STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105528	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TERRACE OF ST CLOUD, THE	**3855 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34769**

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 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, interviews, and record review, the facility failed to provide the necessary treatment and services to promote healing and prevent worsening of existing pressure ulcer for 1 of 3 residents reviewed for pressure ulcers out of a total sample of 42 residents, (#47). Findings: According to the National Pressure Ulcer Advisory Panel (NPUAP), There are Stage 1 to 4 pressure ulcers, unstageable and suspected deep tissue injury (SDTI) .Stage 2 has partial thickness loss of dermis presenting as a shallow open ulcer with red/pink wound bed, without slough .Stage 3 has full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed . Stage 4 has full thickness tissue loss with exposed bone, tendon or muscle Unstageable depth is unknown and presents with full thickness tissue loss in which the base of the ulcer is covered by slough (dead tissue) .SDTI has depth unknown presenting as purple or maroon localized area of discolored intact skin or blood blister due to damage of underlying soft tissue from pressure and /or shear Resident #47 was admitted to the facility on [DATE] and re-admitted on [DATE] from an acute care hospital with [DIAGNOSES REDACTED]. The resident's minimum data set (MDS) assessment dated [DATE] indicated he was rarely/never understood, was totally dependent on 1-2 persons for all his activities of daily living, was bedbound, unable to turn himself in bed and always incontinent of urine and bowel. The resident was at risk of developing pressure ulcers and had 1 stage 2 and 2 unstageable pressure ulcers present at the time of his admit/re-entry to the facility. The assessment indicated the skin and ulcer treatments that applied were pressure ulcer/injury care and application of ointment/medications other than feet. A review of resident #47's medical record revealed the following physician orders [REDACTED]. Cleanse sacrum superficial open area with normal saline, pat dry, apply [MEDICATION NAME] to area, leave open to air. Indication: sacrum superficial open area. An order dated 2/11/20 read, Weekly skin checks on Sunday 11-7 shift. Special Instructions: Skin check head to toe, for questionable new area initiate treatment and protocol, and notify Wound Care Nurse. A physician order [REDACTED]. The medical record contained a care plan for potential for impaired skin integrity initiated on 9/21/15 and revised on [DATE], related to impaired cognition, decreased mobility, incontinence, requires assist with care, poor PO (by mouth) intake .with goal that he will not develop areas of pressure related breakdown thru target date 4/10/20. He also had care plan initiated on 2/10/20 for, Impaired skin integrity as evidenced by pressure ulcer sacral stage 2, with goal that area will resolve without complications post treatment regimen and interventions included: Apply treatment to skin as ordered, observed skin daily with care and report abnormalities, bruise, skin tear, and red areas to nurse, weekly skin observation as scheduled, wound consult as needed .Notify Physician, responsible party of area of pressure ulcer/changes in skin integrity, document weekly and as needed appearance of surrounding tissue and wound bed progress toward healing or lack thereof . The re-admission assessment dated [DATE] documented that resident #47 had a stage 2 pressure ulcer- wound size- 2 cm (centimeters) x 1.5 cm/2.5 cm x 1/5 cm present sacrum area and DTI present lateral right foot and medial left foot. Review of the Advance Registered Nurse Practitioner (ARNP) progress note dated 2/12/20 revealed that resident #47 was seen and assessed by the ARNP this day. The ARNP documented that resident #47 had a stage 2 pressure ulcer of the sacral region with partial thickness skin loss which was stable at that time measuring 5 cm by 2 cm and depth of 0.1 cm. A physician noted dated 2/13/20 indicated that resident #47 had wound to sacrum and DTI left medial foot and right lateral foot. Hospice nurse completed an initial assessment and start of care on 2/18/20 and documented that the resident had a stage 2/partial thickness pressure ulcer to the sacral region measuring 3 cm x 4 cm x 0.1 cm deep. The wound bed had 75 to 100% epithelization (to form a covering of [MEDICATION NAME] cells over, as a wound) and no necrotic tissue (dead cells). Review of the facility' Registered Dietician note dated 2/11/20 revealed that resident #47 has a stage 2 pressure ulcer sacrum, DTI present lateral right foot and medial left foot . Review of the facility nurse's documentation revealed the following: 2/16/20- Sacral wound treatment in progress, lower extremity dry skin 2/21/20- Treatment/wound care in place due to excoriated buttocks 2/22/20- Wound Care Note- given care to right buttocks and sacrum area as ordered, area continues improving, no drainage noted during procedure, applied skin prep to bilateral heels, right great toe and left lateral foot as order . 