STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	69SC	A. BUILDING: _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 02/27/23 to 03/02/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M615 during the survey. The census at the time of survey was 85 and the facility was licensed for 106 beds.	M 000		
M 615 SS=D	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide the necessary assessment and treatment to promote the healing of a pressure ulcer for one (1) of three (3) residents reviewed for pressure ulcers. Resident # 136. Findings include: Review of facility policy titled, "Pressure Injury Prevention and Management" dated 3/2022, revealed, "This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment	M 615	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. On February 27, 2023, a skin assessment was completed for Resident #136 by the Wound Care Nurse. 2. Residents with skin issues have the potential to be affected by the failure to obtain a skin assessment upon admission 3. On March 2, 2023, in-servicing of	3/24/23

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M 615	Continued From page 1 and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries." Policy also revealed, "...3. Assessment of Pressure Injury Risk will be completed by a licensed nurse. 4. Interventions for Prevention and to Promote Healing: a. After completing an assessment/evaluation, a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions shall be introduced. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. c. Interventions for prevention will be implemented for residents who are assessed at risk or who have a pressure injury present. d. Treatments in accordance with current standards of practice will be provided for all resident who have a pressure injury present." An interview on 2/27/23 at 12:10 PM, with Resident #136 revealed he had sores on his bottom that have healed then recurred multiple times over the past several years. He stated he had no pain from these areas and no dressings to his bottom were needed at this time. An interview with the Director of Nursing (DON) on 2/28/23 at 12:30 PM, revealed the resident had pressure ulcers on his buttocks that were present on admission on 2/24/23, and he received care to these areas. She stated the resident had been a resident in the facility in the past and he also had these wounds during that previous admission. An interview and observation with the Treatment Nurse of the wound care on 2/28/23 at 3:00 PM, revealed Resident #136 was receiving wound care for two stage two pressure ulcers, one on his	M 615	licensed nurses was initiated by the Staff Development Coordinator (SDC) and Director of Nursing (DON) to complete a resident skin assessment upon admission to the facility and direct any skin issues noted to the Wound Care Nurse or Nurse Practitioner. 4. The DON or Wound Care Nurse will monitor newly admitted residents skin assessments for any noted skin issues on March 3, 2023, weekly x four weeks, monthly x two months. The monitoring results will be submitted by the DON to the Quality Assurance Performance Improvement Committee beginning on March 23, 2023, for review and recommendations monthly x three months.	

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M 615	Continued From page 2	M 615		

left buttock and one on his right buttock. The Treatment Nurse stated the resident had an order for dressing changes daily and the wounds have improved.

An interview on 3/1/23 at 1:40 PM, with the Treatment Nurse revealed she works Monday - Thursday on the day shift and if a resident is admitted during the time that a Treatment Nurse is not in the facility, the admitting Licensed Practical Nurse (LPN) will do an "informal skin assessment and look over the resident" and will notify the treatment nurse of any findings. She stated the LPNs do not diagnose or stage any area of concern, but they note what they saw and notify her of the findings, and she will contact the nurse practitioner and get orders. The Treatment Nurse stated she was notified of Resident #136's admission skin concerns and notified the Nurse Practitioner (NP). She stated when she came in on Monday, 2/27/23, she did the full skin assessment and documented the findings on the wound assessment form.

An interview with Registered Nurse (RN) #1 Supervisor on 3/1/23 at 1:55 PM, revealed the facility has guidelines with timeframe's to follow for new admissions and the skin assessment should be done within 24 hours of admission. She stated the LPNs do a basic head to toe to check for bruising, edema, redness, or other concerns on admissions and notify the Treatment Nurse of the findings. She stated the LPN could communicate to the Treatment Nurse by the secure conversation site where messages can be sent from one staff member to another. She stated there is also a wound care communication book where concerns are documented to be used by the Treatment Nurse so she can follow up on concerns. There were no notations for this

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M 615	Continued From page 3	M 615		

resident in the communication book (through record review as well as through interview as RN Supervisor was looking for an entry). She stated that since information on Resident #136 was not in the communication book, the communication must have been through the secure message system, but she did not have access to the messages sent between other staff members.

