

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

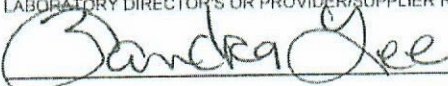
PRINTED: 09/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495149	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2020
NAME OF PROVIDER OR SUPPLIER PORTSMOUTH HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 900 LONDON BOULEVARD PORTSMOUTH, VA 23704		
(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	<p>INITIAL COMMENTS</p> <p>An unannounced Medicare/Medicaid abbreviated survey was conducted onsite on 9/10/20 and offsite on 9/11/20 and 9/14/20. Two complaints were investigated during the course of survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements.</p> <p>The census in this 120 bed facility was 96 at the time of survey. The survey sample consisted of one current record review (Resident #1).</p>	F 000	<p>To remain in compliance with all Federal and State regulations, the facility has taken or will take the actions set forth in the following plan of correction.</p> <ol style="list-style-type: none"> 1. Resident #1 currently has no pressure ulcers and/or skin integrity impairment. 2. Current residents have the potential to be affected by this practice. Skin check on residents residing in the facility will be conducted to assess for pressure ulcers and/or skin integrity impairment. 3. Licensed nurses and certified nursing assistants will be re-educated on the Policy and Procedure for skin assessments and wound documentation. 4. DON/designee will conduct weekly audits x 3 months to confirm that weekly skin assessments and documentation are completed timely and accurately. Results of the audit will be reviewed in the monthly QAPI meeting to maintain compliance. 5. Compliance date: 9/30/20 		

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F 686 SS=D	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that staff failed to accurately assess a pressure ulcer; and failed to conduct weekly wound measurements and assessments until the wound has resolved for one of one sampled residents; Resident #1.</p>	F 686		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/21/20

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: P6GM11 Facility ID: VA0035 If continuation sheet Page 1 of 6

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	<p>Continued From page 1</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 3/24/16 and readmitted on 2/13/18 with diagnoses that included but were not limited to Alzheimer's disease and type two diabetes. Resident #1's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 7/9/20. Resident #1 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status exam). Resident #1 was coded in Section G "(Functional Status)" as requiring extensive assistance from two plus persons with bed mobility, dressing, eating and personal hygiene; and total dependence on staff with toileting.</p> <p>Review of Resident #1's weekly wound assessments revealed on 6/16/20 she developed stage one (1) pressure ulcers to her bilateral heels. The following in part was documented on the wound assessments: " Left Heel: Date first observed: 6/16/20. Stage: 1...4.5 x 6.0 CM (centimeters). Depth: 0. Drainage: small bright red drainage. Odor: none. Granulation: none.</p> <p>Right Heel: Date first observed: 6/16/20. Stage: 1...3.2 x 4.5 CM. Depth: 0. Drainage: none. Granulation: none."</p> <p>The following orders were put into place on 6/16/20: Skin prep wipes apply to left heel every shift...Skin prep wipes apply to rt heel every shift for DTI (Deep tissue injury) (2)."</p> <p>An order for a "low air loss mattress" was also put into place on 6/18/20.</p>			

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F 686	<p>Continued From page 2</p> <p>The following skin preventative measures were put into place prior to the development of her Stage 1 pressure ulcers:</p> <p>An order for Vitamin C was put into place on 2/13/20.</p> <p>An order for a multivitamin was put into place on 2/13/20.</p> <p>An order for 2 cal (calorie supplement) was put into place on 2/13/20.</p> <p>The next skin assessment dated 6/22/20 documented that Resident #1 had DTI's to her bilateral heels. The following was documented: "Site: right heel. Size: 3.0 x 4.4... Stage: DTI...T/P (Turning and Repositioning Q (every) one to two hours...protective devices: Heels float. Left Heel 4.4 x 6.0...Stage: DTI...T/P (Turning and Repositioning) Q (every) one to two hours...protective devices: Heels float."</p> <p>There were no further weekly wound assessment for Resident #1's bilateral heels after 6/22/20. There was no weekly wound assessment documenting that the areas on Resident #1's heels were resolved. There was also no clarification on what stage her wounds were to her bilateral heels (Stage 1 or DTI).</p> <p>On 9/10/20 at 11:15 a.m., an observation of Resident #1's skin was conducted with LPN (Licensed Practical Nurse) #1. Resident #1 was observed to have bilateral heel boots in place. Resident #1 had no open areas or any other skin concerns to her bilateral heels.</p> <p>On 9/11/20 at 11:00 a.m., a telephone interview was conducted with ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the</p>	F 686		

