Citation Num	ber: #5359				Date: Aug	ust 26, 2021
Facility Name Oakview Nurs	: ing and Rehabilitation		Survey		4.0 4.0	0004
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58.19(2)j	 residents. The resident shall provide, as appropring services under qualified nurses with an these rules: 58.19(2) Medication and <i>j</i>. Provision of accurate intervention for all resid adverse symptoms whice mental, emotional, or phereical adverse symptoms whice mental adverse symptoms and staff document wound care to report signs of infection of 5 sampled (Resident # 76/20 and had a Brief I (BIMS) score of "11" incomplete advection. The MDS docemental advection. The MDS docemental advection. 	cillary coverage as set forth in d treatment. assessment and timely ents who have an onset of ch represent a change in hysical condition. (I, II, III) d review, policy review, hospital interview, the facility failed to reatment, assess wounds, and timely for a surgical wound in 1 #5) with wounds. This resulted ospitalized for surgical nd. The facility reported a (MDS) dated 7/15/20 to admitted to the facility on nterview for Mental Status dicating moderately impaired		\$8, 75 (Colle		Upon Receipt

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	 wounds receiving surgio The Care Plan document incisions/wounds to the foot. The Care Plan data to: a. Administer antibiotic is b. Assess the surgical wwith healing. c. Monitor and drain Jaco ordered. d. Monitor for signs and redness, swelling, warm provider if present. e. Treatment as ordered. Hospital Discharge Sum directed wound care: a. Abdominal incision: keintact 	The resident had surgical cal wound care by the facility. Inted Resident #5 had surgical abdomen, right thigh, and left ted 7/17/20 directed the staff as ordered. Wounds weekly for progress ckson Pratt (JP) drain as symptoms of infection: pain, oth, loss of function. Notify				

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c. Left ankle: to remain covered in xeroform gauze In addition, it directed Resident #5 to take Keflex (an oral antibiotic) for 7 days. It did not address treatment for the right thigh skin graft.
A Progress Note dated 7/8/20 documented Resident #5 had the following surgical incisions/wounds:
a. Midline surgical incision measured 31centimeters (cm) by 0.3 cm.
b. Hardened area right of midline incision measured 10 cm in diameter.
c. Unable to assess the top left foot.
d. Skin graft to right thigh measured 15 cm by 9 cm.
e. Hardened area around Jackson Pratt drain measured 5 cm by 7 cm.
Review of the Skin Condition Record sheets revealed the facility failed to measure the surgical sites/wounds from July 8, 2020 to July 20, 2020. The sheets revealed the following measurements:

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	 by 5 cm (increased in w b. The hardened right m incision on 7/8/20 meass 7/20/20 measured 17 cr since admit). c. The top left foot surging assess. d. The right thigh skin g by 9 cm. e. The hardened area a site measured 5 cm by the area measured 5 cm by the area measured 5 cm tissue and serosanguing The facility's Order Sum dated: On 7/8/20 for cep 7/15/20. a. On 7/8/20, Cephalexi b. On 7/15/20, Complete Basic Metabolic Panel (c. On 7/17/20, remove the series of the se	hidline abdomen surgical bured 10 cm in diameter. On m by 12 cm (increased in size cal site on 7/8/20 unable to raft on 7/8/20 measured 15 cm round the Jackson Pratt drain 7 cm on 7/8/20. On 7/20/20 n by x 3 cm with epithelial eous drainage mary Report indicated orders bhalexin (generic Keflex) until in (generic Keflex) until 7/15/20. e Blood Count (CBC) and				

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A Nursing Home Documentation Sheet revealed Resident #5's Primary Care Provider saw her for a routine visit on 7/15/20. The provider noted a midline (abdominal) dressing with a drain, a compression dressing on the left ankle, and healing graft. The provider ordered a CBC and BMP for the following week and did not note any reports of, or concerns for, infection.		
The facility's Order Summary Report failed to document any treatment orders for the right thigh skin graft. It also failed to address the abdominal incision treatment until 7/20/20 when orders were added:		
a. Gauze pad over JP removal site twice daily		
b. Abdominal (gauze) pad twice daily to midline abdominal incision		
c. Silvadene cream (topical antibiotic) to abdominal incision twice daily		
The Treatment Administration Record (TAR) showed no treatment orders for the right thigh skin graft site and no treatment orders for the abdominal incision until 7/20/20.		
The Medication Administration Record (MAR) showed no treatment orders for the right thigh skin graft site and no treatment orders for the abdominal incision.		
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 Progress Note entries revealed nurse documentation: a. On 7/15/20 at 9:57 PM: Firm red, non-warm area mid right side of abdominal dressing. Distal end of dressing loose with foul smell. Reinforced with opsite (adhesive) dressing. Resident complaining of intermittent right lower abdominal discomfort b. On 7/16/20 at 5:15 AM: Resident complained of intermittent right lower abdominal discomfort. Pain medication given with good results 			
c. On 7/17/20 at 5:42 AM: Resident complained of intermittent right lower abdominal discomfort. Pain medication given with good results			
d. On 7/17/20 at 10:32 PM: Has abdominal incision that is covered, a skin graft site- changed dressing on it, and changed dressing to left foot. Emptied 5 mL of putrid smelling brown liquid drainage from JP drain in abdomen.			
e. On 7/18/20 at 9:30 PM: Abdominal dressing changed. Had foul smelling drainage. Area cleansed with sterile water, telfa (not adherent) and abdominal (absorbent) dressings applied.			
f. On 7/19/20 at 9:28 PM: Abdominal dressing changed using telfa and abdominal dressings. Slightly foul odor. Scant amount of brownish yellow drainage.			Page 6 of 1

