STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385136	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLISAN CARE CENTER	**9750 NE GLISAN STREET PORTLAND, OR 97220**

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 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide appropriate bathing services for 1 of 3 sampled residents (#11) reviewed for hygiene. This placed residents at risk for poor hygiene. Findings include: Resident 11 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was cognitively intact. The 6/18/20 care plan indicated Resident 11's bathing preference was to shower on Tuesday and Friday evenings. The 6/25/20 Admission MDS Assessment indicated bathing did not occur during the seven day assessment period. A review of the 6/2020 and 7/2020 Bathing Task Report revealed the following: 6/23 - Resident Refused 6/26 - Resident Refused 6/30 - Resident Refused 7/3 - Resident Refused 7/7 - Shower completed 7/10 - Resident Not Available 7/14 - Resident Refused 7/17 - Resident Refused 7/21 - Resident Refused A review of the Clinical Alerts Listing Report from 6/18/20 through 7/22/20 revealed nursing staff reviewed and cleared alerts for Resident Refused Shower/Bathing seven times and for No Bathing or Shower Documented in 7 Days on POC five times. A 6/29/20 Progress Note indicated the resident refused her/his shower and reported she/he would shower on 6/30 after her/his friend brought in clean clothes. There were no other progress notes related to the five other shower refusals. On 8/11/20 at 11:25 AM Resident 11 reported she/he did not have any showers while at the facility. The resident reported one time staff informed her/him it was time for a shower, told her/him they would be right back and never returned. Resident 11 reported she/he used wash cloths and the sink to give her/himself sponge without assistance from staff. On 8/17/20 at 2:06 PM Staff 13 (CNA) reported he could not recall the resident and was unable to provide information related to the shower refusals. Attempts to speak with other CNA staff who documented shower refusals for Resident 11 were unsuccessful. On 8/17/20 at 2:24 PM Staff 3 (RCM-LPN) stated he expected nurses to look into shower refusals and document their findings when they cleared an alert. He confirmed only one shower was documented for Resident 11 during her/his time at the facility.
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 interview and record review it was determined the facility failed to recognize the signs of an infection for 1 of 3 sampled residents (#11) reviewed for wound care. This placed residents at risk for infections. Findings include: Resident 11 admitted to the facility in 6/2020 with [DIAGNOSES REDACTED]. The resident was cognitively intact. A 6/18/20 Initial Wound Evaluation completed by Staff 4 (LPN) indicated the resident's wound measured 18 cm x 0.5 cm. There was no description of the type of tissue found in the wound bed. The surrounding skin was normal and there was no drainage or odor. The evaluation indicated the wound was to be cleaned with normal saline every other day, new dressing applied and wrapped with an ace bandage. No orders or documentation related to the every other day wound care was found in the chart. The only order related to the BKA surgical wound was to monitor the dressing and reinforce as needed. The 6/25/20 Weekly Wound Evaluation completed by Staff 4 indicated the wound measured 18 cm x 1 cm. The wound bed contained 25% slough (non-viable, yellow tissue). There was no documentation to indicate what the remaining 75% of the wound bed was comprised of. The surrounding skin was noted to be red and macerated (softened by drainage) with minimal watery drainage and a slight odor. Staff 4 determined the wound had deteriorated since the previous evaluation and notified the surgeon. Orders to perform daily wound care and dressing changes were obtained. The 7/2/20 Weekly Wound Evaluation completed by Staff 4 indicated the wound measured 18 cm x 1.5 cm. The wound bed contained 25% slough and there was no documentation to indicate what the remaining 75% of the wound bed was comprised of. The surrounding skin was again noted to be red and macerated. There was no drainage or odor. Staff 4 determined the wound had improved since the previous evaluation. The 7/9/20 