STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 09/22/2021

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MONROE HEALTH & REHAB CENTER	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite from 09/21/2021 through 09/22/2021. 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 on 09/21/2021 through 09/22/2021. Three complaints were investigated during the survey: VA00052198 was unsubstantiated with a related deficiency, VA00051145 was unsubstantiated with a related deficiency, and VA00050272 was unsunstantiated. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 122. The survey sample consisted of 9 current resident record reviews (Resident #4 through Resident #12) and 3 closed record reviews (Resident #1 through Resident #3). There were 22 COVID-19 positive cases in the facility at the time of the survey. The facility was testing staff and residents two times per week. The last facility wide testing was conducted on 09/20/2021 that included 86 residents and 69 staff. Three vaccinated residents tested positive. Two staff tested positive; one was vaccinated and one unvaccinated.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		10/4/21

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

Electronically Signed | 10/04/2021

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F 677	Continued From page 1 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide nail care for one of twelve residents in the survey sample, Resident #4. Resident #4 was observed with long, jagged toenails. The findings include: Resident #4 was admitted to the facility on 7/16/21 with diagnoses that included Parkinson's disease, diabetes, spinal stenosis, chronic pain syndrome, depression and dementia. The minimum data set (MDS) dated 7/26/21 assessed Resident #4 with moderately impaired cognitive skills and as requiring the extensive assistance of one person for hygiene. On 9/21/21 at 2:10 p.m., Resident #4 was observed in bed. The resident's feet were visible from under the bed covers and with the resident's permission, her feet/nails were observed. The toenails on both feet were thick, long and jagged. The third and fourth toenails on the right foot were curled over the end of the toes. The fourth and pinky toenails on the left foot were thick and extended beyond the end of the toes. The second toenail on the left foot was sharp/pointed and extended beyond the end of the toe. Resident #4 stated at the time of the observation that her toenails needed cutting. On 9/21/21 at 2:15 p.m., accompanied by the certified nurses' aide (CNA #1) caring for Resident #4, Resident #4's toenails were	F 677	1. Nail care was performed on 9/21/2021 for resident # 4 2. Unit Managers conducted an audit of all residents in house requiring nail care on 9/23/2021. Nails were trimmed and filed as needed. 3. DON/Designee educated all nursing staff on the policy of nail care and if resident refuses nail care to report to nurse immediately education completed 10/01/2021. Newly hired nursing staff will be educated on the nail care policy and process during orientation. 4. DON/Designee will perform audits of 5 residents per unit twice weekly x 4 weeks then weekly x 4 weeks then monthly x1. All findings will be reviewed and brought to QAPI x 3 months for any follow up that is needed 5. DOC 10/4/2021	

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F 677	Continued From page 2 observed. CNA #1 stated she did not routinely care for Resident #4 but she would try to cut the nails. CNA #1 stated if nails were difficult to cut, they were put on a list for podiatry. CNA #1 stated the resident had not been in the facility very long and she did realize the nails were long. On 9/21/21 at 2:20 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about Resident #4's toenails. LPN #2 stated aides usually cut toenails when needed. LPN #2 stated if aides were not able to cut the nails then the resident was added to a list for podiatry. LPN #2 stated aides did not cut nails for diabetic residents and the podiatrist came to the facility about once every three months. Resident #4's plan of care (revised 8/3/21) documented the resident had a "self-care deficit" regarding activities of daily living. Interventions listed to meet personal care needs included, "Assist with activities of daily living, dressing, grooming, toileting, feeding, oral care..." This finding was reviewed with the administrator and director of nursing during a meeting on 9/22/21 at 4:15 p.m.	F 677		
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	F 686		10/4/21

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F 686	Continued From page 3	F 686	Past noncompliance: no plan of correction required.	

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 clinical record review, the facility staff failed to assess and implement interventions to prevent a pressure ulcer for one of twelve residents in the survey sample, Resident #4. Resident #4 developed a sacral pressure ulcer initially identified as unstageable with necrotic tissue. There was no prior assessment of impaired skin on the sacrum. A nurse with knowledge of redness on the sacrum failed to document or report the redness prior to the development of the ulcer.

The findings include:

Resident #4 was admitted to the facility on 7/16/21 with diagnoses that included Parkinson's disease, diabetes, spinal stenosis, chronic pain syndrome, depression and dementia. The minimum data set (MDS) dated 7/26/21 assessed Resident #4 with moderately impaired cognitive skills and as requiring the extensive assistance of one person for bed mobility.