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g. On 7/20/20 at 2:37 PM: JP drain removed with a 5 x 3 cm incision underneath and mucous-like drainage. Midline abdominal incision measuring 27×5 cm with surrounding skin a deep red color. Area oozing with a very foul odor. The bottom of the incision looks at if		
dehiscing and becoming necrotic (tissue death). The hardened area seems to be spreading, measuring 17 x 12 cm. Specialty physician and local nurse practitioner updated.		
h. On 7/20/20 at 3:14 PM: New orders received for abdominal pads over the abdominal incision.		
i. On 7/20/20 at 3:51 PM: New orders received for silvadene cream to the abdominal incision and an appointment on 7/21/20 at the clinic.		
j. On 7/20/20 at 5:33 PM: Facility set up ambulance transfer as ordered by Advanced Registered Nurse Practitioner (ARNP) as medically necessary for transport to 7/21/20 appointment.		
The Clinical Record lacked documentation of the appearance of the abdominal incision from 7/8/20 until 7/20/20 and a lack of Physician notification of the odorous drainage from the abdominal incision from 7/15/20 until 7/20/20.		
A Phone Message/Call document dated 7/21/20 from Advanced Registered Nurse Practitioner (ARNP) to local Physician stated the facility called her (ARNP) on		

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	 open area with green, for when removing the JP of showed a white blood of the wound infection. A Plastic Surgery Note of Resident #5 presented to follow up. Resident #5 extremity reconstruction and split thickness skin Surgery Nurse spoke to Jackson Pratt drainage placed to the facility on reported areas of necrostabdominal incision. Resident Resident	ent's wound having a small pul-smelling, mucus present drain. The resident's labs ell (WBC) of 14.9, likely from dated 7/21/20 documented to the clinic for post-operative had a status of post left lower with free retus abdominis flap graft on 6/2/9/20. Plastic facility on 7/17/20 to discuss outputs. A follow up call 7/20/20, at which time a Nurse sis to Resident #5's midline sident #5 presented to clinic tissue necrosis to the midline				

A Discharge Summary from the hospital noted an admission date of 7/21 20 and a discharge date of 8/4/20. Resident #5 admitted from the clinic for abdominal wound dehiscence and infection. The resident underwent wound debridement in the operating room on 7/22/20 and 7/30/20 and at bedside on 8/3/20. Treatment included a wound vac (negative pressure wound treatment) and intravenous (IV) and oral antibiotics.

The Protocol for Skin Care policy dated 9/05 directed the following:

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a. Visual assessment with every dressing change, documented assessment at least weekly.		
b. Documented assessment includes: size in centimeters, depth, condition of surrounding skin, presence of drainage, odor, amount, condition of wound bed, current treatment and response, watching for symptoms of wound infection (foul-smelling drainage, inflammation of tissue around wound, fever), and medical intervention if the wound is infected (notification of doctor, progress note by physician and treatment order from physician).		
On 8/9/21 at 1:55 p.m., Staff A (Registered Nurse) stated the nurses' measure and assess the wounds on Tuesdays or Wednesdays, half each day split up between the morning and evening shifts.		
On 8/10/21 at 11:05 a.m., the MDS Coordinator reported wound treatment orders are normally on the TAR, occasionally on the MAR. Signs of infection include redness, drainage, smell, and an increase in size of a wound. Staff should report any of these symptoms to the provider and follow-up within a day if no response.		
On 8/10/21 at 12:20 p.m., Staff B (Licensed Practical Nurse) reported wound treatment orders are in the electronic health record on the MAR or TAR. Signs of wound infection include swelling, redness, tenderness, area warm to the touch, or the presence of pus. Staff		Page 9 of 1

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	 should report these symptoms to a provider right away so the wound does not get worse. On 8/11/21 at 4:30 p.m., The Director of Nursing (DON) stated nurses are expected to measure wounds and document the assessment every 7 days. If the wounds worsen, staff should notify the doctor and request new orders. Review of the In-Service Attendance Sheets dated 7/22/20 at 1:00 p.m., 2:00 p.m., and 3:00 p.m. revealed the Director of Nurses Provided staff education on the facility protocol for skin assessments which included continuous skin observations by direct care staff, reporting areas to the nurse, addressing skin areas with daily skilled charting, what to do if a new skin area develops, what to do if an area worsens, when to notify the Physician and Dietitian, what to do when an area heals, and not to apply a bandage without a Physician's order unless used to control bleeding or further injury until an order is received 					

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