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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 02/02/2021 and offsite 02/03/21 through 02/04/2021. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey and Focused Infection Control survey was conducted onsite 02/02/2021 and offsite 02/03/2021 through 02/04/2021. Two complaints was investigated: VA00050586 was substantiated with deficiencies and VA00050343 substantiated without deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements, 42 CFR Part 483.80 infection control regulations, and the CMS and Centers for Disease Control (CDC) recommended practices for COVID -19. The census in this 154 certified bed facility was 94 at the time of survey. Twenty-eight (28) residents have tested positive for COVID-19, (5) on currenlty on quartine and 24 residents (24) have recovered. Twenty-six (26) employees have tested positive and twenty-six have recovered.	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	F 684		

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

Chris Acorn | Administrator | 3/5/21

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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to clarify the use of a helmet upon admission for one of 8 sampled residents, Resident #8 that led to the reopening of a pressure ulcer* to his posterior head and an abrasion to his forehead and nose. The findings included: Resident #8 was admitted to the facility on 10/12/20 and readmitted on 10/31/20 with diagnoses that included but were not limited to iron deficiency anemia, traumatic subdural hemorrhage with loss of consciousness, of unspecified duration, traumatic brain injury with loss of consciousness, gastronomy status, tracheotomy status. Resident #8's most recent MDS (Minimum data set) was a discharge assessment with an ARD (Assessment Reference Date) of 1/7/21. Resident #8 was coded in Section B as being in a persistent "Comatose" state. Resident #8 was coded as requiring total dependence on all ADLS (Activities of Daily Living) from staff. Resident #8 was documented in Section H (Bladder and Bowel) as always being incontinent of bowel and having a Foley catheter. Review of Resident #8's clinical record revealed that he was admitted to the facility on 10/12/20 with a stage three pressure ulcer to the back of his head. The following skin note was documented: " Resident arrived via medical transportation from (Name of hospital) with recent	F 684	1. It was identified that resident #8 was wearing a helmet after being sent from the hospital without orders and/or clarification regarding the usage of the helmet. Pressure ulcer areas identified as new to the forehead and nose, areas were treated with medication as ordered by physician. Usage of the helmet was discontinued 12/9/20 after consult with physician. Resident #8 was discharged to the hospital 1/7/21. 2. Residents who are admitted to the facility with adaptive equipment are at risk for usage without clarification of orders. Physician's orders specifically those relating to the usage of helmets were reviewed with the physician to ensure pro per usage. 3. Licensed nursing staff will be educated by ADON and/or designee on clarifying orders for usage of residents with devices. 4. Current and new admissions admitted after 2/4/21 admission orders were reviewed for the use of ordered devices. Any residents identified without clarified orders will be reviewed with the attending physician for recommendation of usage. The DON and/or designee will audit new resident charts 5 times a week for 3 months. The results of these audits will be reported by the DON for review during QAPI monthly for 3 months. 5. Date of compliance: 3/12/21. 3/12/21	

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significant head trauma ...Stage 3 (1) to rear of head, 2.5 x1.5x 0.3 (centimeters) present on admission ... Helmet for head protection from flap, no skull to right side of head. surgical incision well healed. PA (Physician Assistant) validated skin check and all medications as per discharge summary ... "

Review of Resident #8's hospital discharge orders dated 10/12/20, failed to evidence orders for the use of his helmet.

Review of Resident #8's clinical record failed to evidence that facility staff had clarified the use of his helmet upon admission.

Resident #8's care plan dated 10/12/20 documented the following: "Resident is required to wear a helmet." There was no further instruction on when Resident #8 should be wearing the helmet and when the helmet should be removed.

Review of Resident #8's weekly wound assessments revealed the wound to Resident #8's posterior head had healed on 11/5/20.

Review of Resident #8's skin assessments revealed that Resident #8's posterior head wound had opened back up on 11/24/20. The following was documented in a weekly wound note: "unstageable (2) ...posterior head ...2 x 2 cm ...date wound identified 11/24/20 ...CA (Calcium Alginate) (treatment) off load with foam ... re opening from previous admission ... I spoke with residents RP (responsible party) his sister about the area on his posterior head re-opening. left note to DR. (Doctor) and wrote order for treatment. "

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Review of Resident #8's November 2020 TAR (Treatment Administration Record) revealed that staff were documenting that they were implementing the above order for his head pressure ulcer.

Review of Resident #8's clinical record revealed that he obtained a hematoma to his forehead due to his helmet on 11/28/20. The following note was documented: "Occurrence Details: a hematoma was discovered when restorative went to do his arm braces. she came to get me, and he has a knot in the middle of his forehead with a scratch in the center. It appeared to have been an abrasion to me... I left a note for the DR. (Doctor) to see him on Monday. Immediate Intervention: measure, place a cold compress for 20 minute intervals which is helping with the swelling. "

A nursing note dated 11/30/20 documented the following: "noted to have scab to front forehead, potentailly caused by helmet necessary to protect brain from MVA (Motor Vehicle Accident) in August 2020. MD notified sister notified. Small scab to bridge of nose, potentially from helmet as well..."

