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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495280 | A. BUILDING _____ B. WING _____ | C 03/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER AT LAKE RIDGE | 12185 CLIPPER DRIVE LAKE RIDGE, VA 22192 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated survey was conducted 03/11/2021 through 03/15/2021. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey.<br><br>The census in this 60 certified bed facility was 28 at the time of the survey. The survey sample consisted of 5 resident reviews. | F 000 | Westminster at Lake Ridge ("Center") is filing this Plan of Correction for the purposes of regulatory compliance. This Center is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. | |
| F 686 SS=E | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, facility documentation review, and in the course of an investigation, the facility staff failed to implement wound treatment orders for 2 residents (Resident #2, Resident #3) in a sample size of 5 residents.<br><br>The findings included: | F 686 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/7/2021

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 686 | Continued From page 1 | F 686 | **F686: Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)** | 4/19/21 |

For Resident #2:

1a) the facility staff failed to ensure wound treatments were in place for an unstageable pressure wound observed on 03/11/2021.

1b) the facility staff failed to perform hand hygiene between glove changes.

1c) and applied santyl directly to a wound with a contaminated cotton-tipped applicator on 03/11/2021 increasing the risk of wound infection.

Resident #2, a 76-year-old male, was admitted to the facility on 02/26/2021. Diagnoses included but were not limited to unsteadiness on feet, pain in right lower leg, muscle weakness, and type 2 diabetes mellitus.

Resident #2's admission Minimum Data Set was not completed.

1a) On 03/11/2021 at approximately 12:50 P.M., an interview with Registered Nurse A (RN A) was conducted outside Resident #2's room near the treatment cart. When asked about Resident #2's wound, RN A stated that [Resident #2] was admitted to the facility with an unstageable wound to his coccyx region. This surveyor and RN A entered Resident #2's room. Resident #2 was observed awake in his bed, wearing a hospital gown. The head of the bed was elevated approximately 45 degrees and Resident #2 was watching TV. RN A called another staff member for assistance to turn Resident #2 for the wound observation. RN A and the other staff member, Licensed Practical Nurse A (LPN A), assisted

**1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

Current residents who reside in the facility have the potential to be affected by the deficient practice.

Resident #2 no longer resides in the facility.

1a) An audit was completed on 3/11/21 by the Director of Nursing of all wound treatments to validate treatments were in place.

1b) Licensed Nursing staff were educated by the Director of Nursing to perform hand hygiene between glove

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| F 686 | Continued From page 2 | F 686 | changes. | |

Resident #2 to turn to his left side. RN A removed Resident #2's brief. There was no dressing on the wound or in the brief or in the bed. There was approximately 70% eschar and slough in the wound bed. RN A measured the wound as 10cm length x 5cm width. When asked about the absence of a dressing, RN A stated he changes the dressing every morning and that "Maybe it fell off." When asked if the certified nursing assistant (CNA) caring for Resident #2 RN A talked to him about the dressing, RN A stated that the CNA did not tell him the dressing was off.

On 03/11/2021 at approximately 1:35 P.M., an interview with Certified Nursing Assistant A (CNA A) was conducted. CNA A verified she was assigned to care for Resident #2 today. When asked if she had performed incontinence care on Resident #2 today, CNA A stated, "Twice." When asked if Resident #2 had a bowel movement today, CNA A stated that Resident #2 had a bowel movement the second time she changed the brief. When asked what Resident #2's wound looked like, CNA A stated that the wound was pink and red and "a little bit open." When asked if Resident #2 had a dressing over the wound, CNA A stated that Resident #2 did have a dressing on but with the second time she changed his brief, the dressing was messy and coming off so she removed it. When asked what she did next, CNA A stated that she cleaned the skin and the wound with the skin wipes and put a clean brief on. When asked what she did next, CNA A stated she then told the nurse (RN A) that she cleaned the area and that the dressing was off.

On 03/12/2021 at approximately 9:00 A.M., the clinical record was reviewed. A physician's order with a start date of 03/05/2021 documented,

1c) RN #A was immediately educated by the Director of Nursing on aseptic technique during wound dressing changes.

Resident #3 no longer resides in the facility.