A phone interview with LPN #1 on 3/1/23 at 2:10 PM, revealed she completed the admission when Resident #136 came in on Friday evening. She stated that typically when a new resident is admitted, she does a head-to-toe check and documents the findings, and she will notify the DON and the wound nurse and get orders if concerns are noted. She cannot remember the situation with this resident's skin assessment, but stated she was on her way into work at 3:00 PM, so she will look at her notes and we will continue the interview then.

An interview with the DON on 3/1/23 at 3:00 PM, revealed the RN's and LPNs are trained on assessments of residents, including skin, and on a resident's admission, the LPN is to perform a head-to-toe assessment and contact the Treatment Nurse for any concerns. She stated the LPNs do not stage or diagnosis, but they are responsible to do a thorough assessment and report their findings and the RNs are responsible to perform the full skin and wound assessment including measurements. The facility schedules RNs on Monday through Friday from 7:00 AM until 3:00 PM, and on Saturday and Sunday from 7:00 AM until 7:00 PM. The DON revealed the admitting LPN (LPN #1) on the evening shift on Friday 2/24/23, should have completed a thorough head to toe assessment and contacted the Treatment Nurse and reported her findings,

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M 615	Continued From page 4	M 615		

but according to the documentation, the wound assessment was not done on this resident until Monday, 2/27/23. She stated LPN #1 should have assessed and reported findings to the Treatment Nurse and orders should have been given and implemented. Then, when the RN came in on Saturday, the full wound and skin evaluation with pictures and measurements should have been done. She stated the resident had these wounds during a past admission at the facility. She revealed that without admission documentation, it is difficult to know for certain if wounds improved or deteriorated or remained unchanged from Friday until Monday. She confirmed that on admission, the resident was not assessed properly, and the Treatment Nurse and the Nurse Practitioner were not notified of skin concerns, therefore, treatments to promote healing were not ordered and implemented timely.

An interview with LPN #1 on 3/1/23 at 3:25 PM, revealed she worked Friday (2/24/23) evening shift when Resident #136 was admitted. She stated when the resident came in, she did a brief skin assessment, but did not check his back side. She stated, "I was busy taking care of residents and passing medications and I just didn't look." She confirmed she had been in-serviced and she knew she should have completed a thorough assessment and contacted the Treatment Nurse with her findings. She stated she only observed the areas to his left forearm and to his toes, and she did not observe his bottom area. She revealed she did not contact the Treatment Nurse to notify her of the findings.

During an interview on 3/1/23 at 3:28 PM, the DON confirmed the facility failed to provide a timely assessment and treatment to a resident

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M 615	Continued From page 5	M 615		

with a pressure wound, so therefore, wound healing was not promoted. She confirmed she felt that the residents received good care at the facility, but that the lack of an assessment and treatment for this resident "does not meet the standards of care that we want for our residents." She stated that working in a nursing home is a busy job, but the staffing at the facility is more than sufficient, and the staff know they can call for assistance if needed.

An observation of wound care and wound measurements and interview with the Treatment Nurse on 3/2/23 at 9:00 AM, revealed the automated camera system for wound measurements system was not working, so the measurements were done manually. The wound to the left buttock measured 0.5 centimeters (cm) by (x) 0.2 cm x 0.5 cm. The wound to the right buttock measured 1.0 cm x 1.5 cm x 0.5 cm. There was no drainage noted.

An interview with LPN #3 on 3/2/23 at 10:00 AM, revealed she worked Friday 2/24/23 and saw Resident #136 briefly when he arrived. She stated LPN #1 was to do the admission and the assessment for the resident and she is not sure why it was not completed, but when she worked on Monday 2/27/23, she realized the admission assessment task was not completed. She stated since she did see the resident briefly on arrival to facility, she was able to complete part of the information on the form, but since she had not done a skin assessment, she was unable to document a direct observation. She stated that since she did not do the skin assessment on admission, and LPN #1 was to do this, she was unaware of any skin concerns, therefore she did not notify the Treatment Nurse. She stated the standard procedure is for the admission LPN to

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M 615	Continued From page 6	M 615		

perform the assessment on admission and to notify the Treatment Nurse for skin concerns and to document findings on the admission assessment form and the LPN that admitted Resident #136 failed to do this.

