STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035144	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEORIA POST ACUTE AND REHABILITATION	13215 NORTH 94TH DRIVE PEORIA, AZ 85381

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** - Some	**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 staff interviews, record review and review of policies and procedures, the facility failed to ensure that one resident's (#2) representative was informed that resident #2 had developed DTI's (Deep Tissue Injuries) on both heels and the right lateral foot, and failed to notify the resident's family and the physician when there was a worsening of the DTI on the right heel. The deficient practice could result in a delay in resident representatives being notified when a resident experiences a significant change in condition. Findings include: Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record revealed an Admission Record/Face Sheet that included contact information for the resident's wife and son. An Initial Admission Record dated April 21, 2020 included that the resident had been admitted for [MEDICAL CONDITION] femur, was alert and oriented at times and able to follow simple directions. The assessment included that the resident had normal skin and heels intact. An Admission MDS (Minimum Data Set) assessment dated [DATE] included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 7, which indicated that he was severely cognitively impaired, required extensive physical assistance from two or more persons for bed mobility and had functional impairment in range of motion in his lower extremity on one side. The assessment included that resident #2 had no unhealed pressure ulcers. A nursing note dated May 1, 2020 at 9:54 a.m. included that resident #2 had reported pain to bilateral heels while in therapy and had suspected DTI's to both heels which were dark purple in color, painful and non-blanchable. The note included that resident #2 also had a suspected DTI to the right lateral foot. The note included that the wound nurse was aware of the suspected DTI's, the physician was notified and there were new (physician's) orders for skin prep every shift, an air mattress and a wedge cushion. physician's orders [REDACTED]. The nursing note dated May 1, 2020 at 9:54 a.m. did not include any additional information that a resident's family member had been notified of the suspected DTI's to both heels and the right lateral foot. A Weekly Pressure Ulcer Review dated May 1, 2020 included an assessment of the following SDTI's (Suspected Deep Tissue Injury) that were present on that date, and had not been present upon admission: -The left heel had a SDTI that measured 2.0 cm. (Centimeters) x 2.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. -The right heel had a SDTI that measured 6.0 cm. x 4.0 cm. with defined margins, peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. -The right lateral foot had a SDTI that measured 2.5 cm. x 3.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. Review of the clinical record revealed the following eMAR (electronic Medication Administration Record) change of condition notes: -An eMAR note dated May 3, 2020 at 12:28 p.m. included that there had been a change in condition for suspected DTI to bilateral heels and the right lateral foot. The note included that the resident had darkened areas to bilateral heels. -An eMAR note dated May 3, 2020 at 4:28 p.m. included that there had been a change in condition for suspected DTI to bilateral heels and the right lateral foot. -An eMAR note dated May 4, 2020 at 8:56 p.m. included that the resident there had been a change in condition for suspected DTI to bilateral heels and the right lateral foot, and that the wound(s) had not opened. The change of condition notes dated May 3, and 4, 2020 did not include any additional information that a resident's family member had been notified of the DTI's to both heels and the right lateral foot. A Change in Condition note dated May 7, 2020 at 8:08 p.m. included that that resident had a change in condition which was a cough, and that the physician and the resident's family had been notified, and that a phone message had been left for the family member at 12:00 a.m. The Change in Condition note did not include any additional information that the resident's family had also been notified of the DTI's on bilateral heels and the right lateral foot. A Weekly Pressure Ulcer Review dated May 8, 2020 included the following: -The left heel DTI measured 2.0 cm. x 2.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. -The right heel had a DTI that now measured 7.0 cm. x 4.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. -The right lateral foot had a DTI that measured 2.5 cm. x 3.