2/23/20- No new concern 2/25/20- Treatment/wound care in place due to buttock excoriated area, will continue to monitor . 3/1/20 at 2:17 AM - Sacral area excoriation treatment in progress, bilateral feet treatment in progress 3/1/20 at 10:19 AM - Registered Nurse (RN) A wound care note read, received resident in bed .Wound care is done. Observed sacral area with small open area with small amount moderate yellow secretion . There was no evidence that RN A had ever notified the physician or communicated with the weekend supervisor regarding change in resident #47's wound condition. His sacral area now open and draining. An attempt was made during survey to interview RN A and the Director of Nursing (DON) stated on 3/5/20 at 12:39 PM that she has been trying now to reach RN A since yesterday and has not had any response. The facility policy for Change in a Resident's Condition or Status, with revision date of November 2015 read, Our facility shall promptly notify the resident, his or her attending physician .of changes in the resident's medial/mental condition and/or status .Will not normally resolve itself without intervention by staff .requires interdisciplinary review and/or change to the care plan . On 3/4/20 at 9:43 AM, resident #47 was observed in the shower room with certified nursing assistant (CNA) B. CNA B turned the resident onto his right side while he was lying on a shower bed and he was observed to have an open pressure ulcer on his left buttock which was approximately 2 cm by 1 cm and had yellowish slough noted in wound bed. The resident was confused, non-verbal, and in no distress at the time of the observation. CNA B said that he did not have any other open areas besides the one on his buttock. On 3/4/20 at 10:37 AM the DON checked resident #47's medical record and said that they do not have orders for wound dressing at this time and they had been applying [MEDICATION NAME] on his sacral/buttock area. The DON stated that she would assess the wound. On 3/4/20 at 10:40 AM, CNA B stated that she had brought the resident to activity room after she showered the resident, dressed him and put on his brief. She stated that the DON only looked at his feet and not his bottom. No treatment was provided by the nursing staff to his bottom/buttock wound after the resident was showered. He was taken via recliner chair to activities without the wound being dressed. On 3/4/20 at 10:45 AM, Licensed Practical Nurse (LPN) C stated that she was not resident #47's nurse. She said his usual nurse was RN D. The LPN C stated that if a wound opened or started draining, I would have called the physician to report the changes and obtained orders for change in wound treatment. On 3/4/20 at 11:05 AM, the DON said the nurse who documented that resident #47's wound was open and draining over the weekend (3/1/20) should have notified the physician and obtained change in treatment orders. On 3/4/20 at 11:07 AM, Unit Manager (UM) of Unit 2 said he was not aware of any changes in resident #47's wound status and had not received any report regarding this from the weekend staff either. On 3/4/20 at 11:10 AM, an observation with the DON in the resident's room was conducted. The Unit 2 UM and LPN C assisted with positioning resident #47. The resident was lying on specialty mattress, was not verbal and did not show any signs of discomfort during observation. The DON was observed measuring the wound and stated, left buttock open wound measures 3.3 cm x 1.6 cm x 0.1 cm deep, this wound was a stage 2 when he came back from the hospital and is now gearing toward a stage 3 pressure ulcer with 40% slough seen in the wound bed. The DON then proceeded to provide the wound care with the [MEDICATION NAME] cream to his buttock and skin prep to the discolored areas on his bilateral feet/DTI. On 3/4/20 at 3:30 PM, the

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

