STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065332	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF AURORA	**14101 EAST EVANS AVE AURORA, CO 80014**

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 record review and interviews, the facility failed to notify the physician of a change in assessment for one (#1) of five sample residents. Specifically, the facility failed to document and notify the physician when changes were recognized during neurological checks for Resident #1. Findings include: I. Resident status Resident #1, age 89, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 5/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of five out of 15. II. Record review The 5/26/2020 event note revealed the resident was found on the floor by therapy staff on her bottom leaning towards her right side with blood coming from the right side of her head. It indicated pressure and ice were applied and the resident was sent to the emergency room via ambulance. The 5/26/2020 health status noted revealed the resident returned from the emergency room after being assessed after a fall with a head injury. It indicated the resident's pupils were equal and reactive, neuro's were within normal limits and the resident had staples noted to the top right side of her scalp with no active bleeding. Review of the neurological check list revealed the following: -Evaluations were started on 5/26/2020 at 6:15 p.m. when the resident returned from the hospital; -On 5/27/2020 at 9:00 a.m., 1:00 p.m. and 5:00 p.m., the resident's blood pressure was low at 90/40, 90/50 and 90/54, however, it was not evaluated further or reported to the physician (the resident's blood pressure at 3:00 a.m. had been 110/80 and at 9:00 p.m. had been 117/63); and -On 5/30/2020 at 5:00 a.m. the resident was confused and the upper and lower motor functions were unable to be assessed or obtained, however, this change was not evaluated further or reported to the physician. II. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/2/2020 at 3:39 p.m. He said neurological checks are a very important part in assessing the resident's after a fall with head injury because any vitals that are abnormal could indicate a problem such as increased cranial pressure. He said the physician should be notified of any changes to the resident's assessment. Unit manager (UM) #1 was interviewed on 7/2/2020 at 4:20 p.m. She said vital signs were a very important part of the neurological assessment and any abnormal readings should be further evaluated and reported to the provider. The director of nursing (DON) was interviewed on 7/2/2020 at 5:08 p.m. He said an important part of the neurological assessment was vital signs because any change in them could indicate a problem and needed to be reported to the physician. He said any change in the resident's assessment including nausea and vomiting after a head injury was concerning even if it was three days after a fall and should be further evaluated.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement an effective discharge plan for one (#1) of three residents reviewed for discharge planning of the five sample residents. Specifically, the facility failed to ensure the resident and family were fully informed of the care needs of Resident #1 prior to being discharged . Cross-reference F661: the facility failed to have a completed discharge summary Findings include: I. Resident status Resident #1, age 89, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 5/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of five out of 15. The resident was expected to stay in the facility. II. Record review The resident did not have a care plan to address her discharge status or goals. According to a 5/27/2020 communication progress note with the family, the family requested a COVID-19 test be performed so they could take the resident home. The 5/29/2020 care management progress note revealed the resident's daughter wanted to take the resident home upon completion of her skilled services and was prepared to care for her at whatever level she required at that time. Discharge was to be scheduled when the resident was ready to come off skilled services. The 6/4/2020 communication progress note with the family revealed the resident was scheduled to be discharged home on[DATE]. It indicated the daughter felt that the resident's poor appetite could be related to being away from her family and she thought the resident would start feeling better if she went home to be with family. The 6/7/2020 discharge summary progress note revealed the resident discharged home at 11:40 a.m. at the resident's baseline stable condition and the midline intravenous (IV) line to the right upper arm was discontinued and a pressure dressing was applied. It