A physician's note dated 11/30/20 documented in part, the following: "Previously healed stage III pressure ulcer of occiput scalp has worsened. Nursing staff was not utilizing foam cushion inside of helmet. Now has large unstageable pressure wound of occipital scalp with overlying eschar, as well as small DTI (Deep Tissue Injury) on frontal region of scalp/forehead. Wound care orders have been updated, and (Name of wound care physician) had been notified and will be assessing on Thursday ... "

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Review of Resident #8's clinical record revealed that the wound care physician had seen Resident #8's posterior head on 12/3/20. The following was documented: "Unstageable due to necrosis of the posterior head ...3.5 x 7.5 x not measurable ...12/3 would recommend notifying neurosurgery; since its at the end of the incision line and with the craniectomy, there is concern for open wounds that would be exposed ...Dakins solution apply once daily for 30 days: ¼ strength dakins solution ... "

A nursing note dated 12/4/20 documetned the following: "Spoke with resident sister she is concerned that resident is wearing his helmet while in bed. as per sister resident should only be wearing his helmet when out of bed. Will communicate with MD as per sister wishes."

A note from the physician's assistant dated 12/9/20 documented in part, the following: "...I have asked nursing staff to remove his helmet as I see no clinically utility for wearing constantly, and I belive its causing more harm than good as now he has two wounds associated with wearing it."

A note dated 12/10/20 from the physcian's assistant documented in part, the following: "...Unstageable wound of scalp appears to be healing better since his protective helmet was taken off 2 days ago...I spoke with sister/POA today...She confirms that indeed he was not supposed to wear his protective helmet continuously, only during medical transport or if he is having seizure activity...

Review of Resident #8's clinical record revealed

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that Resident #8 had an appointment with neurosurgery on 12/14/20 for his posterior head wound. The following recommendations were given: Silvadene Cream 1% (percent) (treatment) apply to rear of head topically every shift for Pressure Ulcer foam dressing to support. "

A physician progress note (from the primary care physician) dated 12/22/20 documented in part, the following: " ... had multiple sacral wounds and the scalp pressure wound. The scalp wound was evaluated by neurosurgery at the request of the wound care doctor. This is because it was close to where he had skull removal. This is done better since we took the foam helmet off. He had no signs of any seizures does not need the protective helmet anymore ...

On 2/3/20 at 10:08 a.m., an interview was conducted with RN (Registered Nurse) #1, the clinical manager on the 400 hall. When first asked about Resident #8's pressure ulcer to his posterior head, RN #1 stated that Resident #1 had been admitted to the facility with either a stage 2 or 3 to the back of his head. RN #1 stated that she could not remember. When asked if there were any instructions on how to utilize the helmet; such when to take off the helmet and how long to leave it on, RN #1 stated that she did receive any instructions from the hospital on when to use the helmet. When asked how nursing staff were utilizing the helmet, RN #1 that nursing staff always left the helmet on except for during skin checks and bathing. When asked if the use of his helmet should have been clarified prior to his head wound re-opening; RN #1 stated, "I am sure if (Name of PA) or (Name of Physician) had a concern, they would clarify." When asked if there should be directions on the

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resident's care plan on how to utilize the helmet and when to remove the helmet, RN #1 stated that she would not necessarily see this information on a care plan because it was nursing judgement to remove the helmet during hygiene and skin checks. When asked the purpose of the care plan, RN #1 stated that the purpose of the care plan was to give direction and expectations for nursing care. When read RN #1 the above note that the PA had written on 11/30/20 regarding nursing staff not utilizing foam for Resident #8's helmet, RN #1 stated that staff were utilizing the foam; that she wasn't sure why the PA had written that staff were not using the foam. RN #1 stated that since Resident #1 had a previous history of skin breakdown in that area, that it was more likely to reopen, especially since it was not easy to turn and reposition his head due half his skull missing. RN #1 then stated that staff were also utilizing the black foam until Resident #8 was seen by neurosurgery and a green foam was recommended.

On 2/3/21 at 1:36 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, a nurse who frequently worked with Resident #8. When asked how Resident #8 was supposed to wear his helmet, LPN #3 stated that Resident #8 was supposed to wear it at all times. When asked if there should be an order for the use of a helmet, LPN #3 stated, "I think so." When asked when the helmet was removed, LPN #3 stated it was removed during bathing and skin checks. When asked if she expected directions on how to utilze the helmet be on the the care plan, LPN #3 stated that she didn't know if she would check the care plan but she would clarify orders with the MD (medical doctor) if there was no clear directions on how to utilize the helmet.

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On 2/3/21 at 3:53 p.m., an interview was conducted with ASM #5, the (Physician's Assistant). When asked about the use of Resident #8's helmet, ASM #5 stated that the in the beginning she was told that Resident #8 was supposed to wear the helmet continuously. ASM #5 stated that it seemed odd, but that Resident #5 had extensive trauma to the brain. ASM #5 stated that Resident #8 was admitted with a stage three wound to the posterior head. ASM #5 stated that the wound had healed at one point and then opened back up. ASM #5 stated that staff were then instructed to utilize black foam inside the helmet to offload pressure off the posterior head wound. ASM #5 then stated that staff stopped utilizing the black foam because offloading pressure to the back of the head, was then causing pressure to the front of Resident #8's head. ASM #5 stated that Resident #8 ended up getting an abrasion to his forehead due to offloading pressure to the back of his head. When asked if the wound to Resident #8's posterior head was caused by staff not utilizing the black foam per her note on 11/30/20; ASM #5 stated that she had originally thought that was the case and then realized the order was not in place until after the wound had developed and then she had found out the black foam was causing more harm than good. ASM #5 stated that she should have written a clarification note. ASM #5 stated that after the abrasion had occurred, she made the decision to call neurosurgery and to clarify the use of the helmet. ASM #5 stated that the wound care physician also wanted Resident #8 to be seen by neurosurgery due to his posterior head wound being close to the incision line and digging into the dura matter. ASM #5 stated that several appointments were made that ended up being

