STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 11/30/2021

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LYNCHBURG HEALTH & REHABILITATION CENTER	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abreviated survey was conducted 11/29/2021 through 11/30/2021. Two complaints were investigated. VA00053632 and VA00053728 were both substantiated with deficencies cited. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 133 at the time of the survey. The survey sample consisted of 2 current resident reviews and 2 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		1/3/22

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

Electronically Signed | 12/17/2021

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, and in the course of a complaint investigation, the facility staff failed to promote dignity for one of four residents in the survey sample, Resident #1. Two staff members made verbal comments regarding the resident that did not respect his dignty. Findings were: Resident #1 was originally admitted to the facility on 03/14/201 and most recently readmitted on 05/08/2021. His diagnoses included, but were not limited to: cerebrovascular disease, pneumonia, disc degeneration, hypertensive chronic kidney disease, hypertension, malignant neoplasm of the prostate, dementia, and diabetes mellitus. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/21/2021, assessed Resident #1 as moderately impaired	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 = D 1- Resident #1 no longer in the facility. 2- Current residents in the center have	

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F 550	Continued From page 2 with a cognitive summary score of "10". A tour of the wing where Resident #1 had resided was conducted on 11/29/2021 at approximately 11:40 a.m. CNA (certified nursing assistant) #1 was interviewed and asked if he had worked with Resident #1 when he was a resident at the facility, and if so how often. He stated, "Yes, I took care of him, but not a lot...it just depends on how many we have working, if it's five of us then I have the lower hall, if it's just four then I have his room too." He was asked if he had taken care of Resident #1 the day he left the facility to go to the hospital. He stated, "Oh, yes. I had him...his daughter was here the day before to visit him (Resident #1) and he was a mess. She was mad." CNA #1 was asked what he meant by the "He was a mess." He stated, "He had eye boogers, he was soaked, his skin was all scaly and dry. He had a hole in his butt." He was asked if he had stated to Resident #1's daughter that she should see his ass. He stated, "Yeah, I told her that...he had a big hole back there." He was asked how often Resident #1 had been changed and repositioned. He stated, "When I would come in his room in the mornings, he would be soaked, his bed would be wet. He was a large man, they don't want to turn him and change him because it's hard work." LPN (licensed practical nurse) #2 was in the hallway. She was asked if she remembered Resident #1 and if so had she worked with him. She stated, "Yes, I had him the day his daughter was in here. She was upset, screaming and hollering. She was asking me about him and I told her, that I didn't know much about him, I don't usually work with him, I didn't know his medical conditions."	F 550	the potential to be affected. 3- Facility staff will be educated the Staff Development Coordinator/designee on providing ADL care for current residents in the center. Education also included, when dignity issues are identified, notification must be made immediately to the Administrator/DON. 4- The DON/designee will via direct observations during rounding monitor ADL care for residents to ensure care is being provided. Any issues reported with ADL care will be discussed in clinical meeting for resolution. 5- The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. Date of compliance- January 3,2022	

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F 550	Continued From page 3 The above information was discussed with Admin #3, a corporate nurse consultant on 11/30/2021 at approximately 10:00 a.m. He stated, "The nurses know they are supposed to get the information if they don't have the answers the family needs." No further information was obtained prior to the exit conference on 11/30/2021.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to accurately complete a discharge MDS (minimum data set) for one of 4 residents, Resident #1. Findings were: Resident #1 was originally admitted to the facility on 03/14/201 and most recently readmitted on 05/08/2021. His diagnoses included, but were not limited to: cerebrovascular disease, pneumonia, disc degeneration, hypertensive chronic kidney disease, hypertension, malignant neoplasm of the prostate, dementia, and diabetes mellitus. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/21/2021, assessed Resident #1 as moderately impaired with a cognitive summary score of "10".	F 641	F641 = D 1- Resident #1 discharge MDS was modified with correct information for section M. 2- An audit was completed for MDS(s) completed in the last 30 days to ensure section M was coded correctly. 3- MDSC(s) will be education by the Regional DAVS/designee on accurate coding of section M on the MDS. Clinical Leadership will also, be educated to provide the current wound report the MDS department on a weekly basis. 4- The Regional DAVS/designee will audit 10 MDS weekly to ensure section M has been coded correctly. 5- The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no	1/3/22