2a) An audit was completed on 3/11/21 by the Director of Nursing of all wound treatments to validate treatments were in place.

2b) Licensed Nursing staff were educated by the Director of Nursing to perform hand hygiene between glove changes.

**2) How will you identify other residents having the potential to be affected by the same**

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| F 686 | Continued From page 3 | F 686 | **deficient practice and what corrective action will be taken?** | |

"Santyl 250 unit/gram topical ointment [collagenase clostridium histo.] - 1 unit cleanse sacral wound with NSS [normal saline solution], apply santyl, and calcium alginate to sacral wound QD [every day], cover with foam dressing. Topical once daily for changes in skin texture." This order on the Treatment Administration Record was signed off as administered 03/05/2021 through 03/11/2021.

On 03/12/2021 at approximately 10:40 A.M., the administrator and Director of Nursing (DON) were notified of findings. When asked about expectations for wound treatments, the DON stated that there should've been a wound treatment in place and [Resident #2] should've had a dressing on the wound. A copy of their policy on wound care was requested.

On 03/15/2021, the facility staff provided a copy of their policies associated with pressure injuries entitled, "Pressure Injuries Overview", "Prevention of Pressure Injuries", and "Pressure Injury Risk Assessment." The policies did not address providing wound treatments as ordered by the physician to promote wound healing.

1b) On 03/11/2021 at approximately 12:50 P.M., this surveyor observed RN A gather supplies from the treatment cart outside Resident #2's room. RN A stated that Resident #2 was admitted to the facility with an unstageable wound to his coccyx region. RN A stated that the wound doctor ordered Santyl and optifoam dressing for a wound treatment. RN A then filled a medicine cup with santyl ointment, and gathered the following supplies: a chux, gauze packs, optifoam dressing, and a cotton tip applicator (not in wrapper). This surveyor and RN A entered

Residents with wounds have the ability to be affected. An audit was completed by the Director of Nursing to validate treatments were in place for all identified residents. 4/19/21

**3) What measures will be put into place or what systemic changes will be made to ensure the practice does not recur?**

a) Licensed Nurses will be educated by the Director of Nursing to ensure treatments prescribed by the physician are in place for residents with wounds.

b) Licensed Nurses will be educated by the Director of Nursing to ensure infection control/aseptic technique during all wound care treatments

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| F 686 | Continued From page 4 | F 686 | | |

Resident #2's room. Resident #2 was observed awake in his bed, wearing a hospital gown. The head of the bed was elevated approximately 45 degrees and Resident #2 was watching TV. RN A washed the tray table with a wipe and placed supplies on the tray table. RN A balanced the cotton-tipped applicator across the top of the medicine cup. RN A then called another staff member for assistance to turn Resident #2 for the wound observation. RN A and the other staff member, Licensed Practical Nurse A (LPN A), assisted Resident #2 to turn to his left side. RN A removed Resident #2's brief. There was no dressing on the wound or in the brief or in the bed. There was approximately 70% eschar and slough in the wound bed. RN A measured the wound as 10cm length x 5cm width. RN A then sprayed the wound with skintegrity. RN A then removed his gloves and donned a new pair of gloves without washing his hands. RN A then opened a gauze package with his gloved hands and patted the wound dry.

1c) The cotton tip applicator had rolled off the top of the medicine cup and unto the tray table. RN A picked up the cotton tipped applicator, placed it into the santyl and applied santyl over the wound bed. RN A then applied the optifoam dressing.

On 03/12/2021 at approximately 10:40 A.M., the administrator and Director of Nursing (DON) were notified of findings. When asked about expectations for wound care, the DON stated that staff are expected to wash their hands between glove changes. The DON also stated that the cotton-tipped applicator that rolled onto the table should not have been used because it was contaminated. The DON stated it's an infection control issue.

**4) How will the corrective action be monitored to ensure the deficient practice will not recur?**

a) Director of Nursing/designee will complete random audits five days per week for four weeks of current wound treatments; this audit will be followed by weekly audits for two months.

b) Director of Nursing/designee will complete audits of Licensed Nurses during wound treatments for five days per week for four weeks wound treatments are in place; this audit will be followed by weekly audits for two months.

