STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING _____ B. WING _____	C 01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 survey was conducted 1/23/20 through 1/24/20. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 177 certified bed facility was 115 at the time of the survey. The survey sample consisted of seven current resident reviews and three closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to ensure residents' call bells were within reach for three of ten residents in the survey sample, Residents #1, #2 and #3. The facility staff failed to ensure Resident #1's call bell was within reach while the resident was in bed and in the wheelchair on 1/23/20. The facility staff failed to ensure Resident #2's call bell was within reach while the resident was in bed on 1/23/20, and failed to ensure Resident #3's call bell was within reach while the resident was in bed on 1/23/20.	F 558	F558 1) Resident #1, #2 and #3s call bell is within reach 2) A review of residents was conducted to ensure call bells were in reach. 3) Staff will be re-educated on ensuring call bells are within reach of the residents. 4) Audits of call bells being in reach of the residents will be conducted during care keeper rounds. Audits of these will be conducted weekly for 12 weeks.	2/6/20

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

Electronically Signed | 02/03/2020

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F 558	Continued From page 1 The findings include: 1. Resident #1 was admitted to the facility on 7/13/19. Resident #1's diagnoses included but were not limited to diabetes, heart failure and muscle weakness. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/20/19, coded the resident's cognition as moderately impaired. Section G coded Resident #1 as requiring extensive assistance of one staff with bed mobility and transfers. On 1/23/20 at 9:56 a.m., Resident #1 was observed lying flat in bed. Resident #1's call bell was clipped to the call bell cord approximately two to three inches from where the cord was attached to the wall, behind and to the left side of the bed. The call bell was not within Resident #1's reach. On 1/23/20 at 5:09 p.m., another observation of Resident #1 was conducted. The resident was sitting in a wheelchair on the right side of the bed. The call bell remained clipped to the call bell cord approximately two to three inches from where the cord was attached to the wall, behind and to the left side of the bed. The call bell was not within Resident #1's reach. At this time, an interview was conducted with Resident #1. The resident was not aware of where the call bell was located. Resident #1 stated at this moment, she was physically able to stand up and retrieve her call bell but would not be able to do so if she became sick or broke her leg. Resident #1 further stated she was not sure if she would be able to propel over to the wall to retrieve the call bell because of the limited space between the bed and her	F 558	Audits will be reviewed during monthly and quarterly QAPI meetings. Any discrepancies will be addressed and reeducation provided as needed. 5) Compliance Date: 2/6/2020	

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F 558	Continued From page 2	F 558		

roommate who was sitting in a wheelchair.

Resident #1's comprehensive care plan dated 7/14/19, documented, "I am at risk for FALLS related to: Use of psychotropic medication, dementia, muscle weakness, insomnia...Interventions: Call light (call bell) or personal items available and in easy reach..."

On 1/23/20 at 5:40 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked where call bells should be positioned in relation to residents and why. CNA #1 stated call bells should always be positioned within residents' reach in case they need something or if something happens.

On 1/23/20 at 5:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked where call bells should be positioned in relation to residents and why. LPN #3 stated calls bells should be placed where residents can reach them in case residents need help or any kind of assistance.

On 1/23/20 at 6:17 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

On 1/24/20 at 9:04 a.m., ASM #2 stated the facility did not have a specific policy regarding call bells but call bell placement is observed during daily care keeper rounds.

No further information was presented prior to exit.

2. Resident #2 was admitted to the facility on 4/25/13. Resident #2's diagnoses included but

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F 558	Continued From page 3	F 558		

were not limited to stroke, paralysis and heart failure. Resident #2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/16/19, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of one staff with bed mobility and as being totally dependent on two or more staff with transfers.

On 1/23/20 at 9:40 a.m., Resident #2 was observed in the bed. The head of the bed was elevated approximately 45 degrees. Resident #2's call bell cord was clipped to the top right side of the mattress, behind the resident, and the call bell was hanging straight down approximately two feet from the floor. The call bell was not within Resident #2's reach.

On 1/23/20 at 4:51 p.m., an interview was conducted with Resident #2. Resident #2 was made aware of the above call bell observation earlier in the day. Resident #2 confirmed the call bell had not been within his reach and stated he had wondered where it was. Resident #2 stated he cannot find his call bell every time he wakes up and this concerns him because he has a lot of seizures.

