STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105706	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OCOEE HEALTH CARE CENTER	**1556 MAGUIRE RD OCOEE, FL 34761**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate resident representative contact information (#1), and failed to notify designated emergency contacts of changes in condition for 2 of 10 sampled residents, (#1 & #2). Findings: 1. Resident #1 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) discharge return anticipated assessment with assessment reference date (ARD) of 4/05/20 revealed resident #1 had an unplanned discharge to the hospital. He had a memory problem and modified independence in cognitive skills for daily decision-making. On 8/03/20 at 11:06 AM, in a telephone interview with resident #1's daughter, she stated she received a telephone call from a hospital on [DATE]. She was informed her father had been transferred to the hospital from his nursing home. Resident #1's daughter stated she received no telephone calls from facility staff regarding a change in her father's condition. She explained she was very upset that the facility did not contact her about any new health issues and the need for transfer to the hospital. Resident #1's daughter said, The doctor at the hospital told me he was not doing well. He was in a bad condition. Resident #1's care plan for self-care deficits revealed instructions for staff to notify the family or responsible party of changes as needed. Review of resident #1's medical record revealed a change in condition SBAR Communication Form dated 4/05/20 at 9:15 AM. The document indicated resident #1 had a change in level of consciousness. He was noted to be non-responsive with an elevated temperature and decreased oxygen levels. The communication form revealed Licensed Practical Nurse (LPN) A attempted to notify resident #1's daughter but had the wrong telephone number. A nursing note written by LPN A on 4/05/20 at 10:59 AM read .number on list is wrong. Later that day at 3:35 PM, LPN A wrote that she was still unable to contact resident #1's representative. On 8/05/20 at 10:01 AM and 2:25 PM, LPN A recalled on the day resident #1 was sent to the hospital she tried to notify his family but discovered the number listed on the face sheet and in the computer was incorrect. LPN A explained contact numbers for newly admitted residents were usually obtained from the hospital face sheet or transfer form and entered into the electronic medical record. LPN A stated these forms were kept in residents' charts. LPN A acknowledged she looked only at resident #1's face sheet, but did not check for representative contact numbers anywhere else in the chart because she was rushing to arrange the transfer. She confirmed she did not go through resident #1's chart after he left the facility to see if there were other contact numbers for his family. Review of resident #1's chart revealed an AHCA Form 5000-3008 hospital transfer form dated 3/09/20. There were 2 names and 2 telephone numbers, for both resident #1's daughters, prominently listed in the section for emergency contact information. A social services progress note dated 4/01/20 at 11:38 AM revealed resident #1's daughter called the facility to discuss her father's discharge plans and finances. The note also included a contact number for resident #1's daughter. On 8/04/20 at 3:18 PM, the Social Services Director (SSD) stated it was a team effort to obtain and maintain accurate contact information for all residents. He explained contact information could be collected by admissions, nursing and/or social services staff and should be updated throughout a resident's stay in the facility. On 8/05/20 at 12:06 PM, the Social Services Assistant (SSA) stated she had conversations with both resident #1's daughters but did not recall verifying their contact information. The SSD stated he was not sure who had access to update the face sheet with contact information at that time, but the social services department did not. On 8/05/20 at 5:14 PM, the administrator stated the accuracy of residents' contact information was the joint responsibility of the admissions, nursing and social services departments. She stated after collection of initial admission information, there were opportunities to revise or correct contact information including during care plan meetings and in any interactions with representatives. The facility did not provide a policy and procedure or guidelines on accuracy of the medical record. 