STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Complaint survey was conducted 4/3/18 through 4/5/18. One complaint was investigated. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 77 certified bed facility was 73 at the time of the survey. The survey sample consisted of 4 current Resident reviews (Residents #1 through Resident #4) and one closed record reviews (Resident #5).	F 000	Preparation and submission of the plan of correction does not constitute an admission, or agreement by the provider of the truth or the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of the requirement under state law.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility failed for one resident (Resident #5) in a survey sample of five residents, to be free from neglect, requiring	F 600	1. Root Cause Analysis completed on (3/12/18. Ad Hoc QAPI Committee Meeting held on (3/21/18). Four Step Performance Improvement Plan initiated on 3/12/18. Resident #5 no longer resides in facility. Resident #2 skin has been reassessed, treatment plan in place. Wound Care Nurse no longer employed by facility. 2. Quality Review conducted by DON/Designee of resident's current skin condition utilizing Weekly Skin Evaluation Tool on (3/12/18). Regional Director of Clinical Services to validate findings.	

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

Executive Director 5/2/18

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F 600	Continued From page 1 hospitalization for severe sepsis due to failure to assess and treat an acquired sacral wound, dehydration, amputation of the first and second toes on the right foot due to gangrene and bilateral unable to stage pressure wounds on the heels resulting in harm. Resident #2 did not receive treatment for an acquired stage II sacral pressure wound. 1. Resident #5's acquired sacral wound, heel pressure wounds were not treated and the resident suffered dehydration from lack of appropriate interventions, such as IV (intravenous fluids) or placement of a tube for feeding resulting in harm. 2. Resident #2 acquired a stage II sacral wound that did not receive treatment. The findings included: 1. Resident #5's acquired sacral wound, heel pressure wounds were not treated and the resident suffered dehydration from lack of appropriate interventions, such as IV (intravenous fluids) or placement of a tube for feeding resulting in harm. Resident #5 was admitted to the facility on 2/9/15 and discharged to the hospital on 3/11/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, anxiety, dysphagia (difficulty swallowing) and dementia. Resident #5's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 2/14/18 coded Resident #5 with both short and long term memory loss with severe cognitive impairment. The MDS was	F 600	2. Quality Review conducted by DON/Designee on (3/12/18) of resident's with pressure ulcers prescribed treatments verifying transcription to Treatment Record (TAR), completed as prescribed. Regional Director of Clinical Services to validate findings. Quality Review conducted by MDS Coordinator/Designee of skin/pressure ulcer care plans conducted appropriate skin/pressure ulcer interventions on (4/13/18). Regional MDS Coordinator to validate findings. Quality Review conducted by DON/Designee of licensed nurse evaluation/communication of resident change in condition/use of SBAR on (3/12/18).	

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F 600	Continued From page 2 completed as a significant change in status assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. There were no wounds documented on the MDS, and the resident was coded as being at risk for skin breakdown. Review of the clinical record revealed a nurses note dated 2/23/18 which read: "IDT (interdisciplinary team) held, Resident triggered for 14.3% weight loss over a six month period. Recommended med pass 60 ml (milliliters) three times daily to increase daily kcal (kilocalories) intake. Continue to monitor weight per facility protocol." The weights were documented as followed: 10/6/17: 160 # (Pounds) 11/6/17: 156# 12/17/18: 155# 1/7/18: 150# 2/7/18: 138 # On 3/2/18, a dietary note revealed: "Per nursing staff at weekly wound meeting, resident has a stage 2 sacral ulcer and wound between right great toe and 1st toe. Recommend addition of multivitamin and Prostat 30 cc (cubic centimeters) to promote skin integrity and wound healing." The Prostat (protein supplement) was initiated on 3/6/18, but the multivitamin was not on the MAR (medication administration record); there was no documentation the multivitamin was given.	F 600	2. Quality Review conducted by Registered Dietician (RD) of residents identified with significant weight loss to determine appropriate interventions on (4/27/18). Quality Review conducted by DON/Designee to verify interventions for residents with significant weight loss implemented/documented in medical record as applicable i.e. TAR, IDT Notes, etc. on (). Regional Director of Clinical Services to validate findings. Quality Review of Morning Clinical Meeting/weekly IDT Meeting(s) conducted by Regional Director of Clinical Services on (3/17/18) to validate process correct/effective. Quality Review of weekly IDT resident review meetings conducted by Regional Director of Clinical Services on (3/17/18) to validate process correct/effective. Follow up based on findings.	

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F 600	Continued From page 3 Review of the resident's care plan dated 12/6/17 revealed the resident did not address the resident's potential for skin breakdown. There were no interventions for the prevention of pressure wounds. On 3/5/18 (after development of the acquired pressure wound), the care plan had been updated to include interventions for prevention, but was not updated to include the sacral wound or the wounds on the toes. On 4/5/18, an interview with the MDS coordinator (RN-registered nurse A). When asked to identify prevention for skin breakdown on the care plan, RN(A) stated, "No prevention, just care planned for pain." She went on to state that the resident "should be care planned for pressure ulcer prevention." On 3/5/18, a nurses note documented the following: "Resident noted to have a 5 cm by 3 cm (centimeter) stage 2 sacral ulcer covered with slough, green foul smelling drainage noted. Resident also has an elevated temperature of 100.2 (degrees). Notified (name of physician) of resident's condition, new orders were given to start Keflex 250 mg twice a day for 10 days and to refer resident to the wound care clinic. Review of the TAR (treatment administration record) for March, 2018, revealed no treatment orders for this wound, or for treatment of the toes. The NPUAP (national pressure ulcer advisory panel) describes a stage 2 as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present." "Slough is defined as yellow	F 600	3. Regional Director of Clinical Services provided individual re-education for Director of Nursing on Best Practice for Pressure Ulcer/Skin, Best Practice Morning Clinical Meeting, Weekly IDT Meeting Process, and Resident Change in Condition (SBAR), Neglect Policy and Neglect Regulation on (3/17/18). Regional Director of Clinical Services to complete re-education of IDT on Director of Nursing on Best Practice for Pressure Ulcer/Skin, Best Practice Morning Clinical Meeting, Weekly IDT Meeting Process, Neglect Policy and Neglect Regulation on (4/3/18). DON/Designee provided Licensed Nurses re-education on Best Practice for Pressure Ulcer/Skin, Resident Change in Condition (SBAR), Neglect Policy and Neglect Regulation on (3/12/18).	

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F 600	Continued From page 4 devitalized tissue, that can be stringy or thick and adherent on the tissue bed. This wound bed has both yellow stringy slough as well as thick adherent slough. Slough on a wound bed should be surgically debrided to allow for ingrowth of healthy granulation tissue." On 3/9/18 revealed the following nurse's note: "Reassessment of wound 3/9/18 of sacral region. Stage 3 wound pink with some slough. Hydrogel applied with dressing. MD notified and RP (responsible party) notified of treatment regimen." Further review of the MAR revealed no treatment order was written, nor was treatment documented on the TAR. The NPUAP describes a stage 3 ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." On 3/10/18 at 12:44 PM, the nurse's note read: "Resident on ABT (antibiotic therapy). Temperature of 102.1 Attempted to administer po (by mouth) Tylenol 650 mg. Resident having trouble swallowing. medication. Notified FNP (family nurse practitioner). New orders given for Tylenol suppositories 650 mg prn (as needed) every 6 hours for elevated temperature and pain."	F 600	3. Regional MDS Coordinator provided re-education to MDS Department regarding pressure ulcer/skin care plan content/interventions on (4/17/18). 4. DON/Designee to conduct Quality Improvement Monitoring of resident's skin condition 5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. DON/Designee to conduct Quality Improvement Monitoring utilizing Morning Clinical Meeting Process to verify residents with pressure ulcers treatment orders transcribed/ implemented/completed 5x/week x4weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn.	

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F 600	Continued From page 5 On 3/11/18 at 3:10 AM, the nurse's note read: "Resident remains on ABT. She is running a temperature of 101.0 pushed fluids gave Tylenol bring down temperature. will check again." On 3/11/18 at 9:15 AM, the nurse's notes read: "Upon assessing resident noticed residents (sic) condition had worsened since yesterday. Left sided facial drooping remains, resident lethargic and only moans/responds to painful stimuli. Unable to swallow any fluids or food. Attempted to offer resident medication and water unsuccessful. Resident has a temperature of 101.4. FNP in facility at this time and evaluated resident upon request. New orders were given to send resident to (name of hospital)." On 3/11/18, the FNP note read: "Asked by staff to see resident . Was called yesterday because she had a fever. Is on Cephalexin at present. She was less active yesterday, not eating, drooling and not as responsive as usual. She is lying in bed turned towards left. She clenched eyes shut but PERLA (pupils equal and responsive to light, accommodation). Her mouth drooped left side. She has legs drawn up towards chest. No edema. She has a sacral wound with a very foul odor. Her lungs remain clear. A/P (assessment /plan): Fever obtunded : DM (diabetes); dysphagia, sacral decubitus. She is full code. I advised to send her to hospital for evaluation due to worsening condition." Review of the hospital records revealed on 3/11/18 at 11:50 AM note by the receiving nurse documented, "Pt (patient) with gown on that had dried food on it."	F 600	4. DON/Designee to conduct Quality Improvement Monitoring utilizing Morning Clinical Meeting Process of identification/communication of resident change in condition use of SBAR 5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. MDS Coordinator/Designee to conduct Quality Improvement Monitoring of residents skin/pressure ulcer care plans for appropriate interventions weekly x 6 weeks, every other week x 4 weeks, then monthly and prn. RD/Designee to conduct Quality Improvement Monitoring of residents with significant weight loss for effective interventions weekly x 8 weeks, then monthly and prn. DON/Designee to conduct Quality Improvement Monitoring utilizing Morning Clinical Process of resident with significant weight loss medical	

