STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 82801**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 5/20/21. The survey was prompted by complaint intake WY00003230. It was determined, based upon the findings of the survey team that no deficiencies pertaining to the focused infection control survey were identified. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements was conducted. The following common abbreviations are used throughout this document: MDS: Minimum Data Set BIMS: Brief Interview for Mental Status DON: Director of Nursing	F 000		
F 686 SS=D	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:	F 686		6/18/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/11/2021

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F 686	Continued From page 1 Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure interventions to prevent the development of pressure ulcers were implemented for 2 of 6 sample residents with pressure ulcers (#2, #3). The findings were: 1. Review of the 5/7/21 admission MDS assessment for resident #2 showed the resident was admitted to the facility on 5/3/21 with diagnoses that included unspecified fracture of upper end of right humerus, unspecified severe protein-calorie malnutrition, acute kidney failure, dehydration, history of falling, unspecified dementia with behavioral disturbance, iron deficiency anemia, and chronic obstructive pulmonary disease. The resident had a BIMS of 12 of 15 (cognitively intact). Further review showed the resident required at least one person physical assistance with all mobility and activities of daily living (ADL) except eating. Further, the MDS assessment showed the resident had no unhealed pressure ulcers/injuries at the time of the assessment. Review of the resident's care plan (last updated 5/20/21) showed the resident had " ... potential for pressure ulcer development r/t [related to] immobility." Interventions included "If the resident refuses treatment, confer with the resident, IDT [interdisciplinary team] and family to determine why and try alternative methods to gain compliance. Document alternative methods." The following concerns were identified: a. Review of "Nursing Daily Skilled Charting" notes showed a daily head to toe assessment was performed from 5/6/21 through 5/15/21. Documentation in the Skin/Wound section showed the resident's skin was intact during that time, with the exception of sutures to his/her right	F 686	CORRECTIVE ACTION: Resident #2: a reposition out of wheelchair schedule has been implemented and all direct care staff caring for Resident #2 were educated to document refusals from resident of participation in the reposition out of wheelchair schedule. Resident #3: Padding was placed on the oxygen tubing over the resident's ears. INDENTIFICATION OF OTHERS: All residents with current pressure ulcers will be reviewed to be verify that current interventions are effective and care plans are up to date. SYSTEMIC CHANGE: Education provided by the DON/designee related to documentation required when a resident refuses interventions for wound prevention. Wound care nurse will audit wound documentation weekly for 4 weeks and then monthly for 3 months to ensure appropriate interventions are in place. This education will be provided on or before the date of compliance. MONITORING: The wound nurse reviews these audits monthly and reports any patterns/trends to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Improvement Committee deems it prudent to continue.	

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eyebrow. On 5/15/21, the assessment noted "Suture to right brow CDI [clean, dry, and intact] Small open area to rt [right] inner buttocks, 0.5 (centimeter) cm x 0.5 cm, Wound bed white, No sign or symptoms (s/s) infection, purple 1.25 cm x 1.25 cm area to coccyx, No open No complaint of (c/o) from resident."

b. Review of the Weekly Pressure Ulcer Record on 5/17/21 showed a pressure injury to the resident's coccyx, described as a "Suspected Deep Tissue Injury" measuring 3.1cm x 3.1cm, as well as a stage II pressure ulcer to the right gluteal fold, measuring 0.4 cm x 0.6 cm.

c. Review of a 5/4/21 IDT admission progress note showed " ...Due to [resident] being at risk, the following interventions have been implemented: Pressure reducing mattress on bed, specialized gel cushion in wheelchair ..." Further review of the current care plan showed these interventions were not documented as being in place until 5/17/21. Review of the May 2021 TAR and current physician orders showed no preventive or curative interventions were in place until 5/17/21.

d. Review of 5/17/21 "Communication Form and Progress Note" annotated the resident made the condition or symptom worse by " ...refusing to get out of [his/her] wheelchair." Review of all progress notes since admission showed no documented refusals, resistance to cares, or objections to interventions while at the facility. Further review showed no progress notes communicating staff concerns, or communication with the resident's family, regarding potential worries surrounding skin breakdown or injuries.

2. Review of the annual MDS assessment dated 2/21/21 showed resident #3 had diagnoses which included cardiorespiratory conditions, COVID-19,

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Type 2 diabetes, anxiety, and sleep apnea. Further review showed the resident required oxygen and was at risk for developing a pressure ulcer, but did not have a pressure ulcer. Review of the care plan, last revised on 5/20/21, showed interventions which directed staff to keep oxygen tubing cushions over both ears, and to have the resident wear the oxygen tubing under the right ear. The following concerns were identified:

a. Review of the 5/11/21 "Weekly Pressure Ulcer Record" showed a new stage II pressure ulcer on the resident's right ear.

b. Review of the physician order dated 5/11/21 showed "Ensure that resident is not wearing [his/her] oxygen tubing above [his/her] right ear. Make sure that foam tubing cushions are in place to both sides. every shift." Further review showed a second order of "Stage II pressure ulcer to right ear upper crease: Cleanse area and ensure it is dry. Place collagen to the wound bed and then cover with a small piece of cutimed mesh [a type of wound dressing]. Cover with bandage. every day shift every other day." Review of the physician order dated 5/20/21 showed "Stage II Pressure ulcer to right ear upper crease: Cleanse area and ensure it is dry. Place collagen to the wound bed cover with bandage. every day shift every other day."

c. Observation on 5/20/21 at 9:53 AM showed the resident in his/her wheelchair in his/her room. The resident was wearing an oxygen cannula looped over his/her head and the tubing was looped over the left ear and not over the right ear. The oxygen tubing was pressed tightly across the resident's right cheek. Further, observation showed no cannula tubing wrap was in place along any of the cannula tubing. Observation at 10:05 AM showed RN #1 addressed the pressure ulcer to the right ear. She cleansed the open

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area, then placed collagen to the wound, and a bandage. Interview with the resident at that time revealed the dressing frequently fell off and the oxygen cannula tubing wrap "fell off all the time". Interview with the RN #1 at that time revealed "We try and put the pad on, but it gets knocked off all the time. So, [s/he] doesn't have the pads on." The RN made no attempt to place a tubing wrap on the left ear cannula tubing.

d. Interview with the DON on 5/20/21 at 1:16 PM revealed the facility's expectation was the padding for the oxygen cannula to be in place if the resident was wearing the cannula around the ears. Further, she revealed the resident was at risk for pressure ulcers and the facility was doing weekly checks prior to him/her developing the pressure ulcer on the right ear.

3. Review of the facility Skin Management policy, last revised July 2017, showed "Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed and provided treatment to promote healing, prevent infection, and prevent new ulcers from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes."