STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495347	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 9/16/19 through 9/17/19. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The census in this 114 certified bed facility was 109 at the time of the survey. The survey sample consisted of 1 current Resident review (Resident #2) and 1 closed record review (Resident #1).	F 000		
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 interviews, clinical record review and facility document review the facility staff failed to provide the necessary care and services to prevent the development and promote healing of a facility acquired pressure injury for 1 of 2 residents in the survey sample, Resident #2.	F 686	1. Resident remains in the facility and continues to have treatments as ordered by the physician and weekly skin assessments to ensure appropriate prevention and treatments continue to be in place. Resident #2 was assessed by the wound physician 09/10/19. A	10/15/19

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

Electronically Signed | 09/30/2019

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F 686	Continued From page 1 The facility staff failed to correctly identify a pressure injury, failed to apply treatment as ordered, and failed to identify and notify the physician of a decline in the wound to obtain appropriate and timely treatment prior to the wound physician identifying it as an unstageable pressure injury on Resident #2's left calf. The findings include: Resident #2 was originally admitted to the facility on 5/28/19 and re-admitted on 8/6/19 following a hospitalization for a fractured right hip as a result of a fall at the facility on 7/30/19; other diagnoses included, but not limited to, muscle weakness, atrial fibrillation, high blood pressure, coronary artery disease and dementia with behavioral disturbance. The MDS (Minimum Data Set) a significant change with an assessment reference date of 8/13/19 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident was dependent on two staff for bed mobility and transfers. The resident had limited range of motion to the right lower extremity and was wheelchair bound. Section M. Skin Conditions coded the resident as having a stage II pressure injury (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough, may also present as an intact or open/ruptured blister. The area was a blister was to the left heel. The comprehensive person-centered plan of care dated 6/25/19 identified the resident was at risk for development of pressure injury related to bowel and bladder incontinence and dementia.	F 686	pressure assessment was completed on 09/11/19 along with peripheral vascular and arterial studies were completed on 09/11/19 and 09/12/19 respectively. The physician concluded the resident's wounds to be unavoidable on 09/12/19 and the resident was referred to Hospice on 09/12/19. 2. Current residents that reside in the facility are at risk for skin impairment. The Unit Manager or designee will complete skin assessments on all current residents to ensure areas are correctly identified and treatments are ordered by 09/20/19. No further issues were identified. 3. The DCS or designee will complete education for clinical staff on wound care and the facility wound policy by 09/27/19. 4. DON/designee to conduct Quality Improvement Monitoring of wound care/assessments for completion and accuracy daily five times a week for two weeks, weekly for two weeks, then monthly for three months. The results will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the Executive Director monthly for 3 months for further compliance and/or revision.	

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The resident developed two fluid filled blisters to the right inner and outer heel that merged on 8/22/19 and opened on 8/23/19. The care plan was revised on 9/17/19 and identified the resident with an open area to the left calf. The goal was for the pressure injuries to show signs of healing and have minimal risk of infection by the next review date 11/14/19. Interventions listed included to administer treatments as ordered and monitor for effectiveness, Heels up boots when in bed. Pressure reducing mattress to bed and w/c (date initiated is 8/19/19), monitor/document/report PRN (as needed) any changes in skin status.

The nurses notes dated 9/6/19 written by Licensed Practical Nurse (LPN#1) read: "Called to residents room by therapist, resident has old skin tear to posterior left leg, received order from PA (physician assistant) to cleanse area with NS (normal saline), apply bacitracin and cover with dry dressing daily. RP (representative party) notified."

There was no additional description of the skin tear in the clinical record. There was no skin tear investigation of how or what caused the skin impairment per the Corporate Nurse. The bacitracin was scheduled to be applied every day at 9:00 a.m.

On 9/17/19 at 3:45 p.m., the therapist (licensed physical therapy assistant #1) who initially identified the left calf wound and notified the nurse on 9/6/19 was interviewed. She stated that during a therapy session in the resident's room she was assisting the occupational therapist to remove the resident's pants. After the pants were removed they observed a open area to the

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residents left calf. She then notified the nurse (LPN#1). The therapist stated the resident propels himself in the wheelchair with the left leg, the fractured right leg is elevated on the wheelchair leg rest and when he rests he puts the left leg over on top of the wheelchair leg rest pedal or over his right leg, demonstrating the exact area where the wound is located. The therapist described the open area as measuring approximately 4 centimeters (cm) in length and 1 cm in diameter.

On 9/17/19 at 6:31 p.m., LPN #1 was interviewed. She stated the left calf open area "Looked like it was an old skin tear, dried up looking like it was there a couple of days...maybe an injury from the wheelchair?" She stated she did not measure it but stated it was about an inch in length.

The Treatment Administration Record for August evidenced the staff failed to cleanse the wound or apply the bacitracin treatment as ordered to the left calf on the following days; 9/8/19, 9/11/19, and 9/16/19.