2. Resident #2 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Review of the medical record revealed resident #2's sister was listed as her second contact. On 7/31/20 at 12:11 PM, in a telephone interview, resident #2's sister stated she was the health care surrogate and emergency contact. The sister stated on 7/04/20 the facility notified her that her sister was transferred to the hospital with a fever, difficulty breathing and low blood pressure. She stated hospital staff told her that her sister had a bad urinary tract infection [MEDICAL CONDITION] that spread to her whole body. The sister said, They didn't call and tell me she had an infection. I was shocked because another thing I found out was she had very bad pressure sores on her bottom and both heels. Her skin was fine as far as I knew. They used to call me for anything about her. I even got a call from the facility the day before she went out to tell me they had COVID ([MEDICAL CONDITION] Disease) patients in the facility and sent to the hospital. Resident #2's sister reiterated she was not informed of the UTI or pressure sores. The MDS discharge return anticipated assessment with ARD of 7/04/20 revealed resident #2 had an unplanned discharge. She had modified independence in cognitive skills for daily decision making. The assessment indicated resident #2 did not have any pressure ulcers. However, review of Weekly Skin Check forms revealed on 6/02/20 a nurse identified redness on resident #2's buttocks. On 6/09/20 and 6/16/20, the weekly skin evaluations showed resident #2 had an open area to buttocks. Review of the electronic and paper medical records revealed no evidence the physician and sister were notified of resident #2's skin breakdown. There was no documentation that her sister was notified of the UTI [DIAGNOSES REDACTED]. On 8/05/20 at 12:18 PM, LPN B recalled during resident #2's last week in the facility he was informed she had an area of concern on her buttocks. LPN B stated he evaluated the area and directed a certified nursing assistant (CNA) to apply protective barrier cream. LPN B stated he mentioned the skin concern to the wound nurse but did not document his findings nor notify the physician and family. On 8/05/20 at 4:30 PM, the Director of Nursing (DON) stated her expectation was nurses would document on and report any newly identified areas of skin breakdown to the physician and wound nurse. She confirmed a family member or representative should be notified of any changes in condition and new treatments. Review or resident #2's care plans revealed she was at risk for pressure ulcers. The interventions included notify the physician, family and responsible party of changes. The facility's Skin System Policy & Procedure revised in September 2004 revealed Physician and family will be notified of any changes of skin condition . and notification documented in the resident's medical record.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of neglect to determine if the allegation was substantiated and if corrective actions were required for 1 of 10 sampled residents, (#2). Findings: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) discharge return anticipated assessment with assessment reference date of 7/04/20 revealed resident #2 had modified independence in cognitive skills for daily decision making. She required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene, and was totally dependent on staff for bathing. Resident #2 was occasionally incontinent of urine and always incontinent of bowel. The MDS assessment showed resident #2 had no pressure ulcers. On 7/31/20 at 12:11 PM, in a

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) telephone interview with resident #2's sister, she explained the facility notified her of her sister's transfer to the hospital on [DATE]. She stated hospital staff informed her that her sister was admitted with . very bad pressure sores on her bottom and both heels. She stated she spoke with facility staff as recently as the day before her sister's discharge, and she was never informed of the pressure sores. Review of the State required Five Day Report filed by the facility revealed a State agency informed them an allegation of neglect related to care and services for wounds was filed by resident #2's representative. The report indicated the facility's immediate response was to conduct staff interviews, obtain statements and review resident #2's medical record. The investigative findings noted resident #2 was independent with activities of daily living (ADLs) and had a superficial open area noted to buttock on 6/16/20. The document indicated a skin assessment completed prior to discharge on 7/04/20 showed no skin issues. The facility determined the neglect allegation was not substantiated. On 8/05/20 at 10:58 AM, the investigation of the neglect allegation was reviewed with the facility's administrator and Director of Nursing (DON). They stated the State agency informed them resident #2 allegedly had open areas to her coccyx and feet when she arrived at the hospital from the facility. The administrator explained she pulled resident #2's medical record and interviewed Registered Nurse (RN) E who did the transfer paperwork. She stated her investigation revealed RN E did a skin assessment and noted no areas of breakdown, but she was