STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	**1530 BROAD AVE GULFPORT, MS 39501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint survey for Complaint Investigation (CI) MS #15951 and CI MS #16039 from 8/27/2019 to 8/29/2019. The SA substantiated CI MS #15951, related to failure to prevent the development of a pressure ulcer for Resident #3, who was admitted by the facility on 02/06/19, with a Stage 3 pressure ulcer to the sacrum. Resident #3 was identified high risk for developing pressure sores at the time of admission. The Stage 3 sacral pressure ulcer healed on 02/21/19. However, the facility failed to perform weekly body audits, skin observations and/or assessments from the time the sacral pressure ulcer healed on 02/21/19 to 05/09/19. The facility identified an unstageable pressure ulcer to Resident #3's sacral area on 05/09/19. Resident #3 required hospitalization on 05/22/19 for Wound Infection, Urinary Tract Infection (UTI) and Sepsis, and the need for debridement of the wound. Due to the facility's failure to perform the weekly body audits, skin observations and assessments to prevent and/or identify skin alterations Resident #3 suffered harm. Resident #3 did not return to the facility after her discharge from the hospital on 06/04/19. Resident #3 was admitted to another facility. CI MS #15951 also addressed concerns with Resident #3's fluid and meal intake, incontinent care, and turning/positioning. Per Resident #3's closed record review, the SA did not substantiate these concerns during the survey as evidenced by observations of other residents identified with these same concerns, record review and interviews. The SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited F-656 and F-686 related to CI MS #15951.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/10/2019

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 000	Continued From page 1 The SA did not substantiate CI MS #16039 regarding the administration of pain medications in a timely manner. The SA determined the complaint was not substantiated by record review and interviews. The SA did not cite any deficiencies related to CI MS #16039. The facility's census on 8/29/19 was 137 residents and the facility is licensed for 180 beds.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		10/29/19

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F 656	Continued From page 2 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to implement Resident #3's Care Plan for high risk for skin impairment. The facility failed to perform weekly body audits to monitor, assess and prevent the reoccurrence of a pressure ulcer. The facility identified Resident #3 at high risk for pressure ulcers on admission, 02/06/19, due the presence of a Stage 3 sacral pressure ulcer. As a result, Resident #3 suffered harm due to the development of a Stage 3 sacral pressure ulcer identified, on 05/09/19, which required hospitalization for wound infection and debridement of the wound. This concern was identified for one (1) of six (6) wound care plans reviewed. Findings Include: Record review of the facility's policy titled, "Comprehensive Care Plan Policy", dated November 2017, revealed a Comprehensive Care	F 656	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the Federal and State law. F656 1. Resident #3 was discharged from the facility on 5/22/19. 2. Skin checks/body audits were completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON)September 4, 2019 for the entire facility population to ensure all wounds had been addressed and are receiving treatment. The comprehensive Care Plans of all residents who are at high risk for pressure ulcers are being reviewed and revised.	

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F 656	Continued From page 3 Plan that includes measurable objectives and timetables to meet resident's medical, nursing, mental and psychological needs shall be developed for each resident. An interdisciplinary team, in coordination with the resident, his/her family or representative, develops and maintains a Comprehensive Care Plan for each resident. The Comprehensive Care Plan has been designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, build on residents strength, reflect treatment goals and objectives in measurable outcomes, Identify the professional services that are responsible for each element of care, prevent declines in the resident 's functional status/functional levels, enhance the optimal functioning of the resident by focusing on a rehabilitative program, ensure care plan is individualized and person-centered and reflects the resident's goal for admission and desired outcomes, and discharge plans. Review of the facility's policy titled, "Prevention of Pressure Ulcers", dated April 2019, revealed the skin observation schedule would be completed as follows: C.N.A.s (Certified Nursing Assistants) will complete total body observations at minimum on bath days. Charge Nurse will complete weekly skin observations on each resident, "Licensed Nurse Weekly Skin Observation Form". Any residents with wounds will be documented on the Weekly Wound Information Sheet. The Care Plan will be revised/updated. Record review of Resident #3's Comprehensive Care Plan revealed the Focus, no date, for high risk for impaired skin integrity related to (r/t) occasional Bowel Incontinence, Diabetes, Lymphedema and Actual Sacral Wound acquired	F 656	This audit is to be done in partnership with the Care Plan Nurse and the Director of Nursing (DON) and Assistant Director of Nursing (ADON). This audit will be completed by October 14, 2019. 3. An in-service with the Interdisciplinary Team will be provided regarding care plan processes and the development of individualized Resident-Centered Care Plans that integrate high risk skin impairments into the plan of care. This education is scheduled for October 22, 2019 and will be provided by the Care Plan Nurse Coordinator and the DON and ADON. Education was provided to all nursing staff on the importance of completing accurate skin checks, as well as performing routine licensed weekly skin observations on September 4, 2019 by the DON and ADON. Education was provided to all Certified Nursing Assistants (CNAs) regarding their role in pressure ulcer prevention, reporting changes, and the implementation of planned interventions on September 4, 2019 by the DON and ADON. The DON and ADON will monitor the weekly skin checks daily to ensure compliance. 4. Monitoring for ongoing compliance will be completed through audits as part of the facility□s end-of-month changeover/chart review to validate that care plans reflect accurately for all residents receiving wound care or who are at risk for pressure ulcers. This audit will be completed	