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F 641	Continued From page 4 A stage 2 pressure ulcer was identified on Resident #1's buttocks on 10/28/2021. The discharge transfer summary completed by LPN (licensed practical nurse) dated 11/07/2021 documented that Resident #1 had a stage 2 pressure injury at the time of discharge. At the time of his transfer to a local hospital on 11/07/2021, the discharge MDS did not identify Resident #1 as having any pressure areas. On 11/30/2021, hospital records were obtained. Per the admission history and physical report, Resident #1, "Daughter mentioned a likely decubitus ulcer for which will need wound care..." A wound care progress note dated 11/08/2021 contained the following information: "...patient's first wound is a sacral pressure injury stage III. The wound bed is pink and there is a scant amount of odorous drainage..." The MDS nurse was interviewed on 11/29/2021 at 4:00 p.m., regarding the discharge MDS. She looked at the documentation and stated, "The information was there, we didn't code it properly on the MDS. I'll make the correction." The above information was discussed with the DON (director of nursing), the administrator, and the corporate nurse consultant during an end of survey meeting on 11/30/2021. No further information was obtained prior to the exit conference on 11/30/2021.	F 641	longer exists, audits will be conducted on a random basis. Date of compliance January 3rd, 2022	
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 out activities of daily living receives the necessary	F 677		1/3/22

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F 677	Continued From page 5 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide ADL care for one of four residents, Resident #1. Resident #1 was observed by a family member with dried skin and lips, eyes stuck together, and a dirty face. Findings were: Resident #1 was originally admitted to the facility on 03/14/201 and most recently readmitted on 05/08/2021. His diagnoses included, but were not limited to: cerebrovascular disease, pneumonia, disc degeneration, hypertensive chronic kidney disease, hypertension, malignant neoplasm of the prostate, dementia, and diabetes mellitus. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/21/2021, assessed Resident #1 as moderately impaired with a cognitive summary score of "10". Section "G", Functional Status, coded Resident #1 as needing extensive assistance of "2+ persons physical assist" for bed mobility, extensive assistance of one person for toilet use, was totally dependant on staff with one person physician assist for personal hygiene and bathing. A tour of the wing where Resident #1 had resided was conducted on 11/29/2021 at approximately 11:40 a.m. CNA (certified nursing assistant) #1 was interviewed and asked if he had worked with Resident #1 when he was a resident at the facility, and if so, how often. He stated, "Yes, I took care of him, but not a lot...it just depends on	F 677	F677 1- Resident #1 no longer in the facility. 2- Current residents in the center have the potential to be affected. 3- Facility staff will be educated the Staff Development Coordinator/designee on providing ADL care for current residents in the center. Education also included, when dignity issues are identified, notification must be made immediately to the Administrator/DON. 4- The DON/designee will via direct observations during rounding 5x weekly to monitor ADL care for residents to ensure care is being provided. Any issues reported with ADL care will be discussed in clinical meeting for resolution. 5- The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. Date of compliance- January 3,2022	

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F 677	Continued From page 6	F 677		

how many we have working, if it's five of us then I have the lower hall, if it's just four then I have his room too." He was asked if he had taken care of Resident #1 the day he left the facility to go to the hospital. He stated, "Oh, yes. I had him...his daughter was here the day before to visit him and he was a mess. She was mad." CNA #1 was asked what he meant by "He was a mess." He stated, "He had eye boogers, he was soaked, his skin was all scaly and dry. When you took off his socks it looked like snow flakes." He was asked why Resident #1 was in that condition. He stated, "It's neglect...When I would come in his room in the mornings, he would be soaked, his bed would be wet. He was a large man, they don't want to turn him and change him because it's hard work....the day that his daughter was here and she was so upset, I just hadn't gotten to him yet, but I got him all cleaned up for her."

The clinical record documented the following:

"11/07/2021 11:32 (a.m.) Resident's daughter voiced concerns about the appearance of her father. She stated the he [sic] face looked like it had not been washed and that her father looked like he was declining..."

