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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated (complaint) survey was conducted 3/5/19 through 3/6/19. Three complaints were investigated during the survey. Corrections are required for compliance with the 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 157 at the time of the survey. The survey sample consisted of 2 Resident reviews: One current resident review (Residents #1) and 1 closed record review (Residents #2).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff, resident and family interview, it was determined the facility staff failed to conduct complete and accurate skin assessments in accordance to the comprehensive assessment and care plan for 1 of 2 residents (Resident #2) in the survey sample. The facility staff failed to conduct complete and accurate assessments of Resident #2's skin based on dark skin tone which resulted in a delay	F 684	1. Resident #2 was seen by the wound physician and admitted to the hospital on 2/20/19. Therefore, no further actions were taken. 2. The Director of Nursing/Designee completed a head to toe assessment of residents with darker skin tones to ensure these residents have a complete and accurate skin assessment. Any variance will have a treatment order, care planned and MD/RR notifications as indicated.	4/15/19

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

Electronically Signed | 03/18/2019

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

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F 684	Continued From page 1 in treatment and care to her right outer foot. The findings include: Resident #2 was admitted to the nursing facility on 1/16/18 with diagnoses that included dementia, hyperlipidema, hypertension, osteoarthritis, osteoporosis and peripheral vascular disease (PVD). Resident #2's Admission Minimum Data Set (MDS) assessment dated 1/23/18 coded Resident #2 on the Brief Interview for Mental Status (BIMS) with a score of 7 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for decision making. The resident was assessed to require two staff for bed mobility, dressing and personal hygiene. The resident was coded totally dependent on two staff for toilet use and transfers. Resident #2 was assessed totally dependent on one staff for bathing and locomotion on and off the unit. The resident had range of motion limitations in both upper and lower extremities. The resident was not assessed with any pressure ulcers upon admission, but assessment to be at risk for them based on the Braden Scale Assessment and clinical assessments. The resident was not coded to have any foot problems or any other rashes, wounds or skin integrity problems. Resident #2 was coded to require pressure reducing devices for chair and bed, and nutrition and hydration interventions to manage skin problems. The Braden Scale Assessments presented to this surveyor dated 1/17/18, 5/29/18, 8/24/18 and 11/27/18 were identical in all areas of assessments and scored the resident with a 16	F 684	3. The policy and procedure on performing complete and accurate skin assessment along with pressure ulcer prevention was reviewed. RNs/LPNs/CNAs were reeducated on performing complete and accurate skin assessments. The in-service included but was not limited performing complete and accurate skin assessments on residents with darker skin tones and pressure area prevention and treatment. 4. The Director of Nursing/designee will audit weekly 15 residents for 6 weeks with darker skin tones to ensure an accurate and complete skin assessment will be completed. The Director of Nursing/Designee will report any trends or variance to Quality Assurance Performance Improvement Committee at least a quarterly	

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that indicated the resident was at risk for the development of pressure ulcers.

The care plan dated "1/31/18 to present" identified Resident #2 was at risk for pressure ulcers related to decreased mobility. The goal that the staff set for the resident was that she would remain free of skin breakdown. Some of the approaches to accomplish the set goal included check skin for redness, discoloration, bruises, open areas, swelling or pressure areas and report any signs of skin breakdown. Use pillows, pads, or wedges to reduce pressure on heels and pressure points, and turn/reposition.

The care plan dated "1/31/18 to present" identified Resident #2 had peripheral vascular disease. The goal set by the staff for the resident was that the skin on feet/legs will remain intact through next review. Some of the approaches the staff would implement to accomplish this goal included check feet and legs for redness, skin tears, swelling or pressure areas daily. Report any signs of skin breakdown. Perform complete skin assessments and record. Podiatrist to examine feet and trim nails.

The following information chronicles the right lateral foot wound:
-2/9/18-The wound care nurse's notes indicated an open area on lateral right foot that measured 2.0 centimeters (cm) long by (x) 2.0 wide cm x 0.1 depth with seroanquinous drainage. She noted the resident has a history of PVD, thus she entered in her note that the area was vascular related. Order: Cleanse *SilvaSorb topical gel extended release to wound bed and cover with dry dressing daily. *SilvaSorb Gel is infused with ionic silver technology for sustained antimicrobial

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protection; Advanced fluid handling capable of donating or absorbing moisture (https://www.medline.com/product/SilvaSorb-Silver-Antimicrobial-Wound-Gel/Antimicrobial-Gel/Z05-PF00181)

-4/11/18-The wound care specialist started following the resident. The wound measured 1.2 cm x 1.4 cm x 0.2 cm. with serous exudate. Treatment changed to cleanse with normal saline, apply *Collagen Ag to wound bed and cover with dry dressing every two days. Appetitive fair and on multivitamins. She had been ordered Remeron to increase appetite. Cannot detect DP pulse in left extremity, DP and PT pulse detected by portable Doppler in right extremity. *Collagen Ag is a sliver Collagen Matrix Dressing with Silver is intended for use on partial- and full-thickness wounds (https://www.woundsource.com/product/dermacol-ag-collagen-matrix-dressing-silver).

