

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345184</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CITADEL ELIZABETH CITY LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 SOUTH HALSTEAD BOULEVARD</b> <b>ELIZABETH CITY, NC 27909</b>		
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F 000	INITIAL COMMENTS  The survey team entered the facility on 8/20/20 to conduct a complaint investigation and exited on 8/25/20. Additional information was obtained on 8/26/20 - 8/27/20 and 9/2/20. Therefore, the exit date was changed to 9/2/20. Two of the five allegations were substantiated.	F 000			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.  §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		9/30/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/14/2020

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

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F 583	<p>Continued From page 1</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and text message documentation the facility failed to provide privacy and confidentiality by sending unencrypted text messages with personal health information for one (Resident #1) of one resident reviewed for privacy of health information. Finding included:</p> <p>Documentation in the admission Medicare 5-day minimum data set assessment dated 7/6/20 revealed Resident #1 was severely cognitively impaired.</p> <p>Documentation in a 7/20/20 wound care follow-up progress note written by a nurse practitioner revealed Resident #1 had acquired pressure ulcers on her left heel, right heel, right medial foot, right medial ankle, right buttock, and left buttock.</p> <p>A phone interview was conducted on 8/26/20 at 9:57 AM with Nurse #1. Nurse #1 stated that she notified the physician for Resident #1 on 7/20/20 with a phone call that the pressure ulcers on Resident #1 were getting worse.</p> <p>The facility provided screen shots of text message communication dated 7/20/20 at 2:26 PM from the phone of Nurse #1 and the physician for Resident #1 as evidence of the communication regarding the resident's health.</p>	F 583	<p>F Tag 583</p> <p>Problem: The facility failed to provide privacy and confidentiality by sending unencrypted text messages with personal health information for one (Resident #1) of one resident reviewed for privacy health information:</p> <p>How the issue will be resolved for the resident:</p> <p>Resident #1 has expired. The text message was deleted from Nurse #1's cell phone. Resident #1's family has been notified of the unencrypted text message. As corrective action for HIPAA violations must include employee sanctions and this is a first known offense, Nurse #1 has been re-educated in accordance with the facility's company policy. The company policy states that "unless directly related to the performance of a task identified in your job description, confidential information may not be copied, sent (including, but not limited to email or text) or discussed with anyone inside or outside the Company, or used for any other purpose." The medical director submitted his resignation on 9/1/2020.</p> <p>Completion date: 9/15/2020</p> <p>DON/designee</p> <p>How will other residents at risk be identified:</p> <p>The DON/designee conducted a</p>		

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F 583	<p>Continued From page 2</p> <p>Documentation in the text message communication dated 7/20/20 at 2:26 PM revealed Nurse #1 wrote, "[Resident #1] wounds are declining. She [now] has DTI (deep tissue injury) to bilateral heels and right buttock. Stage 2 to left buttock. Do you think it would help to do ABI (ankle brachial index) study?" The screen shot indicated Nurse #1 subsequently sent another text, "[Resident #1] ABI study?" The text message response from the physician stated, "What ABI study?" The text message response from Nurse #1 stated, "Should we order one for [Resident #1]? Her wounds are deterioration. DTI bilateral heels, DTI right buttock, Stage 2 left buttock." The text message response from the physician stated, "Sure can. Buttocks aren't vascular. And heels usually aren't either." The text message response from Nurse #1 stated, "Ok well I won't bother if you think it's not necessary. We are trying to order [an] air mattress for her and will start supplements and vitamins. The wound nurse came today for her weekly assessment." The physician responded in text, "Ok. Gotcha."</p> <p>There was no documentation in the electronic medical record for Resident #1 regarding communication Nurse #1 had with the physician on 7/20/20.</p> <p>An additional phone interview was conducted with Nurse #1 and the Director of Nursing on 8/27/20 at 10:03 AM. Nurse #1 indicated on 7/20/20 she had both a verbal conversation on the phone and a text message conversation with the physician for Resident #1. Nurse #1 acknowledged she did not put any documentation in the medical record regarding the telephone conversation or the text message conversation she had with the physician</p>	F 583	<p>documented interview of Nurse #1 to identify any other residents who might be affected by the deficient practice. Based on this interview, the DON/designee was unable to identify any other notifications sent by non-encrypted text message that contained identifiable PHI. The DON also conducted documented interviews of other licensed nursing staff and was unable to identify any other notifications sent via non-encrypted test message that contained identifiable PHI.</p> <p>Completion date: 9/18/2020 DON</p> <p>What systematic changes will be put into place to prevent the problem from recurring?</p> <ol style="list-style-type: none"> <li>1. The facility will educate the facility staff regarding the presence of a HIPAA Compliance, Privacy, and Security Officer. Completion date 9/22/20 DON/SDC/designee</li> <li>2. The administrator, HIPAA Compliance, Privacy, and Security Officer, and/or designee will complete a HIPAA risk assessment to self-evaluate the facility's compliance program. This risk assessment includes evaluation of the following: <ol style="list-style-type: none"> <li>a. Completion of the following six annual audits/assessments taken place: security risk assessment, privacy standards audit, HITECH Subtitle D Privacy Audit, Security Standards Audit, Asset and Device Audit, and Physical Site Audit.</li> <li>b. Identification of any gaps uncovered through completion of the audits outlined in section "a" above.</li> <li>c. An outline of any remediation plans necessary to address these gaps</li> </ol> </li> </ol>		

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F 583	Continued From page 3 on 7/20/20. Nurse #1 acknowledged that she did routinely send text messages to the physician about residents' medical care. Nurse #1 indicated that she did not have the capability to send encrypted messages to the physician and she indicated she had not received encrypted messages from the physician. The Director of Nursing stated that text messages were the physician's preferred method of communication.	F 583	<p>d. Audit of facility staff training to ensure that annual HIPAA training has taken place and there is documentation of this training.</p> <p>e. Ascertainment that the facility has 1) policies and procedures relevant to the annual HIPAA Privacy, Security, and Breach Notification Rules; 2) attestation by facility staff members that they have read those policies and procedures; and 3) documentation for annual reviews of policies and procedures.</p> <p>f. Identified that facility vendors and business associates have contracts that include any necessary confidentiality agreements</p> <p>g. A defined process for tracking, managing, and investigating incidents or breaches</p> <p>Completion date 9/25/2020 Administrator/Security Officer or designee</p> <p>3. The facility nursing staff and contracted medical providers/extenders who provide primary care or medical directorship will be educated by the facility's privacy officer or designee regarding privacy and confidentiality. This education will include the prohibited use of texting to communicate protected health information in keeping with corporate policies at this time. Licensed nursing staff will also be educated to communicate any resident/patient-related information with any physician or physician extender notification either via fax or via telephone and to document the method of communication utilized. This same education will be provided during</p>	

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F 583	Continued From page 4	F 583	orientation for new LPN and RN employees. This education will be provided annually to facility staff. Completion date 9/25/2020 SDC What practices will be put into place to monitor adherence to changes: 1. Orientation records will be audited by the privacy officer or designee weekly x 4 weeks, every two weeks x 4 weeks, and monthly x 4 weeks to ensure HIPAA education has taken place. These records include signed attestation of receipt of the facility employee handbook containing the privacy and confidentiality policy reference above and a signed in-service sheet showing the education related to privacy, confidentiality, and HIPAA. 2. The results of the HIPAA risk assessment will be reported to the QAPI team to evaluate any gaps noted after completion of the assessment and determine if additional policies and procedures are needed. 3. Any negative outcomes found in education (such as a lack of documented education having taken place) as a result of the audit and the risk assessment will be reported to the QAPI team to identify areas where remediation is required.  Completion date: 9/30/2020 Security Officer or designee		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		9/30/20	

