| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| (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 |
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| {F 000} | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid second revist to a Medicare/Medicaid abbreviated survey conducted on 11/04/19 through 11/05/19 was conducted on 01/14/2020 through 01/15/2020. The first revisit survey was conducted on 12/10/19 through 12/11/19. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements.<br><br>The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of five current record reviews (Residents #201, #203, #204, #205, and #206) and one closed record review (Resident #202). | {F 000} | | |
| {F 657} SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. | {F 657} | | 1/28/20 |

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

Electronically Signed | 01/22/2020

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| {F 657} | Continued From page 1<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for pressure ulcer care and treatment, for one of 6 residents in the survey sample (Resident #203).<br><br>Findings include:<br><br>Resident #203 was admitted to the facility on 04/26/18. Diagnoses for this resident included, but were not limited to: depression, pain, glaucoma, COPD (chronic obstructive pulmonary disease) oxygen dependent, high blood pressure, pressure ulcer, adult failure to thrive, and palliative care.<br><br>The most current MDS (minimum data set) was a significant change assessment dated 12/18/19. This MDS assessed Resident #203 with a cognitive score of "3", indicating the resident was severely impaired for daily decision making skills. The resident was also assessed as requiring total assistance from one staff person for most all ADLs (activities of daily living) including bed mobility. The resident was coded as having one unstageable pressure ulcer. The resident was also assessed on this MDS as receiving "application of dressings to feet (with or without topical medications)." | {F 657} | The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.<br>To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.<br><br>Resident #203□s wound care was corrected at the time of the survey. Resident #203□s orders were reviewed by MD and treatment adjusted for prevention. Care plan now includes treatments as ordered for Left foot impairment and Right foot prevention. MD and Responsible party have been notified of Care plan updates.<br><br>All residents receiving treatments for wound care or prevention are at risk.<br><br>SDC or designee to educate all licensed nursing staff on updating the care plan to include treatments as ordered for all skin impairments and at-risk for skin | |

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| {F 657} | Continued From page 2<br>Resident #203's current physician's orders were reviewed. Resident #203 had an order for, but not limited to: "...[order date: 12/16/19] [start date: 12/16/19] left 5th toe: apply iodine place abdomen [ABD] pads around foot, secure with tubigrip [Tubigrip is a specially designed bandage that is tubular in shape that fits over and around your foot and calf] as needed for accidental removal or soilage...[order date: 12/16/19] [start date: 12/16/19] Right foot: wrap abdomen pad around foot, covering bony prominences. Secure with tubigrip as needed for accidental removal or soilage..."<br><br>Resident #203's current CCP was reviewed and documented, "...Comfort care...make MD [medical doctor] aware of changes needed to keep resident pain free...change dressings as ordered and prn [as needed] to prevent odors, specialty mattress for comfort, turn and reposition q [every] 2 hours or more often if needed for comfort and need arises...ADL task...bed mobility: staff will provide bed mobility assist…staff will provide toileting task care...The resident has an unable to stage pressure ulcer to left 5th toe...disease process, immobility, history of pressure ulcers...administer treatments as ordered and monitor effectiveness…educate the resident/family/caregivers as to causes of skin breakdown...positioning requirements...good nutrition...position resident as needed...report dressing if not intact during care to nurse...devices: air mattress, wedge/pillows for turning and repositioning...bed cradle, wedge as tolerated for leg positioning...float heals while in bed...keep skin clean and dry..."<br><br>There was no information on Resident #203's CCP for any type of treatment and/or | {F 657} | impairment care plan focuses.<br><br>DON or designee will audit 100% of residents with skin impairment for preventative treatments to ensure their care plan reflects the treatment on the at-risk for skin impairment care plan focus. Then 50% of residents with skin impairment for preventative treatments on their at-risk skin impairment care plan 5x weekly for 2 weeks, then 3x weekly for 2 weeks. Findings will be reviewed at QAPI meeting.<br><br>Date of Compliance- 1.28.2020. | |

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| {F 657} | Continued From page 3 | {F 657} | | |

interventions specifically related to the right foot (as ordered by the physician on 12/16/19).

On 01/15/20 at approximately 8:55 AM, LPN (Licensed Practical Nurse) #1 was asked to observe Resident #203's feet. LPN #1 removed the resident's socks from both feet. Resident #203 had a small wound on the left 5th toe (as described in the resident's chart). There was no dressing seen on either foot. LPN #1 stated that the resident was supposed to have an ABD (abdominal) pad [ABD Pads are highly absorbent, multi-layer, soft, non-woven moisture barriers, with sealed edges-typical size is 5 in x 9 in] dressing on the left foot. LPN #1 then picked up theResident #203's sock and shook the sock and a drain sponge [used for peg tube protection/leakage around insertion site-typical size is 4 in x 4 in] came out of the sock. LPN #1 stated, "That's not the right dressing." There was not dressing of any type for the right foot.