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F 600	Continued From page 6 On 3/11/18, the emergency department nursing note documented a call from the DON (director of nursing) from the discharging facility which read: "I just want you all to know, this patient has an awful wound, and it has been treated. She is sick and dying. We have been treating with antibiotics. I just want you to know this is not neglect on our parts. It has not been neglected." On 3/11/18 at 11:32 AM, the ER nurse documented, "Has a sacral wound that smells awful and the staff at (name of facility) has not changed it." On 3/11/18 at 11:52 AM, the ER physician documented: "The patient presents with decubitus ulcers. The onset was unknown. The course/duration of symptoms is worsening. Location, sacral. The character of symptoms is pain, redness, drainage and warmth. The degree of symptoms is severe. ... per nh (nursing home) increased lethargy over the last 3 days with worsening sacral ulcer... nursing home resident, concerns of neglect." "Skin: warm, dirty, undated sacral dressing removed, a large stage 4 sacral decubitus measuring 6 cm by 4 cm with large eschar, inferior edge of eschar is open and draining purulent drainage. Ulcer tracks under the skin bilaterally and inferiorly, + malodor, no bleeding. 2 cm by 1 cm eschar on right shin no fluctuance, no drainage. Ulceration with purulent drainage noted between right first and second toes. Bilateral heel eschars noted no fluctuance, no drainage. Impression and Plan: Dehydration, Sepsis, Stage 4 decubitus ulcer, Hypernatremia (high sodium)." Review of the labs done 3/11/18 at the hospital revealed:	F 600	4. record to validate interventions completed as ordered5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. Quality Improvement Monitoring of Morning Clinical and weekly IDT Meetings for effective process to be conducted by Regional Director of Clinical Services weekly x 4 weeks, monthly x 2 months, then quarterly and prn. Quality Improvement Monitoring to be conducted by Regional MDS Coordinator of skin/pressure ulcer Care Plans for verification of interventions weekly x 4 weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of Compliance 05/16/18	

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F 600	Continued From page 7 Sodium 157 (Critical) Normal 134-149 Chloride 117 (high) Normal 95-108 Glucose 298 (high) Normal less than 120 BUN 52 (high) Normal 7-20 Creatinine (1.01 (high) Normal 0.5-1.4 White blood count 21.8 (high) Normal 4.5-10 NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable" On 3/13/18, the resident underwent surgical amputation of her right first and second toes due to :"gangrene." The sacral wound was surgically debrided. A PEG (percutaneous endogastric) tube was placed for feeding and hydration. On 3/21/18, the discharge summary read, "Discharge diagnosis: 1. Severe sepsis. secondary to multiple skin lesions. 2. Stage 4 sacral decubitus status post debridement up to the bone. 3. Right 1-2 toe gangrene status post amputation. 4. Advanced dementia. 5. Chronic issues. At time of discharge she was stable and afebrile." The resident was not discharged back to the discharging facility. On 4/4/18 at approximately 9:30 AM, the DSS (department of social services) was notified that	F 600		

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F 600	Continued From page 8	F 600		

surveyor was on site for the complaint. She stated, "I want you to see my notes." A copy of the notes was received. The following notes were recorded from the DSS SW (social worker) of her conversation with the DON: 3/6/18: "Documented as a stage 2, patient not eating (could not get anything in her). Nurse informed worker that patient not taking in nutrients wound were not going to heal, but the wounds were being treated. Husband was notified of about what was going on with his wife."

3/9/18: "(Name of resident) health declined. She is a full code (if stop breathing full code) wanted husband to change from full code. He would not agree. Wound was measured and it had increased in size. She had no nutrients to feed the body." Worker asked the question several times, how many days does a person not eat before it is determined to seek medical attention outside of the nursing home and if wound care was not working when do you seek medical attention outside of the nursing home. Nurse (name of DON) response was skin breakdown happens fast when a patient is not eating... worker never received a direct answer to the question.

Review of the nurse's notes written by the wound care nurse, (WCN C) were written as late entries on 3/19/18 (after the 3/11/18 discharge note):

3/19/18 for 3/1/18: "Stage 2 to sacral region. Wound pink with drainage noted. size 1 by 1. Odor noted. Hydrogel dressing ordered every day to sacral ulcer. MD notified and received order." No order for this treatment was written, nor was the order written on the TAR.

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F 600	Continued From page 9 3/19/18 for 3/1/18: Necrotic tissue noted to toes on right foot with ulcer stage 1 between great toe and second toe. Order for Hydrogel and gauze dressing ordered per MD and RP (responsible party was notified." No order for this treatment was written or documented on the TAR. 3/19/18 for 3/1/18: Wound noted on the right lower leg stage 2, 3 by 1. No drainage, redness noted. Sureprep ordered. MD and RP contacted." No order was written nor documented on the TAR. 3/19/18 for 3/1/18: Wound noted to right second toe, 2 by 2. Stage 2 with yellowish drainage. Sureprep and gauze dressing ordered. MD contacted and RP notified. Again, no treatment order was written, nor was treatment documented on the TAR. 3/19/18 for 3/1/18: Wound noted between great toe and 2nd toe. Slough drainage..sureprep administered. MD and RP notified. No treatment order was written nor were any treatments documented on the TAR. 3/19/18 for 2/28/18: Sacral wound observed. 1 by 1. Stage 2 wound bed pink with exudate, odor noted. Hydrogel and dressing applied. MD notified and RP notified. No treatment order was written, nor were any treatments documented on the TAR. Review of the wound tracking notes revealed hand written notes with an entry for 2/28/18 (on tracking the documentation stated it was first observed 3/1/18) for 1 by 1 cm stage 2 sacral wound) and a stage 1 right toes with "necrotic tissue" right toes. The next tracking note dated	F 600		

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F 600	Continued From page 10 3/9/18 which has the notation on the bottom of the record, "late entry" shows a 7 cm by 4.0 cm by 1cm depth,stage 3. On 4/3/18 at 2:00 PM, a brief interview was conducted with the wound care nurse, WCN (C). When asked who was responsible for the wound tracking, she stated, "I guess I am; I didn't know that I was supposed to." On 4/4/18 at 9:00 AM, the Divisional Executive Director stated, "(name of WCN C) will not be in today; we told her to take care of things at home." 4/4/18 at 3:40 PM, an interview with the DON (director of nursing) was conducted. She stated, "It is a hot mess. I was doing wounds and I showed the ADON (assistant director of nursing-WCN (C)) how to." The DON went on to state that there "were no treatments documented." 4/4/18 at 3:40 PM, the Administrator was present for above interview. She stated, "We thought she had a lot of experience- we were told she was a certified wound nurse; she was not." On 4/5/18 at 9:30 AM, an interview was conducted with LPN (B). She stated, "It was brought to my attention there was a dark spot on her sacrum." She went on to state that the CNA (certified nursing assistant) was told to keep cream on it. It (sacral area) opened up on Monday. "I never heard anything else about it." She went on to say that two days later, it had an odor and the CNA thought it looked "funny". "I measured it myself, it was 5 cm by 3 cm, open with green drainage." She stated that she called the physician who said to start antibiotics and	F 600		

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F 600	Continued From page 11	F 600		

refer to the wound clinic. She denied knowledge if lab work was ordered, and stated, "It was all on (name of wound nurse,WCN (C))."

On 4/5/18 at 11:40 AM, CNA (A) was interviewed. She stated she was familiar with Resident #5. She stated that the resident fed herself, ate very slowly, and that she pocketed food. She stated, "I would massage her throat." She also stated she had "stopped eating for two weeks", that "she ate less and less." She said that she reported this toWCN (C). The CNA reported that the wound on her back had greenish discharge and a very strong odor. She went on to state that for "a couple of days before (resident was sent out) her diaper (sic) had no urine." She also stated, "She literally was not eating in the last two days and would moan when she was turned."

On 4/5/18 at 11:55 AM, a telephone interview was conducted with the resident's physician. He stated, "I was following her for her feet and sacrum, she had ups and downs." The physician was asked if he had observed the wounds. He stated, "I don't recall." The physician was asked if the family had been offered the option of a feeding tube, as the resident was a full code. He stated, "I think we did a couple of years ago." He was asked if he had been aware the wound had progressed to a stage 3 with odor, fever, would he have sent her out earlier, he stated, "I think I would." The physician was asked if he had ordered labs, he stated, "Sometimes I get a CBC (complete blood count). Apparently she had not been eating or drinking."