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F 641	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the MDS (Minimum Data Set) in the areas of skin conditions and pain for 1 (Resident #1) of 1 resident reviewed for accurate minimum data set assessments. Findings included:</p> <p>Resident #1 was admitted to the facility on 6/29/20 with multiple diagnoses some of which included cervical disk disease, peripheral artery disease, bilateral veonostasis disease (poor blood flow in legs), stage 3 chronic kidney disease, hypertension, and cerebrovascular disease with recent cerebrovascular accident (stroke).</p> <p>Documentation in an occupational therapy note dated 7/3/20 revealed precautions for the resident were a fall risk, cervical collar on always, spinal cord compression from C3-C5, and extensive pain in bilateral lower extremities. The documentation further stated, "[Occupational therapy] assisted [with] repositioning of [lower extremities] in bed and noticed sock was crinkled at the top, so adjusted sock, but realized sock may be causing issues so [occupational therapy] removed [both] socks to allow skin to air out. [Occupational therapy] noticed skin issues [with] [bilateral lower extremities] and notified [Registered Nurse] immediately, notified [Director of Rehabilitation] as well. [Registered Nurse] came to room to check [patient's] skin."</p> <p>Documentation in a nursing progress note dated 7/3/20 stated, "Resident has pressure sores to both heels and right inner ankle, and redness to some toes on both feet. Was brought to my</p>	F 641	<p>F Tag 641 Accuracy of Assessments How the issue will be resolved for the patient:</p> <ol style="list-style-type: none"> <li>An amended MDS will be submitted that accounts for Resident #1's pain and presence of pressure ulcers. Completion date: 9/15/2020 MDS team How will other residents who are potentially affected by the same deficient practice be identified? <ol style="list-style-type: none"> <li>The DON or designee will audit sections J and M on the MDS of all current residents and patients to check for the accuracy of these sections against nursing pain assessments, nursing wound and skin assessments, staff interview, and resident/patient observation. Completion date: 9/18/2020 DON/designee</li> <li>Any discrepancies noted will be submitted to the MDS coordinator and/or designee for corrections to the MDS. Completion date: 9/23/2020 MDS team What systemic changes will be put into place to keep the problem from recurring? <ol style="list-style-type: none"> <li>The MDS nurse will be re-educated by the corporate regional MDS coordinator or designee regarding what factors and assessments should be included in conducting the MDS look back for pain and skin issues. Completion date: 9/18/2020 Corporate MDS coordinator</li> <li>A second MDS nurse who is credentialed as a registered nurse will begin assisting with conducting MDS assessments on a weekly basis.</li> </ol> </li> </ol> </li> </ol>		

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F 641	<p>Continued From page 6</p> <p>attention by physical therapy. Her heels are necrotic with a blister surrounding both areas. With movement there is a lot of pain. Areas wiped with skin prep and cover with foam covering over heels and boots applied, Pain medication was given. Daughter and MD (medical doctor) made aware."</p> <p>Documentation on the physician orders for Resident #1 revealed orders, dated as initiated on 7/3/20 and discontinued on 8/11/20, revealed boots to both heels were to be applied daily on every shift for pressure sores.</p> <p>Documentation in a physical therapy progress note for Resident #1 dated 7/4/20 revealed, "Screams out in pain regardless of pain medication with [bilateral lower extremity] movement, co tx (simultaneous treatment with both therapists) recommended. Wounds to [right] medial ankle and heel significant NO weight bearing of any kind to heel."</p> <p>Nurse #5 was interviewed on 8/25/20 at 2:57 PM. Nurse #5 stated that on 7/5/20 Resident #1 was in a lot of pain and cried out in pain as he moved her. Nurse #5 said he rolled the resident over and saw that she had excoriation on her buttocks but no open skin. Nurse #5 stated that he did not look at the heels of Resident #1 on 7/5/20 because the resident was in so much pain. Nurse #5 stated that the resident had soft boots on her feet on 7/5/20.</p> <p>Documentation on the admission Medicare 5-day MDS dated 7/6/20 coded Resident #1 as having severely impaired cognition requiring extensive to total assistance with all activities of daily living. The documentation revealed that based on</p>	F 641	<p>Completion date: 9/16/2020 DON/administrator assigned nurse What practices will be put into place to monitor the changes?</p> <p>1. DON or designee will audit sections J and M of two MDS's per week x 4 weeks, sections J and M of two MDS's every other week x 4 weeks, sections J and M of two MDS's every month x 1 month to assess if section J responses and section M responses correlate with nursing/physician documentation, assessment, and/or resident interview. Any instances of correlation issues noted will be brought to the MDS team and/or regional MDS coordinator for re-education, remediation, and/or disciplinary action as indicated per facility policy. Completion date: 9/30/20 DON/designee</p> <p>2. DON or designee will report the audit findings, i.e., any correlation issues noted in sections J and M, to the QAPI team for further evaluation and assessment to determine if additional auditing or other interventions are required. Completion date: 9/30/2020 DON/designee</p>		

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F 641	<p>Continued From page 7</p> <p>clinical assessment and a formal assessment tool, Resident #1 had no pressure ulcers/injuries but was at risk for pressure ulcers/injury. The documentation coded the resident as receiving scheduled pain medication and as needed pain medication with no pain expressed by the resident upon interview. Resident #1 was assessed as having a range of motion impairment on one side of her upper extremity and no range of motion impairment on her lower extremities.</p> <p>An interview was conducted with the MDS coordinator (Nurse # 8) on 9/2/20 at 1:26 PM. Nurse #8 explained that she did not have a documentation or assessment to confirm the pressure ulcers on the heels and feet of Resident #1 at the time of the MDS assessment on 7/6/20. Nurse #1 explained that the documentation of the pressure sores was too vague and there were no measurements, so she did not put the information on the MDS assessment on 7/6/20. Nurse #8 stated that Resident #1 was on scheduled pain medication and received as need pain medication at the time of the assessment. Nurse #8 stated that she interviewed Resident #1 regarding her pain and the resident stated that she was not in pain. Nurse #8 stated that the scheduled pain medication was managing the pain Resident #1 was experiencing. Nurse #8 revealed she looked at the pain assessment and the daily skilled notes for which Resident #1 was not documented as being in any pain.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/2/20 at 4:47 PM. The DON indicated that it was her expectation that the MDS nurse look at the documentation in the chart, talk to the staff, and observe the resident before</p>	F 641			

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F 641	Continued From page 8 completing the MDS documentation. The DON also indicated that for a resident who was cognitively impaired a facial scale for pain assessment be used as well as documentation review and staff interview to determine how to code an MDS for pain assessment.	F 641			
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interview the facility failed to implement a comprehensive approach to pressure ulcer care and services for a resident at risk for pressure ulcers for 1 (Resident #1) of 2 residents reviewed for pressure ulcers in the facility. Eight pressure ulcers were identified after admission to the facility. Findings included:  Resident #1 was admitted to the facility on 6/29/20 with multiple diagnoses some of which included cervical disk disease, peripheral artery disease, bilateral venostasis disease (poor blood	F 686	F Tag 686 Pressure Ulcers How the issue will be resolved for the resident? Resident #1 has expired. How will other residents at risk for the same deficient practice be identified? 1. The nursing administration team (DON/ADON/UM/Nursing Supervisor/wound nurse) will conduct an updated Braden assessment on all residents to determine current risk for skin breakdown. Completion date: 9/23/2020 Nursing	9/30/20	