unable to assess resident #2's heels because she refused to take her shoes off. The DON stated she reviewed resident #2's last weekly skin check and it showed no wounds. Resident #2's Weekly Skin Check forms were pulled from the chart for review with the administrator and DON. The forms indicated on 6/02/20, resident #2 had redness to buttock area and on 6/09/20 and 6/16/20 she had open area to buttocks. The forms dated 6/23/20 and 6/30/20 were blank with a line struck through the page. The administrator suggested the blank forms indicated there were no skin concerns and resident #2's skin was intact. She did not answer when asked if an unsigned, blank form in a medical record was acceptable and accurate documentation on resident status. The administrator was asked to provide the facility's policy and procedure for documentation and/or accuracy of the medical record. The DON remained silent. The administrator and DON were informed there was no evidence the skin issues identified by nurses were reported to a physician or nurse manager, and no treatment orders were noted. This information was not included in the investigative findings. In addition, due to resident #2's illness during her last week in the facility, she was not independent with ADLs as described in the facility's investigation. Instead, she was incontinent and had increased risk for skin breakdown according to her regular nurse, Licensed Practical Nurse (LPN) B, who was interviewed on 8/05/20 at 12:18 PM. The administrator was asked how the facility concluded the neglect allegation was not substantiated if the issues noted in resident #2's medical record were not investigated thoroughly. In addition, she was asked how she completed an investigation without viewing the hospital record to obtain details of resident #2's pressure ulcers. The administrator stated the facility was not able to obtain resident #2's hospital record despite multiple attempts. She explained the facility determined the allegation of neglect was not substantiated based on the information on hand. The administrator stated she believed she did a thorough in-house investigation and made maximum efforts to get information from the hospital. On 8/12/20 at approximately 2:00 PM, in a telephone interview, the administrator was informed a thorough review of resident #2's hospital record revealed she arrived in the hospital emergency department on 7/04/20 with 3 pressure ulcers, 1 on her coccyx and 2 on her heels. The administrator reiterated she did everything in her power to get the hospital record but had to complete the investigation of the neglect allegation without that information. She was asked if she attempted to contact the hospital's risk manager to request resident #2's hospital record since this was the usual process. The administrator stated she had not thought of pursuing that option. Review of the facility's policy and procedure Abuse, Neglect, Exploitation & Misappropriation revised 11/28/17, revealed Neglect was the failure to provide necessary good and services to avoid physical harm. The procedure indicated the facility would investigate all allegations of Neglect and Upon completion of the investigation, a detailed report shall be prepared. The facility was not able to provide policy and procedures or clinical guidelines related to documentation and accuracy of the medical record at the time of exit on 8/05/20 at 6:15 PM.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure effective communication and collaboration between members of the interdisciplinary team (IDT) to provide necessary care and services to attain the highest practicable well-being for 1 of 10 sampled residents, (#1). The facility's failure to recognize and treat a change in condition resulted in actual harm. Resident #1 was admitted to the facility for wound care and rehabilitation services. After 3 weeks, he developed signs and symptoms of an infection and had changes from his baseline status. He was transferred to the hospital a few days later for a change in level of consciousness, fever and decreased oxygen levels. Resident #1 was diagnosed with [REDACTED]. He died 4 days later on hospice. Findings: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set discharge return anticipated assessment dated [DATE] indicated resident #1 had an unplanned discharge to the hospital. On [DATE] at 11:06 AM, in a telephone interview with resident #1's daughter, she stated she spoke to her father on [DATE], the day before he was transferred to the hospital. She described him as . very confused, very different from his usual self. The daughter stated she had not received any phone calls from the facility regarding any changes, infections or worsening of her father's condition. Resident #1's daughter stated on [DATE], she received a telephone call from a hospital to inform her that her father was transferred there from his nursing home. She said, The doctor at the hospital told me he was not doing well. He was in a bad condition. Resident #1's daughter explained her father was diagnosed with [REDACTED].