5/16/19 at 8:30 a.m. the DON confirmed the photos from the skin assessments on 3/25/19 showed 4 skin areas caused by pressure.</p> <p>In a follow-on 5/16/19 at 9:18 a.m., Resident # 97's family reported the resident remained at the hospital and the family would be pursuing comfort cares. The family stated the doctors said there would be a high risk for the resident's kidneys to go into failure and need dialysis if they tried to attempt a surgical fix for the pressure area. The family stated the resident more alert that day and voiced being in pain, therefore, they just wanted to pursue comfort cares.</p> <p>The facility reported on 5/16/19 at 9:30 a.m. the previous electronic software system utilized January 2019 thru the beginning of March 2019 lacked documentation of any skin assessments.</p> <p>On 5/16/19 at 12:30 p.m., Staff B, CNA, recalled her witness statement from 3/22/19 re: Staff F, LPN, refusing to help clean up Resident # 97 when she had incontinent stools. Staff B stated she was literally</p>			

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	<p>brand new to the facility and could not recall specifics about how the resident's bottom looked. Staff B reported she and another aide who was pregnant assisted the resident to try to stand to get cleaned. Staff B said she recently had surgery so neither aide felt she should do heavy lifting and the resident a bigger lady. Staff B stated when they stood the resident, Resident # 97 slipped in the poop because it was loose stool that just kept falling out of her. The resident had trouble standing and not really bearing weight Staff B stated they couldn't get the loose stools under control and had been in the resident's room multiple times. Staff B stated they asked the ADON for help and she made Staff F go in the room to help. Staff B said Staff F entered the room with the resident's insulin shot, gave it, commented his job done, he's not an aide, and left the room. Staff F reported she told the ADON again and she made Staff F go back in but as soon as she left, he left again stating he was out of there.</p> <p>On 5/16/19 at 12:40 p.m., the DON presented a timeline of the resident's pressure sore measurements and assessments. The DON pointed out the facility skin assessments documented the primary ARNP saw the resident on 4/10/19 and 4/15/19 and she wrote new orders each time. The DON confirmed the ARNP did not physically examine the resident. The DON said Staff P showed the ARNP the picture of the wound and the ARNP gave new orders. The DON stated the ARNP Wound Nurse first saw the resident on 4/22/19. The DON stated the staff did not get the UA on 5/10/19</p>			

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	<p>because they faxed out for the UA 5/10/19 and the ARNP did not answer back on the fax until 5/13/19.</p> <p>2. The MDS assessment dated 2/17/19 for Resident #9 identified a BIMS score of 00 without signs/symptoms of delirium. A score of 00 indicated severe cognitive impairment. The resident required the extensive physical assistance of 1 person for bed mobility, totally dependent upon 2 persons for transfers, and the resident did not walk in room or corridor during the 7 day look-back period. The MDS coded a functional limitation in range of motion on 1 side of the body, both upper and lower extremity. The MDS documented diagnoses Peripheral Vascular Disease (PVD), non-Alzheimer's dementia, hemiparesis/hemiplegia (paralysis/weakness on 1 side of the body), and generalized muscle weakness. The resident at risk of pressure ulcers/injuries but did not have any unhealed pressure sores.</p> <p>The care plan revealed the following:</p> <p>a. On 12/5/18, a focus area identified a self-care deficit due to diagnoses of dementia, hemiparesis/hemiplegia, muscle weakness, and unaware of needed cares to maintain quality of life. The care plan identified a potential for altered skin integrity due to incontinent of bowel and bladder, the resident preferred to stay in bed most of the day, and the resident needed assist with repositioning. The care plan approaches included: nurse will do twice weekly skin assessments and notify doctor as needed;</p>			

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	<p>treat skin issues as ordered; alternating air mattress; avoid skin to skin contact with pillows; skin assessment daily; lotion to BLE (bilateral lower extremity) and BUE (bilateral upper extremity) 2 times a day; and encourage frequent turns and reposition.</p> <p>b. On 3/19/19, a focus area identified 2 Stage II pressure areas at the right knee and left knee, 1 Stage III pressure area on the left shin, and 1 Unstageable pressure area on the dorsal right foot related to contracture, decreased bed mobility, and poor nutrition. The care plan interventions included: apply pillows between BLE to alleviate pressure; encourage good nutrition and hydration in order to promote healthier skin; frequent reposition and turns; keep skin clean and dry, use lotion on very scaly skin; and treatment of pressure areas per physician order.</p> <p>c. On 3/20/19, the care plan directed staff to avoid skin to skin contact by placing pillows as needed, keep pillow between knees in bed, and place body pillow along the wall in bed.</p> <p>d. On 4/1/19, staff directed to administer NIP (nutritional supplement).</p> <p>e. On 4/11/19, a new focus area identified a Stage II pressure sore at the left shin related to contracture and poor nutrition. The care plan interventions initiated included: apply pillows between BLE to alleviate pressure; NIP supplement; apply treatment as ordered; frequent repositioning and turns; weekly treatment documentation to include measurement of each area of skin cellulitis (inflammation of the skin) width, length, color and exudate (drainage) and any other notable changes or observations; and record observations of the site with wound dressing change.</p>			