indicated the daughter had been instructed to monitor the site for bleeding and could remove the dressing the following day. -There was no mention of the [MEDICAL CONDITION] with staples. According to the June 2020 CPO, the resident had orders to remove the staples from the right side of her head on 6/7/2020. This was not included on the resident's discharge paperwork or instructions given to the resident or family upon discharge. The 6/5/2020 provider progress note revealed the resident had issues with vomiting and constipation over the last two weeks but had a large bowel movement on 6/4/2020 per nursing staff and was scheduled to be discharged home for comfort care on 6/8/2020. It indicated the resident had no pain related to the scalp laceration and the resident was being escorted back to bed after meals to ensure safe transition. The 6/6/2020 provider discharge summary progress note revealed the resident was being discharged home with home health services to include physical therapy (PT), occupational therapy (OT) and a registered nurse (RN). The resident was to continue [MEDICATION NAME] twice a day for constipation. -There was no mention of the [MEDICAL CONDITION] or when the staples to the laceration should be removed. The 6/7/2020 Discharge Summary Information was incomplete. It did not document the [MEDICAL CONDITION], the removal of the midline IV site, the residents last bowel movement or need for therapy services after discharge. (Cross reference F661) III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/2/2020 at 3:39 p.m. He said he was unfamiliar with the discharge process but said he would expect instructions to be given on how to care for any skin issues the resident might have. He said he also thought it would be important to know when the resident's last bowel movement was so the resident did not go too long without having one before interventions were put into place. Unit manager (UM) #1 was interviewed on 7/2/2020 at 4:20 p.m. She said the resident and family needed to be updated on any follow up appointments, medications, dressing changes, and home health services that were going to be needed after discharge. She said it was definitely important for the family to know when the resident's last bowel movement was so they could give medications appropriately to maintain a routine bowel program. She said the information about Resident #1's laceration, the presence of staples and how to care for it, should have been included in the discharge instructions given to the family The director of nursing (DON) was interviewed on 7/2/2020 at 5:08 p.m. He said when a resident discharged home, it was important to go over all the resident's medications, physician orders, home health orders and any durable medical equipment (DME) needed with the family. He said the staff should review all the cares delivered and how they were delivered to the resident with the family to ensure a smooth transition home. He said knowing when the resident's last bowel movement would be important information to relay to the family because they did not want the resident to go too long without having a movement and no interventions.

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

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 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1)
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have a completed discharge summary that included a recapitulation of the stay for one (#1) of three residents reviewed of five sample residents. Specifically, the facility failed to ensure a discharge summary was completed and reviewed prior to Resident #1's discharge from the facility. Cross reference F660: the facility failed to ensure a safe discharge Findings include: I. Resident status Resident #1, age 89, was admitted on [DATE] and discharged on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 5/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of five out of 15. II. Record review The resident did not have a care plan to address her discharge status or goals. According to the June 2020 CPO, the resident had orders to remove the staples from the right side of her head on 6/7/2020. The 6/6/2020 provider discharge summary progress note revealed the resident was being discharged home with home health services to include physical therapy (PT), occupational therapy (OT) and a registered nurse (RN). The resident was to continue [MEDICATION NAME] twice a day for constipation. -There was no mention of the [MEDICAL CONDITION] or when the staples to the laceration should be removed. The 6/7/2020 discharge summary progress note revealed the resident discharged home at 11:40 a.m. at the resident's baseline stable condition and the midline intravenous (IV) line to the right upper arm was discontinued and a pressure dressing was applied. It indicated the daughter had been instructed to monitor the site for bleeding and could remove the dressing the following day. (There was no mention of the [MEDICAL CONDITION] with staples). The 6/7/2020 Discharge Summary Information revealed to be incomplete. The following information was not included in the summary: -The resident's last bowel movement; -Special treatments and procedures; -Mental, psychosocial and behavior status; -Activity pursuits; -Needs, strengths, goals, life history and preferences; -Customary routines; -Vision status; -Skin condition; -Rehabilitation potential; and -Dental condition. It indicated the resident did not need outpatient rehab services after discharge. The dietary, activity, social service and rehab discharge summary sections were incomplete. The Discharge Summary Information did not document the laceration with staples to the resident's head with instructions for care or when to have the staples removed. It also did not include monitoring the pressure dressing to the IV midline removal site and when to remove the dressing. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/2/2020 at 3:39 p.m. He said he was not familiar with the discharge process and did not know whether he was responsible for completing any part of the discharge summary or not. Registered nurse (RN) #1 was interviewed on 7/2/2020 at 4:15 p.m. He said when a resident discharged from the facility the unit manager was responsible for completing the nursing section of the discharge summary. Unit manager (UM) #1was interviewed on 7/2/2020 at 4:20 p.m. She said each member of the interdisciplinary team (IDT) was responsible for completing their section of the discharge summary. The director of nursing (DON) was interviewed on 7/2/2020 at 5:08 p.m. He said each member of the IDT, including nursing, dietary, social services, activities, and rehab had a section to complete prior to the discharge date . Then on the day of discharge, the nurse should print out the summary, go over it with the resident and family, have them sign it and make a copy for the chart.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three residents reviewed out of five sample residents received medication management, treatment and services in accordance with professional standards. Specifically, the facility failed to: -Ensure staff followed physician orders [REDACTED].#1; and, -Ensure staff followed physician orders [REDACTED].#1. Findings include: I. Resident status Resident #1, age 89, was admitted on [DATE] and discharged on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 5/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of five out of 15. The resident was incontinent bowel and bladder. She did not have a [DIAGNOSES REDACTED]. UA orders A. Record review According to the 5/4/2020 telephone order, the resident was to have a routine urine analysis (UA) done. When the order was put into the computer it was entered incorrectly as urine sensitive. Review of the resident's record on 7/2/2020 revealed no results for the UA ordered on [DATE] were available. B. Staff interviews The director of nursing was interviewed on 7/2/2020 at 11:45 a.m. He said medical records were unable to find the results for the UA ordered on [DATE] and it was probably not done. He said the nurse told him the resident was resistant to allowing a clean catch specimen and should have gotten an order to obtain the specimen via straight catheter. He said he was not able to find any documentation to support the claim that the resident resisted the collection of a urine specimen or the physician had been notified. Licensed practical nurse (LPN) #1 was interviewed on 7/2/2020 at 3:39 p.m. He said when an order for [REDACTED]. He said if the sample was not able to be obtained on his shift he would tell the on-coming nurse in report so they could obtain it. He said he would put a note in the progress notes that the specimen was unable to be collected and the next shift would try. He said if the specimen was not able to be collected by the next day, the provider needed to be notified. Unit manager #1was interviewed on 7/2/2020 at 4:20 p.m. She said if an order for [REDACTED]. She said it was the floor nurses responsibility to follow up on any laboratory results that were pending. She said if a specimen was unable to be collected, the physician needed to be notified for further orders, such as obtaining the specimen via straight catheter. The DON was interviewed again on 7/2/2020 at 5:08 p.m. He said when an order to obtain a UA was received the nurse should obtain the specimen, do the paperwork and notify the laboratory so they can come and pick it up. He said if a specimen was not able to be obtained, the family should be called to assist and if they were still unable to obtain it the physician needed to be notified so an order for [REDACTED]. III. Bowel protocol A. Record review The constipation care plan, last revised 3/19/2020, revealed the resident was at risk for constipation related to her decreased mobility and weakness. Interventions included: -Encourage the resident to sit on the toilet to evacuate bowels if possible; -Follow facility bowel protocol for bowel management; -Observe for medication side effects of constipation. Keep the physician informed of any problems; -Observe for complication related to constipation; -Record bowel movement pattern each day; -Ensure resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible; and, -Provide education. According to the June 2020 CPO, orders included: -Milk of magnesia (MOM) 400 milligrams (mg)/ 5 milliliter (ml) give 30 ml by mouth daily as needed in no bowel movement in three days for constipation; -[MEDICATION NAME] suppository 10 milligrams (mg) inset 10 mg rectally daily as needed for constipation if no results from MOM in eight hours for constipation; -Fleet enema insert one application rectally as needed if not results from suppository for constipation. Review of the resident's bowel and bladder elimination report from 5/1/2020-5/31/2020 revealed the resident had a medium bowel movement (BM) on 5/21/2020. The next time the resident had a BM recorded was on 5/29/2020. (The orders for constipation were not followed at this time). The May 2020 Medication Administration Record [REDACTED]. Review of provider progress notes for May 2020 revealed no documentation of the resident having constipation until 5/29/2020 (even though the MAR indicated [REDACTED]. It indicated the plan was to administer a [MEDICATION NAME] suppository and obtain a KUB (kidney, ureter, bladder) x-ray to rule out obstruction/volvulus (twisting of the intestine). The 5/29/2020 health status note revealed the resident had an episode of emesis during the day shift and a complaint of abdominal pain. It indicated she had been on the BM list for three days and received MOM on 5/28/2020. It indicated the resident was assessed by the provider, received a [MEDICATION NAME] suppository without results and a stat KUB was ordered to rule out obstruction. Review of the resident's bowel and bladder elimination report from 5/31/2020-6/7/2020 revealed the resident had a medium bowel movement (BM) on 5/31/2020. The next time the resident had a BM recorded was on 6/4/2020. She did not have another bowel movement before she discharged on [DATE]. The 6/4/2020 provider progress note revealed the resident was on the BM list as she had not had a BM and she had at least two episodes of vomiting in the last week. It revealed a rectal exam was performed with soft stool in the rectal vault with no blood present. The results of the KUB were negative and there were no dilated bowel loops. It indicated that an upper gastrointestinal (GI) obstruction should be considered due to the resident coughing while eating. According to the June 2020 CPO, the resident received orders on 6/4/2020 for [MEDICATION NAME] 10 gram (GM)/15 ml give 15 ml by mouth two times a

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) day for constipation for two days and every 12 hours as needed for constipation. B. Staff interviews LPN #1 was interviewed on 7/2/2020 at 3:39 p.m. He said the night nurse ran a report every night of all the resident's bowel movements and any resident that had not had a BM in three days was placed on the bowel list so that the bowel protocol could be initiated by the day shift. He said the bowel protocol consisted of MOM, followed by a [MEDICATION NAME] suppository if no results, then an enema if still no results. He said the residents that had not had a bowel movement in over three days needed to be monitored for bowel obstruction that included abdominal pain, decreased appetite, nausea and vomiting. UM #1 was interviewed on 7/2/2020 at 4:20 p.m. She said if a resident had not had a BM in three days, they were placed on the BM list to receive the ordered bowel protocol of MOM, a [MEDICATION NAME] suppository and enema if needed. She said Resident #1 had not been eating well for several weeks and the staff contributed her not having a bowel movement to this and did not feel like they needed to intervene. She said the resident's bowel status was discussed in daily rounds however it was not documented anywhere. The DON was interviewed on 7/2/2020 at 5:08 p.m. He said each resident was checked daily to ensure they were having regular bowel movements. If the resident did not have a BM reported after three days the nurse was to start the bowel protocol that included MOM, suppositories and enemas until the resident had results.
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 observations, record review and interviews the facility failed to provide care and services to prevent the development and worsening of a pressure injury for one (#4) residents out of five sample residents. Specifically, the facility failed to: -Implement and care plan interventions to prevent the development of an unstageable pressure injury to Resident #4's left heel; -Implement treatment to an unstageable pressure injury to Resident #4's left heel when readmitted from the hospital; and, -Implement and care plan interventions to prevent the worsening of Resident #4's left heel pressure injury after the resident was readmitted adding to the failures as a delay in care. Findings include: I. Facility policy and procedure The Skin Integrity and Pressure Ulcer/Injury Prevention and Management Policy and Procedure, effective 10/3/2019, provided by the director of nursing (DON) on 7/2/2020 at 12:47 p.m. included in pertinent part, A skin assessment/inspection occurs on admission/readmission then weekly by a licensed nurse. Measures to maintain and improve the patient's tissue tolerance to pressure are implemented in the plan of care. Measures to protect the patient against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care. When skin breakdown occurs, it requires attention and a change in the plan of care to appropriately treat the patient. II. Resident status Resident #4, age 82, was admitted on [DATE], discharged to the hospital on [DATE] and readmitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. A new [DIAGNOSES REDACTED]. The 5/15/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of five out of 15. She required extensive assistance from two staff for transfers and bed mobility and extensive assistance of one staff for locomotion in her wheelchair. The resident was at risk for pressure ulcer development but did not have any wounds at the time of the assessment. III. Observations On 7/1/2020 at 3:29 p.m. Resident #4 was lying on her bed. She did not have prevalon boots on and her heels were not being floated off the mattress. On 7/2/2020 at 4:03 p.m. Resident #4 was lying on her bed. She had prevalon boots on both feet. A sign was on the wall across from the bed to remind staff to keep the boots on at all times while in bed and float heels off the mattress. IV. Record review According to the June 2020 CPO, the resident had the following orders: -Apply [MEDICATION NAME] to the redness on the left heel every shift, ordered 4/12/2020 and discontinued on 6/6/2020; and -Apply prevalon boots to bilateral heels at all times while in bed as tolerated by the resident, ordered 4/6/2020. A 6/8/2020 skin/wound progress note revealed the resident had a stage 2 open area to the left heel measuring 4 centimeters (cm) by 5 cm by 0.1 cm. -No other description of the wound was provided to help assist with the proper treatment of [REDACTED]. This order was discontinued on 6/15/2020 due to the resident being hospitalized . The June 2020 treatment administration record (TAR) revealed the resident did not receive any wound treatment to the left heel for two days from 6/6/2020 until 6/9/2020 (delay in care). The 6/11/2020 change of condition evaluation revealed the resident was being sent to the hospital for a lethargy with a decreased appetite and fluid intake. It indicated the resident had a wound to the left heel that was apparently a minor recent wound now developing redness, swelling or pain. -This documentation would not be accurate according to the 6/12/2020 hospital progress note below. According to a 6/12/2020 hospital progress note, the resident had an unstageable pressure wound to the left posterior heel, fully covered with thick necrotic eschar (dry, dead tissue) with no visible healthy tissue. It indicated there was scant clear drainage with no odor or purulence and the surrounding tissue was red. The 6/16/2020 wound care discharge instruction from the hospital revealed the left posterior heel wound was to be cleansed with normal saline, the area of eschar was to be painted with [MEDICATION NAME] solution and the area covered with a [MEDICATION NAME] dressing daily and as needed. It indicated the facility should continue diligent use of prevalon offloading boots at all times while in bed for heel pressure relief. It indicated the resident should be encouraged to have good protein intake with meals and would likely benefit from protein supplementation and a daily multivitamin to aid with wound healing. The instructions revealed the resident had been referred to an outpatient wound center for outpatient follow-up and an appointment was to be made in one to two weeks following hospital discharge. The 6/17/2020 readmission assessment revealed the resident had an unstageable wound to the left heel measuring 4 cm by 5 cm. No further description of the wound was provided. Review of the record on 7/2/2020 revealed no wound care orders were entered into the resident's record and no wound care was provided after the resident was readmitted to the facility until 6/19/2020. None of the instructions/recommendations provided on the hospital discharge were carried over at the facility. The order for the prevalon boots was discontinued by the facility when the resident was discharged to the hospital and were not re-ordered when the resident was readmitted to the facility to help with off loading pressure to the heel. The June 2020 CPO revealed wound care orders for the left heel were received on 6/19/2020 to include: cleanse the wound with wound cleanser, pat dry, apply skin prep to periwound and allow it to dry. Apply Triad to the wound bed then cover with [MEDICATION NAME] every day. The 6/24/2020 wound observation tool (this was not done for seven days after the resident was readmitted) revealed the resident came back from the hospital with the left heel unstageable pressure wound that was worsening. It indicated the wound measured 3.5 cm by 3.9 cm by 0.3 cm and the wound bed had 20% eschar, 50% slough and 30% granulation tissue with the periwound being macerated and had a moderate amount of serosanguinous drainage. Wound care treatment was changed to apply medi-honey alginate to the wound bed instead of the Triad. The 6/30/2020 wound observation tool revealed the unstageable pressure wound to the left heel measured 3.5 cm by 3.5 cm by 0.3 cm and the wound bed had 50% eschar, 50% slough and had a moderate amount of serosanguinous drainage. The skin integrity care plan, initiated 2/21/2020, revealed the resident was at risk for a break in skin integrity. Interventions included: -Clean and dry skin after each incontinent episode; -Weekly skin checks; -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; -Educate on causative factors and measures to prevent skin injury; -Encourage good nutrition and hydration in order to promote healthier skin; -Use draw sheet or lifting device to move resident; -Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface; and -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The care plan was not updated to include the stage 2 pressure wound to the left heel, treatment or interventions to prevent the development or worsening of the wound. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/2/2020 at 3:39 p.m. He said skin assessments were completed weekly by the floor nurse and wound rounds were done weekly by the DON and unit managers. He said any resident admitted with a wound should come with wound care orders and if they did not, the physician should be contacted and orders obtained immediately. He said the wound team was responsible for measuring and staging wounds, implementing wound care orders and updating the care plan. Registered nurse (RN) #1 was interviewed on 7/2/2020 at 4:15 p.m. He said he had been caring for Resident #1 since she returned from the hospital. He said she had an open wound with mostly slough to her left heel that was being treated daily. He said it was being monitored by the wound team on weekly rounds. He said they tried to keep prevalon boots on both of her feet whenever she was in bed. He said the physician should have been notified immediately to obtain wound care orders after the resident was readmitted to the facility. He said waiting two days was too long. Unit manager (UM) #1 was interviewed on 7/2/2020 at 4:20 p.m. She said she was part of the wound team that made rounds weekly. She said the wound team followed all pressure ulcers. She said when a resident is admitted or readmitted to the facility, the admitting nurse should do an initial skin assessment and then the unit manager is supposed to go in the next day and do a second skin assessment to ensure no issues were missed and ensure the treatment ordered was appropriate. She said if a resident was admitted with a wound and no orders, the nurse should look at the wound, confer with the provider and get immediate orders even if it is just something to put on it until

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) the provider sees it. She said she had not realized Resident #4 had gone several days without a treatment order to her foot. She said an order should have been received right away. The DON was interviewed on 7/2/2020 at 5:08 p.m. He said wound rounds were being done weekly by himself and the unit managers. He said the facility was attempting to get a wound care physician to attend the rounds also. He said the wound team saw any new resident with wounds to ensure the proper documentation and orders were put in. He said anytime a resident was admitted with a wound, the nurse should call the physician with a report of the wound and either verify or clarify the wound care orders. Wound care orders should be obtained right away, within the same shift and no wound should go without orders.