The facility presented the following when asked for their policy and procedure for pressure ulcers: "Best Practices_ Skin & Wound": Under skin

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F 600	Continued From page 12 observation: Re-evaluate wound/skin treatment within two weeks of start date and every 2 weeks thereafter. Skin Health: Relieve and protect heel pressure. Provide pressure redistribution cushions for residents in wheelchairs, evaluate for adaptive equipment/positioning devices/specialty mattress. Therapy screen/evaluation as indicated. Nutrition: Monitor lab values to include, but not limited to CBC, prealbumin levels. Monitor weight trends. Review and update care plan reflecting interventions. It is to be noted that the family was not offered a PEG tube for nutrition, no labs were drawn to measure degree of infection and there were no preventative interventions in place to prevent the skin breakdown such as cushions or a specialty mattress, or heel pressure cushions/boots. 2. Resident #2 acquired a stage II sacral wound that did not receive treatment. Resident #2 was admitted to the facility on 5/3/14 and discharged to the hospital on 3/7/18 and readmitted on 3/15/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, hyperlipidemia and dementia. Resident #2's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 3/29/18 coded Resident #2 with a BIMS (brief interview of mental status) of "9" out of a possible 15, or moderate cognitive impairment. The MDS was completed as a 14 day assessment. The resident required extensive	F 600		

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care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. The resident was coded as having a stage 4 pressure ulcer on readmission.

On 2/23/18, the nurse's notes contain the following entry: "Wound assessment performed. Stage 2 to sacral area region. Measurements obtained. No odor noted. Treatment as ordered." Review of the February, 2018 MAR (medication administration record) revealed there were no orders written or treatments documented for the sacral wound through the entire month of February.

Review of the wound care tracking records for 2/28/18 revealed: Measurements of 1 cm by 2 cm with no depth recorded, as a stage II. On 3/9/18, documented as a "late entry" , the measurements were 1.5 cm by 2 cm, with no depth recorded, stage II.

The resident was sent to the hospital on 3/6/18 and returned on 3/15/18 with a stage 4 sacral ulcer. There was no wound description from the hospital.

Review of the March, 2018 TAR revealed the return treatment for the sacral wound start date was 3/17/18, but the wound was not treated until 3/19/18. The wound was documented as being treated on 3/20/18, no documentation for 3/21/18 to 3/23/18, 3/26/18 and 3/30/18.

On 4/4/18 at 2:10 PM, wound treatment was done by LPN (A). The wound dressing was not in

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place; the CNA had told LPN (A) and she told the CNA to take it off. There were two wounds, one on the right and one on the left. The wound on the right buttock was approximately 3 by 5 cm with scattered slough. The wound on the left was approximately 2-3 cm in diameter with granulation tissue. Hydrogel was applied to the wound bed, sure prep applied around the wounds and a foam dressing was applied. The dressing was dated by the LPN. The LPN was asked to take off the heel boots. On the right heel, it had a dry, dark blister, which was treated with sure prep. The left heel was intact, sure prep was applied. The heel boots were re-applied. LPN(A) washed her hands appropriately. The resident showed no signs of pain or discomfort during the treatment. The resident was on a Low air loss mattress.

Review of the care plan dated 4/3/18 revealed the resident was care planned for risk of skin impairment and had been revised to include the sacral and heel wound.

The facility presented the following Plan of Correction (does not have an AOC (allegation of compliance date) dated 3-11-18:

1. NP (nurse practitioner) in facility to assess resident for wound infection. Resident presented with temp, wound increase, exudate. Family and DON notified. Nurse had not yet changed treatment to sacral wound. DON notified hospital of patient condition.

2. All other residents were assessed by facility nurse to ensure there were no signs of wound infection. Facility sweep was initiated (completed 3/14/18).

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F 600	Continued From page 15 3. DON provided re-education of nurses regarding skin assessments, notification of family and physician and wound formulary. (3-12-18). Contacted EMT for wound nurse to provide additional wound care education. CNA education if any skin alteration is noted to inform nurse immediately (need to complete Stop and Watch). Any new skin alteration will be discussed during the clinical meeting to ensure notification and treatments are in place. UDA weekly skin assessments will be monitored daily during the clinical meeting. 4. DON/Designee will complete Quality Monitoring Tool 5 times weekly x 4 weeks. This information will be presented by DON at monthly QAPI (quality assessment performance improvement) to assess the need for ongoing education and need for further monitoring. The DON stated there had been no QA meeting since the POC.	F 600		
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	F 656	1. Root Cause Analysis completed on (4/19/18). Ad Hoc QAPI Committee Meeting held on (3/21/18). Resident #5 no longer resides in facility. 2. Quality Review of current residents Care Plans completed by MDS	

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F 656	Continued From page 16 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 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 staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed to for one resident (Resident #5) of five residents in the survey sample, to develop a care plan for the prevention of pressure ulcers. Resident #5 acquired a pressure ulcer to the sacrum, which progressed to a stage 4 wound, as well as unable to stage wounds on both heels, requiring hospitalization for severe sepsis due to the sacral	F 656	2. Coordinator/Designee (4/13/18) to ensure plan in place for preventative skin breakdown/pressure ulcer. Quality Review findings validated by Regional MDS Coordinator utilizing Quality Monitoring process on (4/20/18). Follow up based on findings. 3. Regional MDS Coordinator provided individual re-education regarding implementation of skin/pressure ulcer prevention care plans to MDS Department on (4/17/18). Regional MDS Coordinator provided re-education to IDT team regarding implementation of skin/pressure ulcer prevention care plans. Director of Nursing/Designee Licensed Nurses re-education on skin/pressure ulcer prevention care plans. Residents with Pressure ulcers reviewed weekly through Clinical Meeting process to ensure care plans reflect services and treatments.	

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F 656	Continued From page 17 wound. Resident #5 did not have a care plan developed for prevention of skin breakdown. The findings included: Resident #5 was admitted to the facility on 2/9/15 and discharged to the hospital on 3/11/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, anxiety, dysphagia (difficulty swallowing) and dementia. Resident #5's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 2/14/18 coded Resident #5 with both short and long term memory loss with severe cognitive impairment. The MDS was completed as a significant change in status assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. There were no wounds documented on the MDS, and the resident was coded as being at risk for skin breakdown. On 3/2/18, a dietary note revealed: "Per nursing staff at weekly wound meeting, resident has a stage 2 sacral ulcer and wound between right great toe and 1st toe. Review of the resident's care plan dated 12/6/17 revealed the resident did not address the resident's potential for skin breakdown. There were no interventions for the prevention of pressure wounds. On 3/5/18 (after development	F 656	4. MDS Coordinator/Designee to conduct Quality Improvement Monitoring of resident care plans for skin/pressure ulcer prevention care plans weekly x 6 weeks, every other week x 4 weeks, then monthly and prn. Quality Improvement Monitoring to be conducted by Regional MDS Coordinator of skin/pressure ulcer Care Plans for verification of interventions weekly x 4 weeks, monthly x 2 months, then interventions weekly x 4 weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of Compliance 05/16/18.	

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F 656	Continued From page 18 of the acquired pressure wound), the care plan had been updated to include interventions for prevention, but was not updated to include the sacral wound or the wounds on the toes. On 3/11/18 at 11:52 AM, the ER physician documented: "The patient presents with decubitus ulcers. The onset was unknown. The course/duration of symptoms is worsening. Location, sacral. The character of symptoms is pain, redness, drainage and warmth. The degree of symptoms is severe. ... per nh (nursing home) increased lethargy over the last 3 days with worsening sacral ulcer... nursing home resident, concerns of neglect." "Skin: warm, dirty, undated sacral dressing removed, a large stage 4 sacral decubitus measuring 6 cm by 4 cm with large eschar, inferior edge of eschar is open and draining purulent drainage. Ulcer tracks under the skin bilaterally and inferiorly, + malodor, no bleeding. 2 cm by 1 cm eschar on right shin no fluctuance, no drainage. Ulceration with purulent drainage noted between right first and second toes. Bilateral heel eschars noted no fluctuance, no drainage. Impression and Plan: Dehydration, Sepsis, Stage 4 decubitus ulcer, Hypernatremia (high sodium)." On 4/5/18, an interview with the MDS coordinator (RN-registered nurse A). When asked to identify prevention for skin breakdown on the care plan, RN(A) stated, "No prevention, just care planned for pain." She went on to state that the resident "should be care planned for pressure ulcer prevention." On 4/5/18, at approximately 10:00 AM, the Administrator and Corporate Consultant were notified of above findings.	F 656		

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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 observation, staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed to prevent, assess appropriately, treat and monitor a pressure ulcer of the sacrum for one Resident, Resident #5 (closed record) in a survey sample of 5 residents, resulting in a stage 4 pressure ulcer of the sacrum and bilateral unable to stage pressure wounds to the heels. The resident required hospitalization for severe sepsis due to wound infection. In addition, the resident's first and second toes on the right foot had to be amputated due to lack of treatment to the toes. For Resident #2, the facility failed to treat an acquired stage II pressure wound on the sacrum resulting in harm 1. Resident #5 sustained a sacral wound that was not treated, was inaccurately assessed by the wound nurse, which progressed to a stage 4, requiring hospitalization for severe sepsis of the	F 686	1. Root Cause Analysis completed on (3/12/18). Ad Hoc QAPI Committee Meeting held on (3/21/18). Four Step Performance Improvement Plan initiated on 3/12/18. Resident #5 no longer resides in facility. Resident #2 skin has been reassessed, treatment in place. Wound Care Nurse no longer employed by facility. 2. Quality Review conducted by DON/Designee of resident's current skin condition utilizing Weekly Skin Evaluation Tool on (3/12/18). Regional Director of Clinical Services to validate findings utilizing Quality Monitoring Process. Quality Review conducted by DON/Designee on (3/12/18) of resident's with pressure ulcers prescribed treatments verifying transcription to Treatment Record (TAR), completed as	