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canceled by the Neurosurgeon's office. ASM #5 stated that Resident #8 ended up going to neurosurgery on 12/14/20. ASM #5 stated that neurosurgery recommended Silvadene with green foam to the posterior head wound. ASM #5 stated that Neurosurgery never clarified the use of his helmet at that appointment and that after several attempts, she got in touch with the surgeon who stated, "Wear it or not wear it-whatever." ASM #5 stated that she also talked to the RP (Resident #8)'s sister who stated that Resident #8 was only supposed to be wearing the helmet during transport or if he starts showing seizure like activity. ASM #5 stated that she then decided to remove the helmet unless he was being transported. When asked who made her aware that Resident #8 was supposed to wear the helmet continuously when he was first admitted, ASM #5 stated that she was told EMS (Emergency Medical Staff) had told the nursing staff that he was supposed to always wear the helmet. When asked if she expected staff to clarify the use of the helmet sooner, such as upon admission, ASM #5 stated, "Sure, I expect staff to call and clarify." ASM #5 then stated that when Resident #8 developed the abrasion to his forehead, she went through his chart and could not find any admission orders for the use of the helmet. ASM #5 stated that she clarified the use of the helmet but maybe staff could have clarified the helmet sooner. ASM #5 stated that there was no real urgency to clarify the use of the helmet unit his wound had opened back up. ASM #5 stated that Resident #8's head wound started healing up nicely after the helmet was removed until sometime in January, in a matter of days, the head wound had significantly increased in size. ASM #5 stated that her and the wound care physician decided to send the resident out to the

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hospital due to fluid that was found to his posterior head wound. ASM #5 stated that they were afraid the fluid was from the brain.

On 2/4/21 at 11:43 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #2, a CNA who frequently worked with Resident #8. When asked if she ever worked with Resident #8 when he was wearing his helmet, CNA #2 stated the thought by the time the resident was on her assignment, that he only had the bandage to his posterior head. When asked how she would know how to utilze the helmet if their were no clear instructions, CNA #2 stated, "I would just get the nurse."

On 2/4/21 at 12:00 p.m., an interview was conducted with CNA #3, another CNA who frequently worked with Resident #8. When asked how Resident #8 utilized his helmet, CNA #3 stated that Resiident #8 always had to have it in place, that she was told never to remove the helmet. CNA #3 also stated that she never removed the helmet during bathing. CNA #3 stated that she was always told not to touch his head.

On 2/4/21 at 2:29 p.m. an interview was conducted with ASM #1 (Administrative Staff Member), the Administrator and ASM (Administrative Staff Member) #2, the DON (Director of Nursing). ASM #1 and ASM #2 were made aware of the above concern. ASM #1 then stated that not all orders get clarified upon admission and that the PA had clarified the use of Resident #8's helmet with neurosurgey. This writer informed ASM #1 that clarification was not done until after Resident #8's posterior wound had reopened and he obtained an abraison to his

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forhead and nose. It was requested that the facility send any evidence that the PA or any other nursing staff had clarifed the use of his helmet prior to his skin breakdown.

On 2/4/21 at 4:56 p.m., further interview was conducted with ASM #2. When asked who was responsible for reconciliation of medications upon admission, ASM #2 stated the nurse doing the admission was responsible for entering the orders and that the unit manager went behind and reconciled medications. ASM #2 stated that she would have expected her staff to clarify the use of his helmet and when to remove etc When asked if there should be an order for the use of a helmet, ASM #2 stated, "Yes."

No further information was presented prior to exit.

Facility policy titled, "Physician's Orders" did not address the above concerns.

The following information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

*Pressure Ulcer- A pressure ulcer is localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer that 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 also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of soft tissue.

(1) Stage Three Pressure Ulcer - Full thickness

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F 684	Continued From page 11 tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. (2) Unstageable Pressure Ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.	F 684		
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 staff interview, clinical record review and facility document review, it was determined that facility staff failed to conduct an initial wound assessment to a sacral pressure ulcer upon admission; identify wounds to the right and left ischium prior to an advanced stage; AND failed to conduct complete and accurate weekly wound assessments from 12/4/20 through 12/30/20 that	F 686	Past noncompliance: no plan of correction required.	

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led to the deterioration of both the left and right ischium which constitutes harm for one of eight sampled residents, Resident #8.

The findings included:

Resident #8 was admitted to the facility on 10/12/20 and readmitted on 10/31/20 with diagnoses that included but were not limited to iron deficiency anemia, traumatic subdural hemorrhage with loss of consciousness, of unspecified duration, traumatic brain injury with loss of consciousness, gastronomy status, and tracheotomy status. Resident #8's most recent MDS (Minimum data set) was a discharge assessment with an ARD (Assessment Reference Date) of 1/7/21. Resident #8 was coded in Section B as being in a persistent "Comatose" state. Resident #8 was coded as requiring total dependence on all ADLS (Activities of Daily Living) from staff. Resident #8 was documented in Section H (Bladder and Bowel) as always being incontinent of bowel and having a Foley catheter.

Review of Resident #8's care plan dated 10/12/20 revealed the following skin preventative interventions were put into place:
- Administer treatments as ordered and monitor for effectiveness.
- Assess/document/report to MD (Medical Doctor) PRN (As needed) changes in skin status.
- Assess/record/monitor wound healing per routine.
- Educate the family/and/or caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.