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F 656	Continued From page 4 on 05/09/2019. Interventions included Skin Observations weekly, and the staff assigned was the nurse. Further review of the Care Plan revealed a Focus for high risk for altered behavioral patterns as evidenced by the resident was short tempered with staff, and had episodes of cursing, attempting to hit staff, hitting and pinching staff when she does not want them to provide care. Resident also declines weights and medications at times. During an interview, on 08/29/19 at 10:00 AM, Registered Nurse (RN) #1/Treatment Nurse revealed Resident #3 was admitted with a healing Stage 3 sacral pressure ulcer on 02/06/2019. RN #1 stated the wound was healed on 02/21/2019. RN #1 said a Certified Nursing Assistant told her to check Resident #3's buttocks on 05/09/2019. RN #1 said Resident #3 was noted with a 10 centimeter (cm) x 5 cm unstageable sacral wound with a small amount of serosanguineous drainage. RN #1 reported the wound bed was covered with slough, and progressively worsened. RN #1 said she had not seen Resident #3's buttocks since 02/22/2019 (the date the sacral pressure ulcer had healed at the time of admission). RN #1 said the nurses on the floor are responsible for doing the body audits every week. RN #1 confirmed Resident #3 was considered high risk for the wound to reopen on her sacrum because she was obese, Diabetic, Chronic Urinary Tract Infections (UTIs), and a History of Pressure Ulcers. Review of Resident #3's medical record revealed no Weekly Skin Observations Forms were located from 02/21/19 until 05/09/19. Review of Resident #3's May 2019 Treatment	F 656	monthly by the Care Plan Nurse Coordinator, the DON, the ADON, and/or Unit Managers. All findings will be brought by the DON, ADON, and/or Unit Managers to the monthly Quality Assurance and Performance Improvement (QAPI) meeting to review and follow up for any needed changes/recommendations for six months. Monitoring for ongoing compliance will be completed through audits for all residents with pressure ulcers and altered skin to be conducted weekly beginning October 18, 2019; 8 residents per week, one at a time, for 6 weeks to ensure all residents skin integrity is assessed appropriately. The DON and ADON, Minimum Data Set (MDS) Nurse, Unit Managers, and/or Wound Care Nurses will be responsible for the random audits. All skin assessments will be audited with scheduled Minimum Data Set (MDS) assessments and significant changes. All findings by the Director and Assistant Director of Nursing, Minimum Data Set (MDS) Nurse, Unit Managers, and/or Wound Care Nurses will be discussed in the monthly Quality Assurance and Performance Improvement (QAPI) meeting to review and follow up for any needed changes/recommendations for six months.	

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Administration Record (TAR), revealed an order dated 05/09/19 to cleanse the wound to the sacrum with Normal Saline (N/S). Pat dry. Apply Santyl to wound. Apply Calmoseptine to periwound. Cover with dry dressing daily and as needed (PRN) for soiled/dislodged dressing every day shift.

Review of the hospital Emergency Department (ED) notes revealed Resident #3's service time and date was 05/22/19 at 12:59 PM. History of Present Illness: She was sent in because of change in hydration and alertness. Decreased diet and is refusing to take medications, meals, and fluids. Level of consciousness was alert, awake, and aware. Calm and cooperative. Diagnoses included: Wound Infection, Acute Urinary Tract Infection, Acute Renal Failure, Sacral Decubitus Ulcer, Diabetes, and History of Stroke.