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. The review included that the DTI's continued to be treated with skin prep daily. Physicians orders dated May 8, 2020 included an order for [REDACTED]. both heels and the right lateral foot, or that the DTI on the resident's right heel had enlarged or worsened on May 8, 2020. A Daily Skilled Note dated May 11, 2020 at 11:26 p.m. included that the right heel had a pressure ulcer that was 7 cm. in diameter, with no pain, and was black in color, and that the skin condition was a new onset. The clinical record did not include any additional information that the physician and the resident's family had been notified of the worsened right heel wound which previously had been assessed as a DTI that measured 6.0 cm. x 4 cm. and had worsened to a pressure ulcer that was 7.0 cm. in circumference, and was black and non-painful or that additional treatments or interventions had been obtained for the resident's right heel after the nurse had assessed the wound. A nursing note dated May 17, 2020 at 10:00 a.m. included that resident #2 had been found unresponsive and was transferred to the hospital. During an interview conducted on June 17, 2020 at 1:35 p.m. with the DON (Director of Nursing/staff #146) the DON stated that there was a wound meeting with the wound nurse, the dietitian, and the ADON (Assistant Director of Nursing) and there was a discussion whether or not the resident's pressure wounds were avoidable. The DON stated she did not remember any additional specific details regarding the meeting, and she did not remember if they had discussed the resident's pressure ulcers with his family. During an interview conducted on June 24, 2020 at 10:40 a.m. with the DON, she stated that there had been a change in condition note written on May 7, 2020 and that the nurse had been unable to reach the family. The DON stated that if the nurse had been able to reach the family they would have explained everything that was going on with the resident. The DON stated that she recognized at the time that there was a problem with change in condition notifications being done and that a new form was put into place. The DON was unable to provide any additional documentation that the family had been notified that resident #2 had developed DTI's on bilateral heels and the right lateral foot when the DTI's were assessed on May 1, 2020, or when the right heel DTI was assessed to have enlarged on May 8, 2020, or when the DTI on the right heel became blackened and non-painful and again enlarged on May 11, 2020. A policy and procedure titled Change of Condition Reporting/Monitoring included that it is the policy of the facility that all changes in resident condition will be communicated to the physician and resident representative, and that monitoring residents for changes of condition occurs with each resident observation and if changes are noted, further assessment and notifications. The policy included that any sudden or serious change in a resident condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation, and the responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. The policy included that all attempts to reach the physician and responsible party will be documented in the nursing progress notes and that documentation will incude time and response.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of records and review of policies and procedures, the facility failed to ensure that a comprehensive care plan for one resident (#2) was updated to include interventions to prevent the development of DTI's (Deep Tissue Injuries) on bilateral heels and the right lateral foot, and prevent worsening of the DTI on the right heel. The deficient practice could result in care plans not being updated to include pressure ulcer prevention interventions for multiple residents. Findings include: Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. An Initial Admission Record dated April 21, 2020 included that the resident had been admitted for [MEDICAL CONDITION] femur, was alert and oriented at times and able to follow simple directions. The assessment included that the resident had normal skin and heels intact. A Braden Scale assessment for predicting pressure sore risk dated April 21, 2020 included that the resident had a risk score of 16.0, which indicated that resident #2 was at low risk for developing a pressure sore. A care plan dated dated April 22, 2020 included that the resident had potential/actual impairment to skin integrity (which was a surgical incision). The care plan included the following interventions: -Encourage good nutrition and hydration in order to promote healthier skin. -Use caution during transfers and bed mobility to prevent to prevent striking arms, legs and hands against any sharp or hard surface. The care plan did not include any additional interventions that addressed preventing pressure sores in the feet or heels. An Admission MDS (Minimum Data Set) assessment dated [DATE] included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 7, which indicated that he was severely cognitively impaired, required extensive physical assistance from two or more persons