At approximately 9:15 AM, LPN #1 was asked about Resident #203's dressing and was again asked to observe Resident #203's feet and legs. The right foot did not have a dressing of any type. LPN #1 stated that she would dress that foot as well, but had to locate the tubigrip that was ordered to hold it in place.

The LPN was then made aware of the concerns with Resident #203 not having the correct dressing on the left foot and not having a dressing at all on the right foot, as ordered and that the resident's legs and feet were not floated with the wedge or the pillow on initial observation.

At approximately 10:50 AM on 01/15/20, the administrator, DON (director of nursing), and

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| {F 657} | Continued From page 4<br>corporate nurse (CN) #1 and #2 were made aware of the above observations and findings regarding Resident #203. The DON was asked if a resident has an intervention and/or physician order for a specific treatment that involves the resident's plan of care, should that information be on the resident's CCP. The DON stated that it should be addressed. The DON and staff were made aware that there was no mention of the treatment and/or intervention for the resident's right foot on the resident's CCP. The DON then stated that in the care plan where it addresses "treatments as ordered" applies to the right foot treatment and interventions as well. The DON was made aware that, that information was listed specifically for the resident's left foot wound and treatment, but there was not information to address the right foot.<br><br>No further information and/or documentation was presented prior to the exit conference on 01/15/20 at 12:30 PM, to evidence that the facility staff reviewed and revised the CCP for Resident #203 for inclusion of the physician's specific order/intervention (dated 12/16/19) for the resident's right foot for the prevention of pressure ulcers. | {F 657} | | |
| {F 686} SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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 | {F 686} | | 1/28/20 |

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| {F 686} | Continued From page 5<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review, the facility staff failed to implement care and services for the prevention of pressure ulcers, and failed to implement interventions to promote healing for an existing pressure ulcer, for one of 6 residents in the survey sample, Resident #203.<br><br>Findings include:<br><br>Resident #203 was admitted to the facility on 04/26/18. Diagnoses for this resident included, but were not limited to: depression, pain, glaucoma, COPD (chronic obstructive pulmonary disease) oxygen dependent, high blood pressure, pressure ulcer, adult failure to thrive, and palliative care.<br><br>The most current MDS (minimum data set) was a significant change assessment dated 12/18/19. This MDS assessed Resident #203 with a cognitive score of "3", indicating the resident was severely impaired for daily decision making skills. The resident was also assessed as requiring total assistance from one staff person for most all ADLs (activities of daily living) including bed mobility. The resident was coded as having one unstageable pressure ulcer. The resident was also assessed on this MDS as receiving "application of dressings to feet (with or without topical medications)." | {F 686} | Resident #203□s interventions and treatments were reviewed with MD and orders adjusted to promote healing of the existing pressure ulcer, and prevention of new impairments. Responsible party have been notified.<br><br>All residents are at risk for skin impairment. Any resident scored at moderate, high, or very high risk using the Braden Scale or has current pressure ulcer has been evaluated to ensure appropriate interventions and treatments are in place.<br><br>SDC or designee will educate:<br><br>All licensed nursing staff on importance of accurately implementing wound care orders including preventative orders for potential skin impairment.<br><br>DON or designee will audit 100% of resident□s with wound care orders, including preventative treatment orders, for accurate implementation. Then 50% of residents with wound care orders, including preventative treatment orders, for accurate implementation 5x weekly for 2 weeks, then 3x weekly for 2 weeks. Findings will be reviewed at QAPI | |