A phone interview with the Nurse Practitioner (NP) on 3/2/23 at 10:45 AM, revealed she was not notified of Resident #136's skin concerns when he was admitted on Friday or through the weekend. She stated when she saw him on Monday, she did a physical exam and at that time she found the areas to his buttocks. She stated two areas were noted, and since she had taken care of him last year in August, she was aware he had these at that time also. She stated the areas were like dry skin patches, but since slightly open, she staged them as stage 2. She stated that prior to a resident being admitted to the facility, the hospital sends her the resident's record and the medication list and when she received these from the hospital there was no indication of a skin concern to his bottom and there was also no wound care ordered. She stated since she was not notified by staff of a skin concern and it was not in the preadmission record from the hospital, she had no way of knowing there was an issue. She stated on Monday when she did Resident #136's assessment, she noted the areas and ordered the treatment to be done.

An interview with the Treatment Nurse on 3/2/23 at 11:30 AM, to clarify her earlier statement. She stated LPN #1 did not notify her of any skin concerns to Resident #136. She was also not notified throughout the weekend. She stated she did the skin assessment on Monday and the treatments were started. She stated that with her earlier statement, she meant to say that normally she would be notified by the LPN on any skin

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M 615	Continued From page 7	M 615		

concerns and the NP would be notified and orders for treatment would be given, but this did not occur.

An interview with the Administrator on 3/2/23 at 12:15 PM, revealed the facility's policies were not followed. The Administrator confirmed the facility failed to promote the healing of a pressure wound by not timely assessing and treating a resident with pressure wounds, and this is not the standard of care they want for their residents.

Record review of Physician's Orders revealed an order dated 2/27/23, to cleanse Stage 2 to left buttock with wound cleanser, pat dry with 4x4 gauze and apply small amount of Medi-honey to wound bed and cover with foam dressing every day for treatment.

Record review of Physician's Orders revealed an order dated 2/27/23, to cleanse Stage 2 to right buttock with wound cleanser, pat dry with 4x4 gauze and apply small amount of Medi-honey to wound bed and cover with foam dressing every day for treatment.

Record review of the Electronic Treatment Administration Record for February 2023 revealed wound care to stage 2 pressure ulcers to left and right buttock was done on 2/28/23. There were no other dates of wound care done during February 2022.

Record review of Nursing Admission Screening/History form for Resident #136 revealed he was admitted to the facility on 2/24/23. There is no documentation date and time of completion of this form, but the interview with LPN #3 revealed she completed this on 2/27/23.

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M 615	Continued From page 8 Record review of Nurse Practitioner's History and Physical dated 2/27/23 for Resident #136 revealed two pressure wounds, one on right buttock stage 2 and one on left buttock stage 2, both with the date identified of 2/27/23. Record review of hospitalization discharge summary record from 2/21/23 until 2/24/23, revealed the resident with a Decubital Ulcer status: Acute. Record review of Resident #136's Progress Note by LPN #1 dated 2/24/23 at 18:15 (6:15 PM), Type: Admission Summary revealed no documented skin assessment was completed. Record review of the Wound Evaluation dated 2/27/23 revealed a Stage 2 Pressure Ulcer to left buttock measuring length of 3.23 cm and width of 2.19 cm; and a Stage 2 Pressure Ulcer to right buttock measuring length of 0.86 cm and width of 0.46 cm. Record review of in-service on the admission process and required assessments according to admission protocol dated 2/13/23 revealed LPN #1 attended the in-service. Record review of Staff Education Record dated 2/22/23 revealed in-service on Skin Observations was done and LPN #1 attended. Record review of the Admission Record revealed Resident #136 was admitted to the facility on 2/24/23. Diagnoses included Fluid Overload, Atherosclerotic Heart Disease, Type 2 Diabetes Mellitus, Hypertension, Congestive Heart Failure, and Chronic Kidney Disease.	M 615		

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M 615	Continued From page 9 Record review of the Brief Interview for Mental Status (BIMS) score dated 3/1/23 revealed a BIMS of 13, which indicated the resident was cognitively intact. The Admission Five Day Minimum Data Set has not been completed but is due 3/3/23.	M 615		