Review of the hospital Discharge Summary revealed Resident #3 was admitted to the hospital, on 05/22/19, and discharged on 06/04/19. Resident #3 underwent an Excisional Debridement of a 15 cm X 15 cm sacral and bilateral gluteal stage IV (4) decubitus ulcer. Incision and drainage of a left medial abcess. The discharge diagnoses included: Wound infection with Proteus mirabilis and Enterococcus faecalis. Sepsis, unspecified organism. Initial blood culture was positive for Staphylococcus lugdunensis. Repeat blood cultures were negative. Acute Urinary Tract Infection: Urine cultures were positive for Kliebsiella pneumonia and Enterococcus faecalis. Sacral Decubitus Ulcer. Acute Renal Failure.

An interview with the Director of Nursing (DON),

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on 08/09/2019 at 2:00 PM, revealed the facility failed to follow Resident #3's Care Plan for high risk for skin alterations. The DON revealed she was not the DON at that time, however she was able to confirm the facility had not done weekly body audits for Resident #3 since the sacral pressure ulcer healed on 02/21/19. The DON revealed, as the DON she was responsible to ensure the Care Plans were accurate and implemented, but due to her new position as DON, she had not accomplished reviewing the care plans for accuracy and implementation at this time. The DON said the floor nurses were scheduled to do body audits on different residents every shift. The DON also said Resident #3 was a high risk for pressure ulcers because she had just healed from a wound, was unable to turn herself and was incontinent.

The Certified Nursing Assistants (CNAs) who were assigned to provide Resident #3's care and the Licensed Practical Nurse (LPN) who was responsible to perform Resident #3's weekly body audits from 02/21/19 to 05/09/19 were no longer employed at the facility. The SA made phone call attempts to interview these employees, but either the phone was no longer in use, or no answer, and/or no return calls.

Review of Resident #3's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/19, revealed the resident was admitted with the presence of one (1) Stage 3 pressure ulcer, and was identified as high risk for pressure ulcers. Resident #3's Basic Interview for Mental Status (BIMS) score was 14, which indicated no cognitive impairment. Review of Resident #3's Functional Status revealed she required: Extensive assistance with two persons

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F 656	Continued From page 7	F 656		

physical assist with bed mobility, transfers, and toilet use. Total dependence with one person's physical assist with locomotion on and off the unit. Supervision with set up help with eating. Extensive assistance with one person's physical assist with personal hygiene and bathing. Resident #3 was always incontinent of bowel and bladder. Resident #3 had Range of Motion (ROM) impairment to her upper and lower extremities on one side.

An interview with Licensed Practical Nurse (LPN) #1/Care Plan Nurse, on 08/29/2019 at 1:00 PM, revealed the facility failed to implement Resident #3's Care Plan regarding the high risk for skin alterations due to the nurses failed to perform the weekly body audits to assess the resident for pressure ulcers. LPN #1 confirmed the weekly body audits were performed to assess for and prevent new pressure ulcers, and she would expect the nurses to follow the Care Plan.

A review of the facility's Face Sheet revealed Resident #3 was admitted by the facility, on 02/06/19, with the included diagnoses Type II Diabetes, Cerebral Infarction, Hemiplegia and Hemiparesis, and Acute Kidney Failure.

A review of Resident #3's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/15/2019, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident was cognitively impaired. Resident #3's Skin Condition revealed the presence of an unstageable pressure ulcer. Further review of the MDS revealed Resident #3's Functional Status: Transfers and locomotion on and off the unit was coded an eight (8), which indicated the activity did

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F 656	Continued From page 8 not take place. Dressing, bathing and toilet use, Resident #3 was totally dependent, and required one person's physical assist. Eating required supervision and set up help. Personal hygiene required extensive assistance with one person's physical assist. Resident #3 was always incontinent of bowel and bladder. Resident #3. Resident #3 had Range of Motion (ROM) impairment to her upper and lower extremities on one side.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to perform weekly body audits to monitor, assess and prevent the reoccurrence of a pressure ulcer. The facility identified Resident #3 at high risk for pressure ulcers on admission, 02/06/19, due the presence of a Stage 3 sacral pressure ulcer. As a result, Resident #3 suffered harm due to the facility's identification of an unstageable sacral	F 686	F686 1. Resident #3 was discharged from the facility on 5/22/19. 2. Skin checks/body audits were completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON)September 4, 2019 for the entire facility population to ensure all wounds	10/29/19

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F 686	Continued From page 9	F 686		

pressure ulcer, on 05/09/19, which required hospitalization for wound infection and debridement of the wound. This concern was identified for one (1) of six (6) wound care plans reviewed.

Findings Include:

Review of the facility's policy titled, "Prevention of Pressure Ulcers", dated April 2019, revealed the skin observation schedule would be completed as follows: C.N.A.s (Certified Nursing Assistants) will complete total body observations at minimum on bath days. Charge Nurse will complete weekly skin observations on each resident, "Licensed Nurse Weekly Skin Observation Form". Any residents with wounds will be documented on the Weekly Wound Information Sheet. The Care Plan will be revised/updated.