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F 686	<p>Continued From page 9</p> <p>flow in legs), stage 3 chronic kidney disease, hypertension, and cerebrovascular disease with a recent cerebrovascular accident (stroke).</p> <p>Documentation on an admission daily skin assessment dated 6/29/20 revealed Resident #1 had a cervical collar, a skin tear to her left forearm, and bruising to her right buttock.</p> <p>Documentation on a Braden Scale for predicting pressure sore risk completed by Nurse #2 and dated 6/29/20 revealed Resident #1 scored a 14 or a "moderate risk." Documentation under the "sensory perception" revealed "no impairment," under "moisture" revealed "occasionally moist," under "activity" revealed "bedfast," under mobility revealed "very limited," under nutrition revealed "adequate," and under friction and shear revealed "no apparent problem."</p> <p>Documentation on a physician's progress note dated 6/30/20 revealed Resident #1 was admitted to the facility from the hospital after a fall and was thought to have a C3-C5 compression. (The C3, C4, and C5 vertebrae form the midsection of the cervical spine, near the base of the neck. A cervical vertebrae injury is the most severe of all the spinal cord injuries because the higher up in the spine an injury occurs, the more damage that is caused to the central nervous system.)</p> <p>Documentation on the care plan for Resident #1, initiated on 6/30/30 and dated as last revised on 7/16/20, did not have a focus area for pressure ulcers or wound care.</p> <p>Documentation in an occupational therapy note dated 7/3/20 revealed precautions for the resident were a fall risk, cervical collar on always, spinal</p>	F 686	<p>administration</p> <p>2. The nursing administration team will conduct a skin assessment of all current residents to ensure any current impairment to skin integrity is noted and a corresponding treatment in place. Completion date 9/23/2020 Nursing administration</p> <p>3. The care plans of those residents with a Braden score of 14 or less will be reviewed by the nursing administration team to ensure a care plan addressing the level of risk for potential for impaired skin integrity or actual impaired skin integrity is in place and addresses pressure-reducing surfaces and devices, nutritional status, and the appropriate preventative or actual treatment. Completion date 9/25/2020 MDS team</p> <p>4. The MDS team/nursing administration team will audit the care plans of those residents with wounds to ensure they have the appropriate pressure-reducing surfaces and devices, nutritional status deficiencies are being addressed, and there is an appropriate treatment ordered. Completion date: 9/25/2020 MDS team</p> <p>5. The nursing administration team will conduct an audit of all MARs and TARs of current residents with impaired skin integrity during the morning clinical meeting for the month of September to ensure there is documentation of wound-related treatments. If there is a lack of documentation of wound-related treatments noted, the nursing administration team will contact the nursing staff responsible for missing documentation to ascertain whether the</p>		

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F 686	<p>Continued From page 10</p> <p>cord compression from C3-C5, and extensive pain in bilateral lower extremities. The documentation further stated, "[Occupational therapy] assisted [with] repositioning of [lower extremities] in bed and noticed sock was crinkled at the top, so adjusted sock, but realized sock may be causing issues so [occupational therapy] removed [both] socks to allow skin to air out. [Occupational therapy] noticed skin issues [with] [bilateral lower extremities] and notified [Registered Nurse] immediately, notified [Director of Rehabilitation] as well. [Registered Nurse] came to room to check [patient's] skin."</p> <p>The occupational therapist who wrote the 7/3/20 note was not available for interview.</p> <p>Documentation in a nursing progress note dated 7/3/20 stated, "Resident has pressure sores to both heels and right inner ankle, and redness to some toes on both feet. Was brought to my attention by physical therapy. Her heels are necrotic with a blister surrounding both areas. With movement there is a lot of pain. Areas wiped with skin prep and cover with foam covering over heels and boots applied, Pain medication was given. Daughter and MD (medical doctor) made aware."</p> <p>Documentation on the physician orders for Resident #1 revealed orders, dated as initiated on 7/3/20 and discontinued on 8/11/20, revealed boots to both heels were to be applied daily on every shift for pressure sores. Documentation on the July MAR (medication administration record) revealed this order was not documented as completed on 7/5/20, 7/8/20, 7/9/20, 7/15/20, 7/18/20, 7/19/20, and 7/29/20 on the day shift as well as the evening shift on 7/30/20.</p>	F 686	<p>treatment was or was not completed and document the results. Repetitive offenses by a nurse, defined by routine lack of documentation, will result in remediation and/or progressive disciplinary action as per facility policy.</p> <p>Completion date: 9/25/2020 Nursing administration</p> <p>6. The dietary manager and/or registered dietician will conduct a nutritional assessment of all those residents with wounds to ensure adequate supplementation and interventions are being offered. This will include family input regarding likes and dislikes in the event the resident is not able to communicate this.</p> <p>Completion date: 9/25/2020 Dietary manager/RD</p> <p>7. The nursing administration will review and print the registered dietician's recommendations and present them to the physician/physician extender for review and approval. Orders will be entered into the medical record and the care plan updated as indicated.</p> <p>Completion date: 9/25/2020 Nursing administration</p> <p>8. All existing notes from the wound care nurse practitioner not already scanned into the medical record for August until the date certain will be scanned into the appropriate medical record.</p> <p>Completion date: 9/30/20 Medical records</p> <p>9. The nursing administration team will audit all MARs for the month of September 2020 to determine the presence of any interventions that should</p>		

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F 686	<p>Continued From page 11</p> <p>Documentation in a physical therapy progress note for Resident #1 dated 7/4/20 revealed, "Screams out in pain regardless of pain medication with [bilateral lower extremity] movement, co tx (simultaneous treatment with both therapists) recommended. Wounds to [right] medial ankle and heel significant NO weight bearing of any kind to heel."</p> <p>Documentation on a weekly skin assessment completed by Nurse #5 dated 7/5/20 revealed the resident's skin was intact with no open areas at that time.</p> <p>Nurse #5 was interviewed on 8/25/20 at 2:57 PM. Nurse #5 stated that on 7/5/20 Resident #1 was in a lot of pain and cried out in pain as he moved her. Nurse #5 said he rolled the resident over and saw that she had excoriation on her buttocks but no open skin. Nurse #5 stated that he did not look at the heels of Resident #1 on 7/5/20 because the resident was in so much pain. Nurse #5 stated that the resident had soft boots on her feet on 7/5/20.</p> <p>Documentation on the admission Medicare 5-day minimum data set assessment dated 7/6/20 coded Resident #1 as having severely impaired cognition requiring extensive to total assistance with all activities of daily living. Resident #1 was coded as frequently incontinent of bowel and bladder. The documentation revealed that based on clinical assessment and a formal assessment tool, Resident #1 had no pressure ulcers/injuries but was at risk for pressure ulcers/injury. Resident #1 was coded as having an infection of the foot, skin tears, on a turning and repositioning program, application of ointments/medications,</p>	F 686	<p>be on the TAR rather than the MAR and make any necessary corrections. Completion date: 9/30/2020 Nursing administration What systemic changes will be put into place to keep the deficient practice from recurring?</p> <ol style="list-style-type: none"> <li>1. The SDC and/or designee will educate the nursing staff on the corporation's quick view skin protocol, which includes the following systemic changes: <ol style="list-style-type: none"> <li>a. The nurse will complete and document a resident's initial skin evaluation within 8 hours of resident admission or readmission screener in the EMR.</li> <li>b. The nurse will complete a Braden scale at time of new resident admission/readmission and review the document for resident risk factors.</li> <li>c. If the nurse identifies a wound, the nurse will notify the physician/physician extender and discuss those findings and obtain a treatment order. Nurse will document this communication as well as a description of the identified skin alteration.</li> <li>d. The nurse will initiate a "baseline" care plan based on risk factors and the initial skin evaluation documentation.</li> <li>e. The nurse will notify one of the following: DON/ADON, house supervisor, or wound nurse of an identified wound. The nurse will notify the resident/resident representative (RR) of the alteration and document the notification and their reactions.</li> <li>f. Each resident will have an additional</li> </ol> </li> </ol>		