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	<p>f. On 4/22/19 identified a Stage III pressure sore at the left great big toe related to contracture. The care plan interventions initiated included: NIP supplement; apply treatment as ordered; and encourage good nutrition and hydration in order to promote healthier skin.</p> <p>g. On 5/13/19 an intervention for the wound doctor to assess every week.</p> <p>The Progress Notes revealed the following:</p> <p>a. On 3/7/19 at 12:12 p.m. a Restorative Program Note related to March Contracture Charting. The entry recorded limited range of motion in the following: right wrist extension 30 degrees flexion to 60 degrees; right shoulder abduction 70 degrees; right elbow flexion 90 degrees, extension 50 degrees; right knee extension 60 degrees; and right hip abduction 12 degrees.</p> <p>b. On 3/19/19 at 4:47 a.m. resident assisted by 2 persons to change position and 2 blisters noted where the resident's legs laid together to the medial aspect of the left calf and right inner knee. Staff placed a pillow between the legs for abduction (movement of a limb away from the midline of the body) and a fax notification sent to the primary ARNP (Advanced Registered Nurse Practitioner).</p> <p>At 12:47 p.m. skin follow up, blister to knee and calf, and pillow in place as an intervention.</p> <p>At 2:26 p.m. a Stage II pressure sore at the right knee measured 1.3 cm (centimeters) by 0.9 cm, the left knee measured 1.8 cm by 1.9 cm with 100% granulation tissue (new growth of connective tissue associated with wound healing), and a Stage II pressure sore of a fluid filled blister at the left shin measured 2.5 cm by 5.0 cm. The predisposing factors</p>			

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	<p>mostly likely to contribute to the development of pressure sores: the resident had contractures on the BLE and hips; the resident unable to independently change position while in bed; poor nutrition intake as the resident only liked to consume house supplement for most meals; and the resident incontinent for bowel and bladder. The entry documented prior to the pressure sore development the resident identified as a high risk for pressure sores and preventative measures in place included: monitored pre-albumin (protein) level every 3 months (which was low at 18.8 mg/dl (milligrams per deciliter, low levels an indicator for malnutrition); administered prosource no -carb (supplement) 30 ml (milliliter) daily; restorative nursing program; air mattress; frequent reposition and turns thru the shift, and pillows between knees to alleviate pressure.</p> <p>c. On 3/20/19 at 1:00 a.m. the CNA (Certified Nurse Aide) called the nurse to the resident's room and the resident was turned toward the wall with lateral left knee against wall and a 2.0 cm by 2.0 cm abrasion present. The note recorded if staff positioned the resident on his right side he would reposition self to left side. A body pillow was placed against the wall to prevent recurrence and a fax sent to the ARNP to request treatments. The blistered areas to the medial aspect (inside) of left calf and left knee superficial and open to air.</p> <p>At 1:42 p.m. the (primary) ARNP in the facility and new orders received for Duoderm (a protective bandage) on bilateral knees to be changed every 5 days, betadine on the blister located on shin, and Decubivite (multivitamin) for skin break down.</p>			

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	<p>d. On 3/26/19 at 9:14 a.m. iodine to the blister on the left shin discontinued and a new order received for Duoderm to the left shin and bilateral knees, change every 3 days.</p> <p>e. On 4/20/19 at 3:01 p.m. a verbal okay received for the resident to be seen by the wound doctor.</p> <p>f. On 5/1/19 at 11:38 p.m. resident was seen by the ARNP Wound Nurse and a new order received to apply foam border dressing to the left lower extremity, change twice a week and as needed.</p> <p>g. On 5/6/19 at 10:38 p.m. resident assist of 1 with ADL's (Activities of Daily Living), assist of 2 for transfers via hooyer (mechanical lift), and the resident spent most of the time in bed. The entry documented the resident did use a wheelchair propelled by staff for mobility.</p> <p>h. On 5/12/19 at 9:32 p.m., resident pleasant and cooperative with cares, unable to make needs known, staff needed to anticipate his needs, and the resident stayed in bed at all times.</p> <p>i. On 5/15/19 at 8:55 a.m. a Long Term Evaluation completed. The notes recorded an ability to move left upper extremity, impairment in ROM (range of motion) on one side of upper body (right), and impairment in ROM on both sides of lower body.</p> <p>The Facility Skin & Wound Evaluations revealed the following:</p> <p><u>Pressure sore Right Knee</u></p> <p>a. On 3/19/19 Stage II pressure area measured 1.3 cm by 0.9 cm. The wound bed was 100% granulation tissue with light serosanguineous exudate (bloody,</p>			