Findings will be submitted to the Quality Assurance and Assessment Committee for review. The Committee will determine if further audits and/or actions are required.

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2) For Resident #3, the facility staff failed to:

2a) ensure wound treatments were in place for bilateral posterior thigh pressure wounds on 03/11/2021.

2b) the facility staff failed to perform hand hygiene between glove changes.

Resident #3, 77-year old female, was admitted to the facility on 02/10/2021. Diagnoses included but were not limited to chronic obstructive pulmonary disease, morbid obesity, hypokalemia, and muscle weakness.

Resident #3's most recent Minimum Data Set with an Assessment Reference Date of 02/15/2021 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, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

2a) On 03/11/2021 at approximately 12:00 P.M., this surveyor and Registered Nurse A (RN A) entered Resident #3 room to perform a wound observation. Prior to entering the room, RN A stated that Resident #3 had a DTI [deep tissue injury to her right heel and wounds on her posterior thighs. When asked about the cause of the wounds to her thighs, RN A stated that Resident #3 sits in her wheelchair for a long time and recently he noted that Resident #3 had blisters on the back of thighs which had since

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opened. RN A also stated that Resident #3 has a cushion for her wheelchair and an air mattress on her bed. Upon entering the room, Resident #3 was observed dressed in a hospital gown, seated in her wheelchair watching TV. RN A assisted Resident #3 to stand to visualize posterior thigh wounds. There was an elongated open wound on each posterior thigh. Each wound bed was reddened with no drainage noted. There was no dressing on either wound. When asked to describe the wounds, RN A stated, "They're stage 2." This surveyor asked Resident #3 if staff apply dressings to her wounds, Resident #3 stated that the nurse puts dressings on every evening before she goes to bed. This surveyor asked RN A about the missing dressings and RN A stated that "every morning when getting into the chair, the dressings fall off." RN A stated that they are waiting for the wound doctor to arrive to do the wound treatment and dressing.

On 03/12/2021 at approximately 8:00 A.M., the clinical record was reviewed. A physician's order with a start date of 02/23/2021 documented, "Venelex topical ointment 1 unit topical once daily to R [right] thigh with telfa after cleansing with NSS [normal saline solution]." A physician's order entry with a start date of 02/23/2021 documented, "Venelex topical ointment 1 unit topical once daily to L [left] thigh with telfa after cleansing with NSS [normal saline solution]." The Treatment Administration Record for these physician orders were signed off as administered from 02/23/2021 through 03/11/2021.

A care plan problem entitled, "[Resident #3's name] has an open area on back of L [left] thigh, and blister on back of right posterior thigh ..." The goal associated with this problem documented,

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"[Resident #3's name] will have no new open areas caused by pressure or friction." An intervention associated with this problem included but was not limited to "Tx [treat] daily as per MD's [medical doctor] ordered [sic]."

On 03/12/2021 at approximately 10:40 A.M., the administrator and Director of Nursing (DON) were notified of concerns. When asked about the expectation for wound treatments, the DON stated that "We don't wait" for the wound doctor to do a dressing. The DON stated that the expectation is the wound will be covered. The DON also stated that "what happened yesterday was unacceptable."

On 03/15/2021, the facility staff provided a copy of their policies associated with pressure injuries entitled, "Pressure Injuries Overview", "Prevention of Pressure Injuries", and "Pressure Injury Risk Assessment." The policies did not address providing wound treatments as ordered by the physician to promote wound healing.

2b) On 03/11/2021 at approximately 12:25 P.M., RN A gathered his supplies from the treatment cart to change the dressing on Resident #3 right heel. RN A assisted Resident #3 back to bed in preparation to change right heel dressing. Resident #3 was lying in supine position and the undressed wounds on Resident #3's posterior thighs were in contact with the fitted sheet on the bed. In the course of removing the old right heel dressing and applying the new dressing, RN A did not wash his hands when changing gloves. RN A then assisted Resident #3 back to her wheelchair.