"11/07/2021 13:52 (1:52 p.m.) Resident Daughter (name) in building visiting her father on Saturday 11-6-21 had some concerns about his Appearance and his over all health, and areas to his sacrum. Stated that her dad face looked like it had been washed or even had a bathe (sic), lips was dry and crushed (sic) and skin was dry she washed him up herself. (Name) returned today, Staff had given Resident a good bed bath, Shaved, lotion him down, 3- person assisted into recliner chair with Hoyer lift. hair combed, teeth

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F 677	Continued From page 7 brushed Nurse into to do Dressing change to sacrum. Resident rolled into Restorative dinning with his Oxygen on 2/l via Nc (nasal cannula) where Daughter could sit down and visited with him. Daughter was very please with have (sic) he look today, voice that he should look like this every day. but was still little upset concerning his appearance on yesterday. Voice that she wanted him up daily and Recliner chair, that she will start coming daily to visit him. Writer Educate staff on importance of bathing and grooming and Corrective Action will be taken." LPN (licensed practical nurse) #3 who wrote the note on 11/07/2021 at 1:52 p.m. was interviewed on 11/30/2021 at approximately 10:50 a.m. about her note and the corrective action. She stated, "I got the whole staff down there together, I told them there's no sense in a resident being in that condition. What if that was your momma or daddy. I told them they need to be bathing these residents and getting them up. It was a verbal corrective action." No further information was obtained prior to the exit conference on 11/30/2021.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		1/3/22

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F 684	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of complaint investigation, the facility failed to assess and monitor a change in bowel movements for one of 4 resident's, Resident #2. Resident #2 went 6 days with no bowel movement and no interventions were implemented. The findings include: Resident #2 was admitted to the facility on 5/19/21. Diagnoses for Resident #2 included: Renal failure, stroke, feeding tube placement secondary to dysphagia, and constipation. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/15/21. Resident #2 was assessed with a cognitive score of 9 indicating moderate cognitive impairment. On 11/29/21 Resident #2's medical record was reviewed. A nursing note dated 10/20/21 documented "Resident refused bolus feeding at this time due to episodes of nausea this am [sic]. Will continue to monitor." A nurse practitioners note dated 10/22/21 documented: "Patient being evaluated today for nausea and diarrhea. On 10/20/21 nursing staff stated patient was having periods of feeling full not eating well. He was having some nausea and felt it was related to him getting a total of 437 ml of feeding flushes avery 4 hours. Nursing staff felt that the patient was feeling extra full causing him to be nauseous and not wanting to eat regular meals. The enteral flushes were	F 684	F684= D 1- Resident #2 is no longer a resident in the center. 2- A review of BM records for current residents in the center was completed to ensure residents are having BM(s) q3 days and if not, interventions were implemented. 3- Clinical staff will be educated by the SDC/designee on monitoring BM records daily and to implement proper interventions for residents not having a BM q 3 days. 4- The DON/designee will monitor BM records 3x weekly to ensure residents are having BMS(s) q 3 days, and if not, proper interventions were implemented. 5- The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. 6- Date of compliance- January 3,2022	

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F 684	Continued From page 9	F 684		

decreased from 200 ML to 100 ML every 4 hours. According to the nursing staff today, patient has had 2 episodes of diarrhea and 2 episodes of vomiting which consisted of a small amount of liquid fluid. [...]."

Another nurse practitioners note dated 10/25/21 documented "Patient being evaluated today for follow up for nausea, vomiting, diarrhea [...] Currently today he tells me that he has not had any diarrhea or vomiting, however he does feel nauseous. He tells me he does not feel like eating at all [...]. He does state that he feels weak [...]"

Resident #2's bowel movement record was then reviewed for the month of October 2021 and revealed Resident #2 was having daily bowel movements from 10/1/21 through 10/14/21, then no bowel movements from 10/15/21 through 10/20/21 (time period just prior to being seen by the nurse practitioner), and a bowel movement on the night shift of 10/21/21.

Resident #2's nurses notes for the time period of 10/15/21 through 10/20/21 also did not indicate that Resident #2 was having bowel movements.

Review of the facilities policy titled "Constipation Prevention" read in part "Patients will be monitored for regular bowel elimination as evidenced by a bowel movement every three days or as determined by individual assessment [...]. 1. Nurse will routinely review to determine patients in need of intervention to facilitate bowel movement. 2. Assess the patient for the following symptoms of constipation [...] B. Loss of appetite C. General malaise G. Frequent bouts of diarrhea I. Nausea and/or vomiting."