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F 686	<p>Continued From page 12</p> <p>and oxygen therapy. The documentation coded the resident as receiving scheduled pain medication and as needed pain medication with no pain expressed by the resident upon interview. Resident #1 was assessed as having a range of motion impairment on one side of her upper extremity and no range of motion impairment on her lower extremities. Resident #1 was assessed as being 5 foot 4 inches tall and weighed 151 pounds.</p> <p>Documentation on a Braden Scale for predicting pressure sore risk completed by Nurse #5 and dated 7/6/20 revealed Resident #1 scored a 13 or a "moderate risk." Documentation under the "sensory perception" revealed "very limited," under "moisture" revealed "occasionally moist," under "activity" revealed "bedfast," under "mobility" revealed "very limited," under "nutrition" revealed "adequate," and under "friction &amp; shear" revealed "potential problem."</p> <p>Documentation in the wound care consultant progress notes by Nurse Practitioner (NP #1) dated 7/6/20 revealed Resident #1 had an initial assessment of wounds and treatment recommendations. Wound #1, a left distal heel deep tissue pressure injury, was 5 cm (centimeters) in length, 5.5 cm in width, and 0 cm in depth. Wound #1 was described as, "central heel black, surrounding skin beefy red in color, no swelling." Wound #2, a right distal heel deep tissue pressure injury, was 5 cm in length, 9 cm in width, and 0 cm in depth. Wound #2 was described as, "central heel black, surrounding skin red, no edema." Wound #3, a right medial foot deep tissue pressure injury, was 1.5 cm in length, 1 cm in width, and 0 cm in depth. Wound #3 was described as "bunion area deep red</p>	F 686	<p>full body skin assessment by a licensed nurse/designee at 24 and 72 hours. The nurse will document each of these evaluations and follow the steps outlined above.</p> <p>g. Nurses must complete and document all resident weekly skin observations in the EMR. Weekly skin evaluation will be conducted and documented on the appropriate facility skin condition record.</p> <p>h. An event report will be completed in the event manager by the nurse when a new wound is identified that was not present on admission/readmission.</p> <p>i. On resident shower/bath days, C.N.A.'s will complete total body observations and document them on the CNA skin alert observation. If a new alteration in resident's skin integrity is identified, the CNA will report it to charge nurse and an alert will be sent to the nurse.</p> <p>j. If a new alteration in resident skin integrity is identified by CNA, the Charge Nurse or Assigned Nurse will follow the protocol of notifying the physician and family. The charge nurse or assigned nurse will then review and update the Braden scale as needed in the EMR. The nurse will also complete a pain evaluation in the EMR and implement appropriate measures as well as update the care plan.</p> <p>k. If appropriate, the RD will be notified to assess resident nutritional and hydration status as an intervention.</p> <p>l. Referral to therapy for positioning may also be considered as an intervention.</p> <p>m. Resident wounds will be tracked on the facility's weekly skin tracking tools.</p>		

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F 686	<p>Continued From page 13</p> <p>minimal blanching." Wound #4, a right medial ankle, deep tissue injury, was 1.5 cm in length, 1.5 cm in width, and 0 cm in depth. The treatment recommendations for Wounds #1, #2, #3, and #4 were, "pressure relieving boots at all times, turn side to side per protocol. Monitor carefully [every] shift." The documentation of the pressure relief/off loading recommendations were to follow the facility pressure ulcer prevention protocol.</p> <p>After the 7/6/20 wound care assessment, there was no documentation of an assessment of the mattress on the bed, no care plan was created, and nutrition and hydration was not assessed other than food preferences without the input of the resident or her family.</p> <p>Documentation in an Admission Nutritional Assessment dated 7/7/20 revealed the Registered Dietitian (RD #1) made the recommendation for Resident #1 to have daily weights taken out of concern for congestive heart failure and diuretic medication as well as Ensure 237 ml (milliliters) to be given twice a day due to low intake.</p> <p>RD #1 was interviewed on 9/2/20 at 2:50 PM. RD #1 stated that when she did the initial assessment on 7/7/20 she was not aware Resident #1 had any wounds. RD #1 stated that she looked at the 6/30/20 admission skin assessment and the Braden scale pressure ulcer risk assessment dated 7/6/20 which did not reveal evidence of wounds. RD #1 did not know why the nutritional recommendations she made on 7/7/20 were not implemented because she e-mailed her recommendations to all the risk team members.</p> <p>Documentation in the nursing notes for Resident</p>	F 686	<p>n. Nurses will be educated that they are to document completion of treatments in the medical record and that continued failure to document such completion without an acceptable reason will result in remediation and/or disciplinary action per facility policy.</p> <p>Completion date: 9/23/2020 SDC, nursing supervisor</p> <p>2. The wound care nurse practitioner's weekly report will be placed in the medical director's mailbox at the facility for review and acknowledgement as indicated by the medical director's signature or initials and the date.</p> <p>Completion date: 9/18/2020 Medical records</p> <p>What practices will be put into place to monitor the changes</p> <p>1) The nursing administration team will audit the EMR during the morning clinical meeting to ascertain the presence of the following assessments and elements:</p> <p>a) For new admissions/readmissions:</p> <p>i) The completion of the admission skin assessment, the 24-hour skin assessment, and the 72- hour skin assessment;</p> <p>ii) The completion of the Braden assessment;</p> <p>iii) Documentation of notification to the resident/RP, physician/physician extender, and a member of the nursing administration team if there is a wound identified and any new orders</p> <p>iv) A base line care plan addressing the wound</p> <p>b) For all residents:</p> <p>i) The completion and review of weekly</p>		

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F 686	<p>Continued From page 14</p> <p>#1 on 7/10/20 revealed, "Resident has open area to right buttock, greenish slough is present in wound. Wound bed is well-defined and no signs of infection. Area was cleansed with normal saline and calcium alginate applied and covered with dressing."</p> <p>Documentation in the treatment orders, dated as initiated on 7/11/20 and discontinued on 7/21/20, revealed Resident #1 had an order for the right buttock to be cleansed with normal saline, patted dry, Calcium Alginate applied, and covered with a dry dressing one time a day every other day for an open wound. Documentation on the July TAR revealed Resident #1 was not documented as receiving this treatment on 7/15/20, 7/19/20, and 7/21/20.</p> <p>Documentation in the treatment orders, dated as initiated on 7/11/20 and discontinued on 7/21/20, revealed Resident #1 had an order for the right buttock to be cleansed with normal saline, patted dry, Calcium Alginate applied, and covered with a dry dressing one time a day every other day for an open wound. Documentation on the July TAR revealed Resident #1 was not documented as receiving this treatment on 7/15/20, 7/19/20, and 7/21/20.</p> <p>Documentation in the nursing notes on 7/12/20 revealed Nurse #1 obtained treatment orders for Resident #1 for the resident's right buttock. There was no documentation on 7/12/20 indicating Nurse #1 notified the physician for Resident #1 about the open area on the resident's right buttock on 7/12/20.</p> <p>Nurse #1 was interviewed on 8/26/20 at 9:57 AM. Nurse #1 stated that she notified the physician</p>	F 686	<p>skin assessments and CNA shower sheets</p> <p>ii) The completion and review of a weekly non pressure or pressure wound assessment</p> <p>iii) A review of the event manager to ensure any new wounds have been reported</p> <p>iv) Monitoring of the EMR for completion of treatments Completion date: 9/25/2020 Nursing administration</p> <p>2) If a new wound is observed, the nursing administration team will determine if the following elements were completed:</p> <p>i) a new Braden scale assessment</p> <p>ii) a new pain assessment</p> <p>iii) the RD/therapy notification as appropriate</p> <p>iv) physician/physician extender notification and wound/pain treatment orders were initiated</p> <p>v) Resident/RR notification</p> <p>vi) Nursing administration team notification</p> <p>vii) care plan updated as indicated Completion date: 9/25/2020 Nursing administration</p> <p>3) This monitoring will occur daily Monday – Friday x 4 weeks, twice weekly x 4 weeks, and weekly x 4 weeks. Negative results noted in the audits will be reported to the QAPI team monthly for review and reassessment as indicated. Completion date: 9/30/2020 DON or designee</p>		