On 03/12/2021 at approximately 8:00 A.M., the clinical record was reviewed. A physician's order

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| F 686 SS=D | Continued From page 8 | F 686 | | |

with a start date of 02/23/2021 documented, "Venelex topical ointment 1 unit topical once daily to R [right] thigh with telfa after cleansing with NSS [normal saline solution]." A physician's order entry with a start date of 02/23/2021 documented, "Venelex topical ointment 1 unit topical once daily to L [left] thigh with telfa after cleansing with NSS [normal saline solution]." The Treatment Administration Record for these physician orders were signed off as administered from 02/23/2021 through 03/11/2021.

A care plan problem entitled, "[Resident #3's name] has an open area on back of L [left] thigh, and blister on back of right posterior thigh ..." The goal associated with this problem documented, "[Resident #3's name] will have no new open areas caused by pressure or friction." An intervention associated with this problem included but was not limited to "Tx [treat] daily as per MD's [medical doctor] ordered [sic]."

On 03/12/2021 at approximately 10:40 A.M., the administrator and the Director of Nursing were notified of findings. When asked about expectations for wound care, the Director of Nursing stated the expectation is to wash hands between glove changes.

F 689 SS=D Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent

4/19/21

**F689: Free of Accident/Supervision/Devices CFR(s): 483.25(d)(1)(2)**

1) **What corrective action will be accomplished for those**
2) **residents found to have been affected by the deficient practice?**

F 689 Current residents who reside in the facility have the potential to be affected by the deficient practice.

Resident #2 no longer resides in the facility.
Resident #3 no longer resides

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| F 689 | Continued From page 9 | F 689 | | |

accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, facility documentation review, and in the course of an investigation, the facility staff failed to ensure environment remains free of potential accident hazards for 2 residents (Resident #2, Resident #3) in a sample size of 5 residents.

The findings included:

For Resident #2, the facility staff failed to keep bed in lowest position while Resident #2 was in his bed on 03/12/2021 resulting in a potential accident hazard.

Resident #2, a 76-year-old male, was admitted to the facility on 02/26/2021. Diagnoses included but were not limited to unsteadiness on feet, pain in right lower leg, muscle weakness, and type 2 diabetes mellitus.

On 03/12/2021 at approximately 12:30 P.M., this surveyor and the Director of Nursing (DON) observed Resident #2 lying in his bed with the head of bed elevated approximately 45 degrees. The call bell was within Resident #2's reach. Both half rails were up. The bed controller was located on the outer portion of the half rail (not removable) and out of Resident #2's reach. The bed was not in the lowest position. The Director of Nursing entered Resident #2's room and lowered the bed approximately 4 inches to its lowest position. When asked about the expectation for bed positioning, the DON stated she expects the bed to be in the lowest position due to fall risk. When asked if Resident #2 had a

in the facility.

**2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

a) An audit was completed by the Director of Nursing of current residents in the facility for potential accidents/hazards including height of occupied beds and call lights being within reach of residents.

b) An audit was completed by the Director of Nursing for current residents to validate call bells in reach.

4/19/21

**3) What measures will be put into place or what systemic changes will be made to ensure the practice does not recur?**

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| F 689 | Continued From page 10 | F 689 | | |

history of falls, the DON stated she didn't know and would have to check his record. When asked why his bed was up, the DON stated she didn't know why the bed was not in the lowest position.

On 03/12/2021, the clinical record was reviewed. A problem on the care plan dated 02/26/2021 entitled, "[Resident #2's name] has unstageable in the buttocks." Interventions associated with this problem included but were not limited to:
- "Answer calls quickly, attempt to anticipate needs for prompt response and decrease in attempts to ambulate without proper assist.
- Keep call bell, fluids, and personal items within reach in and out of room.
- Keep bed in lowest position at all times when not working at the bedside."

The facility staff provided an incident log with the date range of 12/01/2020 through 03/11/2021. Resident #2 was not on the list which indicated Resident #2 did not experience a fall since his admission to the facility.

2) For Resident #3, the facility staff failed to ensure Resident #3's call bell was within her reach to prevent a potential accident hazard on two occasions.

Resident #3, 77-year old female, was admitted to the facility on 02/10/2021. Diagnoses included but were not limited to chronic obstructive pulmonary disease, morbid obesity, hypokalemia, and muscle weakness.

Resident #3's most recent Minimum Data Set with an Assessment Reference Date of

a) Nursing staff were educated by the Director of Nursing to ensure identified residents have bed placed in the lowest position. Those who prefer beds in the highest position.