for bed mobility and had functional impairment in range of motion in his lower extremity on one side. The assessment included that resident #2 had malnutrition and was at risk for pressure ulcers. The assessment included that resident #2 had no unhealed pressure ulcers. A Braden Scale assessment dated [DATE] included that the resident now had a score of 14.0 which indicated that the resident was now at moderate risk for developing pressure sores. With the change in score, no update to care plan for pressure ulcer prevention was noted. A nursing note dated May 1, 2020 at 9:54 a.m. included that resident #2 had reported pain to bilateral heels while in therapy and had suspected DTI's (Deep Tissue Injuries) to both heels which were dark purple in color, painful and non-blanchable. The note included that resident #2 also had a suspected DTI to the right lateral foot. A Weekly Pressure Ulcer Review dated May 1, 2020 included an assessment of the following SDTI's (Suspected Deep Tissue Injury) that were present on that date, and had not been present upon admission: -The left heel had a SDTI that measured 2.0 cm. (Centimeters) x 2.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. -The right heel had a SDTI that measured 6.0 cm. x 4.0 cm. with defined margins, peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. -The right lateral foot had a SDTI that measured 2.5 cm. x 3.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. Review of clinical record form did not reveal that any additional interventions were added to the care plan on May 1, 2020 that addressed the newly assessed DTI's to the bilateral heels and the lateral right foot. A Weekly Pressure Ulcer Review dated May 8, 2020 included the following: -The left heel DTI measured 2.0 cm. x 2.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. -The right heel had a DTI that now measured 7.0 cm. x 4.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. -The right lateral foot had a DTI that measured 2.5 cm. x 3.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. The review included that the DTI's continued to be treated with skin prep daily. An IDT (Interdisciplinary Team Note) dated May 8 2020 at 10:14 a.m. included that a meeting had been held to discuss the resident's wounds. The note included that resident #2 had dementia, diabetes, muscle wasting and hypertension and that the resident was placed on a low air loss mattress on admission with orders to float heels while in bed. The note included that the resident now presented with bilateral DTI's to heels despite preventive measures in place, and that the wound nurse had placed treatment orders and educated staff on wound healing and the plan of care. Review of the clinical record did not reveal that the care plan for impairment to skin integrity had been updated to include any additional interventions added to the care plan on May 8, 2020 that addressed the DTI on the left heel and the lateral right foot, and the worsening of the DTI on the right heel. A Daily Skilled Note dated May 11, 2020 at 11:26 p.m. included that the right heel had a pressure ulcer that was now 7 cm. in diameter, with no pain, and was black in color, and that the skin condition was a new onset. The note included that a pressure reducing device for the bed and the chair, and turning and repositioning was being used to maintain skin integrity. Review of the clinical record did not reveal that the care plan for impairment to skin integrity had been updated to include any additional interventions added to the care plan on May 11, 2020 that addressed the continued worsening of the DTI on the right heel. A nursing note dated May 17, 2020 at 10:00 a.m. included that resident #2 had been found unresponsive and was transferred to the hospital. During an interview conducted on June 22, 2020 at 10:00 a.m. with a Wound Nurse/staff #37, the nurse stated that when the resident was in the facility in May 2020, the ADON (Assistant Director of Nursing) was writing care plans, and she did not know if the care plan had been updated (to include interventions for the DTI's on the heels and the right foot). During an interview conducted on June 22, 2020 at 2:30 p.m. with the DON (Director of Nursing/staff #146) she stated that care planning is done according to CMS standards with changes in condition and during care plan conferences and 14 days after admission with the Admission MDS Assessment. The DON stated that the wound nurse and the nurse on the floor can update care plans as needed. During an interview conducted on June 23, 2020 at 12:12 p.m. with the DON she stated that there was no explanation for the resident to not have a care plan for wound prevention that included the heels and feet other than that is something they identified and that they were updating their processes for wound care at that time. A policy and procedure titled Comprehensive Person-Centered Care Planning that included it is the policy of the facility that the Interdisciplinary Team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs are identified in the comprehensive assessment. The policy included that the care plan will be revised as needed, and interventions will be implemented, and the plan of care will be reviewed and/or revised by the IDT after each assessment.