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F 686	Continued From page 20 wound. The resident's first and second toes on the right foot had to be amputated. The resident also had eschar on both heels which the facility did not identify or treat. This resulting in harm. 2. Resident #2 acquires a stage II sacral wound that did not receive treatment. The findings included: Resident #5 was admitted to the facility on 2/9/15 and discharged to the hospital on 3/11/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, anxiety, dysphagia (difficulty swallowing) and dementia. Resident #5's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 2/14/18 coded Resident #5 with both short and long term memory loss with severe cognitive impairment. The MDS was completed as a significant change in status assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. There were no wounds documented on the MDS, and the resident was coded as being at risk for skin breakdown. Review of the clinical record revealed a nurses note dated 2/23/18 which read: "IDT (interdisciplinary team) held, Resident triggered for 14.3% weight loss over a six month period. Recommended med pass 60 ml (milliliters) three times daily to increase daily kcal (kilocalories)	F 686	2. prescribed. Regional Director of Clinical Services to validate findings through Quality Monitoring process. Quality Review conducted by MDS Coordinator/Designee of skin/pressure ulcer care plans conducted appropriate skin/pressure ulcer interventions on (4/13/18). Regional MDS Coordinator to validate findings utilizing Quality Monitoring process. Quality Review conducted by DON/Designee of licensed nurse evaluation/communication of resident change in condition/use of SBAR on (3/12/18). Quality Review conducted by Registered Dietician (RD) of residents identified with significant weight loss to determine appropriate interventions on (4/27/18). Quality Review conducted by DON/Designee to verify interventions for residents with	

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F 686	Continued From page 21 intake. Continue to monitor weight per facility protocol." The weights were documented as followed: 10/6/17: 160 # (pounds) 11/6/17: 156# 12/17/18: 155# 1/7/18: 150# 2/7/18: 138 # On 3/2/18, a dietary note revealed: "Per nursing staff at weekly wound meeting, resident has a stage 2 sacral ulcer and wound between right great toe and 1st toe. Recommend addition of multivitamin and Prostat 30 cc (cubic centimeters) to promote skin integrity and wound healing." The Prostat (protein supplement) was initiated on 3/6/18, but the multivitamin was not on the MAR (medication administration record); there was no documentation the multivitamin was given. Review of the resident's care plan dated 12/6/17 revealed the resident did not address the resident's potential for skin breakdown. There were no interventions for the prevention of pressure wounds. On 3/5/18 (after development of the acquired pressure wound), the care plan had been updated to include interventions for prevention, but was not updated to include the sacral wound or the wounds on the toes. On 4/5/18, an interview with the MDS coordinator (RN-registered nurse A). When asked to identify prevention for skin breakdown on the care plan, RN(A) stated, "No prevention, just care planned for pain." She went on to state that the resident "should be care planned for pressure ulcer prevention."	F 686	2. significant weight loss implemented/documented in medical record as applicable i.e. TAR, IDT Notes, etc. on (4/20/18 Date). Regional Director of Clinical Services to validate findings. Quality Review of Morning Clinical Meeting/weekly IDT Meeting(s) conducted by Regional Director of Clinical Services on (3/17/18) to validate utilizing Quality Monitoring process. Quality Review of weekly IDT resident review meetings conducted by Regional Director of Clinical Services on (3/17/18) to validate process correct/effective utilizing Quality Monitoring process. Follow up based on findings.	

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F 686	Continued From page 22 On 3/5/18, a nurses note documented the following: "Resident noted to have a 5 cm by 3 cm (centimeter) stage 2 sacral ulcer covered with slough, green foul smelling drainage noted. Resident also has an elevated temperature of 100.2 (degrees). Notified (name of physician) of resident's condition, new orders were given to start Keflex 250 mg twice a day for 10 days and to refer resident to the wound care clinic. Review of the TAR (treatment administration record) for March, 2018, revealed no treatment orders for this wound, or for treatment of the toes. The NPUAP (national pressure ulcer advisory panel) describes a stage 2 as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present." "Slough is defined as yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed. This wound bed has both yellow stringy slough as well as thick adherent slough. Slough on a wound bed should be surgically debrided to allow for ingrowth of healthy granulation tissue." On 3/9/18 revealed the following nurse's note: "Reassessment of wound 3/9/18 of sacral region. Stage 3 wound pink with some slough. Hydrogel applied with dressing. MD notified and RP (responsible party) notified of treatment regimen." Further review of the MAR revealed no treatment order was written, nor was treatment documented on the TAR. The NPUAP describes a stage 3 ulcer as a "Full	F 686	3. Regional Director of Clinical Services provided individual re-education for Director of Nursing on Best Practice for Pressure Ulcer/Skin, Best Practice Morning Clinical Meeting, Weekly IDT Meeting Process, and Resident Change in Condition (SBAR), Neglect Policy and Neglect Regulation on (3/17/18). Regional Director of Clinical Services to complete re-education of IDT on Director of Nursing on Best Practice for Pressure Ulcer/Skin, Best Practice Morning Clinical Meeting, Weekly IDT Meeting Process, Neglect Policy and Neglect Regulation on (4/3/18). DON/Designee provided Licensed Nurses re-education on Best Practice for Wound/Skin, Resident Change In Condition (SBAR), Neglect Policy and Neglect Regulation on (3/12/18).	

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F 686	Continued From page 23 thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." On 3/10/18 at 12:44 PM, the nurse's note read: "Resident on ABT (antibiotic therapy). Temperature of 102.1 Attempted to administer po (by mouth) Tylenol 650 mg. Resident having trouble swallowing. medication. Notified FNP (family nurse practitioner). New orders given for Tylenol suppositories 650 mg prn (as needed) every 6 hours for elevated temperature and pain." On 3/11/18 at 3:10 AM, the nurse's note read: "Resident remains on ABT. She is running a temperature of 101.0 pushed fluids gave Tylenol bring down temperature. will check again." On 3/11/18 at 9:15 AM, the nurse's notes read: "Upon assessing resident noticed residents (sic) condition had worsened since yesterday. Left sided facial drooping remains, resident lethargic and only moans/responds to painful stimuli. Unable to swallow any fluids or food. Attempted to offer resident medication and water unsuccessful. Resident has a temperature of 101.4. FNP in facility at this time and evaluated resident upon request. New orders were given to send resident to (name of hospital)."	F 686	3 Regional MDS Coordinator provided re-education to MDS Department regarding pressure ulcer/skin care plan content/interventions on (4/17/18). 4. DON/Designee to conduct Quality Improvement Monitoring of resident's skin condition 5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. DON/Designee to conduct Quality Improvement Monitoring utilizing Morning Clinical Meeting Process to verify residents with pressure ulcers treatment orders transcribed/ implemented/completed 5x/week x4weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. DON/Designee to conduct Quality Improvement Monitoring utilizing Morning Clinical Meeting Process of identification/communication of	

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F 686	Continued From page 24 On 3/11/18, the FNP note read: "Asked by staff to see resident . Was called yesterday because she had a fever. Is on Cephalexin at present. She was less active yesterday, not eating, drooling and not as responsive as usual. She is lying in bed turned towards left. She clenched eyes shut but PERLA (pupils equal and responsive to light, accommodation). Her mouth drooped left side. She has legs drawn up towards chest. No edema. She has a sacral wound with a very foul odor. Her lungs remain clear. A/P (assessment /plan): Fever obtunded : DM (diabetes); dysphagia, sacral decubitus. She is full code. I advised to send her to hospital for evaluation due to worsening condition." Review of the hospital records revealed on 3/11/18 at 11:50 AM note by the receiving nurse documented, "Pt (patient) with gown on that had dried food on it." On 3/11/18, the emergency department nursing note documented a call from the DON (director of nursing) from the discharging facility which read: "I just want you all to know, this patient has an awful wound,and it has been treated. She is sick and dying. We have been treating with antibiotics. I just want you to know this is not neglect on our parts. It has not been neglected." On 3/11/18 at 11:32 AM, the ER nurse documented, "Has a sacral wound that smells awful and the staff at (name of facility) has not changed it." On 3/11/18 at 11:52 AM, the ER physician documented: "The patient presents with decubitus ulcers. The onset was unknown. The	F 686	4. resident change in condition use of SBAR 5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. MDS Coordinator/Designee to conduct Quality Improvement Monitoring of residents skin/pressure ulcer care plans for appropriate interventions weekly x 6 weeks, every other week x 4 weeks, then monthly and prn. RD/Designee to conduct Quality Improvement Monitoring of residents with significant weight loss for effective interventions weekly x 8 weeks, then monthly and prn. DON/Designee to conduct Quality Improvement Monitoring utilizing Morning	