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F 686	<p>Continued From page 3</p> <p>Interim DON (Director of Nursing). When asked how often she expected staff to conduct wound assessments, ASM #2 stated that she expected staff to document weekly on wounds and to document the assessments into PCC (Point Click Care). When asked why nurses would document weekly on a wound, ASM #2 stated that the purpose was to determine the progression or deterioration of the wound and to see if the current treatment is effective. When asked if Resident #1's bilateral heels were stage one pressure ulcers or a DTI (Deep Tissue Injury); ASM #2 stated from what the orders state, she thought they were DTIs. When asked if LPN's were allowed to stage wounds, ASM #2 stated she didn't recommend LPN's to stage wounds, that she recommended RN's to be the wound assessors. When asked if an RN went behind the LPN who assessed Resident #1's heels on 6/16/20; ASM #2 stated they did not. ASM #2 did state that the LPN who conducted the initial wound assessment on 6/16/20 used to be a wound care nurse. ASM #2 stated that the facility did not currently have a wound care nurse. When asked where the rest of the weekly wound assessment sheets were for Resident #1's heels, ASM #2 stated the only other one she had was a wound assessment from 6/22/20. When asked when Resident #1's heels had healed, ASM #2 could not provide a date of when the heels had resolved. ASM #1 and ASM #2 agreed that they were lacking documentation regarding wound monitoring and that this has been an issue they had addressed in an AD HOC meeting on 9/1/20. ASM #2 stated that they did not yet start their plan of correction. When asked what was their root cause analysis for nurses not assessing wounds on a weekly basis; ASM #1 stated that she has mostly agency staff in the building and</p>	F 686		

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F 686	<p>Continued From page 4 stated that there was an issue with "staff compliance." During this meeting LPN #1, the unit manager stated that Resident #1's family also refused (Name of wound group) to see their mom because they were very particular on who treated their mom.</p> <p>On 9/14/20 at 12:03 p.m., ASM #1 provided evidence of the AD HOC meeting conducted on 9/1/20. The following was documented: "Skin Assessments: Initial and Weekly documentation and measurements...Resolution: Agency and Facility Staff educated to policies and procedures and expectations. Calendar of Assigned days and shift...Monitoring Compliance by DON/designee weekly x 3 months, then quarterly to sustain compliance through 2021. Utilize (Name of Wound Group) and report to QAPI (Quality Insurance and Performance Improvement).</p> <p>Facility Policy titled, "Pressure Ulcer Record Policy," documents in part, the following: "To document the presence of a skin impairment. new skin impairment related to pressure when first observed and weekly thereafter. Procedure: Residents have a Pressure Ulcer Record completed for each skin impairment that is related to pressure...Enter the date first observed, enter the stage of the pressure ulcer, enter the size of the pressure ulcer...enter the granulation, enter the drainage, enter the odor of the ulcer...each week the ulcer to be assessed and the following information collected on the Pressure Ulcer Record form: A. Date. B. Stage. C. Length x Width. D. Depth E. Drainage. F. Odor. G. Progress/Remarks- i.e. changes in dressing type- schedule, etc."</p> <p>* Barron's Dictionary of Medical Terms for the</p>	F 686		

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F 686	<p>Continued From page 5</p> <p>Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.</p> <p>(1) Stage One Pressure Ulcer-Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk). This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.</p> <p>(2) Deep Tissue Injury- 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. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.</p> <p>Complaint deficiency.</p>	F 686		