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F 686	<p>Continued From page 15</p> <p>about the open area on the resident's right buttock when she called to verify treatment orders but did not document the notification in the medical record on 7/12/20.</p> <p>Documentation in the physical therapy progress note for Resident #1 dated 7/13/20 revealed, "[Patient] needing noting to have more spasms this date through out [upper extremities] [complained of] discomfort with movement. Staff education on positioning completely on side for off loading due to wound on [right] buttock and starting on coccyx."</p> <p>Documentation in the wound care consultant notes by NP #1 for Resident #1 dated 7/13/20 revealed an initial assessment and recommendations for the wound to the right buttock and reassessments of Wounds #1, #2, #3, and #4. Wound #5, a right buttock pressure ulcer, was a Stage 3 upon the initial exam. Wound #5 was 9 cm in length, 6 cm in width, and 0.2 cm in depth. It was described as 80% epithelial and 20% slough. Treatment recommendations for pressure wounds #1, #2, #3, and #4 were to use pressure relieving boots, monitoring, and turning from side to side. The treatment recommendation for Wound #5 was to cleanse with normal saline, Santyl applied to slough, calcium alginate, dry sterile dressing every day and as needed. The treatment recommendations for pressure relief/off-loading were to follow the facility pressure ulcer prevention protocol and facility pressure redistribution mattress protocol.</p> <p>Documentation on a Braden scale for predicting pressure sore risk completed by Nurse # 2 dated 7/13/20 revealed Resident #1 scored a 15 or "at</p>	F 686			

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F 686	<p>Continued From page 16</p> <p>risk." The resident was documented as improving her "activity" to being "chairfast" and improving her "mobility" to being "slightly limited."</p> <p>Documentation in a risk meeting note dated 7/15/20 stated Resident #1 had new wounds to her bilateral feet, right buttock, and sacrum. The risk meeting note dated 7/15/20 did not note any additional interventions for the resident's wounds other than an upcoming appointment with a neurologist. There was no documentation of an assessment of the mattress on the bed or the need for a care plan.</p> <p>Interview with the DON on 8/25/20 at 1:30 PM revealed the risk meeting documentation was incorrect in that Resident #1 did not have a sacrum pressure wound at the time of the 7/15/20 risk meeting. The DON explained that the staff members documenting in the risk meeting possibly looked at the wrong resident's documentation or made human error.</p> <p>Documentation in a nutrition meeting note dated 7/16/20 for Resident #1 recommended the addition of Ensure 237 ml (milliliters) three times a day, with the medication pass with documentation of percentage consumed relative to varied intake, 30 ml Promod (liquid protein) each day, 220 mg (milligrams) of zinc every day for 14 days, and 500 mg of Vitamin C twice a day for 14 days.</p> <p>Documentation in a nursing progress note completed by Nurse #1 dated 7/17/20 for Resident #1 revealed she had acquired a new Stage 2 pressure ulcer on her left buttocks.</p> <p>Documentation on a weekly pressure wound</p>	F 686			

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F 686	<p>Continued From page 17</p> <p>observation tool completed by Nurse #1, initiated on 7/17/20 and not completed, the physician was documented as notified of the new Stage 2 pressure ulcer on the left buttock of Resident #1.</p> <p>Documentation in a wound care consultant notes by NP#1 dated 7/20/20 for Resident #1 revealed an evaluation of skin changes to heels and both buttocks. An initial exam of Wound #6, a left buttock pressure ulcer, measured 7 cm in length, 4 cm in width, and 0.1 cm in depth. Wound #6 was described as friable (crumbly) and bleeds easily. Treatments recommendations for Wounds #1, #3, and #4 were revised to protect the wound with Abdominal pads and Kling, monitor twice a day, pressure relieving boots, and turning from side to side. The treatment recommendation for Wound #2 was to monitor and wear foam boots. The treatment recommendation for Wound #5 was to cleanse with normal saline, santyl applied to slough, calcium alginate, and a dry sterile dressing applied every day and as needed. The Treatment recommendations for Wound #6 were to cleanse with normal saline, calcium alginate applied, and a dry sterile dressing applied every day and as needed. The treatment recommendations for pressure relief/off-loading were to follow the facility pressure ulcer prevention protocol and pressure redistribution mattress per facility protocol.</p> <p>Documentation on a Braden Scale for predicting pressure sore risk completed by Nurse #1 and dated 7/20/20 revealed Resident #1 scored a 13 or a "moderate risk." Documentation under the "sensory perception" revealed "very limited," under "moisture" revealed "occasionally moist," under "activity" revealed "bedfast," under mobility revealed "slightly limited," under nutrition revealed</p>	F 686			

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F 686	<p>Continued From page 18</p> <p>"adequate," and under friction and shear revealed "problem."</p> <p>Nurse #1 provided text messages she sent to the physician for Resident #1 on 7/20/20 at 2:26 PM. The text messages revealed the physician was notified of the deterioration of the wounds and recommendations were sought by Nurse #1.</p> <p>An interview was conducted with the charge nurse/MDS nurse (Nurse #1) on 8/26/20 at 9:57 AM. Nurse #1 revealed she had a conversation with the physician on 7/20/20 for Resident #1 regarding recommendations for wound care. Nurse #1 stated that it was discussed that the wounds for Resident #1 were getting worse and if an ABI (a simple test to compare blood pressure in the upper and lower limbs) study was necessary. Nurse #1 stated that the physician had no recommendations at that time. Nurse #1 confirmed the communication with the physician was both verbal and through text messages, but she had neglected to document the communication in the medical record.</p> <p>Documentation on the weekly pressure wound observation tools for Resident #1 dated 7/20/20 had assessments for the right buttock, right distal heel, right medial foot, and right medial ankle. Documentation on all the pressure wound observations tools dated 7/20/20 stated Resident #1 was on a pressure reducing mattress.</p> <p>Documentation on the weekly pressure wound observation tool for Resident #1 dated 7/24/20 had an assessment of the left buttock. Documentation on the pressure wound observation tool dated 7/24/20 stated Resident #1 was on a pressure redistribution mattress.</p>	F 686			

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F 686	<p>Continued From page 19</p> <p>There was no weekly pressure wound observation tool for the left distal heel of Resident #1 for the week of 7/20/20.</p> <p>Documentation on the physician orders for Resident #1 revealed orders, dated as initiated on 7/21/20 and discontinued on 7/27/20, for a left heel, right foot bunion, right heel, and right medial ankle pressure ulcers to be protected with ABD (abdominal) dressing, kling, and monitored two times a day. Documentation on the July TAR revealed the physician orders for the left heel, right foot bunion, right heel, and right medial ankle were not documented as completed on the evening shift of 7/21/20.</p> <p>Documentation in the physician's orders for Resident #1 revealed an order, initiated on 7/21/20 and discontinued on 7/27/20, for the right buttock to be cleansed with normal saline, Santyl applied to slough, and covered with a dry dressing daily every evening shift. Documentation on the July TAR for Resident #1 revealed the order for the right buttock was not documented as completed on 7/21/20.</p> <p>Documentation in the treatment orders for Resident #1 revealed a treatment order initiated on 7/21/20 and discontinued on 7/27/20 for the left buttock to be cleansed with normal saline, patted dry, Calcium Alginate applied, and covered with a dry dressing one time daily. Documentation in the July TAR revealed Resident #1 was not documented as receiving a treatment for the left buttock on 7/21/20.</p> <p>Documentation in a risk meeting note dated 7/21/20 stated Resident #1 had multiple pressure</p>	F 686			