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F 684	Continued From page 10 The policy also instructed the nursing staff to initiate interventions and contact physician for any orders. On 11/30/21 at 9:25 AM, the nurse practitioner (other staff, OS #2) was interviewed. OS #2 said she was not made aware that Resident #2 had not had a bowel movement in a 6 day period and relied on nursing staff to report information like this directly to her as she does not have access to a resident's bowel movement report. OS #2 agreed that feeling full, not wanting to eat, nausea, vomiting and diarrhea are all common signs of constipation or possible impaction and said had she known that Resident #2 had not had a bowel movement then it could have pushed her in another direction of possibly getting an x-ray or checking for an impaction. On 11/30/21 at 10:10 AM the director of nursing (DON) was made aware of the above finding. The DON said not having a bowel movement for more than 3 days should have been reported to the nurse practitioner or the physician. No other information was provided prior to exit conference on 11/30/21.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		1/3/22

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F 686	Continued From page 11 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide necessary care and treatment to promote the healing of a pressure ulcer, for one of four residents, Resident #1. The consultant wound nurse practitioner assessed the wound on 11/02/2021 and deemed it a Stage II pressure injury. Recommendations were not implemented, and further assessment was not conducted on the wound after two staff members identified a change, or prior to discharge to the hospital on 11/07/2021. At the time of admission to the hospital the wound was identified as a Stage III pressure ulcer. Findings were: Resident #1 was originally admitted to the facility on 03/14/2021 and most recently readmitted on 05/08/2021. His diagnoses included, but were not limited to: cerebrovascular disease, pneumonia, disc degeneration, hypertensive chronic kidney disease, hypertension, malignant neoplasm of the prostate, dementia, and diabetes mellitus. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/21/2021, assessed Resident #1 as moderately impaired with a cognitive summary score of "10". Section	F 686	F686 = G 1- Resident #1 is no longer in the facility. 2- Current residents in the center have the potential to be affected. 3- Clinical staff will be educated by the SDC/designee on the center□s wound protocol including conducting a skin assessment prior a resident transferring out of the facility. In addition, education will also include completing skin assessments q 7 days with documentation in the EHR. 4- The DON/designee will review in clinical meeting 5x weekly, the documentation of a skin assessment for residents transferred out of the facility. In addition, skin assessments will be reviewed to ensure they have been completed q 7days and any identified areas addressed in the EHR. 5- The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. 6- Date of compliance- January 3,2022	

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"G", Functional Status, coded Resident #1 as needing extensive assistance of "2+ person's physical assist" for bed mobility, extensive assistance of one person for toilet use, was totally dependent on staff with one person physical assist for personal hygiene and bathing. Section "H", Bowel and Bladder assessed Resident #1 as always incontinent of urine and bowel. Section "M", Skin Conditions, assessed Resident #1 as not being at risk for the development of pressure ulcers/injuries, with the use of a "pressure reducing device for his bed."

On 11/29/2021 at approximately 10:00 a.m., Resident #1's family member was interviewed. She stated, "Thank you...I can't believe the shape he was in when he left there...his bedsore was as big as my fist. The wound center at the hospital looked at it...they said it probably wouldn't heal."

Weekly skin assessments for October and November were reviewed. The evaluation on 10/27/2021 documented the following:

"Skin intact without impairment? No; Wound(s) present: Yes; Are any wounds pressure related? No; Site: Right buttock; Type: Other MASD; Stage: II Site: Left buttock; Type: Other MASD; Stage: II
Resident with Stage II to left and right buttock, measuring 5 X 5 cm circular areas with skin off, wound be [sic] red, with small amount of bloody drainage, no odor, cleanse with soap [a]nd water pat dry, applied Calmoseptine Cream to areas, reposition with pillow for relief off sacrum. Wound: Location of Wound: Right buttock...Date acquired: 10/27/2021; Visible Observation of Tissue: granulation tissue present (beefy red), Moist. Percentage of Wound involvement:

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100%...Drainage present/Tunneling/Undermining/description of periwound: Not answered. Describe wound edges: Irregular shape...Special equipment: Specialty bed mattress...Wound: Location of Wound: Left buttock...Date acquired: 10/27/2021; Visible Observation of Tissue: granulation tissue present (beefy red), Moist. Percentage of Wound involvement: Not Answered; Drainage: Yes; Type of Drainage: Sanguineous: bloody drainage; Amount: Small; Tunneling: No; Undermining: No; Description of periwound: Dry intact; Describe wound edges: irregular..."