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- Inform the family/and/or caregivers of any new area of skin breakdown as needed.
- Medications/supplements/etc. to promote wound healing per orders
- The resident requires LAL (Low Air Loss) mattress on bed to help promote wound healing and help prevent further skin breakdown.

Review of Resident #8's POS (Physician Order Summary) also revealed that Resident #8 was placed on the following skin preventative measures:

-Turn and Reposition Q (every) 2 hours as tolerated while in bed. This order was discontinued on 1/8/21.
-Pro-Stat Liquid (Protein) Give 30 mls (milliliters) via Peg-Tube two times a day for wound care. This order was discontinued on 10/27/20.
-ProMod Liquid (Protein) Give 30 ml via peg two times a day for wound care. This order was initiated on 10/31/20 and discontinued on 11/4/20.
-Zinc Capsule 220 MG (milligrams) Give 1 tablet via Peg Tube daily. This order was initiated on 11/1/20 and discontinued on 11/7/20.
-Pro-STAT BID (Two times a day). This was initiated on 11/4/20 and discontinued on 1/8/21.
-Ascorbic Acid (Vitamin C) 250 mg Tablet Give 1 tablet daily for supplement. This order was initiated on 11/1/20 and discontinued on 1/8/21.

Further review of Resident #8's clinical record revealed that Resident #8 was discharged from the facility on 10/27/20 for Respiratory distress. The following note was documented on 10/27/20 at 9:00 a.m.: "Upon morning assessment (sic) patient was found to respiratory distress ...Diminished breath sound at the bases with scattered Rhonchi ...Was unable to get O2

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saturation to stabilize (sic) and patient remained tachycardic (high pulse). Spoke with PA (Physician Assistant) who said to send out 911 ..."

The next nursing note documented on 10/27/20 at 3:40 p.m. documented the following: "Resident admitted to (Name of hospital) for sepsis. Sister notified."

Resident #8 was admitted back to the facility on 10/31/20. The hospital discharge instructions dated 10/31/20 documented Resident #8 as having a stage three (1) pressure ulcer to his sacral area.

The following was documented in an admission note dated 10/31/20, "Patient arrived at facility at 1935 (7:35 p.m.) via stretcher with medical personal. Patient's eyes open and nonverbal, unable to assess due to condition. Vitals stable and patient is afebrile with no signs or symptoms of pain ...Ulcer present on sacral area with, mepilex (dressing) (sic) present which was cleaned with NS (normal saline)."

There was no evidence of any initial measurements or description of Resident #8's sacral wound upon admission to the facility. There was no evidence of a treatment put into place on the physician order summary at this time. However, there was a note by the physician on 11/3/20 that documented in part, the following: "appropriate ointment and dressing to the sacral lesions, wound care consult."

The first documented assessment on Resident #8's sacral wound was by the wound care physician on 11/6/20 (One week later). The following was documented: "Pressure

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...unstageable (2) ...Length: 9 Width: 7 Depth: 0 ...Sanguineous Drainage ...Scant drainage ...Wound bed appearance: slough ... santyl, Dakin's, skin prep, border gauze."

Further review of Resident #8's November 2020 TAR (Treatment Administration Record) revealed staff were completing the above orders for his sacral wound recommended on 11/6/20.

Review of Resident #8's pressure ulcer notes revealed that Resident #8 had also developed an unstageable pressure ulcer to his right ischium as well as a stage three to his left ischium on 11/29/20. There was no evidence of any previous documented skin alterations to these areas prior to an advanced stage. The following wound notes documented by the wound care physician were documented:

"Left ischium ...stage 3 ...Length (cm) (centimeters): 4, Width: 5, Depth: 0.2 ...Drainage Type: Serosanguinous, Drainage: Moderate, Wound bed appearance: Pink ...Treatment: santyl, Dakin's, cover.

Unstageable due to necrosis to the right ischium ...4.5 x 3.5 x not measurable ...The wound is in a (sic) inflammatory stage and unable to progress to a healing phase because of the presence of biofilm ...Surgical Debridement Procedure ...Dakin's solution apply once for 30 days; Santyl apply once daily for 30 days."

Review of Resident #8's clinical record revealed the next visit from the wound care physician was on 12/3/20. Resident #8's sacrum, right and left ischium were assessed. The following was documented:

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"Stage 4 pressure (3) wound sacrum ...7 x 5 x 2.5 cm (centimeters) ...Santyl apply once daily for 26 days; Dakin's solution apply once daily for 26 days; ¼ strength Dakin's moistened gauze ...

Stage three of the left ischium ...6 x 4 x 0.2 cm ...Santyl apply once daily for 26 days; Dakin's solution apply once daily for 26 days...

Unstageable due to necrosis (dead tissue) right ischium ...5 x 4 x not measurable cm ... Dakin's solution apply once daily for 26 days; Santyl apply once daily for 26 days ...

Review of Resident #8's clinical record failed to evidence any further complete weekly wound assessments on the above wounds including measurements; descriptions and stages until 12/30/20. (For 26 days).

A physician progress note from the Medical Director dated 12/11/20 documented in part, the following: " ...My PA is also seen in and agrees with this sacral wounds seem to be improving according to the nursing staff that work with it ...sacral lesions do not look infected ...sacral ulcers; still about 2.5 cm on each gluteal area with no surrounding cellulitis or abscess. Wound care team will follow them show slight improvement."