-4/18/18-The wound care specialist recommended arterial Doppler studies which were completed on 4/20/18 which indicated significant arterial sclerotic disease involving the right lower extremity and the left lower extremity borderline.

-4/25/18-New orders from the wound care specialist: Cleanse with normal saline, SilvaSorb topical gel, extended release once a day to wound bed. Recommendations for a vascular consult.

-5/8/18-Vascular consult indicated he was consulted due to "poor healing wound to right foot". He evaluated the right foot and diagnosed the area to be "pressure ulcer right lateral foot,

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moderate bilateral lower extremity PVD". His recommendations were "pressure relief lower extremities. Need to off load feet by placing foam under calves. Sheep skin booties to both feet (or equivalent) *Mepilex AG to right foot ulcer daily (or equivalent). * Mepilex AG is a Antimicrobial Soft silicone Foam Dressing absorbs exudate and maintains a healthy, moist wound environment (https://www.exmed.net/p-1987-molnlycke-mepilex-ag-antimicrobial-soft-silicone-foam-dressing.aspx). An interview was conducted with the Director of Nursing (DON) and the Director of Nursing Operations (DNO) on 3/6/19 where it was stated regardless of the vascular surgeons assessment that the area was pressure, the wound care specialist who recommended the vascular surgeon's consult did not accept the assessment, nor did she update her records to reflect his expertise assessment of the area as a pressure ulcer. They stated they initiated *Prevalon boots to protect the heels, pillows and wedges for positioning which was placed on the care plan. They stated they did not initiate a physician's order for the Prevalon boots or enter them on the Treatment Administration Record (TAR) to be signed off as in place each shift, but placed the treatment on the care plan as a nursing order. They also stated the resident was non-ambulatory and she curled up when she was in bed, preferred to lay on her right side and she was totally dependent on staff for positioning and remained in the position she was placed until re-positioned by nursing staff. *Prevalon® Heel Protector with Integrated Wedge was specifically designed to help reduce the risk of heel pressure injury while keeping the foot and leg in a neutral position (https://www.woundsource.com/product/prevalon-

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heel-protector-integrated-wedge).

-On 5/18/18, during the podiatrist's routine visit, he documented "pressure ulcer " to lateral right foot *"unstageable".

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (brown to light brown soft necrotic tissue) or eschar (black hard necrotic tissue) (https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/).

-On 8/29/18, the area to the right lateral foot had resolved. No further documentation of assessment of pulses in either lower extremity from the initial assessment by the wound care specialist since 4/11/18.

-On 2/13/19, the licensed nurse conducted a head to toe weekly skin assessment and indicted no skin integrity issues were identified.

-On 2/18/19, during a routine visit from the Podiatrist, he identified as his first assessment "large eschar (black hard necrotic tissue) pressure ulcer to lateral right foot, unstageable". The Podiatrist documented that he discussed his findings with the wound care nurse and ordered Iodosorb gel to right foot and a wound care evaluation.

-On 2/18/19, the wound care nurse evaluates the wound and documents "5.0 cm x 6.2 cm 0.0 depth (depth cannot determined) wound color black". The notes indicated the Resident

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Representative (RR) was notified of the condition of the lateral right foot via a voicemail message with a return call from the RR on 2/19/19. The Unit Manager #1 documented her assessment of the lateral right foot on 2/18/19 as "porous type opening to the right lateral foot, skin discolored and hard. Sanguineous drainage noted with odor. Area cleansed, dressing applied as ordered. Area measures 4 cm x 6 cm".

-On 2/20/19, the Nurse Practitioner (NP) indicated in her progress note that the the right lateral foot was assessed by the wound care specialist and that the wound care nurse reported the wound as necrotic and malodorous. The pulse was present but poor, that she had had a history if a similar wound and had an ongoing referral for a vascular consult in place. The NP documents under diagnosis and assessment, pressure injury of skin, unspecified injury state, daily dressing to right foot. The wound care specialist assessed the right lateral foot on 2/20/19 with orders to send to ER immediately. The resident was transferred to the local hospital ER on 2/20/19 and admitted with plans to amputate the right extremity above the knee.

During an interview with the DON and DNO on 3/6/19 that began at 10:00 a.m., they stated it was their expectation that socks are removed during bathing and that Certified Nursing Assistants (CNA) would report any and all discolored areas during bathing. There there were no nurse's notes that reflected skin problems until identified by the Podiatrist as large, eschar, black to right lateral foot on 2/18/19. The LPN Unit Manager #1 joined the interview at 11:30 a.m. She stated she saw drainage on a sheet but could not recall when in February 2019.

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She further stated she was asked to evaluate the wound on 2/18/19, after the Podiatrist on his routine visit found it, and she described it as porous, hard and black. She stated, "With a person like (Resident #2's name) skin who dark skin toned, you cannot see where there are skin problems. So the staff cannot tell if there is a problem because her skin is dark, it is hard to make accurate skin assessments." During the interview the LPN Unit Manager #1 consistently reiterated that accurate skin assessments could not be made with skin issues or breakdown on darker skin toned residents. The DNO was asked how should accurate skin assessments be made by nursing staff with dark skin in light of Resident #2's history and in general for all residents with darker skin tone, she stated, "The staff should use a bright light to examine the skin and depress the areas for bogginess, hardness, etc.".