A nursing progress note dated 10/28/2021 at 12:52 a.m., documented: "Resident with stage 2 to left and Right Buttocks measuring 5 X 5 cm circular shape, skin off wound bed beefy red, with small amount of bloody drainage, cleaned with soap and water pat dry, applied Calmoseptine Ointment. Pericare administered, ointment applied, reposition with pillow underneath back side."

Physician orders dated 10/28/2021 included, "Referral to in house wound care team for stage 2 to buttocks...Calmoseptine Ointment 0.44-20.6% (Menthol-Zinc Oxide) Apply to right/left buttocks topically every shift for stage 2 r/t (related to) MASD for 14 days."

The wound care nurse practitioner, OS (Other staff) #3 assessed Resident #1 on 11/02/2021 and documented the following, "...Chief Complaint: Comprehensive skin and wound evaluation for Pressure Injury to sacrum...Review of systems: ...patient is obese, morbidly obese...Genitourinary: Heavily

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F 686	Continued From page 14 incontinent...Wounds: Large stage 2 pressure injury to sacrum that extends to bilateral buttocks. See TA (tissue analytics) for full wound assessment details...PRIMARY DIAGNOSIS ICD 10 Ulcer, Sacral Ulcer/sacral/stg 2...Wound plan of care: Patient is at high risk for this wound overcompensating due to his morbid obesity, heavy incontinence, and immobility. See Tissue Analytics Documentation for full wound description and plan of care. Plan of Care Assessment & Plan - Patient has a pressure injury; Pressure reduction and turning precautions discussed with staff at time of visit recommended, including heel protection and pressure reduction to bony prominences. Staff educated on all aspects of care. Factors Affecting Healing: Patient has frequent incontinence which can decrease healing rate of wound. Recommend providing incontinence care as needed, PRN (as needed). Increased moisture at wound site can promote poor prognosis of wound healing. Please keep wound site covered and avoid contamination with feces at all times. Other elements of Patient Evaluation: Staff made aware that wound rounds were completed and of any changes in treatment plan." The Tissue Analytics referred to in OS #3's note was located in the clinical record and contained the following: Length: 4.72 cm Width: 5.51 cm LXW [Length x width]: 26.01 cm Depth: 0.10 cm Total: 12.04 cm Date Wound Acquired: 11/02/2021 % epithelization: 100 Depth (cm): 0.10 Other: Zinc barrier cream	F 686		

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Wound status: New
Acquired in House: Yes
Etiology: Pressure Ulcer-Stage 2
Drain Amount: Moderate
Drain Description: Serosanguinous
Odor: No odor
Periwound: Fragile
Dressing change frequency: Daily
Cleanse Wound With: Wound Cleanser
Pressure Reduction/Offloading: Ensure compliance with turning protocol, Elevate legs regularly, Wedge/foam cushion for offloading, Wheelchair Cushion, Mattress Overlay
Secondary Dressing: See notes
PUSH Score: 16

Resident #1's physician orders were reviewed. There were no orders for the use of wound cleanser to clean Resident #1's wound. There were no orders for heel protectors, mattress overlay, wheelchair cushion, or a turning protocol.

The care plan included the following focus area dated 10/28/2021: "Resident has actual skin impairment to left/right buttocks Stage 2 r/t MASD" was observed, with interventions of, "Keep skin clean and dry. Moisture barrier cream as needed for protection of skin. Weekly skin assessment." The care plan also included a focus area for "...Incontinence r/t immobility" with the goal, "Resident will remain free from skin breakdown due to incontinence and brief use," and intervention of, "Ensure the resident has an unobstructed path to the bathroom. INCONTINENT: Peri-care as needed..."

There were no other interventions listed on the care plan for turning frequency, the use of a wedge/foam cushion to off load pressure areas,

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heel protectors, or a mattress overlay.

An additional weekly skin evaluation completed by the facility staff and dated 11/03/2021 contained the following: "Skin intact without impairment? No; Wound(s) present: Yes; are any wounds pressure related? Yes; Site: Sacrum "Resident currently has a Stage II wound on sacrum. Treatment in place." No other areas of the evaluation were completed.

