STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445442	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AHC CRESTVIEW	**704 DUPREE BROWNSVILLE, TN 38012**

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

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F 0580 **Level of harm** - 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 the National Pressure Ulcer Advisory Panel (NPUAP) quick reference guide, facility policy review, medical record review, observation, and interview, the facility failed to ensure a pressure injury was promptly reported to the physician and failed to obtain a physician's orders [REDACTED].#44) sampled residents reviewed with in-house acquired pressure injuries. The failure of the facility to promptly report a pressure injury to the physician and obtain treatment orders before the pressure injury deteriorated resulted in actual Harm for Resident #44. The findings include: Review of the NPUAP quick reference guide, 2nd addition, published 2014, showed, .A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear .Stage II (2): Partial Thickness Skin Loss .presenting as a shallow open ulcer with a red pink wound bed .May also present as an intact or open/ruptured serum-filled blister .Stage III (3): Full Thickness Skin Loss .Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough (moist devitalized tissue, can be cream, yellow, or tan in color) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling .Stage IV (4): Full Thickness Tissue Loss .with exposed bone, tendon or muscle. Slough or eschar (non-viable dark tissue) may be present on some parts of the wound bed, Often include undermining and tunneling .Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined . Review of the facility's policy titled, Pressure Injury Prevention and Non-Pressure Ulcer Management, revised 11/2019, showed, .This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. It is the policy of this facility to implement evidenced-based interventions for all residents who are assessed at risk or who have a pressure ulcers present, and to promote wound healing of various types of wounds in accordance with current standards of practice and Physicians orders . Review of the medical record, showed Resident #44 was admitted to the facility on [DATE] at 1:50 PM with [DIAGNOSES REDACTED]. Review of a Nursing Admission/Readmission form dated 1/11/2020, showed Resident #44 had no pressure injuries or ulcers, and no rashes or non-ulcer [MEDICAL CONDITION] were present. Review of a Daily Focus Charting form dated 1/12/2020, showed that Resident #44 had a Stage 2 pressure injury approximately 4 centimeters (cm) in diameter to the sacral area (at the bottom of the spine and lies between the fifth segment of the spine and the coccyx (tailbone)). Review of the medical record, showed that there was no documentation the physician was notified for treatment orders for the Stage 2 pressure injury to the sacral area on 1/12/2020. Review of the Wound and Pressure Injury Information form dated 1/13/2020, showed that Resident #44 had a Stage 3 pressure injury to the coccyx measuring 4.5 cm in length, 5 cm in width, the depth was unable to be determined due to the wound bed was covered with 25-50% slough, and the physician was notified of this pressure injury on 1/13/2020 at 5:24 PM. Review of the Physician order [REDACTED].Santyl 250 unit/gram topical ointment (Apply) .Cleanse area to coccyx with WC (Wound Cleanser) or NS (Normal Saline). pat dry. Apply Santyl 250 unit/gram topical ointment, Calcium alginate and cover with dry dressing QD (every day) until resolved . Review of the Wound and Pressure Injury Information form dated 1/14/2020, showed, Resident #44 had an Unstageable pressure injury to the coccyx area measuring 4 cm in length, 4 cm in width, and the depth was unable to be determined due to the wound bed was covered with 25 to 50% slough. Observation in the resident's room during wound care on 3/3/2020 at 2:42 PM, showed Resident #44 was lying in bed on her right side with a pressure injury to the coccyx with slough and necrotic (dead) tissue present. During a telephone interview conducted on 3/5/2020 at 11:20 AM, Registered Nurse (RN) #1 was asked if he notified the physician and obtained treatment orders when he discovered the pressure injury to the sacral/coccyx area. RN #1 confirmed he did not notify the physician to obtain a treatment order for the pressure injury. The facility's failure to promptly notify the physician and obtain treatment orders before the pressure injury deteriorated resulted in actual Harm for Resident #44.