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	<p>watery fluid drainage). The pressure area was in house required.</p> <p>b. On 3/25/19 area measured 3.0 cm by 2.6 cm with 50% epithelial tissue (thin tissues that cover all the exposed surfaces of the body) and 50% slough (a layer or mass of dead tissue separated from surrounding living tissue in a wound). It had light seropurulent exudate (drainage often a sign of infection), the peri-wound (around the wound) had non-attached (edges appear as a cliff). The treatment was povidone iodine with hydrocolloid dressing (a non-breathable dressing that adheres to the skin so no separate taping is needed). The wound bed improved with no signs of infection, continue to put pillow between knees to alleviate pressure, apply Duoderm to wound</p> <p>c. On 4/1/19 area measured 2.2 cm by 3.1 cm with 90% epithelial tissue and 10% slough. It had light serosanguineous exudate, peri-wound had epithelialization.</p> <p>d. On 4/9/19 area measured, 0.6 cm by 0.6 cm with 100% epithelial tissue.</p> <p>e. On 4/15/19 area measured 1.4 cm by 0.1 cm, resolved. Will continue to monitor for 2 weeks.</p> <p>f. On 4/22/19 noted resolved, will continue to monitor in case it reopened</p> <p>g. On 4/29/19 area measured 0.7 cm by 0.5 cm with 100% granulation tissue. Noted on 5/1/19 the resident was seen by ARNP Wound Nurse, for a Stage III pressure area. The area measured 0.8 by 1.1 cm by 0.1 cm with 100% hypergranulation (formation of excessive granulation tissue) It had moderate thin serous exudate (watery fluid drainage). Staff were</p>			

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	<p>directed to discontinue current treatment, start cleanser of choice, apply foam border dressing, change twice weekly and as needed.</p> <p><u>Pressure sore Left Knee</u></p> <p>a. On 3/19/19 a Stage II pressure area measured 1.8 cm by 1.9 cm with 100% granulation tissue. It had light serosanguineous exudate. The pressure area was in house aquired.</p> <p>b. On 4/29/19 the area was noted resolved, wound healed.</p> <p><u>Pressure sore Left Shin</u></p> <p>a. On 3/19/19 - no assessment</p> <p>b. On 3/25/19 documented 1 week old pressure area. No stage status assessed. The area measured 4.9 cm by 2.4 cm with 50% granulation tissue and 50% slough. It had light seropurulent exudate. Noted blister at the left shin broke open. A fax sent to primary ARNP to change the betadine treatment to apply Duoderm</p> <p>c. On 4/1/19 area measured 1.8 cm by 3.7 cm with 10% epithelial tissue and 90% slough. Area had light serosanguineous exudate, the peri-wound had epithelialization.</p> <p>d. On 4/9/19 area measured 3.3 cm by 1.7 cm with 40% epithelial tissue and 60% slough. Area had light serosanguineous exudate.</p> <p>e. On 4/15/19 area marked as Stage II. It measured 3.0 cm by 1.4 cm with 20% epithelial tissue and 80% slough. The wound had light purulent exudate (type of liquid that oozes from a wound that can be a sign of infection). Documentation noted initially the area a Stage II blister that progressed to Stage III. Apply</p>			