[MEDICAL CONDITION] is the body's extreme response to an infection. It is a life-threatening medical emergency. This response to an existing infection triggers a chain reaction throughout the entire body that can cause organ failure, tissue damage and death if not treated in a timely manner. The symptoms [MEDICAL CONDITION] include confusion or disorientation, shortness of breath, high heart rate, fever, shivering or feeling cold. (The Centers for Disease Control and Prevention website at www.cdc.gov, accessed on [DATE]) Review of a nursing progress note dated [DATE], revealed resident #1 was . received in bed prior to breakfast noted shaking, trembling, complain of pain bilateral lower extremities scale of ,[DATE] (severe pain) . Behavior disoriented, hallucinating and cannot follow simple directions . The note indicated resident #1 attempted to get out of bed several times and had a decreased appetite. The respiratory therapist was notified, and resident #1 was given supplemental oxygen at 2 liters per minute . due to anxiety/hyperventilating. The nurse documented she notified the physician and was awaiting a response. A physician's progress note revealed resident #1 was seen by his attending physician on [DATE] (time of visit unknown) . to assess multiple comorbidities. There was no evidence nursing staff communicated resident #1's change in condition to the attending physician, and there were no new orders for diagnostic tests and no changes made in the treatment plan. The following day, on [DATE], resident #1 was seen by the Advanced Registered Nurse Practitioner (ARNP) C. Her progress note indicated he was confused and had increased anxiety. Review of ARNP C's progress notes for visits on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] revealed the symptoms of confusion and anxiety were a change from resident #1's baseline status of Calm; cooperative. ARNP C ordered diagnostic laboratory tests and a psychology consult. Review of the laboratory result report dated [DATE] at 11:37 AM, revealed resident #1 had abnormal complete blood count values including a white blood cell (WBC) count of 24.8 K/ul (thousand per cubic milliliter). This is double the upper level of the normal range of 4.1 to 10.9. In comparison, resident #1's WBC count was 10.1 on [DATE], the day after he was admitted to the facility. On [DATE], the attending physician examined resident #1 and reviewed the laboratory results. The physician initialed the laboratory result report, but did not otherwise address resident #1's elevated WBC count in his documentation. His progress note revealed recommendations for a liquid multivitamin supplement and to continue current medications and treatments. Resident #1 was also seen by a cardiology ARNP on [DATE], who also signed a copy of the laboratory results but did not give any new orders related to the high WBC count. On [DATE], ARNP C reviewed resident #1's laboratory results. Her progress note revealed resident #1 had [MEDICAL CONDITION] or a low number of red blood cells, and although his hemoglobin level was improved, she referred him to a specialist for further evaluation. ARNP C also noted resident #1 had hyperleukocytosis, a high number of WBCs, but her progress note did not include documentation on possible causes and treatments, or orders for additional diagnostic tests or consults. White blood cells are part of the body's immune system. They defend against infection and disease by destroying foreign materials and infectious agents. An elevated WBC count is normally seen when the body attempts to fight off bacterial, [MEDICAL CONDITION] or parasitic infections (Medscape website at www.medscape.com accessed

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) on [DATE]) Review of Departmental Notes from [DATE] to [DATE] revealed no documentation of collaborative efforts between physicians, ARNPs, floor nurses, unit manager (UM), Director of Nursing (DON), infection control nurse, wound nurse, rehab director or respiratory therapist regarding resident #1's sudden change in mental status, respiratory issues and high WBC count. Although resident #1 was evaluated by several clinicians and nurses during this period, there was no evidence the interdisciplinary team (IDT) reviewed evaluations by all disciplines and revised his plan of care to reflect an increased risk for or actual infection and discussed appropriate follow-up procedures. A nursing note dated [DATE] at 9:15 AM, revealed a nurse found resident #1 non-responsive with axillary temperature (taken under the armpit) of 100.1 degrees Fahrenheit, which is the equivalent of an oral temperature of 101.1 degrees Fahrenheit. His blood pressure was ,[DATE] mmHg and his oxygen level was 93% saturation on room air, which was outside the normal range of 95% to 99%. (Mayo Clinic website at www.mayoclinic.org accessed on [DATE]). The facility obtained a physician's orders [REDACTED].