The above note failed to document which gluteal ulcer the physician was referring to and failed to document complete wound measurements, descriptions, and stages of Resident #8's sacral, right and left ischium pressure ulcers.

A physician progress note (Again from the

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Medical Director) dated 12/22/20 documented in part, the following: " ...had multiple sacral wounds ... They were doing bathing so I was able to evaluate all of his wounds for the first time in a while .... He has multiple wounds on his sacral area none of them look secondarily infected ... he has several sacral lesions. The right-side buttocks as a large eschar which is unstageable left side is deeper as is the superior one these are both dressed and packed they just been cleaned of the nurses remove the dressings to show me. There's no secondary infection no foul odor they look well cared for ... multiple decubitus ulcers were evaluated today. All are well cared for the wound care team is seeing the patient. I'll leave issues of debridement up to them. I don't think any of them need antibiotics at this stage."

The above note from the Medical Director again failed to document a complete description off all wounds including stages of the left ischium and the sacral ulcer as well as measurements of all three wounds.

On 12/30/20 it was documented that Resident #8's right ischium wound was draining foul smelling drainage. The following nursing note was documented: "...PRN (as needed) treatment done to sacrum, left and right ischium, wound on right ischium is draining heavily with foul smelling drainage, CM (Clinical Manager) notified ..."

On 12/30/20 the following note by the physician assistant documented in part, the following: "On examination, there is a large communicating unstageable wound of the right buttock traversing anteriorly into the perineum. There is a significant amount of necrotic eschar covering the wound. The area around the wound is swollen and

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palpable. A small hole noted at the edge of eschar on the buttock noted to be draining a small amount of foul smelling green discharge. I inserted my finger into the hole to widen the aperture and could palpate bone. With my hands, I expressed a copious amount of malodorous discharge from the wound defect, estimated 100 to 150 mL altogether. There is no surrounding erythema (swelling) or warmth. No streaking noted. The chronic stage IV wound of the low back/sacrum actually appears to be healing well, with beefy red wound bed, no discharge or bleeding, no swelling or warmth. Unit manager and DON (Director of Nursing) were notified of this significant change. I also contacted (Name of wound care physician) and discussed my findings. She will be coming tomorrow for weekly wound rounds. (She has not been able to come into the facility since 12/7 secondary to COVID-19 outbreak). She advised against starting any antibiotics until she can assess. Wound cultures were obtained and will be sent out in the morning. Labs will also be repeated in the morning. Nursing staff was made aware. Wound care orders were also updated to include Santyl ointment and Dakin's- soaked gauze ... I also spent a good deal of time discussing nutritional status with the dietitian. The patient has appeared more cachectic of late but has not been waived since December 4. I asked nursing staff to weigh him tomorrow. Most recent albumin (plasma protein) remained low at 2.8. Dietitian has recommended adjusting his TF tube feed) a higher-protein formula and continuing pro-stat 30 mL three times daily. He is already receiving vitamin C ..."

On 12/30/20 the Physician Assistant also ordered a Complete Metabolic Panel (Complete Metabolic

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Panel) that showed Resident #8's albumin (protein) level to be low at 2.2. (Normal Range: 3.5-5.7).

Based on the above albumin level the dietician recommended the following on 12/31/20: RD (Registered Dietician) recommend and discussed with NP change ...1) Impact Peptide (4) 1.5 cc/hr x 22 hours with Prostat BID (two times a day) ...Will provide L-arginine (amino acid) to help with wound management ..."

Review of the January 2020 MARS (Medication Administration Record) revealed the above dietary orders were implemented starting 1/1/20.

The next note dated 1/1/20 by the Medical Director documented the following: "HPI: extremely complex extremely ill patient is been followed closely by my partner. She's been in contact with the wound care doctor who unfortunately is not been able to come in to see this patient for some time. (Name of charge nurse) the charge nurse has done wound rounds on this patient with me and will do full wound rounds on this patient today ...They all are foul-smelling and appear to be getting worse ... The wound care Dr. has specified to my PA to not start antibiotics until she saw the patient but after texting back and forth with her today and telling the wound care Dr. patient's wounds were becoming more foul-smelling with discharge we are starting antibiotics at her recommendation. Starting's Zosyn that should cover most everything including anaerobes. Starting a midline or PICC line ..."
Review of Resident #8's POS (Physician Order Sheet) revealed that Resident #8 was started on "Zosyn Solution (antibiotic) Reconstituted 3.3.75

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F 686	Continued From page 20 GM- 1 dose every 6 hours for Decubitus ulcer for 10 days." On 1/1/21 it was documented that right ischium wound had deteriorated and had increased in size. The following assessment was documented: "Note Text: Wound type is pressure. Stage: unstageable Wound Location right lower ischium/buttock Length (cm) 11 Width (cm) 11 Depth (cm). Area is in house acquired ...Skin impairment was not present on admission ...Drainage type: Purulent Drainage Heavy Drainage Wound bed appearance is Yellow Wound bed appearance is Necrotic Wound bed has Slough Strong odor Periwound appearance is Necrotic/Black ...Wound is deteriorating." On 1/1/21 it was determined that the left ischium; that was once a Stage 3 on 12/4/20 had deteriorated to an unstageable pressure ulcer and had increased in size. The following was documented: "Wound type is pressure. Stage: unstageable/dti Wound Location left lower (sic) ischium/buttock Length (cm) 8 Width (cm) 4 Depth (cm). Area is in house acquired. Skin impairment was not present on admission." Further review of Resident #8's clinical record showed no decline to his Stage IV sacral wound on 1/1/21. Review of Resident #8's clinical record revealed	F 686		

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that the wound care physician had evaluated Resident #8's wounds on 1/7/20 (the day of Resident #8's discharge). The following in part, was documented for the right and left ischium:

"Unstageable due to necrosis of the left ischium ...7 x 7 x not measurable ... This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of biofilm. Wound progress: Deteriorated ...Surgical excisional debridement procedure...