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F 686	Continued From page 25 course/duration of symptoms is worsening. Location, sacral. The character of symptoms is pain, redness, drainage and warmth. The degree of symptoms is severe. ... per nh (nursing home) increased lethargy over the last 3 days with worsening sacral ulcer... nursing home resident, concerns of neglect." "Skin: warm, dirty, undated sacral dressing removed, a large stage 4 sacral decubitus measuring 6 cm by 4 cm with large eschar, inferior edge of eschar is open and draining purulent drainage. Ulcer tracks under the skin bilaterally and inferiorly, + malodor, no bleeding. 2 cm by 1 cm eschar on right shin no fluctuance, no drainage. Ulceration with purulent drainage noted between right first and second toes. Bilateral heel eschars noted no fluctuance, no drainage. Impression and Plan: Dehydration, Sepsis, Stage 4 decubitus ulcer, Hypernatremia (high sodium)." NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable" On 3/13/18, the resident underwent surgical amputation of her right first and second toes due to :"gangrene." The sacral wound was surgically debrided. A PEG (percutaneous endogastric) tube was placed for feeding and hydration.	F 686	4. Clinical Process of resident with significant weight loss medical record to validate interventions completed as ordered5x/week x 4 weeks, 3x/week x 4 weeks, weekly x 4 weeks, then monthly and prn. Quality Improvement Monitoring of Morning Clinical and weekly IDT Meetings for effective process to be conducted by Regional Director of Clinical Services weekly x 4 weeks, monthly x 2 months, then quarterly and prn. Quality Improvement Monitoring to be conducted by Regional MDS Coordinator of skin/pressure ulcer Care Plans for verification of interventions weekly x 4 weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 686	Continued From page 26 On 3/21/18, the discharge summary read, "Discharge diagnosis: 1. Severe sepsis. secondary to multiple skin lesions. 2. Stage 4 sacral decubitus status post debridement up to the bone. 3. Right 1-2 toe gangrene status post amputation. 4. Advanced dementia. 5. Chronic issues. At time of discharge she was stable and afebrile." The resident was not discharged back to the discharging facility. On 4/4/18 at approximately 9:30 AM, the DSS (department of social services) was notified that surveyor was on site for the complaint. She stated, "I want you to see my notes." A copy of the notes was received. The following notes were recorded from the DSS SW (social worker) of her conversation with the DON: 3/6/18: "Documented as a stage 2, patient not eating (could not get anything in her). Nurse informed worker that patient not taking in nutrients wound were not going to heal, but the wounds were being treated. Husband was notified of about what was going on with his wife." 3/9/18: "(Name of resident) health declined. She is a full code (if stop breathing full code) wanted husband to change from full code. He would not agree. Wound was measured and it had increased in size. She had no nutrients to feed the body." Worker asked the question several times, how many days does a person not eat before it is determined to seek medical attention outside of the nursing home and if wound care was not working when do you seek medical attention outside of the nursing home. Nurse (name of DON) response was skin breakdown happens fast when a patient is not eating... worker never received a direct answer to the	F 686	5. Date of Compliance 05/16/18	

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F 686	Continued From page 27 question. Review of the nurse's notes written by the wound care nurse WCN (C) were written as late entries on 3/19/18 (after the 3/11/18 discharge note): 3/19/18 for 3/1/18: "Stage 2 to sacral region. Wound pink with drainage noted. size 1 by 1. . Odor noted. Hydrogel dressing ordered every day to sacral ulcer. MD notified and received order." No order for this treatment was written, nor was the order written on the TAR. 3/19/18 for 3/1/18: Necrotic tissue noted to toes on right foot with ulcer stage 1 between great toe and second toe. Order for Hydrogel and gauze dressing ordered per MD and RP (responsible party was notified." No order for this treatment was written or documented on the TAR. 3/19/18 for 3/1/18: Wound noted on the right lower leg stage 2, 3 by 1. No drainage, redness noted. Sureprep ordered. MD and RP contacted." No order was written nor documented on the TAR. 3/19/187 for 3/1/18: Wound noted to right second toe, 2 by 2. Stage 2 with yellowish drainage. Sureprep and gauze dressing ordered. MD contacted and RP notified. Again, no treatment order was written, nor was treatment documented on the TAR. 3/19/18 for 3/1/18: Wound noted between great toe and 2nd toe. Slough drainage..sureprep administered. MD and RP notified. No treatment order was written nor were any treatments documented on the TAR.	F 686		

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F 686	Continued From page 28 3/19/18 for 2/28/18: Sacral wound observed. 1 by 1. Stage 2 wound bed pink with exudate, odor noted. Hydrogel and dressing applied. MD notified and RP notified. No treatment order was written, nor were any treatments documented on the TAR. Review of the wound tracking notes revealed hand written notes with an entry for 2/28/18 (on tracking the documentation stated it was first observed 3/1/18) for 1 by 1 cm stage 2 sacral wound) and a stage 1 right toes with "necrotic tissue" right toes. The next tracking note dated 3/9/18 which has the notation on the bottom of the record, "late entry" shows a 7 cm by 4.0 cm by 1cm depth,stage 3. On 4/3/18 at 2:00 PM, a brief interview was conducted with the wound care nurse, WCN (C). When asked who was responsible for the wound tracking, she stated, "I guess I am; I didn't know that I was supposed to." On 4/4/18 at 9:00 AM, the Divisional Executive Director stated, "(name of WCN (C)) will not be in today; we told her to take care of things at home." 4/4/18 at 3:40 PM, an interview with the DON (director of nursing) was conducted. She stated, "It is a hot mess. I was doing wounds and I showed the ADON (assistant director of nursing-WCN (C)) how to." The DON went on to state that there "were no treatments documented." 4/4/18 at 3:40 PM, the Administrator was present for above interview. She stated, "We thought she had a lot of experience- we were told she was a certified wound nurse; she was not."	F 686		

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F 686	Continued From page 29 On 4/5/18 at 9:30 AM, an interview was conducted with LPN (B). She stated, "It was brought to my attention there was a dark spot on her sacrum." She went on to state that the CNA (certified nursing assistant) was told to keep cream on it. It (sacral area) opened up on Monday. "I never heard anything else about it." She went on to say that two days later, it had an odor and the CNA thought it looked "funny". "I measured it myself, it was 5 cm by 3 cm, open with green drainage." She stated that she called the physician who said to start antibiotics and refer to the wound clinic. She denied knowledge if lab work was ordered, and stated, "It was all on (name of wound nurse, WCN (C))." On 4/5/18 at 11:40 AM, CNA (A) was interviewed. She stated she was familiar with Resident #5. She stated that the resident fed herself, ate very slowly, and that she pocketed food. She stated, "I would massage her throat." She also stated she had "stopped eating for two weeks", that "she ate less and less." She said that she reported this to WCN (C). The CNA reported that the wound on her back had greenish discharge and a very strong odor. She went on to state that for "a couple of days before (resident was sent out) her diaper (sic) had no urine." She also stated, "She literally was not eating in the last two days and would moan when she was turned." On 4/5/18 at 11:55 AM, a telephone interview was conducted with the resident's physician. He stated, "I was following her for her feet and sacrum, she had ups and downs." The physician was asked if he had observed the wounds. He stated, "I don't recall." The physician was asked if the family had been offered the option of a feeding tube, as the resident was a full code. He	F 686		

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stated, "I think we did a couple of years ago." He was asked if he had been aware the wound had progressed to a stage 3 with odor, fever, would he have sent her out earlier, he stated, "I think I would." The physician was asked if he had ordered labs, he stated, "Sometimes I get a CBC (complete blood count). Apparently she had not been eating or drinking."

The facility presented the following when asked for their policy and procedure for pressure ulcers: "Best Practices_ Skin & Wound": Under skin observation: Re-evaluate wound/skin treatment within two weeks of start date and every 2 weeks thereafter.

Skin Health: Relieve and protect heel pressure. Provide pressure redistribution cushions for residents in wheelchairs, evaluate for adaptive equipment/positioning devices/specialty mattress. Therapy screen/evaluation as indicated.

Nutrition: Monitor lab values to include, but not limited to CBC, prealbumin levels. Monitor weight trends. Review and update care plan reflecting interventions.

It is to be noted that the family was not offered a PEG tube for nutrition, no labs were drawn to measure degree of infection and there were no preventative interventions in place to prevent the skin breakdown such as cushions or a specialty mattress, or heel pressure cushions/boots.

2. Resident #2 acquired a stage II sacral wound that did not receive treatment.

Resident #2 was admitted to the facility on 5/3/14

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and discharged to the hospital on 3/7/18 and readmitted on 3/15/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, hyperlipidemia and dementia.

Resident #2's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 3/29/18 coded Resident #2 with a BIMS (brief interview of mental status) of "9" out of a possible 15, or moderate cognitive impairment. The MDS was completed as a 14 day assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. The resident was coded as having a stage 4 pressure ulcer on readmission.

On 2/23/18, the nurse's notes contain the following entry: "Wound assessment performed. Stage 2 to sacral area region. Measurements obtained. No odor noted. Treatment as ordered." Review of the February, 2018 MAR (medication administration record) revealed there were no orders written or treatments documented for the sacral wound through the entire month of February.

Review of the wound care tracking records for 2/28/18 revealed: Measurements of 1 cm by 2 cm with no depth recorded, as a stage II. On 3/9/18, documented as a "late entry" , the measurements were 1.5 cm by 2 cm, with no depth recorded, stage II.

The resident was sent to the hospital on 3/6/18 and returned on 3/15/18 with a stage 4 sacral

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ulcer. There was no wound description from the hospital.

Review of the March, 2018 TAR revealed the return treatment for the sacral wound start date was 3/17/18, but the wound was not treated until 3/19/18. The wound was documented as being treated on 3/20/18, no documentation for 3/21/18 to 3/23/18, 3/26/18 and 3/30/18.