During the aforementioned interview, the wound care nurse, LPN #2 joined the interview at 12:00 p.m. She stated she did not see any wounds unless it was determined from the nurse the wound was a *Stage III or above, thus she did not know about the severity of the lateral right foot. *A stage III pressure ulcer is a full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible (https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/).

During the above interview, the wound care nurse demonstrated where the wound was located on Resident #2 by taking off her shoe and pointing to the center bony area on the lateral right foot. She

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stated it was large, black, hard with some drainage and odor. When asked if the condition of this foot would have occurred in less than 24 hours she said, "No, it had to have been there prior, but I would not have seen it because I see Stage III's and above or when a nurse request me to evaluate an area. No one asked to me to evaluate the area until 2/18/19 when the Podiatrist requested to assess the right lateral foot because it was black." The DNO indicated that the lateral right foot blackened area was due to an acute ischemic incident that happened suddenly on 2/18/19. She also stated that the hospital recorded supported this information through their Doppler studies/PVL studies.

The hospital's PVL studies dated concluded "multi level moderate to severe right lower extremity arterial insufficiency. Moderate left lower extremity arterial insufficiency at the level of the Femoral-popliteal artery. When compared to the previous exam performed on 3/26/15 there is no change". The admission History and Physical indicated their was a infected gangrenous skin ulcer of the right foot, limited to breakdown of the skin, malodorous and dry with no swelling of either lower leg. Laboratory results indicated a systemic infection stemming from the foot ulcer, but there was no documentation of a right leg acute ischemic event. An above the knee amputation of the right leg was performed on 2/22/19 and the resident was discharged to another nursing facility for skilled services on 2/28/19.

On 3/6/19 at 1:02 p.m., during further interview with the DON and the DNO, the DON stated she received a call from one of Resident #2's nieces on 2/20/19 around 4:30 p.m., while she was in the

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ER with the resident, asking about what happened because the resident had to have an amputation. The DON stated she told her she would look into it and get back to her. They stated another niece contacted the corporation on 2/25/19 and scheduled a meeting for 2/27/19 at the corporate office. She stated the RR and one of the nieces were present and the second niece was participating in the meeting via phone. The DNO stated the family members were concerned about how the foot deteriorated to the point of amputation when they were told the wound had healed and no one informed them otherwise. They did not elaborate further about the details of the meeting.

On 3/6/19 at 1:34 p.m., the DON and DNO presented in-service education with sign in sheets on " Pressure Ulcer Prevention, Power Point and Pressure Ulcer Models" with a date of 2/25/19-ongoing (written on side of date). A "2" was marked over the "1" making the date from 2/15/19 to 2/25/19. When asked why the education was presented since they affirmed there was an acute ischemic event and not pressure related, the DNO stated they wanted to be proactive to cover all bases since the meeting with the family on 2/27/19. They could not explain that the date of the training was before the meeting. It was explained that the training covered assessment of different skin tones for pressure ulcer injury to include darker skin. This surveyor reviewed the training and validated it covered those assessment techniques. Out of 30 names on the sign in sheet, only 5 were identified as licensed nurses. They stated the licensed nurses were responsible to make official assessments of skin and that the training was ongoing. None of the Unit Managers were listed

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on the sign in sheet to have completed the essential training.

Several random interviews were conducted with the Unit Managers and Certified Nursing Assistants (CNA) on all three units to determine if they knew the specifics regarding assessment of darker skin tones:

On 3/6/19 at 1:45 p.m., on the Monroe Unit, the LPN UM #3 stated she did not have any recent training, but she would not examine skin differently than any other resident regardless of skin tone.

On 3/6/19 at 2:00 p.m., CNA #1 on the Monroe Unit, whose name was listed on the inservice training, stated she was not aware of any differences, but if she saw anything unusual she would bring it to the attention of the nurse to check it our further.

On 3/6/19 at 2:10 p.m., Licensed Practical Nurse (LPN) #4 on the Monroe Unit, stated she missed the training, but that she would make sure she asked if there was anything special she needed to know, but she conducts head to toe assessments as assigned on a weekly basis. She stated if the CNA's bring forth anything unusual they find during care regarding skin she follows up with a skin assessment.

The LPN UM (Unit Manager) #1 on Armistead Unit (where Resident #2 had resided) had already been interviewed earlier on 3/6/19 at 11:30 a.m. where she stated "With a person like (Resident #2's name) skin who dark skin toned, you cannot see where there are skin problems. So the staff cannot tell if there is a problem because her skin

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is dark, it is hard to make accurate skin assessments." The Unit Manager's name was not on the in-service sign in sheets for the training dated 2/25/19.

On 3/6/19 at 2:16 p.m., LPN #5 on the Armistead Unit stated although she had not attended the 2/25/19 training, she documented on the weekly skin sheets a head to toes assessment if an area was old or new, such as moles, skin tears, discoloration, sores, scabs regardless of skin tone. She stated she checks to see if an area that appears reddened blanches. She stated the physician is called and further orders are obtained if there is a problem. She said if an area is questionable, she gets the wound care nurse involved to make further assessment. She stated she had not had any training that specifically addressed special attention to dark skin tones when assessing questionable skin problems.