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| {F 686} | Continued From page 6<br><br>Resident #203's current physician's orders were reviewed. Resident #203 had an order for, but not limited to: "...[order date: 12/16/19] [start date: 12/16/19] left 5th toe: apply iodine place abdomen [ABD] pads around foot, secure with tubigrip [Tubigrip is a specially designed bandage that is tubular in shape that fits over and around your foot and calf] as needed for accidental removal or soilage...[order date: 12/16/19] [start date: 12/16/19] Right foot: wrap abdomen pad around foot, covering bony prominences. Secure with tubigrip as needed for accidental removal or soilage..."<br><br>Resident #203's current comprehensive care plan (CCP) was reviewed and documented, "...Comfort care...make MD [medical doctor] aware of changes needed to keep resident pain free...change dressings as ordered and prn [as needed] to prevent odors, specialty mattress for comfort, turn and reposition q [every] 2 hours or more often if needed for comfort and need arises...ADL task...bed mobility: staff will provide bed mobility assist...staff will provide toileting task care...The resident has an unable to stage pressure ulcer to left 5th toe...disease process, immobility, history of pressure ulcers...administer treatments as ordered and monitor effectiveness...educate the resident/family/caregivers as to causes of skin breakdown...positioning requirements...good nutrition...position resident as needed...report dressing if not intact during care to nurse...devices: air mattress, wedge/pillows for turning and repositioning...bed cradle, wedge as tolerated for leg positioning...float heals while in bed...keep skin clean and dry..." | {F 686} | meeting.<br><br>Date of Compliance: 1.28.2020. | |

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| {F 686} | Continued From page 7 | {F 686} | | |

On 01/15/20 at approximately 8:45 AM, Resident #203 was observed in her room laying in bed. The resident's bed had a "foot/bed cradle" in place [a device that keeps sheets and blankets from touching and rubbing your legs or feet] at the bottom of the bed, with blankets over top. Resident #203 was covered with blankets. At the foot of the resident's bed was a "wedge" used for positioning, laying on top of the blankets below the "foot/bed cradle".

At approximately 8:55 AM, LPN (Licensed Practical Nurse) #1 was asked to observe the resident's feet. LPN #1 entered the room and donned gloves and then picked up the large wedge off the bed and laid in the chair next to the window. LPN #1 was asked what the wedge was for. LPN #1 stated that the resident had two wedges (and pointed to one behind the bed and the one she just laid in the chair), one for positioning and one for her legs/feet, to keep them elevated. LPN #1 pulled the blankets back from the resident, exposing her legs. LPN #1 was asked why the wedge was not in place, per the resident's CCP. LPN #1 stated that someone probably removed it for breakfast, so that Resident #203 could reach her tray. LPN #1 was made aware that Resident #203 was observed on 01/14/20 at 12:30 PM during lunch and the resident had a red napkin on her tray and that Resident #203 was fed by a staff member. LPN #1 stated that Resident #203 was capable of feeding herself. LPN #1 stated that she thought that the dietary department was reviewing this for Resident #203 and again stated that Resident #203 could feed herself.

LPN #1 then removed Resident #203's socks from both feet. Resident #203 had a small wound

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| {F 686} | Continued From page 8 | {F 686} | | |

on the left 5th toe (as described in the resident's chart). There was no dressing observed on either foot. LPN #1 stated that Resident #203 was supposed to have an ABD (abdominal) pad [ABD Pads are highly absorbent, multi-layer, soft, non-woven moisture barriers, with sealed edges-size is 5 in x 9 in] dressing on the left foot. LPN #1 then picked up the resident's sock and shook the sock, and a drain sponge [used for peg tube protection/leakage around site, size is 4 in by 4 in] came out of the sock. LPN #1 stated, "That's not the right dressing."

LPN #1 stated that she had planned to wait until later to do the dressing change, but since Resident #203 didn't have the correct dressing on the left foot and was now without any type of dressing, she would go ahead and apply the correct dressing now.

At approximately 9:15 AM, LPN #1 was asked about Resident #203's dressing and was again asked to observe Resident #203's feet and legs. LPN #1 stated that she applied the correct dressing to the left foot. LPN #1 then stated, "I think she is supposed to have a dressing on both feet." LPN #1 stated that the dressing for the right foot was for protection and further stated that the resident did not have a wound on the right foot. Upon entering the room, one of the wedge cushions was still in the chair by the window and one was at the head of the bed, as previously observed. LPN #1 again removed the blankets and exposed Resident #203's feet and legs. The correct dressing was now in place for Resident #203, which was the ABD pad wrapped around the resident's left foot and held in place with "tubigrip". Resident #203 also now had a pillow under her legs/feet. LPN #1 stated that

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| {F 686} | Continued From page 9 | {F 686} | | |

she put the pillow in place during the dressing change and that the resident's foot had slipped some, since she applied the dressing. LPN #1 repositioned the pillow in a manner to float Resident #203's heels/feet. The right foot did not have a dressing. LPN #1 stated that she would dress that foot as well, but had to locate the tubigrip that was ordered to hold it in place.