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a safe environment and adequate supervision to prevent accidents for one (#1) of five sample residents. Specifically, the facility failed to: -Perform complete neurological checks after a fall with a head injury for Resident #1; and, -Monitor Resident #1's [MEDICAL CONDITION] with staples after a fall. Findings include: I. Resident status Resident #1, age 89, was admitted on [DATE]. According to the June 2020 computerized physician orders [REDACTED]. The 5/11/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of five out of 15. II. Record review The care plan, last revised 3/19/2020, revealed the resident had a personal history of falls and was at risk for further falls. Interventions included: -Anticipate and meet the resident's needs; -Assist with activities of daily living (ADL) as needed; -Call light within reach; -Complete fall risk assessment; -Educate about safety reminders and what to do if a fall occurs; -Encourage to participate in activities that promote exercise; -Orient to room; -Provide adaptive equipment or devices as needed; and -Physical therapy (PT) to evaluate and treat as ordered or as needed. The 5/26/2020 event note revealed the resident was found on the floor by therapy staff on her bottom leaning towards her right side with blood coming from the right side of her head. It indicated pressure and ice were applied and the resident was sent to the emergency room via ambulance. The 5/26/2020 provider progress note revealed the resident had an unwitnessed fall forward out of her wheelchair and hit her head on the corner of a table where she sustained a large laceration 4 centimeters (cm) in length with significant oozing blood secondary to aspirin use. It indicated the resident wound needed a CT scan and staples at the emergency room and when she returned she would need to call the certified nurse aide (CNA) whenever she needed anything. The 5/26/2020 health status noted revealed the resident returned from the emergency room after being assessed after a fall with a head injury. It indicated the resident's pupils were equal and reactive, neuro's were within normal limits and the resident had staples noted to the top right side of her scalp with no active bleeding. It indicated the resident also had a large swollen green bruise to her left lower extremity. The 5/27/2020 provider progress note revealed the resident had a [MEDICAL CONDITION] that needed to be inspected regularly and the resident needed to be accompanied back to her room after meals and closely monitored to aid her from the chair to the bed. It indicated the resident was not to transfer by herself at that time. The residents care plan was updated on 5/27/2020 to include: -Bed against the wall with a fall mat on the floor next to the open side of the bed; -Up in chair for meals only; and -Up in a wheelchair for short periods of time. Resident to be up for all meals but returned to bed right after. Review of the neurological check list revealed the following: -evaluations were started on 5/26/2020 at 6:15 p.m. when the resident returned from the hospital; -On 5/26/2020 at 7:30 p.m. the resident's level of consciousness was not evaluated; -On 5/26/2020 at 9:00 p.m. the vital signs used for the 8:30 p.m. assessment were used again; -On 5/27/2020 at 5:00 a.m. no vital signs were obtained; -On 5/27/2020 at 5:00 a.m. no vital signs were obtained; and -On 5/29/2020 at 5:00 a.m. no vital signs were obtained. The 5/29/2020 health status note revealed the resident had an episode of emesis during the day shift and complaints of abdominal pain. She was assessed by the provider for constipation. According to the May 2020 CPO, an order was received on 5/29/2020 to remove the staples to the right side of the head on 6/7/2020. There were no other orders related to the [MEDICAL CONDITION]. Review of the resident's record on 7/2/2020, including weekly skin checks and progress notes, revealed there was no further documentation after 5/27/2020 of the laceration to the resident's head being monitored by facility staff. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/2/2020 at 3:39 p.m. He said neurological checks are a very important part in assessing the resident's after a fall with head injury because any vitals that are abnormal could indicate a problem such as increased cranial pressure. He said [MEDICAL CONDITION] should be monitored daily by the staff until it is healed and it should be documented on the weekly skin assessment and progress notes. He said nausea and vomiting are also indicators of possible neurological problems. Unit manager (UM) #1 was interviewed on 7/2/2020 at 4:20 p.m. She said vital signs were a very important part of the neurological assessment and any abnormal readings should be further evaluated and reported to the provider. She said nausea and vomiting could indicate neurological problems. She said any skin issue a resident had needed to be documented and monitored until it was resolved. The director of nursing (DON) was interviewed on 7/2/2020 at 5:08 p.m. He said an important part of the neurological assessment was vital signs because any change in them could indicate a problem and needed to be reported to the physician. He said any change in the resident's assessment including nausea and vomiting after a head injury was concerning even if it was three days after a fall and should be further evaluated. He said lacerations with staples should be on the skin assessment with a physician's orders [REDACTED].