Resident #2's comprehensive care plan dated 10/4/16 documented, "I am at risk for falls due to balance problems. I have the dx (diagnosis) of CVA (cerebrovascular accident [stroke]) with Left Hemiparesis (paralysis) and seizures. I exhibit weakness and debility, I often put my bed in the high position...Interventions: Keep call light (call bell) or personal items available and in easy reach..."

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F 558	Continued From page 4	F 558		

On 1/23/20 at 5:40 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked where call bells should be positioned in relation to residents and why. CNA #1 stated call bells should always be positioned within residents' reach in case they need something or if something happens.

On 1/23/20 at 5:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked where call bells should be positioned in relation to residents and why. LPN #3 stated calls bells should be placed where residents can reach them in case residents need help or any kind of assistance.

On 1/23/20 at 6:17 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

3. Resident #3 was admitted to the facility on 2/21/2000. Resident #3's diagnoses included but were not limited to convulsions, major depressive disorder and pain. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/19, coded the resident's cognition as severely impaired. Section G coded Resident #3 as requiring extensive assistance of one staff with bed mobility and extensive assistance of two or more staff with transfers.

On 1/23/20 at 9:43 a.m., Resident #3 was lying in bed with the head of the bed elevated approximately 30 degrees. The resident's call bell was placed on a plastic organizer rack. The

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rack was positioned approximately one foot to the right of Resident #3's bed and approximately three feet behind the area of the bed where the resident's arm was resting. The call bell was not within Resident #3's reach.

On 1/23/20 at 5:02 p.m., Resident #3 was lying in bed. The call bell was lying on the floor under the bed and was not within the resident's reach. At this time, Resident #3 was asked to explain how to use the call bell. Resident #3 stated, "Just pick it up and use it. Where is it?" Resident #3 was handed the call bell and properly demonstrated the use of it.

Resident #3's comprehensive care plan dated 4/3/18 documented, "I have a self care/ADL (activities of daily living) deficit related to: Self care impairment, Mobility impairment. I have intellectual disabilities...Interventions: Call bell within reach..."

On 1/23/20 at 5:40 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked where call bells should be positioned in relation to residents and why. CNA #1 stated call bells should always be positioned within residents' reach in case they need something or if something happens.

On 1/23/20 at 5:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked where call bells should be positioned in relation to residents and why. LPN #3 stated calls bells should be placed where residents can reach them in case residents need help or any kind of assistance.

On 1/23/20 at 6:17 p.m., ASM (administrative

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F 558	Continued From page 6 staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern. No further information was presented prior to exit.	F 558		
F 656 SS=D	COMPLAINT DEFICIENCY 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 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)-	F 656		2/6/20

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F 656	Continued From page 7 (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 observation, resident interview, staff interview, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to implement the comprehensive care plan for three of ten residents in the survey sample, Residents #1, #2 and #3. The facility staff failed to implement comprehensive care plan for call bell placement for Resident #1, Resident #2 and Resident #3 on 1/23/20. The findings include: 1. Resident #1 was admitted to the facility on 7/13/19. Resident #1's diagnoses included but were not limited to diabetes, heart failure and muscle weakness. Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/20/19, coded the resident's cognition as moderately impaired. Section G coded Resident #1 as requiring extensive assistance of one staff with bed mobility and transfers.	F 656	F656 1) Resident #1, #2 and #3 care plan is being implemented. 2) Audit of care plans to ensure it reflects residents□ current status. 3) Licensed staff will be re-educated on implementing care plans. 4) DNS/Designee will audit care plans for residents with call bells weekly for 12 weeks. Audits will be reviewed during monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed. 5) Compliance Date: 2/6/2020	

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Resident #1's comprehensive care plan dated 7/14/19, documented, "I am at risk for FALLS related to: Use of psychotropic medication, dementia, muscle weakness, insomnia...Interventions: Call light (call bell) or personal items available and in easy reach..."

On 1/23/20 at 9:56 a.m., Resident #1 was observed lying flat in bed. Resident #1's call bell was clipped to the call bell cord approximately two to three inches from where the cord was attached to the wall, behind and to the left side of the bed. The call bell was not within Resident #1's reach.

On 1/23/20 at 5:09 p.m., another observation of Resident #1 was conducted. The resident was sitting in a wheelchair on the right side of the bed. The call bell remained clipped to the call bell cord approximately two to three inches from where the cord was attached to the wall, behind and to the left side of the bed. The call bell was not within Resident #1's reach. At this time, an interview was conducted with Resident #1. The resident was not aware of where the call bell was. Resident #1 stated at this moment, she was physically able to stand up and retrieve her call bell but would not be able to do so if she became sick or broke her leg. Resident #1 further stated she was not sure if she would be able to propel over to the wall to retrieve the call bell because of the limited space between the bed and her roommate who sitting in a wheelchair.