Unstageable due to necrosis of the right ischium ...14.0 x 11.0 x not measurable ...wound deteriorated ...Purulent drainage coming out of wound, large flap of tissue debrided- left with exposed bone ...Will likely need six weeks of antibiotics for clinical osteomyelitis (Inflammation/Infection of Bone). Will discuss with PA (physician's assistant)."

On 1/7/21 it was documented that Resident #8's had been sent out to the hospital for a worsening pressure ulcer of his posterior head that had been followed by neurosurgery. Resident #8 was also sent out for worsening anemia.

On 2/3/20 at 10:08 a.m., an interview was conducted with RN (Registered Nurse) #1, the clinical manager on the 400 hall. When asked who was responsible doing weekly wound measurements, RN #1 stated that the wound care physician usually made rounds on the residents with wounds. When asked if LPNs and RNs could stage wounds, RN #1 stated that they could. When asked if nurses should be conducting weekly wound assessments when the wound care physician was not available or present, RN #1 stated that they should. When

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asked the purpose of weekly wound measurements, RN #1 stated that weekly wound measurements were a way to monitor wounds to see if wounds were improving, getting worse, if treatments need to be changed etc. RN #1 stated that nurses also conducted biweekly skin assessments and should be documenting any new area of skin breakdown. When asked the process if a nurse or certified nursing assistant identifies a new skin area and a new skin area upon admission, RN #1 stated that she expected staff to assess the area, notify her as the unit manager, and initiate a treatment. RN #1 then stated they would also obtain a wound consult from the wound care physician. When asked why nursing staff were not conducting weekly wound assessments on Resident #8 ' s wounds after 12/4/20; RN #1 stated, "I can ' t answer that, I was out sick." RN #1 stated that she had come back on 1/1/21 and did a sweep of the entire unit. When asked if Resident #8 ' s right and left ischium had deteriorated from the previous assessment dated 12/4/20; RN #1 stated, "Yes, ma ' am they really increased in size." When asked what she saw to the left and right ischium on 1/1/21; RN #1 stated that the left ischium did not have an odor, but that the right one appeared to be infected. When asked if the lack of wound assessments from 12/4/20 through 12/30/20 caused the wounds to the left and right ischium to deteriorate, RN #1 stated, "That's a tough call. We try to stay diligent with wound care." When asked if Resident #8's sacral wound was assessed upon admission; RN #1 could not recall. When asked if wounds should be assessed upon admission to the facility, RN #1 stated that they should. When asked if it were probable that Resident #8 could develop an unstageable to his right ischium and a stage three

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to his left ischium overnight; as his skin assessment directly prior to 11/29/20 (the day the wounds were identified at an advanced stage) showed no new areas; RN #1 stated, "Yes, Ma ' am. He has a neurological deficit from a traumatic brain injury, so his blood flow is not concentrating on wound healing." RN #1 proceeded to say that his body was focused on keeping his heart pumping and lungs breathing.

On 2/3/21 at 11:11 a.m., an interview was conducted with ASM (Administrative Staff Member) #3, the Medical Director. When asked if he could tell me about Resident #8 ' s wounds, ASM #3 stated, "I can ' t tell you much." ASM #3 then stated that the wound care specialist is the practitioner who evaluates all wounds, that he will just do a brief overview of the wounds to look for signs of infection. ASM #3 stated that Resident #8 ' s sacral wounds were "Bad all along" but could not go into detail about the status of each wound.

On 2/3/21 at 2:38 p.m., an interview was conducted with the ASM #4, the Wound Care Physician. When asked why she last saw Resident #8 on 12/4/20; ASM #4 stated that there was a COVID outbreak in the building and that she was considered a high-risk exposure to COVID-19. When told ASM #4 that weekly wound assessments could not be found for Resident #8 after 12/4/20 to his right and left ischium and sacral area until 1/1/21; ASM #4 stated, "Absolutely, they drop off." When asked if she expected nursing staff to continue to do weekly wound measurements when she cannot go into a building; ASM #4 stated that she first expected staff to be available to do telemedicine rounds with her. ASM #4 stated that she could not get

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staff to make rounds with her via telehealth during the time she was out. ASM #4 stated that she was not able to go back into the facility until 1/7/21, when the outbreak was under control. ASM #4 confirmed that Resident #4 ' s left ischium had deteriorated to an unstageable and the right ischium wound had necrotic tissue as well as purulent drainage and had increased significantly in size. ASM #4 stated that it was not unusual for Resident #8's wounds to continue to deteriorate after 12/30/20 when the infection was identified. ASM #4 stated that once a resident has an infection of that magnitude it was not uncommon for more wounds to pop up. ASM #4 stated however that prior to 12/30/20, she was not sure how his infection was first identified when copious amount of drainage was coming from his right ischium. ASM #4 stated that even though Resident #8 had a poor prognosis; the degree of his wound decline was significant. ASM #4 stated that she was not sure how his right and left ischium declined to that point.