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 policy review, medical record review, and interview, the facility failed to ensure residents were invited to participate in care planing for 2 of 2 sampled residents (Resident #6 and #25) reviewed of the 6 residents interviewed for participation in care planning. The findings include: Review of the facility policy titled, Comprehensive Care Plans, dated 12/2019, showed that the facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the resident's comprehensive assessment and that the comprehensive Care Plan will be prepared by an interdisciplinary team that includes the resident. 1. Review of the medical record, showed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], showed Resident #6 was cognitively intact. During an interview conducted on 3/3/2020 at 8:34 AM, Resident #6 stated that she was not invited or included in her Care Plan meetings. The facility was unable to provide documentation that Resident #6 was invited to her Care Plan meetings that were done on 6/4/2019, 8/27/2019, and 11/26/2019. During an interview conducted on 3/4/2020 at 10:05 AM, the MDS Coordinator confirmed Resident #6 should have been invited to her Care Plan meetings and stated, It was an oversight. 2. Review of the medical record, showed Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated [DATE], showed Resident #25 was cognitively intact. During an interview conducted on [DATE] at 3:00 PM, Resident #25 stated that he had not been invited or included in his Care Plan meetings. The facility was unable to provide documentation that Resident #25 was invited to his Care Plan meetings that were done on 9/26/2019 and 12/27/2019. During an interview conducted on 3/5/2020 at 12:43 PM, the MDS Coordinator confirmed that Resident #25 should have been invited to his Care Plan meetings. When asked if he had attended any meetings since his admission, the MDS Coordinator stated, Not that I know of.
F 0686 **Level of harm** - 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 National Pressure Ulcer Advisory Panel (NPUAP) quick reference guide, policy review, medical record review, observation, and interview, the facility failed to ensure a pressure injury was accurately assessed, identified, and a physician's order for treatment was promptly obtained before the pressure injury deteriorated to an Unstageable pressure

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) injury for 1 of 3 sampled residents (Resident #44) reviewed with in-house acquired pressure injuries. This failure of the facility resulted in actual Harm for Resident #44. The findings include: Review of the NPUAP quick reference guide, 2nd addition, published 2014, showed, .A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear .Stage II (2): Partial Thickness Skin Loss .presenting as a shallow open ulcer with a red pink wound bed .May also present as an intact or open/ruptured serum-filled blister .Stage III (3): Full Thickness Skin Loss .Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough (moist devitalized tissue, can be cream, yellow, or tan in color) may be present but does not obscure the depth of tissue loss. May include undermining and tunneling .Stage IV (4): Full Thickness Tissue Loss .with exposed bone, tendon or muscle. Slough or eschar (non-viable dark tissue) may be present on some parts of the wound bed, Often include undermining and tunneling .Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined .Comprehensive assessment of the individual and his or her pressure ulcer informs development of the most appropriate management plan and ongoing monitoring of wound healing . Review of the facility's policy titled, Pressure Injury Prevention and Non-Pressure Ulcer Management, dated 11/2019, showed, .The facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. It is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure ulcers present, and to promote wound healing of various types of wounds in accordance with current standards of practice and Physicians orders .'Pressure Ulcer/Injury' refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence .'Avoidable' means the resident developed a pressure ulcer/injury and the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice: monitor and evaluate the impact of the interventions; or revise the interventions as appropriate . Review of the medical record, showed Resident #44 was admitted to the facility on [DATE] at 1:50 PM with [DIAGNOSES REDACTED]. Review of a Nursing Admission/Readmission form dated 1/11/2020, showed Resident #44 had normal skin color, and no pressure injuries, venous ulcers, arterial ulcers, or diabetic ulcers were present. The form also showed that there were no rashes or non-ulcer [MEDICAL CONDITION] present. Review of the Braden Scale for Predicting Pressure Injury Risk dated 1/11/2020, showed a Braden Score of 12, which indicated Resident #44 was at high risk for Pressure Injury. Review of a Daily Focus Charting form dated 1/12/2020 at 3:38 PM, showed, .SKIN CONDITION DOCUMENTATION .Skin condition(s) present .Pressure ulcer .Stage 2 sacral area (at the bottom of the spine and lies between the fifth segment of the spine and the coccyx (tailbone))-multiple areas .approx (approximately) 4 cm (centimeters) diameter w/ (with) [DIAGNOSES REDACTED] (redness of the skin) or open PI (Pressure Injury) . Review of the medical record, showed that there was no documentation that the physician was notified and there was no Physician's Order for treatment obtained for the Stage 2 pressure injury to the sacral area on 1/12/2020. Review of the Wound and Pressure Injury Information form dated 1/13/2020, showed, .Location .Coccyx .Type of Wound .Pressure .Pressure Injury: (Stage) 3 .Length 4.5 cm x (by) Width 5.0 cm x Depth UTD (Unable to Determine) .Tissue Type .Slough .If slough/necrotic (dead/non-viable) tissue present, what % (percent) of wound bed is covered .25%-50% .MD (Medical Doctor) Notified Date .01/13/2020 . Review of the Physician Orders dated 1/13/2020, showed, .Santyl 250 (an agent for removal of dead tissue from wounds) unit/gram topical ointment (Apply) .Cleanse area to coccyx with WC (Wound Cleanser) or NS (Normal Saline). pat dry. Apply Santyl 250 unit/gram topical ointment, Calcium alginate and cover with dry dressing QD (every day) until resolved . Review of the Wound and Pressure Injury Information form dated 1/14/2020, showed, .Location .Coccyx .Type of Wound Pressure .Pressure Injury: Unstageable .Length 4.0 cm x Width 4.0 cm x Depth UTD cm .Tissue Type .Slough .If slough/necrotic tissue present, what % of wound bed is covered .25%-50% .Exudate .Serous . During an interview conducted on 3/5/2020 at 6:29 PM, the Treatment Nurse (the nurse who assessed the wound on 1/13/2020) stated that the pressure injury appeared the same on 1/13/2020 and 1/14/2020 when the Wound Care Physician assessed the pressure injury. The Treatment Nurse stated that the Wound Care Physician explained to her why the wound should be staged as an unstageable pressure injury with slough present in the wound bed. The Treatment Nurse confirmed her assessment of the pressure injury at a Stage 3 was inaccurate on 1/13/2020. During an interview conducted on 3/5/2020 at 7:16 PM, the Regional Nurse Manager was asked if she felt that Resident #44's pressure injury had been assessed accurately. The Regional Nurse Manager stated, No, I do not. Review of a Wound Care Physician form titled, INITIAL WOUND EVALUATION & (and) MANAGEMENT SUMMARY, dated 1/14/2020, showed that Resident #44 had an unstageable pressure injury on her coccyx due to necrotic tissue that required surgical debridement. Review of the admission Minimum Data Set ((MDS) dated [DATE], showed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated Resident #44 was severely cognitively impaired. Resident #44 required extensive assistance for bed mobility, toileting, and personal hygiene, and was totally dependent on staff for transfers. Resident #44 had 1 Unstageable pressure ulcer. Review of the Care Plan dated 1/23/2020, showed that Resident #44 had a pressure injury to her coccyx with interventions of, .Assess and record the size .of skin discoloration, [MEDICAL CONDITION] .Perform complete skin assessment and record .Perform nutritional screening. Adjust diet/supplement as indicated to reduce the risk of skin breakdown .Provide care according to MD and wound consultant orders/recommendations .Use pillows, pads, or wedges to reduce pressure on heals (heels) and pressure points. Turn/reposition .Use pressure-reducing mattress .Observe for changes in pressure ulcer, report to MD if there is an increase in size or stage and follow up as indicated .Treatment as ordered, monitor and report if ineffective . Observation in the resident's room during wound care on 3/3/2020 at 2:42 PM, showed Resident #44 was lying in bed on her right side with a pressure injury to the coccyx with slough and necrotic tissue present. During an interview conducted on 3/5/2020 at 2:27 PM, Resident #44's Physician stated, .I would say that the first one (wound classified as a Stage 2 on 1/12/2020) was not assessed correctly . During an interview conducted on 3/5/2020 at 10:50 AM, the Director of Nursing (DON) and the Regional Nurse Manager were asked if there were any orders for wound care to be provided on 1/12/2020 to Resident #44's sacral/coccyx area. The Regional Nurse Manager confirmed orders were not obtained for the Stage 2 pressure injury discovered on 1/12/2020, and stated, I could not find any orders . During a telephone interview conducted on 3/5/2020 at 11:20 AM, Registered Nurse (RN) #1 was asked about the Stage 2 pressure injury that he discovered on Resident #44's sacral area on 1/12/2020. RN #1 stated, I don't remember any specifics . RN #1 was asked if he actually saw the pressure ulcer. RN #1 stated, I'm sorry I can't say I saw the wound . RN #1 was asked about his documentation on the Daily Focus Charting form dated 1/12/2020. RN #1 stated, If there was a measurement on the form, I actually saw it . RN #1 was asked if he obtained treatment orders when he discovered the pressure injury. RN #1 confirmed he did notify the physician or obtain a treatment order for the pressure injury. The facility's failure to ensure a pressure injury was accurately assessed, identified, and treatment orders were obtained promptly before the pressure injury deteriorated resulted in actual Harm for Resident #44.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and interview, the facility failed to ensure medications were stored securely and failed to keep keys to medication carts under direct observation of authorized staff in areas accessible by residents for 1 of 3 medication carts (Memory Care Unit Medication Cart). The findings include: Review of the facility's policy titled Medication and Biological Storage, Night/Emergency Box and Backup Pharmacy, revised 9/2019, showed that medications are to be stored in medication rooms or carts and to ensure proper security of medications. Observation in the Memory Care Unit Hall on 3/3/2020 at 6:55 AM, showed an unattended medication cart with 1 bottle of Potassium Chloride and 1 [MEDICATION NAME] Hypokit Injection on top of the medication cart. There were no residents or staff observed in the Memory Care Hall when these medications were unattended. Observation in the Memory Care Unit Hall on 3/3/2020 at 6:58 AM, showed LPN #1 left an unattended medication cart with the medication cart keys on top of the cart. There were no residents or staff observed in the Memory Care Hall when the keys were unattended. During an interview conducted on 3/5/2020 at 8:48 AM, the Director of Nursing (DON) confirmed medications and medication cart keys should not be left unattended.