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	<p>Duoderm to site change every 3 days and continue to apply pillow in between legs to alleviate pressure.</p> <p>f. On 4/22/19 area measured 1.7 cm by 2.3 cm with 80% granulation and 20% slough. The area had moderate purulent exudate.</p> <p>g. On 4/29/19 area measured 1.5 cm by 2.3 cm with 100% granulation tissue. It had light sanguineous (bloody) exudate. Referred to wound care specialist for evaluation and treatment.</p> <p>Documented on 5/1/19 Resident #9 was seen by ARNP Wound Nurse. A Stage III area measured 2.8 cm by 1.9 cm by 0.1 cm with 100% hypergranulation. The area had moderate thin serous exudate.</p> <p>Discontinue current treatment and start cleanse with cleanser of choice, apply foam border dressing, change twice a week and as needed.</p> <p>h. On 5/9/19 area measured 2.0 cm by 2.9 cm with 100% hypergranulation tissue. The area had moderate serosanguineous exudate. The resident was seen by wound specialist on 5/7/19, continue to cleanse with cleanser of choice, apply foam dressing twice weekly and as needed</p> <p><u>Pressure sore Right Foot, 5th digit lateral side</u> On 5/7/19 documented an Unstageable pressure sore on dorsum right foot. The area measured 1.5 cm by 1.3 cm with 100% granulation tissue. The area had serosanguineous exudate. The pressure area was in house acquired.</p> <p><u>Pressure sore Left Foot, medial side</u> The clinical record lacked documentation of skin assessments for the pressure sore on the left medial</p>			

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	<p>foot first identified on the care plan 4/22/19 and by the ARNP Wound Nurse during her visit on 5/1/19.</p> <p>Observations revealed the following:</p> <p>a. On 5/13/19 at 12:45 p.m. Resident # 9 laid in bed in room with eyes closed. Staff Y, CNA, reported Resident #9 typically did not come out of his room for lunch; said they take it in to him and sometimes he refuses.</p> <p>b. On 5/14/19 at 8:55 a.m. Resident # 9 rested in bed.</p> <p>c. On 5/14/19 at 11:21 a.m. the room lights on and family present to visit with resident at bedside.</p> <p>At 12:10 p.m. the resident's family gone. Resident # 9 remained in bed.</p> <p>At 1:14 p.m. the ARNP Wound Nurse prepared to assess the resident's pressure sores with Staff P, Registered Nurse (RN)/facility wound nurse. Noted pillows were between the residents legs. The ARNP Wound Nurse exposed the pressure sore on the left medial foot below the great toe and measured 1.5 cm by 1.1 cm with purulent drainage present. The ARNP Wound Nurse then exposed the pressure sore on the left shin, measured 2.5 cm by 1.8 cm, and stated the wound with all red granulation tissue, area improved. The ARNP Wound Nurse exposed the pressure area on the right inner knee and measured the area. The ARNP Wound Nurse then cultured the area on the left medial foot to test for infection. Staff P cleansed the areas and the ARNP Wound Nurse assisted to help hold the resident's legs apart. The ARNP Wound Nurse stated because the facility said the resident crosses his legs the areas came from pressure.</p> <p>d. On 5/15/19 at 4:36 p.m. Resident # 9 laid in bed.</p>			

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	<p>Physician orders, primary ARNP visit, ARNP Wound Nurse visits, and Treatment Administration Records revealed the following:</p> <p>The Fax Order Request sheet dated 3/25/19 documented the resident was seen by the (facility) wound nurse. A blister to left shin had opened, and request for change of treatment to Duoderm to left shin and to bilateral knees approved.</p> <p>The primary ARNP Routine Visit progress notes dated 3/27/19 included: skin review positive for wound on right inner knee and left calf; exhibits deformity/contracture of right arm, bilateral lower extremities; and pressure ulcers on bilateral knees due to contractures. The report documented the plan to continue Duoderm and pillow between the knees to offload pressure.</p> <p>The ARNP Wound Nurse, Wound Treatment Plan dated 5/1/19, documented the resident was seen to assess multiple areas of concern. The resident very contracted, lying in the fetal position, and laid on left side toward the wall. Staff attempt to keep a pillow between the knees however he frequently removed it. When staff positioned the resident on his right side he repositioned himself to the left side.</p> <p><u>The Skin Physical Examination section documented the following:</u></p> <p>a. Unstageable pressure ulcer right lateral foot, 5th digit; measured 0.8 cm by 0.7 cm by 0.1 cm with 100% eschar (presence of dead tissue). Unable to assess wound bed.</p>			