On 3/6/19 at 2:25 p.m., CNA #2 on the Armistead Unit, stated she had been trained about making sure she told the nurse or Unit Manager if during bathing she saw skin problems, but nothing specific about different skin tones.

On 3/6/19 at 2:35 p.m., LPN #6 on the Hampton Unit checked the sign in sheets for the in-service training dated 2/25/19 and stated her name was not on the list. She said the licensed nurse's are assigned weekly skin assessments either on the day or evening shift with head to toe assessments and the information is documented on a sheet and then entered into the computer. She stated, "The area may be more in depth than you think on dark skin than light skin and you have to take a much closer look." She said, "The CNAs should take socks off during bathing to

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wash resident's feet as well and report any breakdown or suspicious area to a licensed nurse to make an assessment, at which time we would ask the wound nurse to take a look or we can contact the physician for treatment orders." LPN #6 stated the Hampton Unit did not have a Unit Manager.

On 3/6/19 at 3:05 p.m., a telephone interview was conducted with the complainant. The complainant stated they were made aware in late summer that the lateral right foot area was healed and were shocked to learn on 2/18/19 there was a large black area on the lateral right foot which was examined by the wound care doctor on 2/20/19 with an immediate need to send the hospital because of the severe condition of the right foot. She stated the wound doctor said that it was probably an ischemic event, which they found out it was not. She said, "We moved Resident #2 from the previous nursing facility where she had no breakdown whatsoever to a facility that was closer to one of the family members, and she encounters breakdown." She stated she was a Nurse Practitioner and knew that necrosis, black eschar would not have occurred in the short time indicated by the facility, and she was told by nursing on 2/13/19 there were no areas anywhere. She stated the family felt the staff neglected to properly assess the resident's skin and provide prompt care to the foot which subsequently led to no other choice than to amputate. She said, "I am not blind to the fact that (Resident
#2's name) has PVD, but it did not automatically excuse lack of assessment and pressure relief, as was done in the previous facility to aggressively protect these type of residents and avoid severe conditions that lead to amputation.

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We regretted transferring her to (current facility's name), so after the amputation we chose to send her back to the previous nursing facility where her care will be monitored more closely. She had spent 6 months there with no skin problems."

On 3/6/19 at approximately 3:45 p.m., 30 minutes before survey exit, the DNO and DON present a Past Non Compliance (PNC) document with "skin integrity" penciled in over another topic and stated they were using this as a template to address the problem this surveyor brought to their attention during the survey. It was penciled in that the training on "skin integrity" started 2/25/19 and would be completed on 3/8/19. The training that had been presented earlier to this surveyor dated 2/25/19 was entitled "Pressure Ulcer Prevention, Power Point and Pressure Ulcer Models." It was determined that PNC could not be accepted based on the lateness of presenting the PNC plan, the discrepancy of education content and titles, the lack of knowledge from the upper management to include the Unit Managers, as well as charge nurses that were responsible to complete accurate skin assessments, and those that were on the list were mostly composed of CNAs with only 4 licensed Nurses. Another reason PNC could not be accepted was due to those that were on the list were not able to verbalize the method of assessing resident's with dark skin tones, which was stated was a reason why the right lateral foot ulcer was missed, easily detected and identified first by the Podiatrist on his routine visit.

The National Pressure Ulcer Advisory Panel state that a pressure ulcer classification system cannot be used to describe tissue loss in wounds other than pressure ulcers

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(https://www.npuap.org/wp-content/uploads/2012/03/Final_Quick_Treatment_for_web_2010.pdf).

The facility's policy and procedures titled pressure ulcer prevention/monitoring for effectiveness of the interventions dated as last reviewed on 4/3/14 indicated "at least daily, staff should remain alert to the potential changes in the skin condition of the resident and should evaluate and document the identified change. Weekly skin assessment by Registered Nurse (RN)/LPN. Monitor residents for condition changes that might increase the risk for breakdown..." "Risk factors that may increase a resident's susceptibility to develop or to not heal pressure ulcers include, but are not limited to: impaired/decreased mobility, decrease functional ability, impaired diffuse or localized blood flow (generalized atherosclerosis, lower extremity arterial insufficiency). Tissue closest to the bone may be the first tissue to undergo necrosis, usually over a bony prominence. The following may need to be evaluated for at risk residents: support surfaces, positioning (a common effective intervention for an individual with a pressure ulcer or who is at risk of developing one), determine if medical device is in use to include orthosis, braces, etc. and whether there are contractures. Assessment of a resident's skin integrity should guide the development and implementation of the repositioning plans which should be included in the care plan, which is critical for residents who are immobile or dependent on staff for repositioning. To effectively support the lower leg to raise feet from contact with the bed pillows, foam wedges, or other measures may be used. CNAs and other direct care staff should report any signs or symptoms of a potential pressure related impairment of skin integrity to the head/charge nurse immediately.