A tour of the wing where Resident #1 had resided was conducted on 11/29/2021 at approximately 11:40 a.m. CNA (certified nursing assistant) #1 was interviewed and asked if he had worked with Resident #1 when he was a resident at the facility and if so how often. He stated, "Yes, I took care of him, but not a lot...it just depends on how many we have working, if it's five of us then I have the lower hall, if it's just four then I have his room too." He was asked if he had taken care of Resident #1 the day he left the facility to go to the hospital. He stated, "Oh, yes. I had him...his daughter was here the day before to visit him (Resident #1) and he was a mess. She was mad." CNA #1 was asked what he meant by the "He was a mess". He stated, " ...He was soaked, his skin was all scaly and dry. He had a hole in his butt." He was asked if he had stated to Resident #1's daughter that she should see his "ass". He stated, "Yeah, I told her that...he had a big hole back there." He was asked if he had told the nursing staff about the "hole" on Resident #1's bottom, and if so who he had reported it to. He stated, "Yes, I told them, I don't remember who was working that day." He was asked how often Resident #1 had been changed and repositioned. He stated, "When I would come in his room in the mornings, he would be soaked,

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his bed would be wet. He was a large man, they don't want to turn him and change him because it's hard work." CNA #1 was asked if Resident #1 had an air mattress on his bed while he was at the facility. He stated, "I don't remember, he had one of those big beds."

At approximately 12:30 p.m., the wound care nurse practitioner, OS #3 was interviewed over the phone regarding Resident #1. She stated she had only seen the resident one time on 11/02/2021. She stated, "I am looking at my notes now...he had a stage two pressure injury, it was from his sacrum to his bilateral buttocks, it wasn't full thickness and it was superficial....4.72 centimeters in length, 5.51 centimeters in width, there wasn't any depth. It was pink." She was asked if there were any open areas, she stated, "No, he had an indentation the size of my finger." She was asked if the indentation was an open area. She stated, "No, there wasn't an opening...I think it was part of his anatomy...I am looking at a picture that I took of the area now...the facility has access to that and can show you what I am talking about." She was asked what she thought had caused his areas on his buttocks. She stated, "From what I remember he had an air mattress, he was incontinent, obese, he wasn't getting up...when I saw the patient he really wasn't able to participate in the exam." She was asked if the pressure injury was avoidable. She stated, "I don't know if they were completely avoidable, I only saw him once...he was heavily incontinent...I've never been asked that before...from what I saw he had an air mattress and turning protocol...I ordered the barrier cream...he may have had some scarred tissue there that is more fragile than the original skin...I really don't know enough about him to answer

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that question."

At approximately 12:45 p.m., Admin #4, one of the corporate nurse consultants was asked if she could access the picture taken by OS #3. At approximately 1:30 p.m. the photograph was reviewed. Observed on the photograph were two areas in a butterfly pattern on the left and right buttocks both pink in color. In the center of the two pink areas was a dark area, darker than the resident's skin. Admin #4 was asked if the area was the indentation described by OS #3. She stated, "I don't know." OS #3 was contacted by Admin #4 and asked to come to the facility to clarify what was being seen on the photograph.

OS #3 arrived at the facility at approximately 2:00 p.m. She looked at the photograph and stated, "I was looking at it on an IPad, I don't see an indentation on this photograph." OS #3 was asked if there had been any open areas when she examined Resident #1. She stated, "No."

On 11/29/2021 at approximately 4:00 p.m., a meeting was held with the DON (director of nursing) and the administrator. The "pressure reducing mattress" coded on the quarterly MDS was discussed. The DON stated, "That is just our regular mattress, everyone has that."

On 11/30/2021 at 9:00 a.m., LPN #2 was interviewed, as she was the last nurse to document a dressing change on the TAR (treatment administration record) for 11/7/21. She was asked what the wound looked like that day. She stated, "I had never seen it before...I put cream on it after I cleaned if off with wound cleanser....it was pink there was an open area at the sacrum, the center of it was pink it was open,

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it wasn't black or anything..." She was asked if she had measured the area or looked at the previous wound assessment so she would know if the area had changed. She stated, "I didn't measure it...I don't think there was that much depth...they had told me it was getting better, but I don't know. The daughter was in there jumping up and down, and screaming. I was just trying to get it done and get out of there and calm her down." She was asked if there had been an air mattress or a wedge for positioning on the bed. She stated, "No, I don't remember that."