On 1/23/20 at 5:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to explain the purpose of the comprehensive care plan, and was asked how the nurses ensure they implement the

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comprehensive care plans. LPN #3 stated, "For us to know what the resident's needs are; how we can meet the resident's needs and what kind of diagnoses and things to help us better care for the resident as well." LPN #3 stated nurses could review residents' care plans online in the computer system. LPN #3 was asked where call bells should be positioned in relation to residents and why. LPN #3 stated calls bells should be placed where residents can reach them in case residents need help or any kind of assistance.

On 1/24/20 at 9:06 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

The facility policy regarding care plans, an excerpt from the Lippincott eight edition nursing procedures manual, documented, "Implementation: Gather the appropriate equipment. Review the patient's medical record...Select interventions that will help the patient achieve the stated outcome..."

No further information was presented prior to exit.

2. Resident #2 was admitted to the facility on 4/25/13. Resident #2's diagnoses included but were not limited to stroke, paralysis and heart failure. Resident #2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/16/19, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of one staff with bed mobility and as being totally dependent on two or more staff with transfers.

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Resident #2's comprehensive care plan dated 10/4/16 documented, "I am at risk for falls due to balance problems. I have the dx (diagnosis) of CVA (cerebrovascular accident [stroke]) with Left Hemiparesis (paralysis) and seizures. I exhibit weakness and debility, I often put my bed in the high position...Interventions: Keep call light (call bell) or personal items available and in easy reach..."

On 1/23/20 at 9:40 a.m., Resident #2 was observed in the bed. The head of the bed was elevated approximately 45 degrees. Resident #2's call bell cord was clipped to the top right side of the mattress, behind the resident, and the call bell was hanging straight down approximately two feet from the floor. The call bell was not within Resident #2's reach.

On 1/23/20 at 4:51 p.m., an interview was conducted with Resident #2. Resident #2 was made aware of the above call bell observation earlier in the day. Resident #2 confirmed the call bell had not been within his reach and stated he had wondered where it was. Resident #2 stated he cannot find his call bell every time he wakes up and this concerns him because he has a lot of seizures.

On 1/23/20 at 5:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to explain the purpose of the comprehensive care plan, and was asked how the nurses ensure they implement the comprehensive care plans. LPN #3 stated, "For us to know what the resident's needs are; how we can meet the resident's needs and what kind of diagnoses and things to help us better care for the resident as well." LPN #3 stated nurses could

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review residents' care plans online in the computer system. LPN #3 was asked where call bells should be positioned in relation to residents and why. LPN #3 stated calls bells should be placed where residents can reach them in case residents need help or any kind of assistance.

On 1/24/20 at 9:06 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

3. Resident #3 was admitted to the facility on 2/21/2000. Resident #3's diagnoses included but were not limited to convulsions, major depressive disorder and pain. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/19, coded the resident's cognition as severely impaired. Section G coded Resident #3 as requiring extensive assistance of one staff with bed mobility and extensive assistance of two or more staff with transfers.

Resident #3's comprehensive care plan dated 4/3/18 documented, "I have a self care/ADL (activities of daily living) deficit related to: Self care impairment, Mobility impairment. I have intellectual disabilities...Interventions: Call bell within reach..."

On 1/23/20 at 9:43 a.m., Resident #3 was lying in bed with the head of the bed elevated approximately 30 degrees. The resident's call bell was placed on a plastic organizer rack. The rack was positioned approximately one foot to the right of Resident #3's bed and approximately

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three feet behind the area of the bed where the resident's arm was resting. The call bell was not within Resident #3's reach.

On 1/23/20 at 5:02 p.m., Resident #3 was lying in bed. The call bell was lying on the floor under the bed and was not within the resident's reach. At this time, Resident #3 was asked to explain how to use the call bell. Resident #3 stated, "Just pick it up and use it. Where is it?" Resident #3 was handed the call bell and properly demonstrated the use of it.

On 1/23/20 at 5:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked to explain the purpose of the comprehensive care plan, and was asked how the nurses ensure they implement the comprehensive care plans. LPN #3 stated, "For us to know what the resident's needs are; how we can meet the resident's needs and what kind of diagnoses and things to help us better care for the resident as well." LPN #3 stated nurses could review residents' care plans online in the computer system. LPN #3 was asked where call bells should be positioned in relation to residents and why. LPN #3 stated calls bells should be placed where residents can reach them in case residents need help or any kind of assistance.