LPN #1 was then made aware of the concerns with Resident #203 not having the correct dressing on the left foot and not having a dressing at all on the right foot as ordered, and that Resident #203's legs and feet were not floated with the wedge or the pillow on initial observation.

LPN #1 was then asked who served Resident #203 the breakfast tray to determine if it was taken out of place at that time.

At approximately 9:20 AM, CNA (certified nursing assistant) #1 entered the room and LPN #1 asked who set the resident up for breakfast. CNA #1 stated that she fed Resident #203 this morning, and further stated that she did not remove the wedge. CNA #1 stated that she saw the wedge on the foot of the bed, but did not touch it or remove it. CNA #1 stated that she fed the resident breakfast and then went on to other tasks.

At approximately 10:30 AM, Corporate Nurse (CN) #1 was made aware of concerns with Resident #203 and a meeting was requested with the administrator, DON and both CN's.

Nursing notes were then reviewed. A nursing note dated 12/16/19 and timed 1:01 PM documented,

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| {F 686} | Continued From page 10 | {F 686} | | |

"resident with unable to stage area to left 5th toe measuring 1 x 0.9 cm, hard area felt in center, black in color, despite interventions in place for prevention...contractures continue, resident with new unavoidable wound. MD to evaluate...orders obtained...LPN #2."

A physician progress note [late entry] was created on 12/29/19 at 12:58 PM and made effective for 12/16/19 12:52 PM. This note documented, "MD requested by nursing to address patient, now with left fifth toe wound-currently receiving iodine w/wrap in ABD pads...comfort care...left fifth toe wrapped...failure to thrive...signature of attending physician."

A nursing note dated 12/17/19 and timed 8:39 AM documented, "...palliative care, comfort care...history of refusing to get out of bed...lower extremity contractures...despite interventions in place; multivitamin, turning and repositioning every 2 hours, foot cradle, positioning wedge, and weekly assessments...has acquired UAST [unable to stage] pressure ulcer on the 5th toe to the left foot...orders obtained and the site will be monitored..."

A physician's progress note [late entry] was created on 12/31/19 at 2:21 PM and made effective for 12/19/19 2:20 PM. This note documented, "...Rectification Visit: ...assessed and evaluated by MD...any acute issues reviewed and addressed...physical exam...unchanged...continue plan of care...signature of attending physician."

A nursing note dated 01/13/20 and timed 1:54 PM documented, "...unstageable black eschar 0.3 x 0.3 cm...treatment continues...pillows/wedge for

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|---|---|---|---|
| | 495282 | A. BUILDING _____ B. WING _____ | R-C 01/15/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOUISA HEALTH & REHABILITATION CENTER | 210 ELM STREET LOUISA, VA 23093 |

| (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 686} | Continued From page 11 | {F 686} | | |

positioning, foot cradle and air mattress in place...receives dietary supplements for healing...signature of LPN #2."

At approximately 10:50 AM on 01/15/20, the administrator, DON (director of nursing), and corporate nurse #1 and #2 were made aware of the above observations and findings regarding Resident #203. The DON stated that the resident will sometimes refuse treatment. The DON was asked if this information was documented, the DON stated that she would attempt to find any documentation or information. The DON, administrator, CN #1 and #2 were made aware at time that no documentation or information could be located in Resident #203's clinical record regarding the resident refusing any type of treatments, and that Resident #203 did not voice refusal during the above observations. Resident #203's MARs/TARs (medication administration records/treatment administration records) were reviewed for the entire month of December 2019 and January 2020 and there were no documented refusals. The resident's nursing notes were reviewed and one nursing note was found for 12/17/19 and timed 8:39 AM [documented above] that the resident had a history of refusing to get out of bed at times.

At 11:50 AM the DON, CN #1, and LPN #2 presented to the survey team a tracking log and stated that LPN #2 had gone into Resident #203's room early this morning and all of the interventions were in place. LPN #2 then stated that Resident #203 did not want the wedge, so she removed it. LPN #2 was asked for this tracking mechanism, if and when a device or intervention was not in place or refused, what does she do in order to accurately track? LPN #2

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|---|---|---|---|---|
| {F 686} | Continued From page 12<br>stated that she would write it down. LPN #2 was asked if she wrote that information down. LPN #2 stated that she did not and that when she went in the room all interventions were in place.<br><br>No further information and/or documentation was presented prior to the exit conference on 01/15/20 at 12:30 PM, to evidence that the facility staff implemented care, services and interventions for the prevention of new pressure related areas for Resident #203, or implemented care, services and interventions to promote consistent healing of an existing pressure ulcer. | {F 686} | | |