On 4/4/18 at 2:10 PM, wound treatment was done by LPN (A). The wound dressing was not in place; the CNA had told LPN (A) and she told the CNA to take it off. There were two wounds, one on the right and one on the left. The wound on the right buttock was approximately 3 by 5 cm with scattered slough. The wound on the left was approximately 2-3 cm in diameter with granulation tissue. Hydrogel was applied to the wound bed, sure prep applied around the wounds and a foam dressing was applied. The dressing was dated by the LPN. The LPN was asked to take off the heel boots. On the right heel, it had a dry, dark blister, which was treated with sure prep. The left heel was intact, sure prep was applied. The heel boots were re-applied. LPN(A) washed her hands appropriately. The resident showed no signs of pain or discomfort during the treatment. The resident was on a Low air loss mattress.

Review of the care plan dated 4/3/18 revealed the resident was care planned for risk of skin impairment and had been revised to include the sacral and heel wound.

The facility presented the following Plan of Correction (does not have an AOC (allegation of compliance date) dated 3-11-18:

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F 686	Continued From page 33 1. NP (nurse practitioner) in facility to assess resident for wound infection. Resident presented with temp, wound increase, exudate. Family and DON notified. Nurse had not yet changed treatment to sacral wound. DON notified hospital of patient condition. 2. All other residents were assessed by facility nurse to ensure there were no signs of wound infection. Facility sweep was initiated (completed 3/14/18). 3. DON provided re-education of nurses regarding skin assessments, notification of family and physician and wound formulary. (3-12-18). Contacted EMT for wound nurse to provide additional wound care education. CNA education if any skin alteration is noted to inform nurse immediately (need to complete Stop and Watch). Any new skin alteration will be discussed during the clinical meeting to ensure notification and treatments are in place. UDA weekly skin assessments will be monitored daily during the clinical meeting. 4. DON/Designee will complete Quality Monitoring Tool 5 times weekly x 4 weeks. This information will be presented by DON at monthly QAPI (quality assessment performance improvement) to assess the need for ongoing education and need for further monitoring. The DON stated there had been no QA meeting since the POC.	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692	1. Root Cause Analysis completed on (4/11/18). Ad Hoc QAPI Committee Meeting held on	

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F 692	Continued From page 34 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #5) in a survey sample of 5 residents, to provide food and fluids to prevent significant weight loss and dehydration requiring hospitalization resulting in harm. Resident #5 had a 14.3 % weight loss in six months. The resident had documented difficultly with swallowing, pocketing food and fever from infected wounds. The facility failed to offer alternative sources of hydration and/or nutrition, resulting in dehydration. This resulted in harm. The findings included: Resident #5 was admitted to the facility on 2/9/15	F 692	1. (3/21/18). Resident #5 no longer resides in facility. 2. Quality Review conducted by Registered Dietician of current facility residents for significant weight loss/interventions. DON and Regional Director of Clinical Services to validate utilizing Quality Monitoring process. Follow up based on findings. 3. Registered Dietician provided re-education to IDT team regarding weight loss including but not limited to significant weight loss/implementation of interventions on (4/27/18). Registered Dietician/Designee provided re-education to Licensed Nurses regarding weight loss including but not limited to significant weight loss/implementation of interventions on (4/27/18). Residents with Weight loss reviewed Weekly in Clinical Meeting.	

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F 692	Continued From page 35 and discharged to the hospital on 3/11/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, anxiety, dysphagia (difficulty swallowing) and dementia. Resident #5's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 2/14/18 coded Resident #5 with both short and long term memory loss with severe cognitive impairment. The MDS was completed as a significant change in status assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. There were no wounds documented on the MDS, and the resident was coded as being at risk for skin breakdown. Review of the clinical record revealed a nurses note dated 2/23/18 which read: "IDT (interdisciplinary team) held, Resident triggered for 14.3% weight loss over a six month period. Recommended med pass 60 ml (milliliters) three times daily to increase daily kcal (kilocalories) intake. Continue to monitor weight per facility protocol." The weights were documented as followed: 10/6/17: 160 # (pounds) 11/6/17: 156# 12/17/18: 155# 1/7/18: 150# 2/7/18: 138 # No weights were obtained after 2/7/18. There were no weekly weights documented.	F 692	4. Registered Dietician/Designee to conduct Quality Improvement Monitoring of residents exhibiting significant weight loss for implementation of interventions weekly x 8 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of Compliance 05/16/18	

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F 692	Continued From page 36 On 3/2/18, a dietary note revealed: "Per nursing staff at weekly wound meeting, resident has a stage 2 sacral ulcer and wound between right great toe and 1st toe. Recommend addition of multivitamin and Prostat 30 cc (cubic centimeters) to promote skin integrity and wound healing." The Prostat (protein supplement) was initiated on 3/6/18, but the multivitamin was not on the MAR (medication administration record); there was no documentation the multivitamin was given. On 3/5/18, a nurses note documented the following: "Resident noted to have a 5 cm by 3 cm (centimeter) stage 2 sacral ulcer covered with slough, green foul smelling drainage noted. Resident also has an elevated temperature of 100.2 (degrees). Notified (name of physician) of resident's condition, new orders were given to start Keflex 250 mg twice a day for 10 days and to refer resident to the wound care clinic." Review of the TAR (treatment administration record) for March, 2018, revealed no treatment orders for this wound, or for treatment of the toes. As stage II pressure wounds do not contain slough, the wound was assessed incorrectly and the information given to the physician about the resident's status was inaccurate. On 3/9/18, a dietary note read: "Per nursing staff at weekly wound meeting, Resident has a stage 2 sacral ulcer and wound between right great and 1st toe. Continue multivitamin and prostat (multivitamin order was not on the March MAR-medication administration record) 30 cc (cubic centimeters) twice daily to promote skin integrity and wound healing, per MD order." On 3/10/18 at 12:44 PM, the nurse's note read:	F 692		

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"Resident on ABT (antibiotic therapy). Temperature of 102.1 Attempted to administer po (by mouth) Tylenol 650 mg. Resident having trouble swallowing. medication. Notified FNP (family nurse practitioner). New orders given for Tylenol suppositories 650 mg prn (as needed) every 6 hours for elevated temperature and pain." No further assessments were documented until 3:10 AM.

On 3/11/18 at 3:10 AM, the nurse's note read: "Resident remains on ABT. She is running a temperature of 101.0 pushed fluids gave Tylenol bring down temperature. will check again." No further assessment until 9:15 AM the next morning.

On 3/11/18 at 9:15 AM, the nurse's notes read: "Upon assessing resident noticed residents (sic) condition had worsened since yesterday. Left sided facial drooping remains, resident lethargic and only moans/responds to painful stimuli. Unable to swallow any fluids or food. Attempted to offer resident medication and water unsuccessful. Resident has a temperature of 101.4. FNP in facility at this time and evaluated resident upon request. New orders were given to send resident to (name of hospital)."

On 3/11/18, the FNP note read: "Asked by staff to see resident . Was called yesterday because she had a fever. Is on Cephalexin at present. She was less active yesterday, not eating, drooling and not as responsive as usual. She is lying in bed turned towards left. She clenched eyes shut but PERLA (pupils equal and responsive to light, accommodation). Her mouth drooped left side. She has legs drawn up towards chest. No edema. She has a sacral wound with a very foul

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F 692	Continued From page 38 odor. Her lungs remain clear. A/P (assessment /plan): Fever obtunded : DM (diabetes); dysphagia, sacral decubitus. She is full code. I advised to send her to hospital for evaluation due to worsening condition." On 3/11/18 at 11:52 AM, the ER physician documented: "The patient presents with decubitus ulcers. The onset was unknown. The course/duration of symptoms is worsening. Location, sacral. The character of symptoms is pain, redness, drainage and warmth. The degree of symptoms is severe. ... per nh (nursing home) increased lethargy over the last 3 days with worsening sacral ulcer... nursing home resident, concerns of neglect." "Skin: warm, dirty, undated sacral dressing removed, a large stage 4 sacral decubitus measuring 6 cm by 4 cm with large eschar, inferior edge of eschar is open and draining purulent drainage. Ulcer tracks under the skin bilaterally and inferiorly, + malodor, no bleeding. 2 cm by 1 cm eschar on right shin no fluctuance, no drainage. Ulceration with purulent drainage noted between right first and second toes. Bilateral heel eschars noted no fluctuance, no drainage. Mouth: Dry mucous membranes. Impression and Plan: Dehydration, Sepsis, Stage 4 decubitus ulcer, Hypernatremia (high sodium)." Review of the labs done 3/11/18 at the hospital revealed: Sodium 157 (Critical) Normal 134-149 Chloride 117 (high) Normal 95-108 Glucose 298 (high) Normal less than 120 BUN 52 (high) Normal 7-20 Creatinine (1.01 (high) Normal 0.5-1.4 White blood count 21.8 (high) Normal 4.5-10	F 692		

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F 692	Continued From page 39 On 4/4/18 at approximately 9:30 AM, the DSS (department of social services) was notified that surveyor was on site for the complaint. She stated, "I want you to see my notes." A copy of the notes was received. The following notes were recorded from the DSS SW (social worker) of her conversation with the DON (director of nursing): 3/6/18: "Documented as a stage 2, patient not eating (could not get anything in her). Nurse informed worker that patient not taking in nutrients wounds were not going to heal, but the wounds were being treated. Husband was notified of about what was going on with his wife." 3/9/18: "(Name of resident) health declined. She is a full code (if stop breathing full code) wanted husband to change from full code. He would not agree. Wound was measured and it had increased in size. She had no nutrients to feed the body." Worker asked the question several times, how many days does a person not eat before it is determined to seek medical attention outside of the nursing home and if wound care was not working when do you seek medical attention outside of the nursing home. Nurse (name of DON) response was skin breakdown happens fast when a patient is not eating... worker never received a direct answer to the question. On 4/5/18 at 11:40 AM, CNA (A) was interviewed. She stated she was familiar with Resident #5. She stated that the resident fed herself, ate very slowly, and that she pocketed food. She stated, "I would massage her throat." She also stated she had "stopped eating for two weeks", that "she ate less and less." She said that she reported this	F 692		

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F 692	Continued From page 40	F 692		

to WCN (C). The CNA reported that the wound on her back had greenish discharge and a very strong odor. She went on to state that for "a couple of days before (resident was sent out) her diaper (sic) had no urine." She also stated, "She literally was not eating in the last two days and would moan when she was turned."