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F 686	<p>Continued From page 20</p> <p>wounds to heels, hip, and bilateral buttocks and the resident was being followed by the wound care consultant. Interventions discussed at the meeting were an upcoming neurology appointment and the registered dietitian would evaluate her weights. There was no documentation of care plan creation, or a reevaluation of the resident's mattress.</p> <p>Interview with the DON on 8/25/20 at 1:30 PM revealed the risk meeting documentation was incorrect in that Resident #1 did not have a hip pressure wound at the time of the 7/21/20 risk meeting. The DON explained that the staff members documenting in the risk meeting possibly looked at the wrong resident's documentation or made human error.</p> <p>Documentation in the physician orders revealed the recommendations made in a nutrition meeting on 7/16/20 for orders for Promod and Vitamin C were initiated on 7/21/20 while orders for Ensure and Zinc were initiated on 7/22/20.</p> <p>An interview with the facility Registered Dietitian (RD #1) on 9/1/20 at 1:57 PM revealed that she attended the weekly risk meeting via the telephone and had not been inside the facility since March. RD #1 revealed she saw in the electronic medical record Resident #1 had an admission weight of 151 pounds. RD #1 stated that the facility was supposed to do daily weights for 3 days and weekly weights for 4 weeks on every new admission. RD #1 stated that she sent numerous emails requesting weights be taken of Resident #1. RD #1 stated that she did not know why she could not get weights for Resident #1 until 7/15/20. RD #1 revealed that she was able to get a nurse to go down to the resident's room and</p>	F 686			

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F 686	<p>Continued From page 21</p> <p>ask her how much she usually weighs and if the weight of 151 pounds was correct. RD #1 stated that she was told by the nursing staff the resident stated that she had never weighed more than 128 pounds. RD #1 stated that on 7/15/20 the facility obtained another weight for Resident #1 of 135 pounds. RD #1 participated in the 7/15/20 risk meeting for Resident #1 and was aware of the wounds the resident had acquired. RD #1 revealed that she e-mailed the entire risk meeting team her recommendations for orders for nutritional supplements for Resident #1 on 7/15/20. RD #1 didn't know why the recommended orders for nutritional supplements for Resident #1 didn't get implemented until the next risk management meeting on 7/21/20.</p> <p>Documentation in a nursing progress note for Resident #1 dated 7/24/20 revealed, "At [6:00 AM] this nurse was called to resident room by CNAs (certified nursing assistants). It was brought to the attention that resident had an area on left collar bone. This nurse assessed area and resident had a raised red bruise on left collar bone next to collar brace. [Physician name] was called and notified of this finding and he said to pad the area so that skin will be protected from collar brace. Area was padded and resident is now in the bed resting."</p> <p>Documentation in a wound care consultant note by NP#1 for Resident #1 dated 7/27/20 revealed there was an evaluation of the skin changes, worsening wounds on the buttocks, and a new area on the resident's neck. Wound #7, a left neck pressure wound, was a Stage 2 measuring 4 cm in length, 0.4 cm in width, and 0.1 cm in depth. The wound care orders changed. Wound #1 and #2 were to have skin prep to the area with</p>	F 686			

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F 686	<p>Continued From page 22</p> <p>a bulky dressing every day. Wound #3 and #4 were to be cleansed with normal saline and protected from rubbing on the sheets. Wound #5 was to be cleansed with normal saline, a dry sterile dressing applied every day and as needed. Wound #6 was to be cleansed with normal saline, Santyl applied to slough, and a dry sterile dressing applied every day and as needed. Wound #7 was to be cleansed with normal saline, silvasor gel applied, a dry sterile dressing applied every day and as needed along with protection from the hard collar. The treatment recommendations for pressure relief/off-loading were to follow the facility pressure ulcer prevention protocol and pressure redistribution mattress per facility protocol.</p> <p>Documentation on the weekly pressure wound observation tool for Resident #1 for 7/27/20 had an assessment of the left neck. The weekly pressure wound observation tools for Resident #1 did not have assessments of the right buttock, right distal heel, right medial heel, right medial foot, the left distal heel, or the left buttock for the week of 7/27/20.</p> <p>Documentation in a risk meeting for Resident #1 dated 7/28/20 recommended no additional interventions but noted she had wounds on bilateral lower extremities, bilateral buttock, and the left neck. The risk meeting did not document a discussion of care plan creation or updates, an evaluation of the mattress on the bed and cushion on the chair, or the completion of a pressure sore risk assessment.</p> <p>Documentation on the physician orders for Resident #1 revealed an order, dated as initiated on 7/28/20 and discontinued on 8/4/20, for the</p>	F 686			

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F 686	<p>Continued From page 23</p> <p>right foot bunion cleansed with normal saline, an ABD pad applied and wrapped with kling one time a day. Documentation on the July and August TAR for Resident #1 revealed the physician's order for the right foot bunion was not documented as completed on 7/29/20, 8/1/20, and 8/2/20.</p> <p>Documentation on the physician orders for Resident #1 revealed an order, dated as initiated on 7/28/20 and discontinued on 8/11/20, for the left heel for skin prep to be applied, ABD pad applied, and wrapped with kling one time a day. Documentation on the July and August TAR for Resident #1 revealed the physician's order for the left heel was not documented as completed on 7/29/20, 8/1/20, 8/2/20, and 8/7/20.</p> <p>Documentation on physician orders for Resident #1 revealed an order, dated as initiated on 7/28/20 and discontinued on 8/11/20, for the right heel to be cleansed with normal saline, an ABD pad applied and wrapped with Kling. Documentation on the July and August TAR for Resident #1 revealed the physician's order for the right heel was not documented as completed on 7/29/20, 8/1/20, 8/2/20, and 8/7/20.</p> <p>Documentation in the treatment orders for Resident #1 revealed a treatment order initiated on 7/28/20 and discontinued on 8/4/20 for the left buttock to be cleansed with normal saline, patted dry, Santyl applied to slough, and covered with a dry dressing daily. Documentation in the July TAR for Resident #1 revealed the treatment order for the left buttock initiated on 7/28/20 was not documented as completed on 7/29/20 and 7/31/20.</p>	F 686			

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F 686	<p>Continued From page 24</p> <p>Documentation on the physician orders for Resident #1 revealed an order, dated as initiated on 7/28/20 and discontinued on 8/4/20, for the right medial ankle to be cleansed with normal saline, an ABD pad applied and wrapped with kling one time a day. Documentation on the July and August TAR for Resident #1 revealed the physician's order for the right medial ankle was not documented as completed on 7/29/20, 8/1/20, and 8/2/20.</p> <p>Documentation in the treatment orders for Resident #1 revealed an order, dated as initiated on 7/28/20 and discontinued on 8/4/20, for the right buttock to be cleansed with normal saline and a dry sterile dressing applied daily on the day shift. Documentation on the July TAR revealed Resident #1 was not documented as receiving this treatment on the day shift on 7/29/20 and 7/31/20.</p> <p>Documentation in an occupational therapy note for Resident #1 dated 7/30/20 stated in part, "[Patient] found to have a new [left] scapular wound and significant odor coming [from] sacral wounds with sacral wound completely necrotic and unstageable at this time. Patient positioned to offset sacrum and left scapula to decrease pressure to allow healing and pillow use to decrease skin contact with bony prominences. Administrator approached for intervention including air mattress with administrator referred us with [Director of Rehabilitation] and [Director of Nursing] to address."</p> <p>Documentation on a weekly pressure wound observation tool for the left scapula dated 7/30/20 revealed Resident #1 was on a pressure reducing mattress.</p>	F 686			

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F 686	Continued From page 25  An interview was conducted with the rehabilitation manager on 8/20/20 at 11:59 AM. The rehabilitation manager explained that Resident #1 was in the facility for rehabilitation services after a fall at home. The rehabilitation manager further explained that the resident was completely dependent at first and initially therapy revolved around staff education for touch, positioning, temperature sensitivity, and sensitivity to all stimuli. The rehabilitation manager revealed the resident was very prone to skin breakdown. The rehabilitation manager explained that the resident would cry out in pain and fear with all movement and would make spastic movements with any change in position.  An additional interview was conducted with the rehabilitation manager on 8/21/20 at 12:28 PM. The rehabilitation manager revealed that an air mattress was obtained for Resident #1 at some point. The rehabilitation manager stated that she thought an air mattress was found in the facility and put on the bed of Resident #1 on the same day it was requested.  Documentation in a physician's order for Resident #1 dated as initiated on 7/31/20 and discontinued on 8/4/20 revealed an order for a left scapula pressure area to be cleansed with normal saline and a foam dressing applied one time a day. Documentation on the July and August MAR revealed the resident was not documented as receiving the left scapula treatment on 7/31/20, 8/1/20, or 8/2/20 on the day shift.  Documentation in a follow up note by the nurse practitioner (NP #2) dated 7/31/20 revealed the nurse practitioner expressed a concern for the	F 686			

