| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER | 831 ELLERSLIE AVE CHESTERFIELD, VA 23834 |

| (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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| E 000 | Initial Comments<br><br>A COVID-19 Focused Emergency Preparedness Survey was conducted 12/16/2020 through 12/17/2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.<br><br>The census in this 196 certified bed facility was 191 at the time of the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey and Medicare/Medicaid abbreviated standard survey was conducted 12/16/2020 through 12/17/2020. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. However, corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey.<br><br>The census in this 196 certified bed facility was 191 at the time of the survey. The survey sample consisted of 12 resident reviews and 3 employee reviews. | F 000 | | |
| F 583 SS=B | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical | F 583 | | 1/25/21 |

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

Electronically Signed | 01/12/2021

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| F 583 | Continued From page 1<br>records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, clinical record review, facility documentation and in the course of an investigation, the facility staff failed to provide privacy and confidentiality of medical records for 1 Resident (#8) in a survey sample of 9 Residents. | F 583 | The filing of the plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of corrections is filed as evidence to comply with requirements of participation and continue to provide high quality resident centered care. | |

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| F 583 | Continued From page 2<br>The findings included:<br><br>For Resident #8, the facility staff included a copy of Resident #8's chest x ray results in Resident #1's discharge packet.<br><br>Resident #8, a 25-year-old female, was admitted to the facility on 10/14/202, and discharged on 12/8/20. Diagnoses include but are not limited to cerebral infarction of left middle cerebral artery, right shoulder pain, traumatic brain injury, hypertension, gastroesophageal reflux, neuromuscular dysfunction of bladder, muscle weakness, reduced mobility, cognitive communication deficit, dysphagia oropharyngeal phase.<br><br>Resident #8's minimum data set with an assessment reference date of 10/20/20 was coded as an admission assessment. The brief interview for mental status was coded as a 12 out of 15, indicating mild cognitive impairment. Functional status for dressing toileting personal hygiene where it was coded as extensive assistance with 2+ physical support resident is non-ambulatory and has a trach. The resident is able to make needs known by mouthing words unable to verbalize and hand gestures also uses a communication board.<br><br>On 12/16/20 during the course of an investigation of a complaint it was noted in the complaint that Resident #8's chest x-ray results were given to Resident #1 in her discharge packet. A copy of the chest x-ray result was submitted to our office with the complaint involving Resident #1.<br><br>On December 17, 2020 at approximately 3 PM the administrator and the corporate registered | F 583 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 discharged from the facility on 11/5/2020 to home.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents have the risk to be affected. All current residents that are scheduled for discharged as of 1/11/2021 had the discharge paperwork audited by the unit manager to verify the paperwork does contain another resident□s paperwork in the resident□s discharge packet.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Facility Educator for 100% of the licensed nurses, social workers and the unit secretaries on the process to maintain the personal privacy and confidentiality of the resident by reviewing and verifying names on the paperwork prior to giving the discharge packet or other paperwork to a resident or to their RP (responsible party) and if identified, remove immediately any other residents information from the discharge paperwork or other paperwork .Initiate education on 1/12/2021.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Unit Manager will conduct weekly audits x 4 | |

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| F 583 | Continued From page 3<br>nurse and the DON were made aware of the document being given to the wrong resident.<br><br>An interview was conducted with the Corporate RN, the Administrator and the interim DON. The Corporate RN stated "We are human and mistakes get made unfortunately." The administrator expressed this as being a learning opportunity and would in turn provide additional training to her staff about HIPAA violations and the importance of ensuring the correct documents go to the Resident.<br><br>On 12/16/20 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided. | F 583 | then monthly x 2 to verify the discharge packets do not contain any other residents information. Initiated on 1/12/2021.<br>Plan of correction information and audits will be reviewed in the quality assurance and<br>performance improvement process for tracking/trending and any necessary additional<br>interventions. All deficits identified will be forwarded to QAPI Monthly and<br>automatically trigger continuation of audits until full compliance is achieved. | |
| F 585 SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available | F 585 | | 1/25/21 |

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| F 585 | Continued From page 4 | F 585 | | |

to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to

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| F 585 | Continued From page 5<br>prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to make prompt efforts to resolve a grievance for one Resident (Resident #5) in a survey sample of 7 residents. | F 585 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #5 discharged for the facility on 9/1/2020. | |

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| F 585 | Continued From page 6<br><br>For Resident #5, facility staff failed to investigate a concern for missing hearing aids.<br><br>The findings included:<br><br>Resident #5 was admitted to the facility on 8/10/2020 for skilled nursing services and PT/OT following hospitalization and discharged on 9/01/2020.<br><br>The Minimum Data Set, which was coded as an Admission Assessment with an Assessment Reference Date (ARD) of 8/24/2020, coded Resident #5 as having a Brief Interview of Mental Status score of "11", indicating moderately impaired cognition.<br><br>On 12/17/2020, in the course of the complaint investigation, Resident #5's clinical record was reviewed in its entirety and found no mention regarding any missing personal items. A personal property inventory sheet which contained a pre-printed list of various items was reviewed. The inventory sheet revealed miscellaneous articles of clothing were inventoried on 8/12/2020 however, no hearing aids were noted. Review of the facility's grievance log for the time Resident #5 was at the facility (8/10/2020 through 9/1/2020) did not reveal any documented concerns or grievances for Resident #5.<br><br>At approximately 10:30 AM, an interview with the Social Services Director, Employee E, was obtained and stated she was aware that one of her employees, Employee F, also with social services, had received a telephone call from a family member for Resident #5 who was concerned about missing hearing aids. | F 585 | 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents have the risk to be affected.<br>The grievances from January 1 ,2021 will be reviewed for lost items and resolution.<br>Initiated on 1/11/2021 by the Administrator.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Administrator for 100% of the IDT (Interdisciplinary department team) includes social service, dietary, maintenance, housekeeping, admission, activities, business office and nursing management) regarding the grievance report process with resolution. Initiate education for the IDT on 1/12/2021.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator will conduct weekly audits x 4 then monthly x 2 to verify the grievance report have been completed and resolved starting on 1/12/2021.<br>Plan of correction information and audits will be reviewed in the quality assurance and<br>performance improvement process for tracking/trending and any necessary additional<br>interventions. All deficits identified will be forwarded to QAPI Monthly and | |

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| F 585 | Continued From page 7<br><br>An interview was conducted with Employee F who stated, "I received a call on 8/20/2020 from [Resident #5's] daughter who was concerned that her mother was missing her hearing aids, I told her I would see if I could find them and let her know, I went down to the resident's room to look for them but could not find them anywhere, I asked the Unit Manager if she had secured the hearing aids somewhere for the resident and she said 'No', at that point I called the daughter back to let her know that I did not find them and that I would fill out a grievance form and escalate it to the Administrator, I reassured her that an investigation would be done and she would hear something back from the facility soon, I completed the grievance form and presented it to [the Administrator] who told me to give it to [Director of Nursing], the DON was not in her office so I left it on her desk, I went to my office and sent the DON an email telling her that I left a grievance form on her desk for [Resident #5] and she acknowledged receipt of it by answering my email that she had it, I did not hear anything else about it after that".<br><br>An interview was conducted with the Facility Administrator who stated, "I am the facility Grievance Officer and I do not recall being told anything about this, the DON no longer works here and I looked all through her office but I could not find anything, I will look into this matter immediately because I do not want any resident to be without their hearing aids, I will be in touch with [Resident #5's] daughter".<br><br>Review of the facility policy entitled, "Grievances/Complaints, Filing", dated April 2017, subtitle "Policy Statement" read, "The | F 585 | automatically trigger continuation of audits until full compliance is achieved. | |

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| F 585 | Continued From page 8<br>Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative" and subtitle "Policy Interpretation and Implementation", item 8 read, "Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint" and item 12 read, "The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems".<br><br>The Facility Administrator was notified of the findings. No further information was provided. | F 585 | | |
| F 641 SS=D | COMPLAINT RELATED DEFICIENCY<br>Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, clinical record review, facility documentation and in the course of an investigation the tacitly staff failed to maintain accurate assessment for 1 Resident (Resident #1) in a survey sample of 9 Residents.<br><br>The findings included:<br><br>For Resident #1 the MDS does not accurately reflect the skin condition and pressure areas on | F 641 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 discharged from the facility on 11/5/2020 to home.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents have the risk to be affected. | 1/25/21 |

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| F 641 | Continued From page 9<br>admission.<br><br>Resident #1, an 82 year old female, was admitted to facility on 09/23/2020 and discharged on 11/05/2020. Diagnoses included but not limited to pneumonia, type 2 diabetes mellitus, idiopathic peripheral autonomic neuropathy, atherosclerotic heart disease, atrial fibrillation, and pressure ulcer of sacral region.<br><br>Resident #1's Minimum Data Set with an Assessment Reference Date of 09/29/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for bed mobility was coded as requiring extensive assistance from staff with 2+ person physical assist for support. Functional status for dressing, toileting, and personal hygiene were coded as requiring extensive assistance from staff with one person physical assist for support. Skin problems were coded as surgical wound and Moisture Associated Skin Damage (MASD).<br><br>Excerpts from the admission progress notes are as follows:<br><br>"Effective Date: 9/23/2020 17:55-Type: Resident Evaluation- No urinary catheter present. No infusion or IV access sites noted. Skin evaluation reveals current skin breakdown/skin conditions; refer to the completed evaluation and physician orders for type and location."<br><br>A Review of the admission assessment revealed:<br><br>"H Skin Evaluation Page 6 of 15 Resident Evaluation - V 7 Resident:[Resident #1 name | F 641 | An audit will be initiated on 1/12/2021 on all residents admitted from January 1,2021 with pressure ulcers on admissions for accuracy of nursing documentation and MDS coding.<br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Facility Educator for 100% of the licensed nurses and the wound nurse on the process and procedure for accurate documentation of pressure ulcers, wound description on admission and physician or NP (nurse practitioner) notified for treatment order if indicated. Initiate education for licensed nurse□s on 1/12/2021. The MDS CRC will educate the MDS Staff on accurate coding for pressure ulcers and will notify the nursing management for clarification of documentation for accuracy prior to coding if unclear. Initiate education for MDS staff<br>on 1/12/2021.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Unit Managers or a nursing management designee will review the resident evaluation form on the section of the skin assessment orders to identify pressure ulcers and verify physician and NP was notified if treatment indicated and review the 24-hour report for pressure ulcer wound documentation for accuracy weekly x 4 weeks and Monthly x 2 starting on 1/12/2021. The MDS staff will verify accuracy of pressure ulcer during UR | |

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| F 641 | Continued From page 10<br>redacted]"<br>"7. Is there any current skin breakdown or skin conditions present? YES"<br>...<br>"31) Right buttock small area of excoriation"<br>" 4) Face dry scabs on both cheecks [sic]"<br>"53) Sacrum sacral split about 1.2 cm x 0.2 cm x 0.1"<br><br>On 12/17/20 at approximately 2:00 PM an interview was conducted with the MDS Coordinator who state that she obtained her information for the MDS from the Resident's chart and the progress notes and assessments as well as interviews with the Resident and or staff caring for her. When asked about the Resident having a pressure area that was not captured on the MDS she stated that she did not see a pressure area listed she only saw what was referred to as MASD (moisture associated skin damage). When asked if an open area to the sacrum is a stage II she stated yes.<br><br>A review of the CMS Quality Reporting Program Provider Training Section M: Skin Conditions (Pressure Ulcer/Injury) September 4, 2018 revealed:<br><br>https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/Downloads/September_2018_IRF_LTCH_Section_M_Webinar_without_answers.pdf<br><br>"Stage 1 pressure injuries and deep tissue injuries are termed "pressure injuries" because they are closed wounds "<br>"Stage 2, 3, or 4 pressure ulcers, or unstageable ulcers due to slough or eschar, are termed "pressure ulcers" because they are usually open | F 641 | (utilization meeting) and review of clinical records for coding weekly x 4 then monthly x 2. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved. | |

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| F 641 | Continued From page 11<br>wounds"<br><br>"M0300A1-G1 [MDS section]<br>Identifies number of unhealed pressure ulcers/injuries at each stage Establishes the patient's baseline assessment<br>Admission Assessment"<br><br>Please Note the admission assessment stated there was an open area to the "Sacrum sacral split about 1.2 cm x 0.2 cm x 0.1"<br><br>On 12/17/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. | F 641 | | |
| 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 | | 1/25/21 |

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| F 657 | Continued From page 12<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 interview, clinical record review, facility documentation and in the course of an investigation the facility staff failed to review and revise a care plan for 1 Resident (#1) in a survey sample of 9 Residents.<br><br>The findings included:<br><br>For Resident #1 the facility staff failed to update the care plan to include the worsening of a sacral pressure ulcer .<br><br>Resident #1, an 82 year old female, was admitted to facility on 09/23/2020 and discharged on 11/05/2020. Diagnoses included but not limited to pneumonia, type 2 diabetes mellitus, idiopathic peripheral autonomic neuropathy, atherosclerotic heart disease, atrial fibrillation, and pressure ulcer of sacral region.<br><br>Resident #1's Minimum Data Set with an Assessment Reference Date of 09/29/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for bed mobility was coded as requiring extensive assistance from staff with 2+ person physical assist for support. Functional status for dressing, toileting, and personal hygiene were coded as requiring extensive | F 657 | 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 discharged from the facility on 11/5/2020 to home.<br><br>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents have the risk to be affected. All Care Plans on residents with pressures ulcers from January 1,2021 will be reviewed and revised if indicated for worsening of wounds, declining wound care, declining of preventative devices or declines that may or will affect wound healing. Initiated audit on 1/11/2021.<br><br>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Facility Educator for the nursing management and the wound nurse on the process of updating and revising care plans as indicated for changes, worsening of pressure ulcers, declining wound care, preventative devices, declines that may or will affect wound healing. Education of the nursing management and the wound nurse initiate | |

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| F 657 | Continued From page 13<br>assistance from staff with one person physical assist for support. Skin problems were coded as surgical wound and Moisture Associated Skin Damage (MASD).<br><br>On 12/16/20 during clinical record review it was discovered that the care plan read:<br>" Focus"<br>"Actual skin breakdown related to abdominal surgical site and MASD to sacrum"<br>"Date initiated 9/23/20 Revision on 9/24/20"<br><br>"Goal"<br>"Will heal within limits of the disease process"<br>"Date initiated 09/24/20"<br><br>"Interventions:"<br>"Administer analgesia per physician orders (offer prior to treatment / therapy)"<br>"Date initiated 09/24/20"<br>"Administer treatment per physicians orders"<br>"Date initiated 09/24/20"<br>"Encourage and assist as needed to turn and reposition; use assistive devices as needed"<br>"Date initiated 09/24/20"<br>"Report evidence of infection such as purulent drainage, swelling,localized heat, increased pain, etc. notify physician PRN"<br>"Date initiated 09/24/20"<br><br>"Focus"<br>"At risk for further alteration in skin integrity related to hypertension, atrial fibrillation, s/p abd surgery with staples"<br>"Date initiated 09/24/20"<br><br>"Goal"<br>"Decrease or minimize skin breakdown Date initiated 9/23/20" | F 657 | on 1/12/2021.<br><br>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Unit Manager or a nursing management designee will complete audits on care plans for residents that are identified with worsening of wounds, declining of wound care, preventative devices, declines that may or will affect wound healing during clinical review of the 24-hour report weekly x 4 weeks and Monthly x 2 starting on 1/12/2021. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved. | |

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"Interventions"
"Encourage and assist to reposition; use assistive device as needed"
"Date initiated 09/24/20"

"Provide preventative skin care routine daily and PRN"
"Date initiated 09/24/20"
"Suspend float heals as able"
"Use pillows or positioning devices"
"Date initiated 09/24/20"

On 12/17/20 at 10:10 AM an interview was conducted with RN A [the wound care nurse] and RN B [unit manager]. RN B explained that she is the current Unit Manage (former wound nurse) however is training RN A as wound nurse. [Note: Both nurses were involved in the care of Resident #1.]

RN B was asked about the stage of the wound Resident had on admission. She stated that the Admission Assessment described it as " Sacrum - sacral split about 1.2 cm x 0.2 cm x 0.1" however the NP called it MASD (Moisture Associated Skin Damage).

RN B produced the document entitled "Tissue Analytics" and explained how it is generated by a computer program. She explained that the Nurse Practitioner takes a photo of the wound and the computer program takes the measurements and description. The Nurse Practitioner then measures the depth of the wound.

A document titled "Tissue Analytics" was submitted by the wound nurse excerpts are as

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follows:
"9/24/20 11-56 AM - Location - Sacrum - Wound Evaluation"
"Length - 1.60 cm [centimeters] RED- 0.00"
"Width - 0.41 cm Black -0.48 cm "
" L X W - 0.66 cm Yellow 0.00"
"Depth - 0.0 cm Pink 0.00"
"Total - 0.48 cm Other- 0.00 cm"
" Observations:"
"Other - Barrier cream TID [three times a day] and PRN [as needed] incontinence"
"Wound Status - New"
"Acquired In House? - NO"
"Etiology - Friction / Shear / Moisture"
"Pressure reduction / offloading - Ensure compliance with turning protocol"

RN A was asked about interventions for the increasing pressure area and she stated that they had tried everything including an air mattress. When asked for evidence that the interventions that were tried she produced a copy of progress notes from physician excerpts are as follows:

"10/9/20 1:39 PM Physician Note
-Musculoskeletal: patient is sitting in her bed with full HOB elevation, with difficulties moving in her bed related to inflatable mattress, still with severe muscle weakness of RLE"

"10/12/2020 11:23 Type: Physician/Practitioner Progress Note Text: c/o increasing pain over back due to air mattress and requesting to change back to regualr [sic] bed saying she promise she will not lie down on her left side to avoid pressure over buttock."

"10/29/2020 13:26 Type: Nursing/Clinical
-Resident previously refused to use an air

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mattress. Resdient [sic]educated on the importance of the air mattress with wound healing. Resident offered air mattress and was still presistent [sic] about refusal. MD made aware."

"11/1/2020 22:42-Type: Nursing/Clinical Writer spoke with resident about receiving a foley catheter to keep urine from getting on sacral wound. Resident refused catheter she said she will think about it but not now."

Review of the clinical record revealed that on 11/2/20 the Resident was seen by the surgeon and he debrided the wound and recommended and Air mattress as well as Antibiotics and a change in the type of dressing.
11/2/20. A progress note from the RN B [wound nurse] read as follows:

"11/3/2020 09:37 -Type: Education/Teaching -Education/Teaching provided to:: R/P Husband, Resident
Topic of Education/Teaching: : Wound Care, Prevention, Intervention, Risks Teaching method(i.e. Verbal, Demonstration, Printed material, Audio/Visual): : Verbal
Outcome of education: : Resident continues to exercise the rights to refuse, turning and repositioning, offloading, air mattress and wound care at times.
Other: : Resident continues to be educated on risks of pressure ulcer worsening because of refusing to offload and reposition, use of air mattress and wound care."

RN A & B submitted copies of the Tissue Analytics for all visits with the wound care team. When asked if the care plan is normally changed

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| F 657 | Continued From page 17<br>if a wound progresses she stated yes. She stated we usually add new interventions or treatments. When asked who updates the care plans she stated anyone can, all of the interdisciplinary team.<br>RN B stated "Looking at the care plan now I see we should have added the changes in care and the interventions even if she did not accept them we could have added refusal of recommended care as well."<br><br>On 12/17/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. | F 657 | | |