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Wound Care Doctor evaluated resident #47's buttock pressure ulcer with DON and the UM at bedside. The Wound Care doctor stated since the wound has 50% slough it is considered an unstageable pressure ulcer because you cannot see the wound bed, it also has 30% granulation and 20% SQ (subcutaneous) tissue. The wound physician instructed the staff to do the same treatment with [MEDICATION NAME] and to also cover with dressing with a follow up in a week. Review of the Wound Care doctor's Initial Wound Evaluation & Management Summary dated 3/4/20 read, He has an unstageable (due to necrosis) coccyx for at least 20-day duration. There is light serous exudate .Etiology (cause) is pressure, Wound size 2.3 x 1.2 cm x not measurable depth, 50% slough, 30% granulation tissue and other viable tissues- 20% (SubQ) . On 3/4/20 at 4:22 PM, the DON stated that the weekend nurse should have reported changes in the wound status to the supervisor, notified the physician and obtained treatment order change. She added that the nurses who were doing the wound care to his buttock wound twice per day with the [MEDICATION NAME] cream should have identified sooner that the wound was now open and draining and should have called the physician for change in treatment orders. She further added that CNA B who gave resident #47 a shower this morning should not have dressed and taken him to activities without the nurse first looking at the open area on his bottom/buttocks and doing treatment/care to the area. The DON acknowldeged that timely notification to the physician was not made regarding change in wound status or changes implemented in the treatment and services until it was brought to their attention at time of survey. On 3/4/20 at 5:47 PM an interview was conducted with the 3-11 nurse, RN F. RN F agreed to interview with the assistance of the DON to interpret Spanish for her. The DON and RN F verified her work schedule. RN F had worked and been assigned to resident #47 on Monday 3/2 and Tuesday 3/3 of this week. She also worked on 2/26 and 2/27 of last week. The nurse said, she did wound care to the resident's buttock wound on those 4 days. She did not remember if the wound was open last week but denied seeing any drainage. This week she saw that his left buttock wound was open on 3/2 and 3/3. The nurse stated she was not sure if she had called the physician to obtain wound orders after noting the wound was open. On 3/5/20 at 12:46 PM, an interview was conducted with resident #47's usual day nurse RN D. The DON assisted with interpretation of Spanish during this interview per the nurse's request. RN D verified that she worked 2/24 thru 2/27 and this week 3/2, 3/3, and 3/5 (today). She said that she did resident #47's wound care with [MEDICATION NAME] to his left buttock daily on her shift and she saw no changes in his wound last week to this week. The nurse said when doing his wound care on 3/2, 3/3 and 3/5 of this week she did see very superficial open area but did not see any slough/yellow tissue. RN D stated, in her opinion, it is superficial and has not changed. She denied receiving report from the weekend staff regarding wound now open and draining. The DON explained to RN D that the wound physician just saw the wound yesterday and assessed the buttock pressure ulcer with 50% slough. The DON then stated, I will need to do some education with RN D regarding staging of wounds. The DON acknowledged she saw slough/yellow in wound on 3/4/20. On 3/5/20 at 1:11 PM, the UM stated the weekend supervisor usually provided a report regarding any changes over the weekend in handwritten, telephone or text report. He was not informed of any changes regarding resident #47's buttock wound and would have expected the weekend nurse to call and get new dressing change orders. He stated that if he had known the resident's wound was now open and draining, he could have called the physician for orders on Monday 3/2/20. UM unit 2 then stated, there is lack of understanding of wounds by the nurses and we do not have a wound nurse at this time. The facility's Pressure Ulcer/Skin Breakdown Clinical Protocol revised 4/18 read, The nursing staff .shall describe and document/report the following: Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue .The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wound develop despite existing interventions .Current approaches should be reviewed for whether the remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing .