STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225537	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY HEALTH CARE CENTER	259 BALDWIN STREET LOWELL, MA 01851

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, for one of three sampled residents (Resident #1), the Facility failed to notify the Physician when there was a change in Resident #1's condition, when on 7/3/20, staff assessed Resident #1 as having a new pressure area on his/her heel, and the Physician was not notified. Findings include: The Policy, titled Change in a Resident's Condition of Status, dated 5/2017, indicated the Facility would promptly notify the Physician of changes in the resident's medical condition. The policy, titled Skin and Wound Care Management Program, undated, indicated: -All staff members were responsible to report any resident that developed a pressure injury to the nurse in charge of the resident upon discovery of the area. -All residents with pressure injury would be evaluated by the wound care team, which included the Physician, weekly until the wound(s) were resolved. Resident #1 was admitted to the Facility in April of 2020, [DIAGNOSES REDACTED]. The Admission Skin Check, dated 4/17/20, indicated Resident #1's feet were dry and intact. The Treatment Administration Record (TAR) dated 7/3/20, indicated that during a routine skin assessment, Resident #1 was found to have a new pressure injury on his/her heel. Documenation on the TAR did not indicate if it was Resident #1's left or the right heel. Review of Resident #1's medical record from 7/3/20 through his/her discharge on 7/7/20 indicated there was no further documentation of the pressure injury on Resident #1's heel, including notification to Resident #1's Physician. During interview on 9/2/20, (DON) #2, said nursing staff were expected to report any new or worsening pressure injuries to the Nursing Supervisor and to the physician, document a detailed description including measurements of each pressure injury in the medical record, and obtain physician's orders [REDACTED].#1 said he was not made aware of the pressure injury on Resident #1's heel, and said his expectation whenever a pressure injury is found by nursing staff, it is the Facility's responsibility to notify the physician.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to update or revise his/her comprehensive plan of care when on 7/3/20, Resident #1 was noted to have a pressure injury on his/her heel, and there was no plan of care developed or implemented related to treatment or management of the pressure injury. Findings include: The policy, titled Skin and Wound Care Management Program, undated, indicated Care Plans would be updated whenever there was a change in the status of a wound, or when the treatment plan was altered. Resident #1 was admitted to the Facility in April of 2020, [DIAGNOSES REDACTED]. The Admission Skin Check, dated 4/17/20, indicated Resident #1's feet were dry and intact. The Treatment Administration Record (TAR) dated 7/3/20, indicated that during a routine skin assessment, Resident #1 was found to have a pressure injury on his/her heel. Documentation on the TAR did not indicate if it was Resident #1's left or the right heel. Review of Resident #1's Care Plan indicated there was no plan of care developed related to the treatment or implementation of interventions to prevent worsening of Resident #1's pressure injury. During interview on 9/1/20, at 10:51 A.M., the Nursing Supervisor said the Care Plan for Resident #1 should have been updated to include interventions for the treatment of [REDACTED]. During interview on 9/2/20, at 10:17 A.M., Director of Nurses (DON) #2, said nursing staff were expected to update the Care Plan to include interventions for treatment of [REDACTED].
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was provide with the necessary treatments and services to prevent the development or worsening of a pressure injury. Findings include: The Facility Policy, titled Skin and Wound Care Management Program, undated, indicated the following: -All residents with pressure injury would be evaluated by the wound care team weekly until the wound(s) were resolved. -The documentation of the stage and size of the pressure injury would be reviewed during weekly risk meetings, and the Director of Nurses was responsible for reviewing the documentation for accuracy. -Care Plans would be updated whenever there was a change in the status of a pressure injury, or when the treatment plan was altered. -Weekly documentation must include a detailed description, size, stage, color, drainage, description of peri-wound (skin surrounding the wound) and any odor observed. -Each pressure injury would be recorded separately on a weekly wound documentation form, which would be filed in the resident's medical record. Resident #1 was admitted to the Facility in April of 2020, [DIAGNOSES REDACTED]. The Admission Skin Check, dated 4/17/20, indicated Resident #1's buttocks and coccyx area were clear and his/her feet were dry and intact. The Nurse Progress Note, dated 6/16/20, indicated Resident had a newly identified open area (pressure injury) on his/her back (later identified as the buttocks and coccyx area) which measured 0.5 centimeters (cm) by 0.3 cm. The Note indicated the treatment to the area was hydrogel, calcium alginate, and covered with an Allevyn (foam) dressing. Review of the Treatment Administration Record (TAR)s dated 6/16/20 through 7/6/20 indicated the following: - Documentation related to the description of wound bed of Resident #1's buttocks/coccyx area pressure injury ranged from coloration of pink, red, and red/black. - Documentation related to the description of drainage from Resident #1's buttocks/coccyx area pressure injury ranged from scant to minimal to moderate. - Documenation related to the description of the odor from Resident #1's buttocks/coccyx area pressure injury initially indicated there was none to drainage was noted to have foul odor. However, although nursing documented descriptions of the pressure injury to Resident #1's buttocks/coccyx area including color and drainage, which were indicators of worsening of the pressure injury, there was no documentation of measurements of the pressure injury which would have shown if the pressure injury size had changed, worsened or remained the same. The Treatment Administration Record (TAR) dated 7/3/20, indicated that during a routine skin assessment, Resident #1 was found to have an open area on coccyx and heel. Documentation on the TAR did not indicate if it was Resident #1's left or right heel. Review of Resident #1's medical record from 7/3/20 through his/her discharge on 7/7/20 indicated there was no further documentation of the pressure injury on Resident #1's heel, including documenation of which heel it was, measurements or treatments. During interview on 9/2/20, at 10:17 A.M., Director of Nurses (DON) #2, said staff were expected to document a detailed description including measurements of each wound in the medical record, and obtain physician's orders [REDACTED].#2 said she was not aware of Resident #1's pressure injuries. DON #2 said weekly wound rounds and tracking of wound measurements were the responsibility of the Nursing Supervisor. During interview on 9/1/20 and 9/2/20, the Nursing Supervisor that the wound specialist would assess wounds weekly, however due to an outbreak of COVID 19, the wound

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

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) specialist had not been to the Facility to assess wounds since April of 2020. The Nursing Supervisor said the Facility had not conducted a weekly Resident at Risk meeting since some time in April 2020. During interview on 9/1/20, at 12:43 P.M., the Nurse Consultant said the Facility had identified concerns regarding wound care and documentation. The Nurse Consultant said she was unable to identify any documentation of measurements of Resident #1's coccyx pressure injury since 6/16/20, or of the pressure injury on Resident #1's heel.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure documentation by nursing in his/her medical record was complete and accurate related to treatments. Findings include: The Facility Policy, titled Skin and Wound Care Management Program, undated, indicated the following: -The documentation of the stage and size of the wound would be reviewed during weekly risk meetings, and the Director of Nurses was responsible for reviewing the documentation for accuracy. -Weekly documentation must include a detailed description, size, stage, color, drainage, description of peri-wound (skin surrounding the wound) and any odor observed. -Each wound would be recorded separately on a weekly wound documentation form, which would be filed in the resident's medical record. Resident #1 was admitted to the Facility in April of 2020, [DIAGNOSES REDACTED]. The Admission Skin Check, dated 4/17/20, indicated Resident #1's buttocks and coccyx area were clear and his/her feet were dry and intact. The Nurse Progress Note, dated 6/16/20, indicated Resident had a newly identified open area (pressure injury) on his/her back (later identified as the buttocks and coccyx area) which measured 0.5 centimeters (cm) by 0.3 cm. The Note indicated the treatment to the area was hydrogel, calcium alginate, and covered with an Allevyn (foam) dressing. Review of the Treatment Administration Record (TAR)s dated 6/16/20 through 7/6/20 indicated the following: - Documentation related to the description of wound bed of Resident #1's buttocks/coccyx area pressure injury ranged from coloration of pink, red, and red/black. - Documentation related to the description of drainage from Resident #1's buttocks/coccyx area pressure injury ranged from scant to minimal to moderate. - Documenation related to the description of the odor from Resident #1's buttocks/coccyx area pressure injury initially indicated there was none to drainage was noted to have foul odor. However, although nursing documented descriptions of the pressure injury to Resident #1's buttocks/coccyx area including color and drainage, which were indicators of worsening of the pressure injury, there was no documentation of measurements of the pressure injury which would have shown if the pressure injury size had changed, worsened or remained the same. The Treatment Administration Record (TAR) dated 7/3/20, indicated that during a routine skin assessment, Resident #1 was found to have an open area on coccyx and heel. Documentation on the TAR did not indicate if it was Resident #1's left or right heel. Review of Resident #1's medical record from 7/3/20 through his/her discharge on 7/7/20 indicated there was no further documentation of the pressure injury on Resident #1's heel, including documenation of which heel it was, of measurements of the area or a description of the pressure injury. There was no documentation to support that the physician was notified or if the the Facility obtained treatment orders for Resident #1's heel. During interview on 9/2/20, at 10:17 A.M., Director of Nurses (DON) #2, said staff were expected to document a detailed description including measurements of each wound in the medical record. DON #2 said weekly wound rounds and tracking of wound measurements were the responsibility of the Nursing Supervisor. During interview on 9/1/20 and 9/2/20, the Nursing Supervisor said documentation including measurements and detailed descriptions of wounds were the responsibility of the Nurses on the units, and oversight of this documentation was the responsibility of the DON or herself. During interview on 9/1/20, at 12:43 P.M., the Nurse Consultant said the Facility had identified concerns regarding wound care and documentation. The Nurse Consultant said she was unable to identify any documentation of measurements of Resident #1's coccyx pressure injury since 6/16/20, or of the pressure injury on Resident #1's heel.