On 1/24/20 at 9:06 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

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	495240	A. BUILDING _____ B. WING _____	C 01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 842	Continued From page 13	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		2/6/20

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F 842	Continued From page 14 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of ten residents in the survey sample, Residents #4 and #10. The facility staff failed to document a physician ordered treatment was provided for Resident #4 on 12/24/19 and 12/26/19. The facility staff failed to accurately, document the location of Resident	F 842	F842 1) Staff is documenting physician ordered treatments for resident #14. Resident #10 documentation on the weekly pressure injury measurement is being accurately documented. 2) Current residents have the potential to	

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F 842	Continued From page 15 #10's wound on a weekly pressure injury measurement assessment dated 8/12/19. The wound was located on the resident's right lateral fifth toe, and LPN (licensed practical nurse) #3 documented the wound was located on the left lateral fifth toe. The findings include: 1. Resident #4 was admitted to the facility on 6/25/15. Resident #4's diagnoses included but were not limited to stroke, paralysis and diabetes. Resident #4's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/17/20, coded the resident's cognition as severely impaired. Section M coded Resident #4 as having one unstageable pressure injury (1). Review of Resident #4's clinical record revealed a physician's order dated 12/19/19 that documented to cleanse the resident's left heel with normal saline, apply medihoney (2), gauze and a dry dressing daily. Further review of Resident #4's clinical record, including the December 2019 TAR [treatment administration record] and December 2019 nurses' notes, failed to reveal documentation that the treatment to Resident #4's left heel was completed on 12/24/19 and 12/26/19. On 1/24/20 at 11:07 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse responsible for completing Resident #4's treatment on 12/24/19. LPN #1 stated she did complete Resident #4's left heel treatment on 12/24/19 but got busy and forgot to document. LPN #1 confirmed she should have documented	F 842	be affected. 3) Licensed Nursing staff will be re-educated on ensuring accurate documentation is completed in the medical record to include but not limited to, documentation of physician ordered treatments and weekly pressure injury measurements assessments. 4) An audit will be conducted weekly times 12 weeks, by ADON/designee, to ensure documentation is completed accurately in the medical record to include weekly pressure injury measurement assessments and physician ordered treatment documentation. Audits will be reviewed during monthly and quarterly QAPI meetings. Any discrepancies will be addressed and re-education provided as needed. 5) Compliance Date: 2/6/2020	

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the treatment.

On 1/24/20 at 11:20 a.m., an interview was conducted with LPN #4, the nurse responsible for completing Resident #4's treatment on 12/26/19. LPN #4 stated he did complete Resident #4's left heel treatment on 12/26/19, but forgot to do the documentation. LPN #4 confirmed he should have documented the treatment.

On 1/24/20 at 12:10 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

The facility policy regarding documentation, an excerpt from the Lippincott eighth edition nursing procedures manual, documented, "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs."

No further information was presented prior to exit.

References:
(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition,

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perfusion, co-morbidities and condition of the soft tissue.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss 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 or eschar (dead tissue)..." This information was obtained from the website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf

(2) Medihoney is medical grade honey used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/

2. Resident #10 was admitted to the facility on 7/26/19. Resident #10's diagnoses included but were not limited to difficulty swallowing, urinary tract infection and major depressive disorder. Resident #10's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/2/19, coded the resident's cognitive skills for daily decision-making as severely impaired.

Review of Resident #10's clinical record revealed an initial pressure injury record dated 8/7/19 that documented Resident #10 presented with a deep tissue injury (1), on the right lateral fifth toe, on 8/6/19. A weekly pressure injury, measurement assessment dated 8/12/19 documented, "Progress and/or Remarks: treatment of hydrocolloid (a dressing used to treat wounds) continues to, left lateral 5th toe." Resident #10's care plan dated 7/31/19 failed to document information regarding accurate documentation of

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wound location.

On 1/23/20 at 6:12 p.m., an interview was conducted with LPN #3. LPN #3 confirmed the 8/12/19 assessment should have documented treatment continued to the right lateral fifth toe instead of the left lateral fifth toe. LPN #3 was asked why it was important to complete accurate documentation. LPN #3 stated it was important to complete accurate documentation to avoid confusion.

On 1/23/20 at 6:17 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

Reference:
(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister...This injury results from intense and/or prolonged pressure and shear forces at

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F 842	Continued From page 19 the bone-muscle interface..." This information was obtained from the website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf	F 842		