#1 to the hospital via 911 for evaluation and treatment. Review of the hospital record revealed when ambulance personnel arrived at the facility, resident #1's blood pressure had decreased to ,[DATE] mmHg and his oxygen level was 94% saturation on oxygen at 3 liters per minute. By the time resident #1 arrived at the hospital, his respiratory rate was 44 breaths per minute (normal range is 16 to 20) and his oxygen level was 92% saturation. The emergency department record revealed resident #1 did not open his eyes or speak but responded with only .incomprehensible sounds. The document read, He was made [MEDICAL CONDITION] alert secondary to reports of low-grade fever, altered mental status, low blood pressure and increased respiratory rate. Diagnostic tests done in the hospital emergency department showed resident #1's WBC count was even higher than before, now increased from 24.8 to 29.3 K/ul. In addition, a chest x-ray indicated pneumonia in both lungs and a urinalysis showed he had a urinary tract infection [MEDICAL CONDITION]. Resident #1 was started on intravenous (IV) antibiotics and admitted as an inpatient with [DIAGNOSES REDACTED]. Review of an Infectious Disease (ID) physician's note dated [DATE] revealed resident #1 continued on IV antibiotics for UTI and pneumonia, and his WBC count had decreased to 15.5 K/ul. However, nurses informed the attending physician resident #1 was .doing poorly . and had very low oxygen saturation levels. The hospital Discharge Summary dated [DATE] revealed resident #1's family selected comfort measures only, and he was discharged to a hospice inpatient unit. In interviews on [DATE] at 1:30 PM and 4:20 PM, the DON explained laboratory results were received by fax and distributed to the appropriate nurses by unit secretaries and UMs. The DON stated her expectation was nurses would communicate abnormal results to the physicians or ARNPs and then document that the notification was made. She described a WBC count of 24.8 as alarming and stated it indicated a probable infection. She stated if the provider was in the facility and did not address an abnormal test result, it was appropriate for a nurse to ask if there was any further action required, such as a re-check or another type of test. The DON stated the medical record should be updated with the physician's or ARNP's response so all staff would have access to the information. The DON stated her expectation was UMs would review results and new orders on the nursing unit, and again with the IDT/clinical team in daily morning meetings. She confirmed the daily clinical meeting attendees included the infection control nurse, wound nurse, UMs, care plan coordinator and herself. The DON stated as a result of care plan review by the clinical team, decisions could be made regarding residents' existing orders and if necessary, requests for new orders from the attending physician or consultants. On [DATE] at 3:04 PM and 4:44 PM, in telephone interviews with ARNP C, she recalled resident #1 had a change in mental status and became anxious and confused. She stated she ordered laboratory tests and a psychology consult. She reviewed her notes and confirmed she visited the facility on [DATE], reviewed the laboratory report and noted resident #1 had leukocytosis. ARNP C confirmed resident #1's WBC count of 24.8 was very high and indicated he had an infection. She asked if resident #1 was being seen by Infectious Disease (ID) and was informed there were no ID progress notes in the medical record. When asked what her usual course of action would be for this situation, ARNP C said, Usually I would repeat the lab then consult the doctor . The ID doctor would have been seeing him from the beginning. ARNP C was again informed there was no evidence resident #1 had an order for [REDACTED].#1's laboratory results on [DATE] but did not refer to the abnormal results in his progress note. He explained he attributed resident #1's high WBC count to his open wounds. The attending physician recalled resident #1 was being followed by a wound care specialist. When asked why he did not provide orders to treat the abnormal WBC count, he explained the wound team would have initiated IV antibiotics if they felt it was necessary. The attending physician was informed ARNP C saw resident #1 the following day, but possibly did not address the high WBC count because she thought resident #1 was being followed by an ID specialist. He was informed the facility conducted a daily clinical meeting attended by nursing management, the wound nurse, infection control nurse and other IDT members, with a purpose of coordinating residents' care needs. The attending physician acknowledged that venue could have been used to discuss any other appropriate interventions for resident #1.