Weekly Wound Evaluation completed by Staff 4 indicated the wound measured 17 cm x 2 cm. The wound bed contained 75% eschar (dry, black, hard dead tissue) and 25% granulation tissue (new tissue which indicates healing). The surrounding skin was normal with no drainage or odor. Staff 4 determined the wound had improved again since the previous evaluation. The 7/16/20 Weekly Wound Evaluation completed by Staff 6 (RN) indicated the wound measured 17 cm x 2 cm. The wound bed contained 50% eschar, 25% slough and 25% granulation tissue. The surrounding skin was normal with no drainage or odor. Staff 6 determined there had been no change to the wound since the last evaluation. A review of Resident 11's TAR revealed the daily wound care was completed daily as ordered with the exception of 7/8/20 and 7/22/20 when the resident had the dressing changed at a physician appointment and on 7/12/20 and 7/17/20 when the resident refused the dressing changes. A 7/22/20 Patient Note from a surgeon follow up appointment revealed Resident 11's left BKA wound was healing poorly and there were concerns for an underlying infection. The resident was sent to the Emergency Department to prepare for wound debridement (the medical removal of dead, damaged or infected tissue). The 7/22/20 Emergency Department Encounter note indicated Resident 11 presented with a BKA that has been neglected and is very infected. According to medical records from the hospital admission from 7/23/20 through 8/1/20 Resident 11's wound culture was positive for pseudomonas bacteria. The resident required surgical debridement of the wound under general anesthesia. During the resident's stay in the hospital she/he received daily doses of multiple IV antibiotics to treat the infection. The TAR indicated Staff 6 regularly performed wound care for Resident 11 and was the last staff to view the wound with documented wound care completed on 7/18/20, 7/19/20, 7/19/20 and 7/21/20. On 8/7/20 at 9:54 AM Staff 6 (RN) stated she performed the daily wound care for Resident 11 as documented on the TAR. She reported the resident's wound was healing poorly but had no signs of infection. Staff 6 verbalized knowledge of the signs and symptoms of infection. On 8/7/20 at 10:14 AM Staff 4 (LPN) stated Resident 11's wound was healing poorly but did not believe it was infected. She verbalized knowledge of the signs and symptoms of infection. On 8/10/20 at 3:40 PM Witness 1 (Complainant) reported when Resident 11 was seen in the surgeon's office on 7/22/20 the wound had a large amount of drainage, was boggy (an abnormal spongy texture usually due to high fluid content), incredibly painful and malodorous. She stated the resident informed her that facility staff had not changed the dressing for four days. Witness 1 reported wound cultures performed at the visit came back positive for pseudomonas (a type of bacteria) infection. On 8/11/20 at 11:25 AM Resident 11 reported the facility staff frequently went three to four days without doing dressing changes to her/his wound. On 8/17/20 at 9:36 AM Staff 10 (CNA) reported Resident 11 informed her that her/his left leg was painful and during the last week the resident was at the facility it seemed she/he was in more pain than usual. Staff 10 reported she informed nursing who administered pain medications. She stated she never visualized the wound as it was covered with a dressing. On 8/17/20 at 9:45 AM Staff 17 (LPN) reported residents have informed her some nurses do not change their dressings when they were scheduled to. On 8/17/20 at 11:05 AM Resident 12 reported she/he had difficulty having her/his

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) wound care done on Fridays as scheduled. The resident reported the problem resolved recently. On 8/17/20 at 12:00 PM Staff 16 (LPN) reported not all nurses performed wound care as they documented on the TAR. The facility's 3/2020 Skin at Risk/Skin Breakdown policy and procedure indicated weekly wound rounds were to be completed by the DNS or designee and the RCM. On 8/17/20 at 2:24 PM Staff 3 (RCM-LPN) stated he expected nursing staff to inform him if there was concerns for infection. He reported nursing staff informed him the resident's wound was not healing well but he was not told the wound was infected. Staff 3 stated he never assessed the wound.