On 4/5/18 at 11:55 AM, a telephone interview was conducted with the resident's physician. He stated, "I was following her for her feet and sacrum, she had ups and downs." The physician was asked if he had observed the wounds. He stated, "I don't recall." The physician was asked if the family had been offered the option of a feeding tube, as the resident was a full code. He stated, "I think we did a couple of years ago." He was asked if he had been aware the wound had progressed to a stage 3 with odor, fever, would he have sent her out earlier, he stated, "I think I would." The physician was asked if he had ordered labs, he stated, "Sometimes I get a CBC (complete blood count). Apparently she had not been eating or drinking."

Review of the care plan dated 2/7/18 revealed there were no new interventions for risk of malnutrition since 2/13/17. Interventions included: Monitor and report to MD for signs and symptoms of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat appears concerned during meals. Another intervention was obtain and monitor lab work and monitor weight per facility protocol.

The policy and procedure for weekly weights included the following: "weekly weights for new admissions, weight losses (5%, 7.5% and 10%)

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F 692	Continued From page 41 and stage III and IV pressure sores." On 4/4/18 at 3:25 PM, the FSM (food service manager) was asked about weekly weights. She stated, "weekly times 4 weeks for wounds, weight loss and tube feeding." She also stated, "The dietician may recommend tube feeding for weight loss." Review of the dietary notes revealed no documentation that the family was offered a feeding tube due to dysphagia, weight loss and pressure wounds. On 4/4/18 at 3:30 PM, the DON stated, "I do not know" when questioned if the family was offered a feeding tube. The resident's family had recently (3-9-18) refused to have the advance directive changed to no code. She remained a full code by request of the family. On 4/5/18, at approximately 10:00 AM, the Administrator and Corporate Consultant were notified of above findings.	F 692		
F 726 SS=G	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726	Root Cause Analysis completed on (3/12/18). Ad Hoc QAPI and Regional Director of Clinical Services to validate utilizing Quality Monitoring process. Follow up based on findings. Committee Meeting held on (3/21/18). (WCN C) is no longer employed by facility.	

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F 726	Continued From page 42 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility failed to ensure one staff member, LPN (licensed practical nurse) C, was competent to provide wound care and tracking for Resident #5, resulting in an acquired sacral wound deteriorating to a stage 4 wound with severe sepsis resulting in hospitalization; nor did LPN (C) document the presence of bilateral unable to stage heel wounds. LPN (C) failed to document treatment and accurate assessments of pressure wounds resulting in deterioration of the resident's condition, requiring hospitalization for treatment of sepsis, surgical debridement of the sacrum, and amputation of the resident's first two toes on the right foot.	F 726	2. DON/Designee to conduct Quality Observation of Licensed Nursing staff for competent provision of skin/pressure ulcer care and service. Regional Director of Clinical Services to validate Licensed Nurse Competency utilizing Quality Monitoring process. Follow up based on findings. 3. Regional Director of Clinical Services provided re-education to Nurse Management Team regarding provision of skin/pressure ulcer care and service on (3/12/18). DON/Designee provided re-education to Licensed Nurses regarding provision of skin/pressure ulcer care and services on (4/19/18).	

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F 726	Continued From page 43 The findings included: Resident #5 was admitted to the facility on 2/9/15 and discharged to the hospital on 3/11/18. Diagnoses included, but not limited to, diabetes, type 2, high blood pressure, anxiety, dysphagia (difficulty swallowing) and dementia. Resident #5's Minimum Data Set (MDS, an assessment protocol) with an Assessment Reference Date of 2/14/18 coded Resident #5 with both short and long term memory loss with severe cognitive impairment. The MDS was completed as a significant change in status assessment. The resident required extensive care with all ADL's (activities of daily living such as bed mobility and toileting) of one staff member. The resident was incontinent of bowel and bladder. The resident was coded as having unplanned, non physician prescribed weight loss. There were no wounds documented on the MDS, and the resident was coded as being at risk for skin breakdown. Review of the clinical record revealed a nurses note dated 2/23/18 which read: "IDT (interdisciplinary team) held, Resident triggered for 14.3% weight loss over a six month period. Recommended med pass 60 ml (milliliters) three times daily to increase daily kcal (kilocalories) intake. Continue to monitor weight per facility protocol." The weights were documented as followed: 10/6/17: 160 # (pounds) 11/6/17: 156# 12/17/18: 155# 1/7/18: 150# 2/7/18: 138 #	F 726	4. DON/Designee to conduct Quality Improvement Monitoring of Licensed Nurse competent provision of skin/pressure ulcer care and service 5 days/week x 2 weeks, weekly x4 weeks, bi weekly x 4 weeks, monthly x 3 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Date of Compliance 05/16/18	

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F 726	Continued From page 44 On 3/2/18, a dietary note revealed: "Per nursing staff at weekly wound meeting, resident has a stage 2 sacral ulcer and wound between right great toe and 1st toe. Recommend addition of multivitamin and Prostat 30 cc (cubic centimeters) to promote skin integrity and wound healing." The Prostat (protein supplement) was initiated on 3/6/18, but the multivitamin was not on the MAR (medication administration record); there was no documentation the multivitamin was given. On 3/5/18, a nurses note documented the following: "Resident noted to have a 5 cm by 3 cm (centimeter) stage 2 sacral ulcer covered with slough, green foul smelling drainage noted. Resident also has an elevated temperature of 100.2 (degrees). Notified (name of physician) of resident's condition, new orders were given to start Keflex 250 mg twice a day for 10 days and to refer resident to the wound care clinic. Review of the TAR (treatment administration record) for March, 2018, revealed no treatment orders for this wound, or for treatment of the toes. The NPUAP (national pressure ulcer advisory panel) describes a stage 2 as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present." "Slough is defined as yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed. This wound bed has both yellow stringy slough as well as thick adherent slough. Slough on a wound bed should be surgically debrided to allow for ingrowth of	F 726		

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F 726	Continued From page 45 healthy granulation tissue." On 3/9/18 revealed the following nurse's note: "Reassessment of wound 3/9/18 of sacral region. Stage 3 wound pink with some slough. Hydrogel applied with dressing. MD notified and RP (responsible party) notified of treatment regimen." Further review of the MAR revealed no treatment order was written, nor was treatment documented on the TAR. The NPUAP describes a stage 3 ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable." On 3/10/18 at 12:44 PM, the nurse's note read: "Resident on ABT (antibiotic therapy). Temperature of 102.1 Attempted to administer po (by mouth) Tylenol 650 mg. Resident having trouble swallowing. medication. Notified FNP (family nurse practitioner). New orders given for Tylenol suppositories 650 mg prn (as needed) every 6 hours for elevated temperature and pain." On 3/11/18 at 3:10 AM, the nurse's note read: "Resident remains on ABT. She is running a temperature of 101.0 pushed fluids gave Tylenol bring down temperature. will check again."	F 726		

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F 726	Continued From page 46 On 3/11/18 at 9:15 AM, the nurse's notes read: "Upon assessing resident noticed residents (sic) condition had worsened since yesterday. Left sided facial drooping remains, resident lethargic and only moans/responds to painful stimuli. Unable to swallow any fluids or food. Attempted to offer resident medication and water unsuccessful. Resident has a temperature of 101.4. FNP in facility at this time and evaluated resident upon request. New orders were given to send resident to (name of hospital)." On 3/11/18, the FNP note read: "Asked by staff to see resident . Was called yesterday because she had a fever. Is on Cephalexin at present. She was less active yesterday, not eating, drooling and not as responsive as usual. She is lying in bed turned towards left. She clenched eyes shut but PERLA (pupils equal and responsive to light, accommodation). Her mouth drooped left side. She has legs drawn up towards chest. No edema. She has a sacral wound with a very foul odor. Her lungs remain clear. A/P (assessment /plan): Fever obtunded : DM (diabetes); dysphagia, sacral decubitus. She is full code. I advised to send her to hospital for evaluation due to worsening condition." Review of the hospital records revealed on 3/11/18 at 11:50 AM note by the receiving nurse documented, "Pt (patient) with gown on that had dried food on it." On 3/11/18, the emergency department nursing note documented a call from the DON (director of nursing) from the discharging facility which read: "I just want you all to know, this patient has an awful wound,and it has been treated. She is sick	F 726		