F 0825 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or get specialized rehabilitative services as required for a resident.**

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F 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure rehabilitative services were provided for 1 of 1 sampled residents (Resident #25) reviewed for rehabilitative services. The findings include: Review of the facility's policy titled, Skilled Services Provided by Rehab (Rehabilitation), revised 9/2017, showed that each patient with verified physician orders [REDACTED]. Review of the medical record, showed Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #25 was cognitively intact and was totally dependent on staff for bed mobility, transfers, locomotion on and off unit, dressing, and toilet use, required extensive assistance for personal hygiene, and was not receiving rehabilitative services. Review of the physician's orders [REDACTED]. Medical record review, showed that Resident #25 had not received an OT or PT evaluation. Review of the Care Plan dated 9/26/2019, showed Resident #25 required assistance with transfers due to weakness, limited mobility, and left sided weakness, with an intervention of Restorative Nursing (nursing program designed to promote the resident's ability to adapt and adjust to living as independently and safely as possible) as indicated. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #25 was cognitively intact and was totally dependent on staff for transfers, locomotion on and off unit, dressing, and toilet use, required extensive assistance for bed mobility and personal hygiene, and was not receiving rehabilitative services. Review of a Physical Therapy Screen dated 3/4/2020, showed, .Based on therapy screen this session .skilled PT Eval (evaluation) is recommended . Observation in the resident's room on [DATE] at 8:42 AM, 10:44 AM, and 12:32 PM, on 3/3/2020 at 8:35 AM and 10:14 AM, and on 3/4/2020 at 5:30 PM, showed Resident #25 was in the bed. During an interview conducted on [DATE] at 3:08 PM, Resident #25 stated that he was not getting any therapy (PT/OT). Observation in the Physical Therapy Department on 3/5/2020 at 10:40 AM, showed Resident #25 was seated upright in a wheelchair, was able to follow commands and move his hands and feet. During an interview conducted on 3/5/2020 at 10:40 AM, the Director of Nursing (DON) confirmed residents should be screened for Physical and Occupational Therapy on every admission and readmission. The DON confirmed Resident #25 had not received PT, OT, or restorative services since his admission. During an interview conducted on 3/5/2020 at 11:01 AM, the Rehabilitation Manager confirmed Resident #25 had not been screened and had not received rehabilitative services since his admission. The Rehabilitation Manager stated, I could have missed it .we are going to do a PT and OT eval on him today.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to label and properly store wash basins and bedpans in shared bathrooms for 13 of the 86 residents (Resident #11, #15, #20, #21, #26, #36, #38, #42, #45, #71, #74, #84, and #236) reviewed, which had the potential to promote cross contamination between these residents. The findings include: Observation of Resident #36's and #42's bathroom on [DATE] at 8:18 AM, showed an unlabeled and uncovered wash basin sitting on the sink. Observation of Resident #15's, #20's, #21's and #45's bathroom on [DATE] at 8:37 AM and 4:29 PM, and on 3/3/2020 at 8:29 AM, showed 2 unlabeled and uncovered bedpans on the back of the toilet. Observation of Resident #38's, #71's, #74's, and #236's bathroom on [DATE] at 9:33 AM and 4:31 PM, and on 3/3/2020 at 8:28 AM, showed an unlabeled and uncovered wash basin upside down on the floor between the toilet and the wall. Observation of Resident #11's, #26's, and #84's bathroom on [DATE] at 8:22 AM, showed 2 unlabeled and uncovered wash basins on a shelf. Continued observations on [DATE] at 10:36 AM, 3/3/2020 at 8:11 AM, and 3/5/2020 at 7:57 AM showed 1 unlabeled and uncovered wash basin on the bathroom shelf. During an interview conducted on 3/3/2020 at 3:34 PM, the Director of Nursing confirmed that personal use items such as wash basins and bedpans should be labeled with the residents' name or room number, the items should be cleaned after use and stored in the residents' bottom drawer or a storage area.