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 observation, interview and record review it was determined the facility failed to identify and appropriately treat a medical device related pressure ulcer for 1 of 3 sampled residents (#13) reviewed for wounds. This placed residents at risk for worsening pressure ulcers. Findings include: Resident 13 admitted to the facility in 12/2019 with [DIAGNOSES REDACTED]. The facility's 3/2020 Skin at Risk/Skin Breakdown policy and procedure indicates the following: If the new skin impairment is noted after admission, the licensed nurse should: *Initiate Alert Charting. *Complete a Braden Scale assessment if the new skin impairment is a pressure sore and evaluate current interventions for effectiveness. *The RCM should complete a comprehensive review of the resident's medical record to evaluate if the pressure ulcer was avoidable or unavoidable. A 5/27/20 Physician Note revealed Resident 13 developed an abdominal wound likely secondary to pressure from the [MEDICATION NAME] brace. Resident 13's comprehensive care plan revised on 6/9/20 revealed the resident had a potential for impairment to skin integrity related to the use of a [MEDICATION NAME] back brace which caused friction. Interventions included treatment to abdominal and include foam barrier against friction. The 6/26/20 Quarterly MDS assessment indicated the resident had no wounds. No documentation was found to indicate any assessments of the pressure ulcer were done. There was no documentation related to the stage of the pressure ulcer, size, tissue type, drainage, signs of infection or whether or not the wound had improved or worsened. On 8/17/20 at 9:24 AM observation of Resident 13's abdominal wound revealed the wound was circular, approximately the size of a nickel, located on the hardened, herniated area of the right abdomen. The resident lifted and adjusted her/his back brace and showed how it rested at the location of the wound. There was no foam barrier noted as indicated in the care plan. On 8/17/20 at 1:46 PM Staff 11 (LPN) stated Resident 13's abdominal wound was likely a pressure ulcer from where the brace rubbed on the area of her/his abdominal hernia. She reported a weekly skin assessment should have been initiated to document the wound weekly however it did not occur. Staff 11 reported initially foam was placed over the area to reduce friction but that was stopped sometime in June. Staff 3 (RCM-LPN) stated he believed Resident 13's wound was an abrasion and was not aware it was a pressure ulcer. He stated he expected the floor nurses to handle wound care for residents and inform him if there was a concern. Staff 3 confirmed there was no regular assessment completed of the wound to monitor the measurements, drainage, symptoms of infection or if it improved or worsened. Staff 3 reported he was unaware the wound was related to pressure from the brace. He reported if he had known it was a pressure wound it would have been treated differently; monitored weekly by the RCM as well as an outside wound care nurse.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to address the nutritional needs of residents with a poor healing surgical wound and pressure ulcer for 2 of 3 (#11 and #13) sampled residents reviewed for nutrition. This placed residents at risk for poor nutrition and wound healing. Findings include: 1. Resident 11 admitted to the facility in 6/2020 with [DIAGNOSES REDACTED]. The resident was cognitively intact. The facility's 3/2020 Skin at Risk/Skin Breakdown policy and procedure indicates the Registered Dietitian should be notified of a worsening wound condition for a nutritional needs assessment. The 6/25/20 Admission MDS Assessment indicated the resident would be seen in the Nutrition at Risk (NAR) meetings related to her/his surgical wound. A 6/25/20 Wound Evaluation indicated Resident 11's surgical wound had deteriorated. A 7/9/20 NAR note indicated the resident was discussed in the NAR meeting related to weight gain. The plan was to reweigh the resident. While it was documented the resident had a surgical wound, there was no documentation related to the deterioration and poor healing of the wound. A review of the resident's weights documented in 6/2020 and 7/2020 revealed there was an error in the documentation and there was no weight gain. On 8/7/20 at 9:54 AM Staff 6 (RN) reported Resident 11's wound was not healing well. On 8/7/20 at 10:14 AM Staff 4 (LPN) reported the resident's surgical wound had broken down, did not look healthy and was not healing well. On 8/17/20 at 2:24 PM Staff 3 (RCM-LPN) reported he knew Resident 11's wound was healing poorly. Staff 3 reported the resident should have been followed on NAR for her/his surgical wound. 2. Resident 13 admitted to the facility in 12/2019 with [DIAGNOSES REDACTED]. The National Pressure injury Advisory Panel 2019 International Clinical Practice Guideline indicates quality nutrition comprised of adequate calories, protein, vitamins and minerals promotes pressure ulcer healing. The document points to fortified foods and nutritional supplements as an intervention for pressure injuries. The facility's 3/2020 Skin at Risk/Skin Breakdown policy and procedure indicates the Registered Dietitian should be notified of new pressure sores for a nutritional needs assessment. A 5/27/20 Physician Note revealed Resident 13 developed an abdominal wound likely secondary to pressure from the [MEDICATION NAME] brace. Nutrition at Risk notes revealed Resident 13 was discussed with the Registered Dietitian on 7/3/20, 7/30/20 and 8/13/20 due to weight gain. There was no documentation related to the pressure ulcer. Resident 13's portion sizes were reduced for all meals. There was no consideration given to the increased nutritional needs to promote wound healing. On 8/17/20 at 2:24 PM Staff 3 (RCM-LPN) reported residents with pressure ulcers are reviewed monthly in the Nutrition at Risk meetings with the Registered Dietitian. He stated he did not have the Registered Dietitian perform a nutritional needs assessment related to wound healing for Resident 13 because he was not aware she/he had a pressure ulcer.