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F 684	Continued From page 15 The head/charge nurse should assess the resident and determine appropriate interventions. The supervisory level nurse/UM should be notified by the head/charge nurse of any areas of concern for further assessment. Complaint Deficiency.	F 684		
F 726 SS=D	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). §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'	F 726		4/15/19

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F 726	Continued From page 16 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff, resident and family interview, it was determined the facility staff failed to ensure licensed nurses and nurse aides had the specific competencies and skill sets to provide nursing and related services to assure residents maintained the highest physical well-being for 1 of 2 residents (Resident #2) in the survey sample. The facility staff failed to demonstrate competency in skills and techniques necessary to conduct complete and accurate assessments of Resident #2's skin based on dark skin tone which resulted in a delay in identification, treatment and care to her right outer foot ulcer. The findings include: Resident #2 was admitted to the nursing facility on 1/16/18 with diagnoses that included dementia, hyperlipidema, hypertension, osteoarthritis, osteoporosis and peripheral vascular disease (PVD). Resident #2's Admission Minimum Data Set (MDS) assessment dated 1/23/18 coded Resident #2 on the Brief Interview for Mental Status (BIMS) with a score of 7 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for decision making. The resident was assessed to require two staff for bed mobility, dressing and personal hygiene. The resident was coded totally dependent on two staff for toilet use and transfers. Resident #2 was assessed totally	F 726	1. Staff involved in the care of resident # 2 were reeducated on techniques of performing an accurate and complete skin assessment on a resident with darker toned skin. 2. Licensed staff will be evaluated to determine competency in skills and techniques in order to conduct complete and accurate skin assessments on residents with darker skin tones. 3. RNs/LPNs/CNAs were reeducated on competency in skills and techniques to conduct complete and accurate skin assessments on residents with darker skin tone. This included but is not limited to techniques such as using bright light, temperate, color and feel of the skin during assessments. 4. The Director of Nursing/designee will audit 10 staff member per week for 6 weeks to ensure they demonstrate competency in skills and techniques necessary to conduct complete and accurate assessments. The Director of Nursing/Designee will report any trends or variance to the Quality Assurance and Performance Improvement Committee at least a quarterly basis.	

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dependent on one staff for bathing and locomotion on and off the unit. The resident had range of motion limitations in both upper and lower extremities. The resident was not assessed with any pressure ulcers upon admission, but assessment to be at risk for them based on the Braden Scale Assessment and clinical assessments. The resident was not coded to have any foot problems or any other rashes, wounds or skin integrity problems. Resident #2 was coded to require pressure reducing devices for chair and bed, and nutrition and hydration interventions to manage skin problems.

The Braden Scale Assessments presented to this surveyor dated 1/17/18, 5/29/18, 8/24/18 and 11/27/18 were identical in all areas of assessments and scored the resident with a 16 that indicated the resident was at risk for the development of pressure ulcers.

The care plan dated "1/31/18 to present" identified Resident #2 was at risk for pressure ulcers related to decreased mobility. The goal that the staff set for the resident was that she would remain free of skin breakdown. Some of the approaches to accomplish the set goal included check skin for redness, discoloration, bruises, open areas, swelling or pressure areas and report any signs of skin breakdown. Use pillows, pads, or wedges to reduce pressure on heels and pressure points, and turn/reposition.

The care plan dated "1/31/18 to present" identified Resident #2 had peripheral vascular disease. The goal set by the staff for the resident was that the skin on feet/legs will remain intact through next review. Some of the approaches the staff would implement to accomplish this goal

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included check feet and legs for redness, skin tears, swelling or pressure areas daily. Report any signs of skin breakdown. Perform complete skin assessments and record. Podiatrist to examine feet and trim nails.

The following information chronicles the right lateral foot wound:
-2/9/18-The wound care nurse's notes indicated an open area on lateral right foot that measured 2.0 centimeters (cm) long by (x) 2.0 wide cm x 0.1 depth with serosanquinous drainage. She noted the resident has a history of PVD, thus she entered in her note that the area was vascular related. Order: Cleanse *SilvaSorb topical gel extended release to wound bed and cover with dry dressing daily. *SilvaSorb Gel is infused with ionic silver technology for sustained antimicrobial protection; Advanced fluid handling capable of donating or absorbing moisture (https://www.medline.com/product/SilvaSorb-Silver-Antimicrobial-Wound-Gel/Antimicrobial-Gel/Z05-PF00181)

-4/11/18-The wound care specialist started following the resident. The wound measured 1.2 cm x 1.4 cm x 0.2 cm. with serous exudate. Treatment changed to cleanse with normal saline, apply *Collagen Ag to wound bed and cover with dry dressing every two days. Appetitive fair and on multivitamins. She had been ordered Remeron to increase appetite. Cannot detect DP pulse in left extremity, DP and PT pulse detected by portable Doppler in right extremity. *Collagen Ag is a sliver Collagen Matrix Dressing with Silver is intended for use on partial- and full-thickness wounds (https://www.woundsource.com/product/dermacol-ag-collagen-matrix-dressing-silver).

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-4/18/18-The wound care specialist recommended arterial Doppler studies which were completed on 4/20/18 which indicated significant arterial sclerotic disease involving the right lower extremity and the left lower extremity borderline.