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F 686	<p>Continued From page 26</p> <p>worsening pressure ulcers on Resident #1. The plan stated in part, "Needs optimized nutrition, low air loss mattress and offloading given her poor overall medical condition. Further recommendations following neurosurgery and vascular surgery follow up. Prognosis is poor overall." The wound consultant notes dated 7/27/20 were not available to NP #2 in the electronic medical record when she was reviewing the electronic medical record of Resident #1 on 7/31/20.</p> <p>NP #2, who wrote the 7/31/20 follow up progress note, was interviewed on 8/25/20 at 10:59 AM. NP #2 stated that on 7/31/20 she was at the facility doing a routine 30 day follow up for Resident #1, and she only came to the facility once every couple of weeks. NP #2 revealed that, "in passing" she was notified by a nursing staff member of the multiple pressure wounds on Resident #1 to include wounds on her left and right buttock. NP #2 stated that she looked to see if the wound care consultant was following Resident #1 and if treatment orders were in place. She stated that she did not observe the wounds but reviewed the documentation that was available.</p> <p>Documentation on a weekly pressure wound observation tool dated 8/3/20 for the left scapula revealed Resident #1 was on an "air mattress" and the wound progress was, "worsening."</p> <p>Documentation in a wound care consultant note by NP #1 for Resident #1 dated 8/3/20 revealed NP #1 was asked to evaluate the wounds on her buttocks, heels, and a new blistered area on her left scapula, that came from lying on a gurney for many hours while at a neurology appointment. NP</p>	F 686			

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F 686	<p>Continued From page 27</p> <p>#1 made the recommendation the resident be seen at a wound clinic for suggestions for treatment. Wound #5, the right buttock pressure ulcer, was 8.5 cm in length, 5.5 cm in width, and 0 cm in depth. Wound #6, the left buttock pressure ulcer, was 8.5 cm in length, 5.5 cm in width, and 0.2 cm in depth. Wound #7, the left neck wound, was assessed as healed. Wound #8, a left scapula wound, was a Stage 2 measuring 5 cm in length, 5 cm in width, and 0.1 cm in depth.</p> <p>Documentation on a physician's follow-up progress note dated 8/5/20 revealed the physician thought an evaluation by a wound clinic for Resident #1 at her bedside would be beneficial. The physician noted her prognosis was poor given the rapid decline in her wounds and overall functional status. The wound care consultant notes from NP #1 dated 8/3/20 were not available in the electronic medical record on 8/5/20 for the physician to review.</p> <p>Documentation on physician orders for Resident #1 revealed an order, dated as initiated on 8/5/20 and discontinued 8/11/20, for the right foot bunion to be cleansed with normal saline and left open to air one time a day. Documentation on the August TAR for Resident #1 revealed the physician's order for the right foot bunion was not documented as completed on 8/7/20.</p> <p>Documentation on the physician orders for Resident #1 revealed an order, dated as initiated on 8/5/20 and discontinued on 8/11/20, for the right medial ankle to be cleansed with normal saline and left open to air one time a day. Documentation on the August TAR for Resident #1 revealed Resident #1 was not documented as</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>receiving the treatment for the right medial ankle on 8/7/20.</p> <p>Documentation on a physician's order for Resident #1 dated as initiated on 8/5/20 and discontinued on 8/11/20 revealed an order for a left scapula pressure area to be cleansed with normal saline and a Xeroform gauze dry sterile dressing to be applied daily. Documentation on the August MAR revealed the resident was not documented as receiving the left scapula treatment on 8/7/20 on the day shift.</p> <p>Documentation in the physician orders for Resident #1 revealed an order initiated on 8/5/20 and discontinued on 8/11/20 for the right buttock to be cleansed with normal saline, Santyl Ointment 250 units/gram to be applied topically to the eschar and covered with a dry sterile dressing.</p> <p>Documentation in the physician orders for Resident #1 revealed an order initiated on 8/5/20 and discontinued on 8/11/20 for the left buttock to be cleansed with normal saline, Santyl Ointment 250 units/gram to be applied and covered with a dry sterile dressing daily.</p> <p>An interview was conducted with the Director of Nursing on 8/24/20 at 3:30 PM. The DON revealed that the documentation for the completion of the treatment orders for the right and left buttock initiated on 8/5/20 were located on the MAR (medication administration record) instead of the TAR. The DON acknowledged that the treatments should be located on the TAR and not the MAR.</p> <p>Documentation in wound care consultant note by</p>	F 686			

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F 686	<p>Continued From page 29</p> <p>NP #1 for Resident #1 dated 8/10/20 revealed NP #1 recommended an evaluation at the local wound clinic for suggestions on treatment of her significant wounds and decline in overall status. NP #1 took wound cultures at the request of the resident's physician during her assessment of the wounds. Wound #6, increased in size to 12.8 cm in length, 8.5 cm in width, and 1 cm in depth but was documented as unchanged.</p> <p>Documentation in nursing notes on 8/10/20 revealed Resident #1 was sent out of the facility for a magnetic resonance imaging but while returning to the facility the resident was noted to have a fever and was taken to the emergency room.</p> <p>Documentation in emergency department provider notes dated 8/10/20 revealed Resident #1 was brought to the emergency room for a fever that was likely caused by a sacral wound infection. The history of present illness upon admission to the hospital stated, "She has developed bilateral heel breakdown as well as bilateral buttock breakdown secondary to immobility and skilled care. She has been on Doxycycline (antibiotic) since the end of last week. She has bilateral eschars on her buttock wounds the right buttock may have some drainage and some odor she will be admitted for Sirs response (inflammatory response) with possibly infected right buttock. Appears to be unstageable at this point."</p> <p>An interview was conducted with NP #1 on 8/24/20 at 2:10 PM. NP #1 indicated that she was under contract with the facility to provide assessments and wound care recommendations for the residents. NP #1 revealed that she</p>	F 686			

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F 686	<p>Continued From page 30</p> <p>provided hand written notes to the Director of Nursing or the Unit Manager after completing her services at the facility. NP #1 stated that she then went home and typed up the notes into the computer and faxed the typed notes to the facility the next day. NP #1 said that she wrote orders for the wound care but that the facility could obtain clarification from the resident's physician. NP #1 indicated that from a physical stand point Resident #1 was more alert on 8/10/20. NP #1 indicated that she had used the wrong words on the assessment to say the wounds were improving or unchanged but that was because the treatment she ordered was doing what it was supposed to be doing so that a better assessment of the wounds could be made.</p> <p>The primary care physician for Resident #1 was interviewed on 8/24/20 at 2:51 PM. The physician stated that he was a hospitalist and he saw Resident #1 when she was brought to the emergency room on 8/10/20 and he was also the physician for Resident #1 at the facility. He stated he was "blindsided" when he saw Resident #1 in the emergency room. He stated he first became aware of the wounds on the resident from a follow up note he saw written by NP #2. He revealed the facility had not told him how bad the wounds had gotten. He stated that he was in the facility twice a week to see his patients and nobody stopped him to ask him to see Resident #1. He stated that maybe if the facility had notified him a week or two earlier about how bad the wounds had gotten, he could have made recommendations and perhaps something different could have been done. The physician indicated that the wound care consultant notes were "buried" in the miscellaneous section of the electronic medical record system and a month or two after the</p>	F 686			