On 2/3/21 at 4:00 p.m., an interview was conducted with ASM #1, the Administrator and ASM #2 the DON (Director of Nursing). When asked if they had a COVID-19 outbreak in December 2019, ASM #2 stated that they did. When asked if physicians were not allowed in the facility at that time, ASM #2 stated that all physicians were allowed and could also do telehealth. When asked if staff were not available to ASM #4, the wound care physician to make rounds on wound patients during the outbreak, ASM #1 and ASM #2 stated that staff were available to her, but that she only wanted to round with just one nurse for continuity of care. ASM #1 stated that the wound care physician could have rounded with the nurses assigned to the patients

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she needed to evaluate.

On 2/4/21 at 8:50 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, a nurse who frequently worked with Resident #8, and who initially saw his right ischium wound infected on 12/30/20. LPN #2 stated that she had worked with Resident #8 in the beginning of December and was then moved to work the COVID unit. LPN #2 stated that when she returned on 12/30/20 to work with Resident #8, she had received report from the 11-7 shift nurse that his sacral wounds were "getting bad." LPN #2 stated that the night shift nurse had told her that she alerted the physician but could not confirm if this really happened. LPN #2 stated that had alerted the clinical manager (RN #1) of what was reported to her, and that she wanted to assess the wound with the clinical manager. LPN #2 stated that she had to remind the clinical manager about 3-4 times that she needed assistance with assessing wounds. LPN #2 was then told by the clinical manager that they can "Just look at them tomorrow." LPN #2 stated that Resident #8's wounds were not bad in the beginning of December, so she didn't feel right leaving the assessment for another day. LPN #2 stated that she asked a CNA (Certified Nursing Assistant) to help her with turning Resident #8. LPN #2 stated on her assessment she found one of the wounds draining a foul-smelling drainage. LPN #2 stated that she could not recall which wound was draining at that time. LPN #2 stated that both areas to the right and left ischium also "looked bigger." LPN #2 stated that the wounds appeared to have significantly declined from when she had seen them last. LPN #2 stated that she was concerned when she had seen his wounds. When asked if she did a complete

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wound assessment by measuring each wound and documenting a description of each wound on 12/30/20; LPN #2 stated that she did not. When asked if nurses were supposed to conduct weekly wound assessments for residents with wounds, LPN #2 stated that the wound care physician made all the wound rounds and that after COVID-19 outbreak, it was not clear who was supposed to be making wound rounds. LPN #2 stated that she had notified the Physician Assistant who had also seen Resident #8 on 12/30/20. LPN #2 stated that Antibiotics were ordered via a PICC line. LPN #2 stated that the line was placed, and an x-ray had to be obtained to verify the placement. LPN #2 stated that the PICC had to be reinserted as it was not properly placed. LPN #2 stated that Resident #8 did not receive his antibiotics for a few days after the infection was identified, due to the issues with the PICC line. When asked the purpose of doing weekly wound rounds, LPN #2 stated that the purpose of assessing each wound on a weekly basis was to see if the wound was improving, deteriorating, or to see if treatment needs to be changed. LPN #2 could not recall Resident #8's sacral wound upon admission. LPN #2 could also not recall if Resident #8 had any skin issues to his right and left ischium prior to being found at an advanced stage.

On 2/4/21 at 11:43 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #2, a CNA who worked the day shift on 11/27/20 and 11/28/20 prior to Resident #8 ' s right and left ischium wound being found at an advanced stage. When asked how often staff turn and reposition residents, CNA #2 stated that she will turn and reposition every two hours. CNA #2 stated that it might be three hours if the day is

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busy. When asked the process if she were to find a new skin area on a resident, CNA #2 stated that she would report any new skin alterations to the nurse on duty. When asked when she would look at resident's skin, CNA #2 stated with bathing, dressing and turning. CNA #2 could not recall seeing a skin area to Resident #2 ' s right and left ischium on 11/27/20 and 11/28/20.

On 2/4/21 at approximately 12:00 p.m., an interview was conducted with CNA #3, a CNA who worked 7p to 7 am on 11/27/20 and 11/28/20. CNA #3 stated that she worked with Resident #8 almost every day. When asked the process if she were to identify a new skin area, CNA #3 stated that she would immediately notify the supervisor. CNA #3 could not recall seeing any skin areas to Resident #8 ' s right and left ischium during that time. CNA #3 stated all that she could recall was the pressure that was bandaged up to his sacral area that was present on admission.

The nurse who did a skin assessment on Resident #8 on 11/28/20; the day before his wounds were identified at an advanced stage was attempted to be reached for an interview on 2/4/21 at 9:10 a.m. and 11:21 a.m. She could not be reached.

On 2/4/21 at approximately 1:00 p.m., further interview was conducted with ASM #4, the wound care physician. When asked if it were probable that Resident #8 could develop an unstageable to his right ischium and a stage three to his left ischium overnight; as his skin assessment directly prior to 11/29/20 (the day the wounds were identified at an advanced stage) showed no new areas of skin breakdown, ASM #4 stated,

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"We all know it didn't come up at that stage." ASM #4 then stated there were probably skin areas to Resident #8 ' s right and left ischium prior to the advanced stage and it may not be clearly documented. ASM #4 stated that she was sure if she looked through his chart, she would be able to find something before each area turned to an advanced stage. ASM #4 was then told that nothing was documented to Resident #8 ' s right and left ischium prior to an advanced stage. ASM #4 stated, "Give them (the facility) a chance to present something. It would be unusual for him to develop those areas at an advanced stage." ASM #4 stated that even with Resident #8 ' s poor prognosis it would be unusual for him to develop those wounds at an advanced stage. ASM #4 clarified again that after his infection was identified on 12/30/20; then she could believe new wounds could pop up quickly at an advanced stage. ASM #4 stated recently, in January of 2021 she had attended a meeting to discuss pressure ulcers in the facility and how to improve care. ASM #4 stated that she now has a designated wound care nurse to make rounds with her. ASM #4 stated that she has seen improvement in the facility with pressure ulcers.