-4/25/18-New orders from the wound care specialist: Cleanse with normal saline, SilvaSorb topical gel, extended release once a day to wound bed. Recommendations for a vascular consult.

-5/8/18-Vascular consult indicated he was consulted due to "poor healing wound to right foot". He evaluated the right foot and diagnosed the area to be "pressure ulcer right lateral foot, moderate bilateral lower extremity PVD". His recommendations were "pressure relief lower extremities. Need to off load feet by placing foam under calves. Sheep skin booties to both feet (or equivalent) *Mepilex AG to right foot ulcer daily (or equivalent). * Mepilex AG is a Antimicrobial Soft silicone Foam Dressing absorbs exudate and maintains a healthy, moist wound environment (https://www.exmed.net/p-1987-molnlycke-mepilex-ag-antimicrobial-soft-silicone-foam-dressing.aspx). An interview was conducted with the Director of Nursing (DON) and the Director of Nursing Operations (DNO) on 3/6/19 where it was stated regardless of the vascular surgeons assessment that the area was pressure, the wound care specialist who recommended the vascular surgeon's consult did not accept the assessment, nor did she update her records to reflect his expertise assessment of the area as a pressure ulcer. They stated they initiated *Prevalon boots

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to protect the heels, pillows and wedges for positioning which was placed on the care plan. They stated they did not initiate a physician's order for the Prevalon boots or enter them on the Treatment Administration Record (TAR) to be signed off as in place each shift, but placed the treatment on the care plan as a nursing order. They also stated the resident was non-ambulatory and she curled up when she was in bed, preferred to lay on her right side and she was totally dependent on staff for positioning and remained in the position she was placed until re-positioned by nursing staff. *Prevalon® Heel Protector with Integrated Wedge was specifically designed to help reduce the risk of heel pressure injury while keeping the foot and leg in a neutral position (https://www.woundsource.com/product/prevalon-heel-protector-integrated-wedge).

-On 5/18/18, during the podiatrist's routine visit, he documented "pressure ulcer " to lateral right foot *"unstageable".

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (brown to light brown soft necrotic tissue) or eschar (black hard necrotic tissue) (https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/).

-On 8/29/18, the area to the right lateral foot had resolved. No further documentation of assessment of pulses in either lower extremity from the initial assessment by the wound care specialist since 4/11/18.

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-On 2/13/19, the licensed nurse conducted a head to toe weekly skin assessment and indicted no skin integrity issues were identified.

-On 2/18/19, during a routine visit from the Podiatrist, he identified as his first assessment "large eschar (black hard necrotic tissue) pressure ulcer to lateral right foot, unstageable". The Podiatrist documented that he discussed his findings with the wound care nurse and ordered Iodosorb gel to right foot and a wound care evaluation.

-On 2/18/19, the wound care nurse evaluates the wound and documents "5.0 cm x 6.2 cm 0.0 depth (depth cannot determined) wound color black". The notes indicated the Resident Representative (RR) was notified of the condition of the lateral right foot via a voicemail message with a return call from the RR on 2/19/19. The Unit Manager #1 documented her assessment of the lateral right foot on 2/18/19 as "porous type opening to the right lateral foot, skin discolored and hard. Sanguineous drainage noted with odor. Area cleansed, dressing applied as ordered. Area measures 4 cm x 6 cm".

-On 2/20/19, the Nurse Practitioner (NP) indicated in her progress note that the the right lateral foot was assessed by the wound care specialist and that the wound care nurse reported the wound as necrotic and malodorous. The pulse was present but poor, that she had had a history if a similar wound and had an ongoing referral for a vascular consult in place. The NP documents under diagnosis and assessment, pressure injury of skin, unspecified injury state, daily dressing to right foot. The wound care

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specialist assessed the right lateral foot on 2/20/19 with orders to send to ER immediately. The resident was transferred to the local hospital ER on 2/20/19 and admitted with plans to amputate the right extremity above the knee.

During an interview with the DON and DNO on 3/6/19 that began at 10:00 a.m., they stated it was their expectation that socks are removed during bathing and that Certified Nursing Assistants (CNA) would report any and all discolored areas during bathing. There there were no nurse's notes that reflected skin problems until identified by the Podiatrist as large, eschar, black to right lateral foot on 2/18/19. The LPN Unit Manager #1 joined the interview at 11:30 a.m. She stated she saw drainage on a sheet but could not recall when in February 2019. She further stated she was asked to evaluate the wound on 2/18/19, after the Podiatrist on his routine visit found it, and she described it as porous, hard and black. She stated, "With a person like (Resident #2's name) skin who dark skin toned, you cannot see where there are skin problems. So the staff cannot tell if there is a problem because her skin is dark, it is hard to make accurate skin assessments." During the interview the LPN Unit Manager #1 consistently reiterated that accurate skin assessments could not be made with skin issues or breakdown on darker skin toned residents. The DNO was asked how should accurate skin assessments be made by nursing staff with dark skin in light of Resident #2's history and in general for all residents with darker skin tone, she stated, "The staff should use a bright light to examine the skin and depress the areas for bogginess, hardness, etc.".