Review of the hospital Emergency Department (ED) notes revealed Resident #3's service time and date was 05/22/19 at 12:59 PM. History of Present Illness: She was sent in because of change in hydration and alertness. Decreased diet and is refusing to take medications, meals, and fluids. Level of consciousness was alert, awake, and aware. Calm and cooperative. Diagnoses included: Wound Infection, Acute Urinary Tract Infection, Acute Renal Failure, Sacral Decubitus Ulcer, Diabetes, and History of Stroke.

Review of the hospital Discharge Summary revealed Resident #3 was admitted to the hospital, on 05/22/19, and discharged on 06/04/19. Resident #3 underwent an Excisional Debridement of a 15 cm X 15 cm sacral and bilateral gluteal stage IV (4) decubitus ulcer.

had been addressed and are receiving treatment.

3. Education was provided to all nursing staff on the importance of completing accurate skin checks, as well as performing routine licensed weekly skin observations on September 4, 2019 by the DON and ADON. Education was provided to all Certified Nursing Assistants (CNAs) regarding their role in pressure ulcer prevention, reporting changes, and the implementation of planned interventions on September 4, 2019 by the DON and ADON. The DON and ADON will monitor the weekly skin checks daily to ensure compliance.

4. Monitoring for ongoing compliance will be completed through audits for all residents with pressure ulcers and altered skin to be conducted weekly beginning October 18, 2019; 8 residents per week, one at a time, for 6 weeks to ensure all residents skin integrity is assessed appropriately. The DON and ADON, Minimum Data Set (MDS) Nurse, Unit Managers, and/or Wound Care Nurses will be responsible for the random audits. All skin assessments will be audited with scheduled Minimum Data Set (MDS) assessments and significant changes. All findings by the Director and Assistant Director of Nursing, Minimum Data Set (MDS) Nurse, Unit Managers, and/or Wound Care Nurses will be discussed in the monthly Quality Assurance and Performance Improvement (QAPI) meeting to review and follow up for any

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Incision and drainage of a left medial abcess. The discharge diagnoses included: Wound infection with Proteus mirabilis and Enterococcus faecalis. Sepsis, unspecified organism. Initial blood culture was positive for Staphylococcus lugdunensis. Repeat blood cultures were negative. Acute Urinary Tract Infection: Urine cultures were positive for Kliebsiella pneumonia and Enterococcus faecalis. Sacral Decubitus Ulcer. Acute Renal Failure.

Resident #3 did not return to the facility at the time of discharge from the hospital. Resident #3 was transferred to another facility.

Review of the facility's Progress Notes, dated 05/22/19 at 9:18 AM, revealed the Nurse Practitioner (NP) documented Resident #3 was sent to the hospital Emergency Department (ED) for evaluation.

An interview with Registered Nurse (RN) #1/Treatment Nurse, on 08/29/2019 at 10:00 AM, revealed Resident #3 was admitted with a healing stage 3 sacral pressure ulcer on February 6, 2019. RN #1 said the wound healed on February 21, 2019. RN #1 then stated, a Certified Nursing Assistant reported to her that she needed to check Resident #3's buttocks on 05/09/2019. RN #1 reported she observed a 10 centimeter (cm) by 5 cm unstageable wound to Resident #3's sacral area with a small amount of serosanguineous drainage. RN #3 also stated the wound bed was covered with slough. RN #1 reported the wound got progressively worse. RN #1 revealed she had not seen Resident #3's buttocks since February 22, 2019. RN #1 said the nurses on the floor are responsible for body audits every week. RN #1 stated Resident #3 was

needed changes/recommendations for six months.

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	255092	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

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considered high risk for the wound to reopen on her sacrum because she was obese, Diabetic, Chronic UTI's (Urinary Tract Infections), and a history of pressure ulcers.

Review of Resident #3's Progress Note, dated 02/21/19 at 5:29 PM, documented by RN #1, revealed the pressure ulcer to the sacrum was healed. Treatment orders were discontinued.

Review of Resident #3's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/19, revealed the resident was admitted with the presence of one (1) Stage 3 pressure ulcer, and was identified as high risk for pressure ulcers. Resident #3's Basic Interview for Mental Status (BIMS) score was 14, which indicated no cognitive impairment. Review of Resident #3's Functional Status revealed she required: Extensive assistance with two persons physical assist with bed mobility, transfers, and toilet use. Total dependence with one person's physical assist with locomotion on and off the unit. Supervision with set up help with eating. Extensive assistance with one person's physical assist with personal hygiene and bathing. Resident #3 was always incontinent of bowel and bladder. Resident #3 had Range of Motion (ROM) impairment to her upper and lower extremities on one side.