On 2/4/21 at 2:16 p.m., further interview was conducted with ASM #1 and ASM #2. When asked if she expected nursing staff to conduct weekly wound assessment on residents with wounds if the wound care physician is not available to assess, ASM #2 stated, "Yes." When asked the purpose of the weekly wound assessments, ASM #2 stated that the purpose was to determine if the wound got bigger, improved or needed a change in treatment. This writer expressed concerns with Resident #8's pressure ulcer. When asked if all nurses, even

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LPNS can assess and stage wounds, ASM #2 stated that they can. ASM #1 stated that the facility was working on a solution for better continuity of wound care such as having one dedicated wound nurse to make wound rounds with the wound care physician. ASM #1 and ASM #2 were made aware of the concern for harm at this time.

On 2/4/21 at 2:34 p.m., ASM #2 presented this writer a POC (Plan of Correction) for pressure ulcers. The following was documented: "Problem 1-15-2021 Weekly Wound Documentation of wound measurements. Corrective Action for affected residents: A review of current residents with orders for pressure injury care: wounds were assessed and documented in the medical record 1-21-21 with assistance from the wound physician.

How will the facility identify other like residents that have the potential to be affected and what corrective action will be done: Licensed nurses completed the facility skin assessments no new areas identified 1-18-21. Care plans were reviewed and updated if indicated. Residents will continue to have biweekly skin assessments completed and daily review of clinical alerts by licensed nurse.

What will you do to prevent this from reoccurring or what systemic change will you implement: 1/11/21 a Wound nurse designated to provide consistency for residents with wounds. Licensed nurses were re-educated on Pressure area prevention and management policy with emphasis on completing weekly wound assessments which includes but not limited to obtaining measurements, a description of the

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wound bed, surrounding tissue, odors, drainage and that status of the wound. Education completed by the DON/Designee on 1/19/21. Wound physician attending weekly wound meeting beginning 1/27/21.

How will you monitor and maintain ongoing compliance: Clinical manager/designee will conduct weekly audits x 4. Audit to include that wound assessment completed, skin assessments completed by licensed nurse, treatment orders in place, care plan reviewed and notification to responsible parties and physician. Audit to include residents with existing wounds and newly identified wounds. Weekly wound log reviewed by the Regional Director of Clinical Services.

AD HOC (Needed) QAPI (Quality Assurance and Performance Improvement) meeting held on 1/25/21 to review identified concern and plan."

Review of the facility's policy titled, "Pressure Ulcer Prevention and Treatment Policy," documents in part, the following: "Residents admitted with existing pressure injuries will receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection. New pressure injuries will not develop unless the individual's clinical condition demonstrates that they were unavoidable.

A. Assessment:
Residents will be assessed for pressure injury risk on admission, quarterly, and with significant changes of condition using the Braden Scale for Predicting Pressure Ulcer Risk. Wound identified will be assessed initially and at least weekly

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thereafter, until closed, to include the following elements:
Location and stage
Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth and the presence, location and extent of any undermining or tunneling/sinus tract;
Exudate, if present: type: (such as purulent/serous), color, odor and appropriate amount;
Pain, if present: nature and frequency (e.g., whether episodic or continuous);
Wound bed: Color and Type of tissue/character including evidence of healing (e.g., granulation tissue, maceration) as appropriate;
Appearance of surrounding tissue;
Any evidence of infection
If a PU/PI (Pressure Ulcer/Pressure Injury fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall condition will be reassessed.

B. Treatment: Pressure Injuries Identified will be documented and orders obtained from providers for treatment.
C. Monitoring: At least weekly (and more when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI will be documented. At a minimum documentation will include all elements listed in Section A.
D. The facility will notify family/resident representatives and the provider of any newly acquired or worsening pressure injuries and any changes in treatment(s)."

On 2/4/21 at 4:38 p.m., ASM #1 presented this writer documents from Resident #8's hospital stay

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dated 10/4/20 that documented in part, the following: "Palliative life expectancy less than 6 months. Neurosurgery note cites prognosis grim ...improving respiratory status patient is being discharged back in fair condition to skilled nursing facility but at high risk for recurrent admission and poor long term prognosis."

On 2/5/21 (after survey was concluded), ASM #1 emailed this writer evidence that the Medical Director (ASM #3) had seen Resident #8 on 12/11/20 and 12/22/20. These notes are in the above complaint and it was determined that there was a lack of wound assessments on these dates from theMedical Director.

No further evidence was presented.

COMPLAINT DEFICIENCY that is past non-compliance.

The following information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(1) Stage Three Pressure Ulcer - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

(2) Unstageable Pressure Ulcer- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

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F 686	Continued From page 33 (3) Stage Four pressure Ulcer- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. (4) Impact Peptide-"Very high protein, calorically dense formula for use in the metabolically stressed, immunosuppressed patient." https://www.nestlemedicalhub.com/	F 686		