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and review of policies and procedures, the facility failed to ensure that one of three sampled resident's (#2) was provided the necessary care and services in accordance with professional standards of care to prevent new pressure ulcers from developing and to promote healing. The deficient practice resulted in the development of DTI's (Deep Tissue Injuries) on the resident's bilateral heels, right lateral foot and later worsening of the pressure wound on the resident's right heel. Findings include: Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. An Initial Admission Record dated April 21, 2020 included that the resident had been admitted for [MEDICAL CONDITION] femur, was alert and oriented at times and able to follow simple directions. The assessment included that the resident had normal skin and heels intact. The assessment included that resident #2 had a surgical incision on the right thigh and blanchable redness on the coccyx. physician's orders [REDACTED].#2 to have a weekly Braden Scale assessment weekly for 4 weeks, weekly skin evaluation, and to encourage the resident to offload heels while in bed as tolerated. Only 2 Braden Scales were conducted instead of the ordered four. A Braden Scale assessment for predicting pressure sore risk dated April 21, 2020 included that the resident had no impairment of sensory perception and responds to verbal commands, occasionally moist skin, very limited ability to make changes in body position, adequate nutrition intake, and a potential problem for friction and sheer. The assessment included a risk score of 16.0, which indicated that resident #2 was at low risk for developing a pressure sore. A care plan dated April 22, 2020 included that the resident had potential/actual impairment to skin integrity (surgical incision) and included multiple interventions. There were no additional details in the care plan that addressed preventing pressure sores on the feet or heels by off loading heels in bed as tolerated as ordered by the physician. CNA (Certified Nursing Assistant) task flow sheets dated April 22, to April 26, 2020 included multiple daily entries that were marked M which indicated that the resident had a pressure relieving mattress. No other pressure reducing devices were recorded during this period that included offloading of heels. Review of the TAR (Treatment Administration Record) dated April 22, through April 27, 2020 revealed daily entries each shift which included that the resident was encouraged to offload heels while in bed as tolerated. There was no entry on the TAR that indicated that the resident's heels had been offloaded during this same period. An Admission MDS (Minimum Data Set) assessment dated [DATE] included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 7, which indicated that he was severely cognitively impaired, required extensive physical assistance from two or more persons for bed mobility and had functional

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) impairment in range of motion in his lower extremity on one side. The assessment included that resident #2 had malnutrition and was at risk for pressure ulcers. Regarding pressure relieving device for the bed and turning, Section M1200 of the MDS assessment included the section titled: Pressure relieving device for the bed, and Turning and repositioning program. Section M1200 included None of the above were provided. The assessment included that resident #2 had no unhealed pressure ulcers. The second Braden Scale assessment dated [DATE] included almost the same identified risk factors for predicting pressure sores as the previous Braden Scale assessment. However, this assessment included the risk score was now 14.0, which indicated that the resident was at moderate risk for developing pressure sores. Review of the care plan revealed that the care plan for skin impairment had been updated on April 27 to include a focus that the resident had actual impairment to skin integrity related to a surgical incision on the right thigh and redness to the coccyx. The care plan did not include any additional interventions that addressed pressure ulcer prevention for the feet or heels even though the physician ordered staff to encourage off loading the residents heels. A CNA task flow sheet included one entry dated April 27, 2020 at 8:34 a.m. was marked FH which indicated that the resident's heels were floated. There were no additional pressure reducing interventions at 8:34 a.m Additional entries dated April 27, 2020 were only marked M. A Physical Therapy note dated April 28, 2020 included that resident #2 required maximum assistance for bed mobility and was unable to follow commands. To encourage off loading heels would have been difficult for the resident to perform on his own. CNA task flow sheets entries dated April 28, 29, and 30, 2020 were only marked with M and did not include additional data that any additional pressure relieving devices or floating heels had been provided. Review of the TAR (Treatment Administration Record) dated April 28, through April 30, 2020 revealed daily entries each shift which included that the resident was encouraged to offload heels while in bed as tolerated. Further review of the clinical record did not reveal additional information regarding how resident was able to offload his heels (with encouragement), or the method used to offload his heels to prevent pressure injury due to the resident having a BIMS score of 7, muscle wasting and a fractured right hip, recent joint replacement surgery and needing assistance of two for extensive assistance for movement in bed. A Daily Skilled Note dated April 30, 2020 at 5:55 p.m. included that the resident's overall skin description was within normal range and fragile related to his age. A NP/PA (Nurse Practioner/Physician's Assistant) Progress Note dated May 1, 2020 at 9:54 a.m. included that resident #2 had been admitted with a primary medical history that included dementia, and that his mentation waxes and wanes and that the resident had heel pain and had started on heel prep and off loading. A nursing note dated May 1, 2020 at 9:54 a.m. included that resident #2 had reported pain to bilateral heels while in therapy and had a suspected DTI's (Deep Tissue Injuries) to both heels which were dark purple in color, painful and non-blanchable. The note included that resident #2 also had a suspected DTI to the right lateral foot, but no description of the wound was given. The note included that the wound nurse was aware of the suspected DTI's, the physician was notified and there were new (physician's) orders for skin prep every shift, an air mattress and a wedge cushion. A Weekly Pressure Ulcer Review dated May 1, 2020 included an assessment of the following SDTI's (Suspected Deep Tissue Injury) that were present on that date, and had not been present upon admission: -The left heel had a SDTI that measured 2.0 cm. (Centimeters) x 2.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. -The right heel had a SDTI that measured 6.0 cm. x 4.0 cm. with defined margins, peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. -The right lateral foot had a SDTI that measured 2.5 cm. x 3.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION] and was treated with skin prep daily. physician's orders [REDACTED]. The physician's orders [REDACTED]. A Nursing Note dated May 1, 2020 at 10:26 p.m. included that the resident was on close observation for bilateral heels DTI's and a DTI to the right lateral foot. The note included that treatment had been provided as per physician's orders [REDACTED]. The note included air mattress delivery pending. Which indicates prior notations that they were using a special mattress was incorrect. A Daily Skilled Note dated May 1, 2020 at 5:55 p.m. included that the overall skin condition was within normal range and that there were no active symptoms effecting the integumentary system observed. However, the note also included that resident #2 had skin ulcer/injury which was located on both heels and was suspected DTI (Deep Tissue Injury) and that a turning and repositioning program was being used to maintain skin integrity. Again no mention of the right lateral foot ulcer. Review of the clinical record revealed the following eMAR (electronic Medication Administration Record) change of condition notes: -An eMAR note dated May 3, 2020 at 12:28 p.m. included that the resident had darkened areas to bilateral heels, was encouraged to float hells while in bed, and had a pressure mattress on the bed. -An eMAR note dated May 3, 2020 at 4:28 p.m. included that the resident had heels floating while in bed. -An eMAR note dated May 4, 2020 at 8:56 included that the resident had DTI's on bilateral heels and the right lateral foot, and that the wound(s) had not opened. Review of the clinical record revealed the following Daily Skilled Notes: -A Skilled Note dated May 2, 2020 at 7:55 p.m. included that no active symptoms effecting the integumentary system had been observed. -A Skilled Note dated May 3, 2020 at 5:55 p.m. included that resident #2 had open [MEDICAL CONDITION] located on bilateral heels, but no descriptions were given of the wound beds of the heel wounds or surrounding skin. -Skilled Notes dated May 4, 5, and 6, 2020 included identical entries that overall the resident's skin was intact, and that there were no active symptoms effecting the integumentary system. No mention of the wound on the right lateral foot was given on May 3, 4 or 5th. An entry in the TAR for May 6, 2020 included an entry space for the weekly Braden Scale assessment dated [DATE] which had been initialed by the nurse that it had been completed. However, continued review of the clinical record did not reveal evidence that a Braden Scale had been completed on that date. A Weekly Pressure Ulcer Review dated May 8, 2020 included the following: -The left heel DTI measured 2.0 cm. x 2.