On 11/30/2021 at 9:20 a.m., OS #2, another nurse practitioner at the facility was interviewed regarding Resident #1. She was asked if she had seen Resident #1's wound. She stated, "Yes, I ordered the cream for it and we consulted wound care." She was asked if there was an air mattress on his bed and if so was something that had to be ordered. She stated, "I don't remember if there was or not and I don't know who makes the decision on those...the wound care team comes in and writes orders. The staff is responsible for putting them in the computer." She was shown the tissue analytics paperwork and asked if those were the wound care orders. She stated, "Yes, I think so....but I know she (OS #3) has had some concerns about the orders in the past and I encouraged her to talk to (name of the administrator)." OS #2 was asked if the areas on Resident #1's buttocks were avoidable. She stated, "With proper turning and changing diapers regularly it would be...the urine is acidic and if it lays on the skin it breaks it down. The skin is red at first and if treatment is put in place, it doesn't progress."

On 11/30/2021 at approximately 9:30 a.m..,

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Admin #3, another corporate nurse consultant and OS #3 were interviewed. OS #3 was asked about documentation on the tissue analytics paperwork were her orders for care. She stated, "Those are my recommendations, I make the same ones on everyone I see. The facility can decide what they want to use." Admin #3 was asked about the recommendations made by OS #3 for heel protectors, mattress overlay, etc. He stated, "It should be on the care plan if it was in place." Admin #3 was asked about the weekly skin evaluation dated 11/03/2021 that did not have measurements or additional information documented. He stated, "When we hired this company to do wounds, the nurses don't have to do measurements anymore based on the agreement we have with the wound company...but if there is a change they should document it."

The discharge transfer summary dated 11/07/2021 documented that Resident #1 had a stage 2 pressure injury at the time of discharge. LPN #3 who completed the form was interviewed at approximately 10:50 a.m. She was asked if she had done a visual wound assessment prior to Resident #1 leaving the facility. She stated, "No, he was already up in the chair. I didn't see the area." Review of the TAR (treatment record) indicated that LPN #3 had not provided wound care to Resident #1 since 11/01/2021, six days prior to his transfer. She was asked if she had based her documentation on 11/07/2021 on the wound appearance on 11/01/2021. She stated, "Yes." LPN #3 was asked about the DTI (deep tissue injury) on Resident #1's right foot identified on the transfer summary. She state, "Yes, it was just a little purple area, I put it on there."

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On 11/30/2021, hospital records for Resident #1 were obtained. The admission history and physical report documented, "Daughter mentioned a likely decubitus ulcer for which will need wound care..."

A hospital wound care progress note dated 11/08/2021 contained the following information: "...patient's first wound is a sacral pressure injury stage III. The wound bed is pink and there is a scant amount of odorous drainage. Orders have been placed for a dressing of: Cleanse with normal saline, apply Maxorb ag to wound bed ONLY, top with an bad and secure with Medipore, daily..."

The hospital discharge summary contained the following: "Discharge Diagnosis...Sacral decubitus ulcer, Stage III...present on admission and seen by wound care..."

A meeting was held on at approximately 12:15 p.m., with the administrator, the DON, and Admin #3. The above information was discussed. Admin #3 was asked if the LPN #3 should have assessed Resident #1's wounds prior to transferring him to the hospital. He stated, "Yes, that is how we train." He was asked if there was any policy or procedure regarding assessments of wounds. He stated, "We don't have a policy on that, that's how we train our staff. That is what they are supposed to do." Concerns were voiced that two staff members, CNA #1 and LPN #2 had both identified an opened area described by one as a "hole" and the other as an open area with depth, on Resident #1's sacrum, without any further assessment or documentation regarding the area. Recommendations made by the wound care nurse practitioner were not implemented or

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F 686	Continued From page 22 care planned, there was no evidence provided that an air mattress was in place for Resident #1, and when he was transferred to the local hospital, his pressure injuries were not assessed prior to leaving the facility. Upon arrival to the local hospital he was assessed as having a Stage III to his sacrum. The administrator, the DON, and Admin #3 were informed that harm was identified. No further information was obtained prior to the exit summary on 11/30/2021.	F 686		