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F 686	<p>Continued From page 31</p> <p>resident was seen. The physician stated that he never received any direct communication from the wound care consultant, and he was never given the wound care notes to sign off on. The physician stated he was a wound care specialist and he may have been able to do something differently had he been included in the wound care communication for Resident #1 earlier. The physician indicated that maybe nothing else could have been done to stop the progression of the wounds due to her multiple comorbidities. The physician stated the family thought the resident was going to the facility for rehabilitation services but perhaps it was an unrealistic hope and Hospice was probably a better choice. The physician revealed that once the resident got to the hospital her wounds were debrided, she then went into heart failure, and then it was too late.</p> <p>A telephone interview was conducted with the Director of Nursing (DON) on 8/26/20 at 9:35 AM. The DON stated that she spoke with the physician for Resident #1 prior to the interview on 8/24/20 at 2:51 PM. The DON revealed that the physician expressed to her his frustration with the wound consultant company and communication with NP #1.</p> <p>An interview was conducted with Nurse #2 on 8/20/20 at 3:53 PM. Nurse #2 was assigned to care for Resident #1 on the day shift on 7/2/20, 7/4/20, 7/5/20, 7/8/20, 7/14/20, 7/15/20, 7/18/20, 7/19/20, 7/29/20, and 8/2/20. Nurse #2 stated that she did the wound care treatments for Resident #1 but had neglected to document in the TAR. Nurse #2 explained that there was an issue with the documenting in the electronic medical record because she was responsible for two halls in the facility and had to switch assignments in the</p>	F 686			

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F 686	<p>Continued From page 32</p> <p>computer system to document care for her residents.</p> <p>An interview was conducted with Nurse #3 on 8/24/20 at 9:15 AM. Nurse #3 was assigned to care for Resident #1 on 8/1/20 on the day shift. Nurse #3 stated she did not recall Resident #1 and did not remember providing any treatments for her.</p> <p>An interview was conducted with Nurse #4 on 8/21/20 at 1:09 PM. Nurse #4 was assigned to care for Resident #1 on 8/7/20 on the morning shift. Nurse #4 stated that she worked for an agency and was only in the facility one time. Nurse #4 stated that she did not recall Resident #1 and she did not recall what treatments she completed or didn't complete.</p> <p>An interview was conducted with Nurse #5 on 8/25/20 at 2:57 PM. Nurse #5 was assigned to care for Resident #1 on the evening shift on 7/15/20. Nurse #5 stated that he did not think he was still working at the facility on 7/15/20 so he could not confirm if the treatment was completed.</p> <p>An interview was conducted with Nurse #6 on 8/21/20 at 11:46 AM. Nurse #6 was assigned to care for Resident #1 on the evening shift on 7/19/20. Nurse #6 indicated that her usual procedure was to look up the treatment orders, write them down on a piece of paper, gather the needed supplies, and then do the treatments as ordered. Nurse #6 stated that she had to remember to go back and document that she did the treatments and she may have neglected to do so on 7/19/20 but that she always completed the treatments assigned to her as ordered.</p>	F 686			

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F 686	<p>Continued From page 33</p> <p>An interview was conducted with Nurse #7 on 8/24/20 at 10:39 AM. Nurse #7 was assigned to care for Resident #1 on the day shift on 7/21/20 and 7/31/20. Nurse #7 indicated she did not know why there was no documentation on the TAR on 7/21/20 and 7/31/20 for the treatment for Resident #1. Nurse #7 indicated that she always did all the treatments that were assigned for her to do.</p> <p>The nurses who were assigned to care for Resident #1 on the evening shift 7/21/20 and 7/30/20 were not available for interview to validate the treatments were completed.</p> <p>Nurse Aide (NA #1) was interviewed on 9/2/20 at 11:30 AM. NA #1 stated that she was assigned to care for Resident #1 once or twice but could not recall the exact dates. NA #1 stated Resident #1 was in a lot of pain in her back, but she was able to turn and reposition Resident #1 to make her comfortable.</p> <p>NA #2 was interviewed on 9/2/20 at 12:18 PM. NA #2 stated that she was assigned to care for Resident #1 on the 11:00 PM to 7:00 AM shift on several occasions in July 2020. NA #2 stated that Resident #1 was totally dependent for all her care needs but, she was able to provide care for Resident #1. NA #2 stated that Resident #1 was always in a lot of pain and that sometimes she had to take a break in providing care to allow Resident #1 to rest, and then continue with the provision of care.</p> <p>NA #3 was interviewed on 9/2/20 at 12:30 PM. NA #3 stated that she was assigned to care for Resident #1 usually on the 7:00 AM to 11:00 PM shift. NA #3 stated that some days the resident</p>	F 686			

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F 686	<p>Continued From page 34</p> <p>was in pain and on some days she was not. NA #3 stated she was able to provide the care Resident #1 needed to include assisting her to eat.</p> <p>An interview was conducted with the Director of Nursing on 8/20/20 at 12:15 PM. The DON stated that Nurse #5 was no longer employed by the facility with part of the reason being that he failed to accurately document the skin issues of Resident #1 on the 7/5/20 weekly skin review. The DON stated that she realized the documentation of the treatments was a concern and that it was on her list of concerns that needed to be addressed with an action plan but that she did not have a current action plan to address this concern. The DON stated that the facility recognized a need for an action plan after it was brought to their attention that Resident #1 had acquired several pressure sores in the facility. The DON provided the action plan and explained that at that point the facility had completed 100% skin assessments of all the residents as well as completed a training for a few nurses on a new protocol for wound care that was also provided. The action plan was undated, but the DON indicated that the action plan was initiated with the skin assessments on 8/13/20.</p> <p>An additional interview with the facility Administrator on 8/26/20 at 12:15 PM revealed that the facility action plan for skin issues was also the action plan to address any documentation issues. The Administrator also revealed that a review of resident care plans for the inclusion of wound care issues as needed was initiated and completed on 8/13/20 as well as the skin assessments.</p>	F 686			

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F 686	<p>Continued From page 35</p> <p>Another interview was conducted with the DON on 8/24/20 at 3:30 PM. The DON indicated the notification and the documentation of the notification of the physician of new wounds or skin issues was a part of an action plan that was initiated on 8/13/20 that was not yet completed.</p> <p>Documentation on the facility action plan for skin issue received on 8/20/20 revealed dates of completion were not included on the plan. Systematic changes that still needed to be completed included the education of the nursing staff on the quick view protocol; the nursing administration/wound care nurse to round with the wound care nurse practitioner; hiring of a wound nurse; nursing administration monitoring adherence to the quick view protocol after education was complete through review of medical records in the morning clinical meeting; any discrepancies noted being addressed with the appropriate staff member for further education and/or disciplinary action as appropriate for reoccurring infractions of skin quick view protocol; and review of skin quick view protocol will be completed with nursing personnel as appropriate during new employee orientation and annually thereafter. The monitoring that still needed to be completed included the results of the administration audits will be reported monthly to the QAPI (Quality Assurance Performance Improvement) committee for further review and action as indicated for the next six months with a goal will be to achieve or be below Accordius target rate for facility acquired pressure ulcers; and if measurable progress is not noted or goal is not achieved, QAPI committee will be modify existing action plan.</p> <p>Documentation on a facility wound care and</p>	F 686			

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F 686	Continued From page 36 pressure ulcer prevention and treatment protocol, provided by the DON on 8/24/20, indicated that upon discovery, decline in wound condition, or no progress in 2 to 4 weeks, considerations should be made of completion of a risk assessment, re-evaluation of support surfaces, complete/update wound documentation, as well as notification of the physician/nurse practitioner and interdisciplinary team. The facility support surfaces guidelines or pressure redistribution mattress protocol were to promote comfort for all bed bound or chair bound residents to prevent skin breakdown, promote circulation, and provide pressure relief or reduction.	F 686			