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F 726	Continued From page 47 and dying. We have been treating with antibiotics. I just want you to know this is not neglect on our parts. It has not been neglected." On 3/11/18 at 11:32 AM, the ER nurse documented, "Has a sacral wound that smells awful and the staff at (name of facility) has not changed it." On 3/11/18 at 11:52 AM, the ER physician documented: "The patient presents with decubitus ulcers. The onset was unknown. The course/duration of symptoms is worsening. Location, sacral. The character of symptoms is pain, redness, drainage and warmth. The degree of symptoms is severe. ... per nh (nursing home) increased lethargy over the last 3 days with worsening sacral ulcer... nursing home resident, concerns of neglect." "Skin: warm, dirty, undated sacral dressing removed, a large stage 4 sacral decubitus measuring 6 cm by 4 cm with large eschar, inferior edge of eschar is open and draining purulent drainage. Ulcer tracks under the skin bilaterally and inferiorly, + malodor, no bleeding. 2 cm by 1 cm eschar on right shin no fluctuance, no drainage. Ulceration with purulent drainage noted between right first and second toes. Bilateral heel eschars noted no fluctuance, no drainage. Impression and Plan: Dehydration, Sepsis, Stage 4 decubitus ulcer, Hypernatremia (high sodium)." NPUAP describes a stage 4 ulcer as a "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have	F 726		

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(adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable"

On 3/13/18, the resident underwent surgical amputation of her right first and second toes due to :"gangrene." The sacral wound was surgically debrided. A PEG (percutaneous endogastric) tube was placed for feeding and hydration.

On 3/21/18, the discharge summary read, "Discharge diagnosis: 1. Severe sepsis. secondary to multiple skin lesions. 2. Stage 4 sacral decubitus status post debridement up to the bone. 3. Right 1-2 toe gangrene status post amputation. 4. Advanced dementia. 5. Chronic issues. At time of discharge she was stable and afebrile." The resident was not discharged back to the discharging facility.

On 4/4/18 at approximately 9:30 AM, the DSS (department of social services) was notified that surveyor was on site for the complaint. She stated, "I want you to see my notes." A copy of the notes was received. The following notes were recorded from the DSS SW (social worker) of her conversation with the DON: 3/6/18: "Documented as a stage 2, patient not eating (could not get anything in her). Nurse informed worker that patient not taking in nutrients wound were not going to heal, but the wounds were being treated. Husband was notified of about what was going on with his wife."

3/9/18: "(Name of resident) health declined. She is a full code (if stop breathing full code) wanted

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F 726	Continued From page 49 husband to change from full code. He would not agree. Wound was measured and it had increased in size. She had no nutrients to feed the body." Worker asked the question several times, how many days does a person not eat before it is determined to seek medical attention outside of the nursing home and if wound care was not working when do you seek medical attention outside of the nursing home. Nurse (name of DON) response was skin breakdown happens fast when a patient is not eating... worker never received a direct answer to the question. Review of the nurse's notes written by the wound care nurse WCN (C) were written as late entries on 3/19/18 (after the 3/11/18 discharge note): 3/19/18 for 3/1/18: "Stage 2 to sacral region. Wound pink with drainage noted. size 1 by 1. Odor noted. Hydrogel dressing ordered every day to sacral ulcer. MD notified and received order." No order for this treatment was written, nor was the order written on the TAR. 3/19/18 for 3/1/18: Necrotic tissue noted to toes on right foot with ulcer stage 1 between great toe and second toe. Order for Hydrogel and gauze dressing ordered per MD and RP (responsible party was notified." No order for this treatment was written or documented on the TAR. 3/19/18 for 3/1/18: Wound noted on the right lower leg stage 2, 3 by 1. No drainage, redness noted. Sureprep ordered. MD and RP contacted." No order was written nor documented on the TAR. 3/19/187 for 3/1/18: Wound noted to right second	F 726		

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toe, 2 by 2. Stage 2 with yellowish drainage. Sureprep and gauze dressing ordered. MD contacted and RP notified. Again, no treatment order was written, nor was treatment documented on the TAR.

3/19/18 for 3/1/18: Wound noted between great toe and 2nd toe. Slough drainage..sureprep administered. MD and RP notified. No treatment order was written nor were any treatments documented on the TAR.

3/19/18 for 2/28/18: Sacral wound observed. 1 by 1. Stage 2 wound bed pink with exudate, odor noted. Hydrogel and dressing applied. MD notified and RP notified. No treatment order was written, nor were any treatments documented on the TAR.

Review of the wound tracking notes revealed hand written notes with an entry for 2/28/18 (on tracking the documentation stated it was first observed 3/1/18) for 1 by 1 cm stage 2 sacral wound) and a stage 1 right toes with "necrotic tissue" right toes. The next tracking note dated 3/9/18 which has the notation on the bottom of the record, "late entry" shows a 7 cm by 4.0 cm by 1cm depth,stage 3.

On 4/3/18 at 2:00 PM, a brief interview was conducted with the wound care nurse, WCN (C). When asked who was responsible for the wound tracking, she stated, "I guess I am; I didn't know that I was supposed to."

On 4/4/18 at 9:00 AM, the Divisional Executive Director stated, "(name of WCN (C)) will not be in today; we told her to take care of things at home."

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F 726	Continued From page 51 4/4/18 at 3:40 PM, an interview with the DON (director of nursing) was conducted. She stated, "It is a hot mess. I was doing wounds and I showed the ADON (assistant director of nursing-WCN (C)) how to." The DON went on to state that there "were no treatments documented." 4/4/18 at 3:40 PM, the Administrator was present for above interview. She stated, "We thought she had a lot of experience- we were told she was a certified wound nurse; she was not." On 4/5/18 at 9:30 AM, an interview was conducted with LPN (B). She stated, "It was brought to my attention there was a dark spot on her sacrum." She went on to state that the CNA (certified nursing assistant) was told to keep cream on it. It (sacral area) opened up on Monday. "I never heard anything else about it." She went on to say that two days later, it had an odor and the CNA thought it looked "funny". "I measured it myself, it was 5 cm by 3 cm, open with green drainage." She stated that she called the physician who said to start antibiotics and refer to the wound clinic. She denied knowledge if lab work was ordered, and stated, "It was all on (name of wound nurse, WCN (C))." On 4/5/18 at 11:40 AM, CNA (A) was interviewed. She stated she was familiar with Resident #5. She stated that the resident fed herself, ate very slowly, and that she pocketed food. She stated, "I would massage her throat." She also stated she had "stopped eating for two weeks", that "she ate less and less." She said that she reported this to WCN (C). The CNA reported that the wound on her back had greenish discharge and a very strong odor. She went on to state that for "a couple of days before (resident was sent out) her	F 726		

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F 726	Continued From page 52 diaper (sic) had no urine." She also stated, "She literally was not eating in the last two days and would moan when she was turned." On 4/5/18 at 11:55 AM, a telephone interview was conducted with the resident's physician. He stated, "I was following her for her feet and sacrum, she had ups and downs." The physician was asked if he had observed the wounds. He stated, "I don't recall." The physician was asked if the family had been offered the option of a feeding tube, as the resident was a full code. He stated, "I think we did a couple of years ago." He was asked if he had been aware the wound had progressed to a stage 3 with odor, fever, would he have sent her out earlier, he stated, "I think I would." The physician was asked if he had ordered labs, he stated, "Sometimes I get a CBC (complete blood count). Apparently she had not been eating or drinking." The facility presented the following when asked for their policy and procedure for pressure ulcers: "Best Practices_ Skin & Wound": Under skin observation: Re-evaluate wound/skin treatment within two weeks of start date and every 2 weeks thereafter. Skin Health: Relieve and protect heel pressure. Provide pressure redistribution cushions for residents in wheelchairs, evaluate for adaptive equipment/positioning devices/specialty mattress. Therapy screen/evaluation as indicated. Nutrition: Monitor lab values to include, but not limited to CBC, prealbumin levels. Monitor weight trends. Review and update care plan reflecting interventions.	F 726		

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F 726	Continued From page 53 It is to be noted that the family was not offered a PEG tube for nutrition or an IV (intravenous) fluids for hydration, no labs were drawn to measure degree of infection and there were no preventative interventions in place to prevent the skin breakdown such as cushions or a specialty mattress, or heel pressure cushions/boots. The facility presented the following Plan of Correction (does not have an AOC (allegation of compliance date) dated 3-11-18: 1. NP (nurse practitioner) in facility to assess resident for wound infection. Resident presented with temp, wound increase, exudate. Family and DON notified. Nurse had not yet changed treatment to sacral wound. DON notified hospital of patient condition. 2. All other residents were assessed by facility nurse to ensure there were no signs of wound infection. Facility sweep was initiated (completed 3/14/18). 3. DON provided re-education of nurses regarding skin assessments, notification of family and physician and wound formulary. (3-12-18). Contacted EMT for wound nurse to provide additional wound care education. CNA education if any skin alteration is noted to inform nurse immediately (need to complete Stop and Watch). Any new skin alteration will be discussed during the clinical meeting to ensure notification and treatments are in place. UDA weekly skin assessments will be monitored daily during the clinical meeting. 4. DON/Designee will complete Quality Monitoring Tool 5 times weekly x 4 weeks. This	F 726		

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F 726	Continued From page 54 information will be presented by DON at monthly QAPI (quality assessment performance improvement) to assess the need for ongoing education and need for further monitoring. The DON stated there had been no QA meeting since the POC.	F 726		