During the aforementioned interview, the wound

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care nurse, LPN #2 joined the interview at 12:00 p.m. She stated she did not see any wounds unless it was determined from the nurse the wound was a *Stage III or above, thus she did not know about the severity of the lateral right foot. *A stage III pressure ulcer is a full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible (https://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/).

During the above interview, the wound care nurse demonstrated where the wound was located on Resident #2 by taking off her shoe and pointing to the center bony area on the lateral right foot. She stated it was large, black, hard with some drainage and odor. When asked if the condition of this foot would have occurred in less than 24 hours she said, "No, it had to have been there prior, but I would not have seen it because I see Stage III's and above or when a nurse request me to evaluate an area. No one asked to me to evaluate the area until 2/18/19 when the Podiatrist requested to assess the right lateral foot because it was black." The DNO indicated that the lateral right foot blackened area was due to an acute ischemic incident that happened suddenly on 2/18/19. She also stated that the hospital recorded supported this information through their Doppler studies/PVL studies.

The hospital's PVL studies dated concluded "multi level moderate to severe right lower extremity arterial insufficiency. Moderate left lower extremity arterial insufficiency at the level of the femoral-popliteal artery. When compared to the

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previous exam performed on 3/26/15 there is no change". The admission History and Physical indicated their was a infected gangrenous skin ulcer of the right foot, limited to breakdown of the skin, malodorous and dry with no swelling of either lower leg. Laboratory results indicated a systemic infection stemming from the foot ulcer, but there was no documentation of a right leg acute ischemic event. An above the knee amputation of the right leg was performed on 2/22/19 and the resident was discharged to another nursing facility for skilled services on 2/28/19.

On 3/6/19 at 1:02 p.m., during further interview with the DON and the DNO, the DON stated she received a call from one of Resident #2's nieces on 2/20/19 around 4:30 p.m., while she was in the ER with the resident, asking about what happened because the resident had to have an amputation. The DON stated she told her she would look into it and get back to her. They stated another niece contacted the corporation on 2/25/19 and scheduled a meeting for 2/27/19 at the corporate office. She stated the RR and one of the nieces were present and the second niece was participating in the meeting via phone. The DNO stated the family members were concerned about how the foot deteriorated to the point of amputation when they were told the wound had healed and no one informed them otherwise. They did not elaborate further about the details of the meeting.

On 3/6/19 at 1:34 p.m., the DON and DNO presented in-service education with sign in sheets on " Pressure Ulcer Prevention, Power Point and Pressure Ulcer Models" with a date of 2/25/19-ongoing (written on side of date). A "2"

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was marked over the "1" making the date from 2/15/19 to 2/25/19. When asked why the education was presented since they affirmed there was an acute ischemic event and not pressure related, the DNO stated they wanted to be proactive to cover all bases since the meeting with the family on 2/27/19. They could not explain that the date of the training was before the meeting. It was explained that the training covered assessment of different skin tones for pressure ulcer injury to include darker skin. This surveyor reviewed the training and validated it covered those assessment techniques. Out of 30 names on the sign in sheet, only 5 were identified as licensed nurses. They stated the licensed nurses were responsible to make official assessments of skin and that the training was ongoing. None of the Unit Managers were listed on the sign in sheet to have completed the essential training.

Several random interviews were conducted with the Unit Managers and Certified Nursing Assistants (CNA) on all three units to determine if they knew the specifics regarding assessment of darker skin tones:

On 3/6/19 at 1:45 p.m., on the Monroe Unit, the LPN UM #3 stated she did not have any recent training, but she would not examine skin differently than any other resident regardless of skin tone.

On 3/6/19 at 2:00 p.m., CNA #1 on the Monroe Unit, whose name was listed on the inservice training, stated she was not aware of any differences, but if she saw anything unusual she would bring it to the attention of the nurse to check it our further.

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F 726	Continued From page 26 On 3/6/19 at 2:10 p.m., Licensed Practical Nurse (LPN) #4 on the Monroe Unit, stated she missed the training, but that she would make sure she asked if there was anything special she needed to know, but she conducts head to toe assessments as assigned on a weekly basis. She stated if the CNA's bring forth anything unusual they find during care regarding skin she follows up with a skin assessment. The LPN UM (Unit Manager) #1 on Armistead Unit (where Resident #2 had resided) had already been interviewed earlier on 3/6/19 at 11:30 a.m. where she stated "With a person like (Resident #2's name) skin who dark skin toned, you cannot see where there are skin problems. So the staff cannot tell if there is a problem because her skin is dark, it is hard to make accurate skin assessments." The Unit Manager's name was not on the in-service sign in sheets for the training dated 2/25/19. On 3/6/19 at 2:16 p.m., LPN #5 on the Armistead Unit stated although she had not attended the 2/25/19 training, she documented on the weekly skin sheets a head to toes assessment if an area was old or new, such as moles, skin tears, discoloration, sores, scabs regardless of skin tone. She stated she checks to see if an area that appears reddened blanches. She stated the physician is called and further orders are obtained if there is a problem. She said if an area is questionable, she gets the wound care nurse involved to make further assessment. She stated she had not had any training that specifically addressed special attention to dark skin tones when assessing questionable skin problems.	F 726		

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On 3/6/19 at 2:25 p.m., CNA #2 on the Armistead Unit, stated she had been trained about making sure she told the nurse or Unit Manager if during bathing she saw skin problems, but nothing specific about different skin tones.