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	<p>b. Unstageable pressure ulcer to the medial; measured 1.2 cm by 1.2 cm by 0.1 cm with 100% stable eschar. Slightly boggy wound bed.</p> <p>c. left knee, trauma resurfaced -intact</p> <p>d. Stage III pressure ulcer to medial right knee. Area measured 0.8 cm by 1.1 cm by 0.1 cm with hypergranulated wound bed and moderate, thin, serous drainage.</p> <p>e. Stage III pressure ulcer to LLE (left lower extremity). Area measured 2.8 cm by 1.9 cm by 0.1 cm with hypergranulated wound bed and moderate, thin, serous drainage.</p> <p><u>Wound Treatment Plan section documented the following:</u></p> <p>a. right lateral foot, 5th digit - discontinue current treatment and cleanse with cleanser of choice, apply skin prep daily</p> <p>b. left medial foot - discontinue current treatment and cleanse with cleanser of choice, apply skin prep daily</p> <p>c. left knee - discontinue current treatment</p> <p>d. right medial knee- discontinue current treatment and cleanse with cleanser of choice, apply foam border dressing, change dressing twice a week and as needed</p> <p>e. left lower extremity - discontinue current treatment and cleanse with cleanser of choice, apply foam border dressing, change dressing twice a week and as needed</p> <p>The ARNP Wound Nurse Wound Treatment Plan dated 5/7/19 documented the resident was seen to assess multiple areas of concern.</p>			

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	<p><u>The Skin Physical Examination section documented the following:</u></p> <p>a. Location - right foot, 5th digit, lateral; Etiology - pressure ulcer, unstageable; Measurement - 0.0 cm by 0.0 cm by 0.0 cm; Wound status - resurfaced; Tissue - 100% epithelial; Wound bed - epithelialized</p> <p>b. Location - left foot, medial; Etiology - pressure ulcer, unstageable; Measurement - 1.2 cm by 1.1 cm by 0.1 cm; Wound status - not healed; Tissue - 100% red granulation; Wound bed - granulation; Exudate - moderate, thin, serosanguineous</p> <p>c. Location - right knee, medial; Etiology - pressure ulcer, Stage III; Measurement - 0.3 cm by 0.6 cm by 0.1 cm; Wound status - improved; Tissue - 100% hypergranulation; Wound bed - hypergranulation; Exudate - moderate, thin, serous</p> <p>d. Location - left lower extremity; Etiology - pressure ulcer, Stage III; Measurement - 2.9 cm by 2.0 cm by 0.1 cm; Wound status - not healed; Tissue - 100% hypergranulation; Wound bed - hypergranulation; Exudate - moderate, thin, serous</p> <p><u>Procedures/Services section documented:</u> Chemical Cauterization - silver nitrate to hypergranulation tissue to left lower extremity wound bed</p> <p><u>Wound Treatment Plan section documented the following:</u></p> <p>a. right foot, 5th digit, lateral - discontinue current treatment and start cleanse with cleanser of choice, skin prep daily x 14 days then discontinue</p>			

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	<p>b. left foot, medial - discontinue current treatment and start cleanse with cleanser of choice, apply foam border dressing, change twice weekly and as needed</p> <p>c. right knee, medial - continue current treatment of cleanser of choice, apply foam border dressing, change twice a week and as needed</p> <p>e. left lower extremity - continue current treatment of cleanser of choice, apply foam border dressing, change twice a week and as needed</p> <p>The May 2019 Treatment Administration Record reflected the facility failed to discontinue treatment to the left knee as ordered on 5/1/19.</p> <p>The TAR documented the treatment of cleanse the left knee daily with cleanser of choice and apply skin prep daily; completed 5/4/19 thru 5/16/19.</p> <p>The TAR documented the treatment of foam dressing bordered pad, apply to left knee topically in the morning every 3 days for pressure ulcer; completed 5/2/19 and discontinued 5/3/19.</p> <p>The TAR lacked an entry to indicate the treatment to the left foot completed as ordered on 5/1/19 or on 5/7/19.</p> <p>Staff Interviews: On 5/15/19 at 10:50 a.m., Staff P stated she believed 3 pressure areas occurred at the same time 3/19/19; the left and right knees and left shin. Staff P said she thought if the care plan had a different date it would have been an input error as they switched electronic software systems in March 2019.</p>			

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	<p>On 5/15/19 at 5:30 p.m., Staff P acknowledged the resident's contractures were present for a long time. Staff P acknowledged the care plan entry 2/20/19 of a pillow between the legs a preventative intervention to protect against pressure sores.</p> <p>On 5/16/19 at 10:33 a.m., the Director of Nursing, (DON), acknowledged the resident's pressure sores on his legs would be consider avoidable. The DON commented she would look in the clinical record for documentation of any refusals to place a pillow between his knees as the resident could be non-compliant.</p> <p>The clinical record lacked documentation of the resident's refusals to keep a pillow between his legs or if refused, attempts at other interventions to keep legs separated.</p>			
FACILITY RESPONSE				