On 9/17/19 at 2:55 p.m., RN #2 was interviewed. She stated the resident liked to cross his legs (left over right). She further stated, " He had a red area from crossing his legs (pointing to the left calf area where the wound was located), I called the physician and got an order for skin prep, a one time order, it was blanchable and had disappeared later that evening". The nurse could not recall what date this occurred, provide the order, a nurses note or any other documentation related to her statement.

Record review revealed on 9/10/19 the wound care physician evaluated the left calf wound. The

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notes read, in part: "... a thorough wound care assessment and evaluation was performed today. He has an unstageable (due to necrosis) of the left calf for at least 1 days duration. There is moderate serous exudate. The patient appears to have associated pain evidenced by grimacing, restless. Appetite-fair. Etiology-Pressure, wound size (Length x width x depth) 7.0 (cm-centimeters) x 3.0 (cm) depth-not measurable, 60% thick adherent black necrotic tissue (eschar), 30% thick adherent devitalized necrotic tissue, 10% granulation tissue. Reason For No Debridement: Debridement refused. Patient/surrogate made aware of risks of not removing necrosis including infection; sepsis; limb loss or death. Dressing Treatment Plan-Santyl (an enzymatic topical debriding agent) apply once daily for 30 days on normal saline moistened gauze. Secondary dressing(s)-gauze island (w/border) apply once daily for 30 days. Plan of Care Reviewed and Addressed. Recommendations-Off-load wound; reposition per facility protocol. This patients care was discussed with another health care provider Nursing Staff Member during this visit."

Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) failed to evidence the physician ordered Santyl from 9/10/19 through 9/16/19. The order for the Santyl was entered on 9/16/19 with a start date of 9/17/19. The treatment cart was checked and a tube of Santyl for Resident #2 was found, with the dispense date of 9/16/19. The treatment in place was the bacitracin which the staff was not applying consistently as noted by blank entries on the TAR for 9/8/19, 9/11/19 and 9/16/19, the bacitracin discontinue date was 9/16/19.

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The facility staff failed to recognize the wound was a pressure injury and bacitracin (an antibiotic ointment) was not an appropriate treatment.

The wound care physician was interviewed via the telephone on 9/17/19 at 4:57 p.m. The wound care physician stated the wound was not a result of a skin tear as described by the staff. She stated the Director of Nursing and the unit manager were not available for the initial consult, however she did have a staff member with her during the consult, RN#1. She stated she gave a verbal order to RN#1 for the Santyl treatment for the pressure injury. The physician stated she herself had applied Santyl to the wound after assessing it and cleaning it during the consult. She further stated her consult notes were transcribed after midnight and would have been available for review no later than Thursday 9/12/19, after she had given access to the staff. She further stated she would have expected no more than a two day delay for the facility to initiate the treatment if she did not give a verbal order.

RN #1 was interviewed on 9/17/19 at 4:07 p.m. She stated she did accompany the physician during the consult. When asked if the wound care physician had given her verbal orders for the treatment of the pressure injury, she stated she did not remember.

The Blue unit manager was interviewed on 9/17/19 at 4:10 p.m. She stated that was the first week that the wound physician had "rounded" in the building. She stated she did not have access to the wound consult notes on 9/11/19 but did see it on Friday 9/13/19 "in the system." While working from home on 9/13/19 she placed the

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order for the Santyl in the "system" but had some computer issues at home and was not sure if the order had transferred. When she returned to work on Monday 9/16/19 she noted the order was not in the computer system. She then placed it in and called the pharmacy to ensure the Santyl order was there and that it would be delivered that day. When asked if she had followed up on Saturday 9/14/19 or Sunday 9/15/19 with the nursing staff to find out if the order was in the system, she stated she had not.

Following the interview with the Blue unit manager this surveyor went with her to the resident's room to examine the pressure injury. The resident was observed sitting up in the wheelchair, the border dressing was peeled back, the pressure injury wound bed was black with redness surrounding the pressure injury. The size appeared to be what was documented by the wound physician based on her examination on 9/10/19.

During the pre-exit meeting on 9/17/19 the above findings was shared with the Administrator, the Director of Nursing (DON) and the Corporate Nurse. The DON stated, "I think we missed it and should have been better and questioned why we were placing bacitracin on a pressure injury." The Corporate Nurse stated, "We self identified that wound education is needed".

No additional information was provided prior to exit.

The facility's Policies and Procedures Clinical Guideline Skin & Wound date 4/1/17 read, in part: Overview: To provide a system for identifying skin at risk, implementing interventions including

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evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of / prevention of pressure injury.
Process:
*Licensed Nurse to report changes in skin integrity to the physician / practitioner and resident/ responsible party an document in the medical record
*Monitor residents' response to treatment and modify as indicated

Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). National Pressure Ulcer Advisory Panel (NPUAP)

Unstageable/Unclassified: Full thickness skin or tissue loss-depth unknown
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythematous or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/)

Debridement-Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.