On 3/6/19 at 2:35 p.m., LPN #6 on the Hampton Unit checked the sign in sheets for the in-service training dated 2/25/19 and stated her name was not on the list. She said the licensed nurse's are assigned weekly skin assessments either on the day or evening shift with head to toe assessments and the information is documented on a sheet and then entered into the computer. She stated, "The area may be more in depth than you think on dark skin than light skin and you have to take a much closer look." She said, "The CNAs should take socks off during bathing to wash resident's feet as well and report any breakdown or suspicious area to a licensed nurse to make an assessment, at which time we would ask the wound nurse to take a look or we can contact the physician for treatment orders." LPN #6 stated the Hampton Unit did not have a Unit Manager.

On 3/6/19 at 3:05 p.m., a telephone interview was conducted with the complainant. The complainant stated they were made aware in late summer that the lateral right foot area was healed and were shocked to learn on 2/18/19 there was a large black area on the lateral right foot which was examined by the wound care doctor on 2/20/19 with an immediate need to send the hospital because of the severe condition of the right foot. She stated the wound doctor said that it was probably an ischemic event, which they found out it was not. She said, "We moved Resident #2 from the previous nursing facility where she had

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no breakdown whatsoever to a facility that was closer to one of the family members, and she encounters breakdown." She stated she was a Nurse Practitioner and knew that necrosis, black eschar would not have occurred in the short time indicated by the facility, and she was told by nursing on 2/13/19 there were no areas anywhere. She stated the family felt the staff neglected to properly assess the resident's skin and provide prompt care to the foot which subsequently led to no other choice than to amputate. She said, "I am not blind to the fact that (Resident #2's name) has PVD, but it did not automatically excuse lack of assessment and pressure relief, as was done in the previous facility to aggressively protect these type of residents and avoid severe conditions that lead to amputation. We regretted transferring her to (current facility's name), so after the amputation we chose to send her back to the previous nursing facility where her care will be monitored more closely. She had spent 6 months there with no skin problems."

On 3/6/19 at approximately 3:45 p.m., 30 minutes before survey exit, the DNO and DON present a Past Non Compliance (PNC)document with "skin integrity" penciled in over another topic and stated they were using this as a template to address the problem this surveyor brought to their attention during the survey. It was penciled in that the training on "skin integrity" started 2/25/19 and would be completed on 3/8/19. The training that had been presented earlier to this surveyor dated 2/25/19 was entitled "Pressure Ulcer Prevention, Power Point and Pressure Ulcer Models". It was determined that PNC could not be accepted based on the lateness of presenting the PNC plan, the discrepancy of education content and

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titles, the lack of knowledge from the upper management to include the Unit Managers, as well as charge nurses that were responsible to complete accurate skin assessments, and those that were on the list were mostly composed of CNAs with only 4 licensed Nurses. Another reason PNC could not be accepted was due to those that were on the list were not able to verbalize the method of assessing resident's with dark skin tones, which was stated was a reason why the right lateral foot ulcer was missed, easily detected and identified first by the Podiatrist on his routine visit.

The National Pressure Ulcer Advisory Panel state that a pressure ulcer classification system cannot be used to describe tissue loss in wounds other than pressure ulcers (https://www.npuap.org/wp-content/uploads/2012/03/Final_Quick_Treatment_for_web_2010.pdf).

The facility's policy and procedures titled pressure ulcer prevention/monitoring for effectiveness of the interventions dated as last reviewed on 4/3/14 indicated "at least daily, staff should remain alert to the potential changes in the skin condition of the resident and should evaluate and document the identified change. Weekly skin assessment by Registered Nurse (RN)/LPN. Monitor residents for condition changes that might increase the risk for breakdown..." "Risk factors that may increase a resident's susceptibility to develop or to not heal pressure ulcers include, but are not limited to: impaired/decreased mobility, decrease functional ability, impaired diffuse or localized blood flow (generalized atherosclerosis, lower extremity arterial insufficiency). Tissue closest to the bone may be the first tissue to undergo necrosis, usually over a bony prominence. The following

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F 726	Continued From page 30 may need to be evaluated for at risk residents: support surfaces, positioning (a common effective intervention for an individual with a pressure ulcer or who is at risk of developing one), determine if medical device is in use to include orthosis, braces, etc. and whether there are contractures. Assessment of a resident's skin integrity should guide the development and implementation of the repositioning plans which should be included in the care plan, which is critical for residents who are immobile or dependent on staff for repositioning. To effectively support the lower leg to raise feet from contact with the bed pillows, foam wedges, or other measures may be used. CNAs and other direct care staff should report any signs or symptoms of a potential pressure related impairment of skin integrity to the head/charge nurse immediately. The head/charge nurse should assess the resident and determine appropriate interventions. The supervisory level nurse/UM should be notified by the head/charge nurse of any areas of concern for further assessment. Complaint Deficiency.	F 726		