Resident #4's clinical record documented the resident was assessed with two acquired sacral pressure ulcers on 9/14/21. A nursing note dated 9/14/21 documented the resident was assessed with an unstageable pressure ulcer on the sacrum measuring 2.2 x 1.5 x 0.1 (length by width by depth in centimeters). This assessment listed

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the ulcer as, "...in house acquired...was not present on admission...No drainage Wound Bed appearance is Necrotic No odor...Periwound appearance is Necrotic/Black..." An additional nursing note on 9/14/21 documented the resident also had a state 2 sacrum pressure ulcer measuring 2 x 1 x 0 (length by width by depth in centimeters). This note documented the stage 2 ulcer as, "...in house acquired...not present on admission...No Drainage Wound bed appearance is Pink No odor Periwound appearance is Pink..." Treatment orders were initiated that included daily dressing changes with wound cleanser, Santyl ointment and foam dressing.

The facility's wound nurse assessed the resident's sacrum ulcers on 9/14/21 and documented the following assessments.

9/14/21 - unstageable pressure ulcer measuring 2.2 cm x 1.5 cm x 0.1 cm, in house acquired, no drainage with necrotic tissue covering the wound bed

9/14/21 - stage 2 pressure ulcer measuring 2 cm x 1 cm x 0 cm, in house acquired, no drainage with pink wound bed

The director of nursing (DON) documented a note dated 9/15/21 at 9:43 a.m. stating, "Resident with 2 open areas on sacrum, area cleansed and covered placed on air mattress...MD to eval [evaluate]..."

The resident's physician assessed the resident on 9/15/21 and documented, "...saw and examined the patient for a new wound on her sacrum. It was discovered today and is very

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superficial. It is not painful or tender. No drainage. No known trauma. It is uncomfortable for the patient to turn from side to side and she needs staff assistance to do so...There is a stage 2 sacral wound which is clean and without slough or drainage..." There was no mention on this assessment of the necrotic pressure ulcer assessed by nursing on 9/14/21.

The consultant wound physician assessed Resident #4 on 9/17/21. The wound physician's note dated 9/17/21 documented, "...a thorough wound care assessment and evaluation was performed today. She [Resident #4] has an unstageable (due to necrosis) sacrum for at least 1 days duration. There is moderate serous exudate. There is no indication of pain..." (Sic) The wound physician's assessment documented the sacral pressure ulcer measured 4 cm x 1 cm x 0.5 cm and was 100% covered with thick, adherent devitalized necrotic tissue.

Prior to the assessed sacral pressure ulcer on 9/14/21, the clinical record documented weekly body audits that listed no impaired skin on the resident's sacrum. The most recent body audit prior to 9/14/21 was on 9/11/21 and documented the resident had no current skin issues and no new skin impairments. Braden pressure ulcer risk assessments were completed on 7/23/21, 7/30/21 and 8/6/21 with the resident listed as "low risk" for pressure ulcer development.

Resident #4's plan of care prior to the sacral pressure ulcer (initiated 7/16/21) documented the resident had potential for skin breakdown. Interventions to maintain intact skin included notification to physician of changes in the skin, Braden scale per protocol, skin assessments per

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protocol, diet as ordered, turn and reposition as indicated and use of pressure relieving devices as indicated.

On 9/21/21 at 1:50 p.m., the licensed practical nurse (LPN #3) responsible for wound care was interviewed about Resident #4's sacral pressure ulcer. LPN #3 stated nursing initially documented two pressure ulcers on the resident's sacrum starting on 9/14/21. LPN #3 stated one ulcer had necrotic tissue and was unstageable while the other open area was assessed as a stage 2 ulcer. LPN #3 stated when the wound physician assessed the resident's sacrum on 9/17/21, the physician listed the area as a "cluster wound" and documented the area as one pressure ulcer. LPN #3 stated she was not aware of any skin impairment to the resident's sacrum until 9/14/21. LPN #3 stated when she first assessed the pressure ulcers on 9/14/21 one of the open areas was unstageable due to necrotic tissue.

On 9/21/21 at 2:20 p.m., the registered nurse (RN #1) caring for Resident #4 on 9/14/21 was interviewed. RN #1 stated on 9/14/21 a certified nurses' aide (CNA) reported to her that the resident had an open area on her sacrum. RN #1 stated she assessed the resident's sacrum on 9/14/21 and found one open area that was pink with no eschar that she listed as a stage 2 ulcer. RN #1 stated the other open area on the resident's sacrum was partially covered with eschar and was assessed as unstageable. RN #1 stated she had no reports from staff of any skin impairments for Resident #4 prior to 9/14/21. RN #1 stated she did not know why the area was not identified earlier. RN #1 stated floor nurses performed body audits once per week.