Nursing staff were educated by the Director of Nursing to check care plan/Resident Care Guide prior to the start of the shift to ensure identified residents have bed placed in lowest position as directed by plan of care.

b) Nursing staff were educated

by the Director of Nursing to ensure call bells are within reach for current residents prior to exiting the room.

**4) How will the corrective action be monitored to ensure the deficient practice**

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495280 | A. BUILDING _____ B. WING _____ | C 03/15/2021 |

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|---|---|
| WESTMINSTER AT LAKE RIDGE | 12185 CLIPPER DRIVE LAKE RIDGE, VA 22192 |

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| F 689 | Continued From page 11 | F 689 | **will not recur?** | |

02/15/2021 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, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

On 03/11/2021 at approximately 12:00 P.M., this surveyor and Registered Nurse A (RN A) entered Resident #3 room to perform a wound observation. Following the wound observation, RN A then assisted Resident #3 back to her wheelchair, which was beside her bed. This surveyor observed RN A did not place the call light within reach for Resident #3. This surveyor and RN A left Resident #3 seated in her wheelchair next to her bed. This surveyor returned to the room to ask Resident #3 if she could reach her call bell. Resident #3 looked around and stated it is usually on her bed where she can reach it but stated it was not there now. This surveyor went to the hall to notify RN A the call bell was not within reach. RN A stated, "Oh." RN A then entered Resident #3 room and put the call bell within her reach.

On 03/12/2021 at approximately 8:00 A.M., the clinical record was reviewed. A care plan problem dated 02/10/2021 entitled, "[Resident #3's name] is at risk of falls related to weakness and disease process. Interventions associated with this problem included but were not limited to "Answer calls quickly, attempt to anticipate needs for prompt response and decrease attempts to ambulate without a proper assist." "Keep call bell, fluids, and personal items within reach in and out of room."

a) Director of Nursing/designee will complete random audits five days per week for four weeks to validate identified residents with bed in lowest position; this audit will be followed by weekly audits for two months. 4/19/21

b) Director of Nursing/designee

will complete random audits five days per week for four weeks to validate identified residents have call bells within reach; this audit will be followed by weekly audits for two months.

Findings will be submitted to the Quality Assurance and Assessment Committee for review. The Committee will determine if further audits and/or actions are required.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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On 03/12/2021 at approximately 10:40 A.M., the administrator and Director of Nursing were notified of findings. When asked about the expectation for call bell availability, the Director of Nursing stated it is expected that the call bell will be within reach. The Director of Nursing also stated the expectation is that staff will ask residents if they need anything before staff leaves the room and make sure the call light, phone, and anything else they may want is within reach.

On 03/12/2021 at approximately 12:45 P.M., this surveyor and the Director of Nursing observed Resident #3 in her bed with the head of the bed elevated approximately 60 degrees. Resident #3's call bell was hanging on her lamp out of reach. The DON put the call bell within Resident #3's reach and stated she didn't know why it was on the lamp out of Resident #3's reach.

F 689

F 697 Pain Management
SS=D CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure pain management was provided for one resident (Resident # 3) in a survey sample of 5 residents.

Findings included:

F 697

**F697: Pain Management CFR(s): 483.25(k)**

4/19/21

**1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?**

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F 697 Continued From page 13

For Resident # 3, the facility staff did not assess and offer pain medication prior to wound care treatment and when the resident expressed pain during the treatment.

Resident #3, a 77-year old female, was admitted to the facility on 02/10/2021. Diagnoses included but were not limited to chronic obstructive pulmonary disease, morbid obesity, hypokalemia, and muscle weakness.

Resident #3's most recent Minimum Data Set with an Assessment Reference Date of 02/15/2021 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

Review of Resident # 3's electronic clinical record was conducted on 3/11/2021 and 3/12/2021.

Review of Physicians Orders revealed an order for Tylenol 325 milligrams two tablets by mouth every 6 hours as needed for pain.

Review of the Care plan revealed entry of "problem" which read:

Problem was listed as "[Resident #3] has alteration in comfort pain level related to [no diagnosis or condition was listed]. Pain level will be decreased in number and/or severity or absent (see pain flow sheet or observations/documentation x 90 days) Goal date 5/11/2021"

F 697 Current residents who reside in the facility have the potential to be affected by the deficient practice.

Resident #3 no longer resides in the facility.

**2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

An audit was completed by the Director of Nursing for residents with wound care; a pain assessment was updated to be competed prior to the start of wound care and during treatment for identified residents.

**3) What measures will be put into place or what systemic**

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| F 697 | Continued From page 14 | F 697 | **changes will be made to ensure the practice does not recur?** | |

"Approaches" with Start date 2/10/2021 read:
Monitor pain every shift and as needed. Administer analgesic as ordered and assess effectiveness. Note trending in pain relief and notify MD (medical doctor) of results, Provide non medication prior to adding pain medications such as Monitor for indicators of pain, documented reevaluated ongoing as needed Utilize pain scale to determine intensity of pain Assess location and duration of pain and any contributing factors or precipitating events, Complete pain assessment per facility protocol.

Observation conducted by Surveyor A:

On 03/11/2021 at approximately 12:25 P.M., RN A gathered his supplies from the treatment cart to change the dressing on Resident #3's right heel. RN A did not assess the quality or severity of Resident #3's pain. RN A did not offer Resident #3 pain medication in preparation for a dressing change.

RN A assisted Resident #3 back to bed. Resident #3 was lying in supine position and the undressed wounds on Resident #3's posterior thighs were in contact with the fitted sheet on the bed.

RN A sprayed the alginate dressing with Skintegrity wound spray then removed the alginate dressing. RN A looked at the area and pulled away dead skin. There was a small purple spot on the lateral heel. RN A pushed on the spot and immediately Resident #3 recoiled her right leg and let out a moan. Surveyor A asked Resident #3 if that hurt and she said, "Yes."

RN A did not assess the quality or severity of Resident #3's pain. After removing the alginate

Licensed Nurses will be educated by the Director of Nursing to complete a pain assessment prior to wound treatment. In the instance that the resident expresses pain, the treatment will stop and resume upon decreased pain by assessment of the Licensed Nurse.

**4) How will the corrective action be monitored to ensure the deficient practice will not recur?**

Director of Nursing/designee will complete random audits five days per week for four weeks to validate pain assessments were completed prior to wound care and during; this audit will be followed by weekly audits for

two months

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F 697 Continued From page 15

dressing, RN A removed his gloves and put on a new pair of gloves. RN A then assisted Resident #3 back to her wheelchair."

On 03/12/2021 at approximately 12:15 P.M., an interview with the Director of Nursing (DON) was conducted. When asked about the expectation for pain management associated with dressing changes,the DON stated that "even before touching" the Resident, she would offer pain medication. The DON also stated she expects staff to wait 30-45 minutes after medication administration and assess effectiveness before continuing with a wound treatment. When informed of Resident #3's expression of pain during the dressing change, the DON stated she expects her staff to stop, assess pain, and offer pain medication before proceeding.

During the end of day debriefings on 3/12/2021 and again on 3/15/2021, the Administrator and Director of Nursing were informed of the findings that RN A did not assess for pain and failed to offer pain medication to Resident # 3 after her expression of pain during the wound treatment. The Director of Nursing stated nurses were expected to assess for pain and offer pain medication prior to treatments.

No further information was provided.

F 842 Resident Records - Identifiable Information
SS=D CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in

F 697 Findings will be submitted to the Quality Assurance and Assessment Committee for review. The Committee will determine if further audits and/or actions are required.

F 842

**F842: Resident Records-Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)**

4/19/21

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| F 842 | Continued From page 16 | F 842 | **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** | |

accordance not to use or disclose the information agreed to in the contract except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

Current residents who reside in the facility have the potential to be affected by the deficient practice.

Resident #2 no longer resides in the facility.

**2) How will you identify other residents having the potential to be affected by the same deficient practice and what**

**corrective action will be taken?**

An audit was completed by the

Director of Nursing of current wounds in the facility to validate the information documented in the clinical record accurately reflects the condition of the

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| F 842 | Continued From page 17 | F 842 | | |

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, and in the course of an investigation, the facility staff failed to maintain an accurate clinical for 1 resident (Resident #2 ) in a sample size of 5 residents. For Resident #2, there was conflicting information about the stage and location of a pressure wound upon admission to the facility on 02/26/2021 and in the subsequent days.