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. No description of the wound bed was given that was previously mentioned as opened. -The right heel had a DTI that had grown larger and now measured 7.0 cm. x 4.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. Again no description of the wound bed was given. -The right lateral foot had a DTI that measured 2.5 cm. x 3.0 cm. with defined margins and peripheral tissue [MEDICAL CONDITION]. The review included that the DTI's continued to be treated with skin prep daily. Review of the clinical record did not reveal that an additional Weekly Pressure Ulcer Review, or that a wound assessment that included measurements, staging or description of each pressure wound had been recorded after May 8, 2020. The next weekly wound assessments should have been conducted on May 15, 2020, the measurements on May 8th was the last assessment before the resident was sent to the hospital. Physicians orders dated May 8, 2020 included an order for [REDACTED]. The note included that resident #2 had dementia, diabetes, muscle wasting and hypertension and that the resident was placed on a low air loss mattress on admission with orders to float heels while in bed. The note included that the resident now presented with bilateral DTI's to heels despite preventive measures in place, and that the wound nurse had placed treatment orders and educated staff on wound healing and the plan of care. The air loss mattress was not ordered until May 1st and no orders to offload heels were given only that staff were to encourage off loading of heels. The IDT note dated May 8, 2020 did not include any additional details regarding whether the bilateral DTI's to the resident's heel were unavoidable or not. Review of the clinical record through May 8, 2020 did not reveal that any additional interventions had been added to the resident's care plan regarding wounds on bilateral heels or the lateral right foot. Review of the TAR for May 2020 revealed entries for wedge cushion to offload heels while in bed, and the use of the low air loss mattress which had a start date of May 8, 2020, and there were no documented entries for the low air loss mattress and wedge cushion prior to May 8, 2020. Skilled Notes dated May 8, 9, and 10, 2020 included identical entries that overall the resident's skin was intact, and that there were no active symptoms affecting the integumentary system. A Daily Skilled Note dated May 11, 2020 at 11:26 p.m. included that the right heel had a pressure ulcer that was now 7 cm. in diameter, with no pain, and was black in color, and that the skin condition was a new onset. The note included that a pressure reducing device for the bed and the chair, and turning and repositioning was being used to maintain skin integrity. No indication of the size of the left heel with description of the wound or the right lateral foot wound. No description of those wounds in detail since May 8, 2020. The clinical record did not include any additional information that the physician had been notified of the worsened right heel wound which previously had been assessed as a DTI that measured 6.0 cm. x 4 cm. and had worsened to a pressure ulcer that was 7.0 cm. in circumference, and was black and non-painful or that additional treatments or interventions had been obtained for the resident's right heel after the nurse had assessed the wound. Skilled Notes dated May 12, 13, and 14 2020 included identical entries that overall the resident's skin was intact, and that there were no active symptoms affecting the integumentary system. A nursing note dated May 17, 2020 at 10:00 a.m. documented that resident #2 had been found unresponsive and was transferred to the hospital. During an interview conducted on June 17, 2020 at 1:35 p.m. with the DON (Director of Nursing/staff #146) the DON stated that when a resident is found to have a DTI on the heels, the nurse will assess the DTI every shift and document the assessment's in the Daily Skilled Notes. The DON stated that the nurse will obtain orders to treat the DTI immediately and that the resident's heels will be floated with a wedge cushion or pillows.