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On 9/21/21 at 2:25 p.m., the certified nurses' aide (CNA #1) caring for Resident #4 was interviewed. CNA #1 stated she was not caring for Resident #4 when the open area was found. CNA #1 stated she worked with the resident only occasionally and was not aware of any skin impairments prior to 9/14/21. CNA #1 described the resident as "total care" and stated the resident "stayed mostly in bed."

On 9/21/21 at 2:30 p.m., the unit manager (LPN #2) caring for Resident #4 was interviewed. LPN #2 stated a CNA reported to her on 9/14/21 that the resident had an open area on the sacrum. LPN #2 stated the registered nurse working on the unit assessed the wounds and notified the wound nurse. LPN #2 stated nobody had reported any skin impairments for Resident #4 prior to 9/14/21. LPN #2 stated Resident #4 was total care for all activities of daily living. LPN #2 stated floor nurses were responsible for completing body audits at least weekly for pressure ulcer prevention.

On 9/21/21/ at 3:10 p.m., LPN #4 that completed the last body audit prior to 9/14/21 was interviewed. LPN #4 stated that on 9/11/21 the resident's sacrum was not open but red. LPN #4 stated the resident liked to stay mostly on her back and he thought the red area was from the resident being positioned on her back. LPN #4 stated he touched the red area and the area was not warm and not painful. LPN #4 stated he did not check if the red area blanched when touched, as registered nurses were required to perform that type of assessment. LPN #4 stated he did not document the redness on the body audit sheet because he thought she just needed repositioning. LPN #4 stated he did not notify the

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provider about the redness because he was on the night shift (11:00 p.m. to 7:00 a.m.). When asked if he reported the red area to the next shift, LPN #4 stated, "No."

On 9/22/21 at 7:45 a.m., with the resident's permission, LPN #3 was observed performing a dressing change to Resident #4's sacral pressure ulcer. The resident had a linear, unstageable pressure ulcer on the sacrum approximately 1.75 inches in length and 0.5 inches wide. This wound was 100% covered with black, leather-looking tissue. The skin surrounding the wound was dark pink/red. On the left buttock, adjacent to the linear necrotic wound, was an irregular shaped open area (approximately 3/4 inch in diameter) with a pink/red wound bed. There was a small amount of dark brownish/red drainage on the existing dressing when removed. The resident stated the area "hurts a little" when the clean dressing was applied.

On 9/22/21 at 11:20 a.m., the resident's physician (administration staff #3) was interviewed about the resident's acquired, unstageable pressure ulcer. The physician stated he recalled notification about a new pressure ulcer. The physician stated, "What I saw when I looked at it, it was superficial."

On 9/22/21 at 2:15 p.m., the unit manager (LPN #2) was interviewed again about any further information regarding Resident #4's pressure ulcer. LPN #2 sated she had nothing else. LPN #2 stated as soon as she was aware of the pressure area, the area was assessed and treated.

The National Pressure Injury Advisory Panel

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(NPIAP) defines a pressure injury as "...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." The NPIAP defines a stage 2 pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel..." The NPIAP defines an unstageable pressure injury as, "Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible...Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (1)

This finding was reviewed with the administrator and director of nursing during a meeting on 9/22/21 at 4:15 p.m.

The facility presented a quality assessment and performance improvement (QAPI) action plan that was initiated on 7/29/21 regarding inaccurate skin assessments, follow-up skin assessment not done, inaccurate wound assessments, worsening of wounds and inaccurate care plans regarding wound care. Root cause analysis was performed and action items implemented included 100% skin sweep of all residents for identification of

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pressure ulcers, designated nurse to round with wound physician and complete wound documentation, weekly tracking of wounds by nurse supervisor and review in weekly wound meeting. Education was provided on 8/3/21 for unit manager about the QAPI plan and their role in monitoring weekly wound/skin assessments. Education was completed on 8/8/21 for nurses on pressure ulcer documentation and accuracy of weekly skin assessments. Weekly monitoring of skin assessments/wounds was ongoing at the time of the survey with the plan correction date listed as 9/14/21. After Resident #4's pressure ulcer was identified on 9/14/21 the facility's audits revealed no further pressure ulcers. There were no other pressure ulcers in the facility at the time of the current survey. The QAPI plan was accepted as evidence of past non-compliance.

This deficiency was cited as past non-compliance.

(1) NPIAP Pressure Injury Stages. National Pressure Injury Advisory Panel. 9/23/21. www.npiap.org/