The findings included:

Resident #2, a 76-year-old male, was admitted to the facility on 02/26/2021. Diagnoses included but were not limited to unsteadiness on feet, pain in right lower leg, muscle weakness, and type 2 diabetes mellitus.

wound.

**3) What measures will be put into place or what systemic changes will be made to ensure the practice does not recur?**

Licensed Nurses will be educated by the Director of Nursing to ensure correct documentation of the wound stage and location is reflected in the clinical record.

**4) How will the corrective action be monitored to ensure the deficient practice will not recur?**

Director of Nursing/designee will complete random audits five

days per week for four weeks to validate correct documentation of wounds in the clinical record; this audit will be followed by weekly audits for two months.

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| F 842 | Continued From page 18 | F 842 | Findings will be submitted to the Quality Assurance and Assessment Committee for review. The Committee will determine if further audits and/or actions are required. | 4/19/19 |

On 03/11/2021 at approximately 12.50 P.M., an interview with Registered Nurse A (RN A) was conducted outside Resident #2's room near the treatment cart. When asked about Resident #2's wound, RN A stated that [Resident #2] was admitted to the facility with an unstageable wound to his coccyx region. This surveyor and RN A entered Resident #2's room. Resident #2 was observed awake in his bed, wearing a hospital gown. The head of the bed was elevated approximately 45 degrees and Resident #2 was watching TV. RN A called another staff member for assistance to turn Resident #2 for the wound observation. RN A and the other staff member, Licensed Practical Nurse A (LPN A), assisted Resident #2 to turn to his left side. RN A removed Resident #2's brief. There was no dressing on the wound or in the brief or in the bed. There was approximately 70% eschar and slough in the wound bed. RN A measured the wound as 10cm length x 5cm width.

On 03/12/2021 and 03/15/2021, the clinical record was reviewed. A Care Plan problem entry dated 02/26/2021 [date of admission] documented, "[Resident #2's name] has unstageable in the buttocks."

An excerpt of an admission nurse's note dated 02/26/2021 at 11:36 P.M. documented, "On assessment ...stage 2 pressure ulcer to sacrum ..."

A physician's order with a start date of 02/28/2021 documented, "Pressure ulcer Stage 2 (dry to scant exudate) cleanse with NSS [normal saline solution], pat dry, apply hydrogel, cover with island dsg [dressing] - to sacrum change daily

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until resolved." This order on the Treatment Administration Record for February 2021 is not signed off as administered.

The physician's History & Physical dated 03/01/2021 did not address any pressure wounds. Under the header, "Skin" there were no narrative comments and the option "No rashes, lesions, or nodules" was selected.

A Minimum Data Set nursing note dated 03/05/2021 at 12:42 P.M. documented, "Spoke with the nurse about the wound, stated the wound is unstageable, slough ..."

A physician's order with a start date of 03/05/2021 documented, "Santyl 250 unit/gram topical ointment [collagenase clostridium histo.] - 1 unit cleanse sacral wound with NSS [normal saline solution], apply santyl, and calcium alginate to sacral wound QD [every day], cover with foam dressing. Topical once daily for changes in skin texture." This order on the Treatment Administration Record was signed off as administered 03/05/2021 through 03/11/2021.

A Skin Evaluation Form dated 03/06/2021 at 1:01 P.M. under the header, "Description" documented, "Stage 2 pressure ulcer on admission."

A nurse's note dated 03/08/2021 at 5:03 P.M. documented, "Wound round with [physician's name] 03/04/2021: Coccyx measures 9 x 3.2 x UTD [unable to determine] with 90% slough, epithelial tissue and scant amount of serous drainage. Treatment: continue to cleanse with wound cleanser, pat dry, apply Santyl, and cover with dry dressing daily."

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

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| F 842 | Continued From page 20 | F 842 | | |

In summary, based on observation, staff interview, and clinical record review, there was conflicting information regarding the stage and location of Resident #2's pressure wound on admission on 02/26/2021 and in subsequent days resulting in an inaccurate clinical record.