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) The DON stated that there was a wound meeting with the wound nurse, the dietitian, and the ADON (Assistant Director of Nursing) and there was a discussion whether or not the resident's pressure wounds were avoidable. The DON stated she did not remember any additional specific details regarding the meeting. During an interview conducted on June 22, 2020 at 10:00 a.m. with a Wound Nurse/staff #37, the nurse stated that resident #2 was brought to her attention by a therapist because he had dark purple discolorations on his feet. The wound nurse stated she was sure that the resident had a low air loss mattress on admission and that his heels were being offloaded by placing pillows under his heels. However, the nurse stated that the resident was not capable of offloading his heels independently and that staff would have had to offload his heels for him. The wound nurse stated that weekly pressure ulcer reviews are to be every 7 days and that she did not remember why she had not done a weekly pressure ulcer review after May 8, 2020. The wound nurse stated that she should have written a note about the resident refusing the assessment. During an interview conducted on June 22, 2020 at 2:30 p.m. with the DON she stated that low air loss mattresses and wedge cushions are ordered from a supply company after the physician verifies the order, and that sometimes there are delays obtaining these items due to COVID-19 issues with supplies. The DON stated that resident care plans can be updated by the wound nurse, or any nurse on the floor and that nurses can update Braden Scale assessments as needed. An E-Mail message received from the DON on June 22, 2020 at 4:24 p.m. included that an unavoidable pressure ulcer injury assessment which had not previously been included in the clinical record, had been attached to the electronic clinical record today. Review of this newly discovered document that was unavailable early in the investigation or mentioned, revealed a document titled 5-15-2020 Unavoidable Pressure Injury. The PDF had been uploaded into the clinical record on June 22, 2020 by the DON. A form titled IDT Review-Unavoidable Pressure Injury(s) & Skin Integrity Risk which had been uploaded on June 22, 2020, by the DON, included a statement that read The resident has and continues to receive all necessary care and services to attain/maintain the highest practicable physical, mental and psychosocial well being in accordance with the individual assessment and plan of care. The resident's medical [DIAGNOSES REDACTED]. Furthermore, the resident is at risk for delayed, poor healing due to the same factors. The Risk form included that the resident's pressure ulcers were unavoidable because of impaired mobility and the following clinical conditions-Severe [MEDICAL CONDITIONS] -Diabetes Mellitus -Continuous Urinary Incontinence (the wounds were on the bilateral feet, hard to believe that urine would cause foot problems it would usually start on the resident's sacral region first and no problems identified) -Chronic Liver and/or [MEDICAL CONDITION] -Muscle Wasting The Risk form included a list of additional risk factors including dementia, hypertension and [MEDICAL CONDITION]. The Risk form also included the following of list of interventions that had been put into place: -Low Air Loss Mattress (not applied until May 3rd according to documentation) -Wedge Cushion (unknown when the cushion was received) -Wheelchair Cushion (protects the sacrum and coccyx areas not the feet) -Supplements -Treatment Order -Elevating Legs (no documentation that this was ever done) -Offloading Heels (only charted once prior to May 8th order to offload) The Risk form was signed on May 15, 2020 by the DON, ADON, Wound Nurse and MDS Nurse, and signed on May 22, 2020 by a Dietitian. During an interview conducted on June 23, 2020 at 10:00 a.m. with the wound nurse/Staff #37, she stated that resident #2 was at risk for developing pressure ulcers because he was unable to move or reposition himself in bed and he wasn't eating well and that because of that the pressure ulcers were unavoidable. During an interview conducted on June 23, 2020 at 12:12 p.m. with the DON she stated that there was no explanation for the resident to not have a care plan for wound prevention that included the heels and feet other than that is something they identified and that they were updating their processes for wound care at that time. A policy and procedure titled Documenting and Charting included that it is the policy of the facility to provide a complete account of the resident's care, treatment, response to the care signs and symptoms etc., as well as the progress of the resident's care. The policy also included that the policy is to provide nursing service personnel with a record of the physical and mental state of the resident and guidance to the physician in prescribing appropriate medications and treatment. A policy and procedure titled Wound Management included that it is the policy of the facility that a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable. The policy included that an unavoidable pressure ulcer is one that developed even though the provider evaluated the individual's clinical condition and pressure risk factors; defined and implemented interventions that are consistent with individual needs and goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.