Review of The Pressure Ulcer Reports revealed the following: 05/10/19, an unstageable pressure ulcer to Resident #3's sacrum. The wound measured 10 cm x 5 cm. The Pressure Relief Device was to turn every (q) two (2) hours, and the Treatment Plan was Santyl. 05/17/19, 10 cm x 10 cm unstageable pressure ulcer to the sacral area. Acquired 05/09/19. Added a wedge for

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pressure relief. Santyl continued for Treatment Plan. 05/24/19, 9.8 cm x 9.8 cm unstageable sacral pressure ulcer. Worsened-yes. Air mattress added for pressure relief, and Santyl for Treatment Plan. Each report was signed by RN #1/Treatment Nurse.

Review of the Weekly Wound Information forms revealed the following: On 05/10/19 at 8:53 AM, on 05/09/19 an unstageable pressure ulcer was acquired. The wound measured 10 cm x 5 cm with a small amount of serosanguineous drainage. No odor. Slough was present. The peri-wound area was red with excoriation. The Responsible Party (RP), who was identified as "Self", was notified on 05/09/19. The date the MD (Medical Doctor) initially notified or date of most recent status update: 05/07/19. The Progress stated: Resident with new unstageable wound to sacrum. Resident is noncompliant with turning and tends to get irritated when aids/nurses try to turn her. On 05/24/19 at 2:35 PM, continued to identify the unstageable sacral pressure ulcer. Measurements: 9.8 cm x 9.4 cm. Moderate amount serosanguineous drainage. Foul odor when dressing removed. Necrotic tissue to the wound base. Redness to perimeter of the wound. No pain. Progress: Wound to sacrum is being treated with Santyl. 90 % eschar and 10 % granulation. Continue to treat with Santyl at this time. The MD was notified on 05/21/19 of the current wound status. The RP, Self, was notified on 05/22/19.

Review of Resident #3's Treatment Administration Record (TAR) for May 2019, revealed an order, dated
05/10/19, to cleanse the sacrum with NS (Normal Saline). Pat Dry. Apply Santyl to wound. Apply

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Calmoseptine to periwound. Cover with dry dressing daily and PRN (as needed) for dislodged/soiled dressing every day shift. The order was discontinued on 05/22/19, the date Resident #3 was transferred to the hospital. The TAR also documented an order for the insertion of a 16 F (French) 10 (10 cubic centimeter {cc}) Foley catheter on 05/16/19. Turn q hours, initiated on 02/06/19, with staff initials documenting Resident #3 was turned q two (2) hours while in bed from May1st to May 22nd, except for one time on the 1st shift on 05/12/19.

During the interview with the Director of Nursing (DON) on 08/09/2019 at 2:00 PM, she confirmed the facility had not done the weekly body audits for Resident #3. The DON said the floor nurses are scheduled to do body audit on different residents every shift. The DON confirmed there were no body audits done after Resident #3's wound healed in February. The DON also said Resident #3 was identified as a high risk for pressure ulcers because she had just healed from a wound and was unable to turn herself and would refuse to eat or drink at times and allow staff to provide care.

The Certified Nursing Assistants (CNAs) who were assigned to provide Resident #3's care, and the Licensed Practical Nurse (LPN) who was responsible to perform the weekly body audits were no longer employed at the facility. The SA made attempts to contact these former staff members by phone, however the SA was unsuccessful due to the numbers were disconnected or there was no answer, or return call for a message left.

A review of the facility's Face Sheet revealed

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Resident #3 was admitted by the facility, on 02/06/19, with the included diagnoses Type II Diabetes, Cerebral Infarction, Hemiplegia and Hemiparesis, and Acute Kidney Failure.

A review of Resident #3's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/15/2019, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident was cognitively impaired. Resident #3's Skin Condition revealed the presence of an unstageable pressure ulcer. Further review of the MDS revealed Resident #3's Functional Status: Transfers and locomotion on and off the unit was coded an eight (8), which indicated the activity did not take place. Dressing, bathing and toilet use, Resident #3 was totally dependent, and required one person's physical assist. Eating required supervision and set up help. Personal hygiene required extensive assistance with one person's physical assist. Resident #3 was always incontinent of bowel and bladder. Resident #3. Resident #3 had Range of Motion (ROM) impairment to her upper and lower extremities on one side.