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 record review and interview, the facility failed to provide care and services to identify, monitor and treat pressure ulcers for 1 of 4 residents reviewed for pressure ulcers, of a total sample of 10 residents, (#2). The facility's failure to evaluate alterations in skin integrity and implement appropriate treatments resulted in actual harm. Resident #2, a long-term resident of the facility, was transferred to the hospital for a change in health status. Hospital staff noted stage II pressure injuries on her coccyx and deep tissue injuries to both heels that were not reported by the facility. Approximately 5 weeks before the hospital transfer, resident #2's medical record showed documentation of redness which worsened to an open area on her buttocks over a 2 week period. There was no record of skin breakdown on her heels, and no treatment orders for pressure injuries implemented. Findings: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was transferred to the hospital on [DATE] for a fever. The Minimum Data Set (MDS) discharge return anticipated assessment with assessment reference date of 7/04/20 revealed resident #2 had modified independence in cognitive skills for daily decision making. She required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene, and was totally dependent on staff for bathing. Resident #2 was occasionally incontinent of urine and always incontinent of bowel. The MDS assessment showed resident #2 did not .reject evaluation or care necessary to achieve the resident's goals for health and well-being . and had no pressure ulcers. Review of resident #2's medical record revealed a care plan for risk for pressure ulcers related to limited mobility, revised on 5/22/20. Interventions directed nurses to conduct weekly skin checks and certified nursing assistants (CNAs) to perform skin checks every shift. Nursing staff were to provide resident #2 with incontinence care as needed, off load her heels, turn and reposition her at least every 2 hours, apply lotion to her legs and place compression stockings in the morning then remove them in the evening. The care plan indicated resident #2's physician, family and responsible party should be notified of changes in skin condition. On 7/31/20 at 12:11 PM, in a telephone interview with resident #2's sister, she explained she was the designated healthcare surrogate and primary emergency contact for her sister. The sister stated the facility notified her of resident #2's transfer to the hospital on [DATE]. She explained she was not aware her sister was being treated for [REDACTED]. The sister said, I was shocked because another thing I found out was she had very bad pressure sores on her bottom and both heels. Her skin was fine as far as I knew. They used to call me for anything about her. I even got a call from the facility the day before she went out to tell me they had COVID ([MEDICAL CONDITION] Disease 2019) patients in the facility and sent to the hospital. She reiterated the facility never informed her about her sister developing pressure sores. Review of Weekly Skin Check forms revealed on 5/26/20, resident #2's skin was evaluated as Intact. On 6/02/20 there was Redness to buttock area and on 6/09/20 a skin check revealed an open area to buttocks. On 6/16/20, the weekly skin check indicated resident #2 still had an open area to her buttocks. Weekly skin check forms were blank, struck through and not signed by a nurse for 6/23/20 and 6/30/20. Review of the Physician order [REDACTED]. Review of resident #2's medical record revealed no nursing notes or change in condition forms regarding resident #2's skin breakdown. There was no documentation the physician, family, unit manager and/or wound nurse were notified of alterations in skin integrity. Resident #2's plan of care did not reflect any revisions related to interventions for actual skin breakdown. A nursing progress note dated 7/04/20, written by Registered Nurse (RN) E, revealed she received an order to transfer resident #2 to the hospital. The note read, Skin check produce no wounds but resident refused to take shoes off for nurse to examine her feet. Review of the hospital emergency department history and physical dated 7/04/20 revealed resident #2's [DIAGNOSES REDACTED]. The hospital admission nursing assessment dated [DATE] detailed 3 pressure injuries. Resident #2 had a wound on her sacrum that measured approximately 5 inches x 7 inches with beefy red tissue and black eschar, or dead tissue noted. The surrounding skin was red, and the wound had bloody drainage. The nurse also observed deep tissue injuries (DTIs) that covered of the surface of both heels. Both heels had blisters and black eschar. Wound treatments orders were implemented at admission for the 3 pressure injuries. The National Pressure Injury Advisory Panel defines a pressure injury as . localized damage to the skin and underlying soft

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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 -** Actual harm **Residents Affected -** Few	(continued... from page 3) tissue usually over a bony prominence . The injury can present as intact skin or an open ulcer . A stage 2 pressure injury involves partial-thickness skin loss that presents as a shallow open ulcer. A DTI (deep tissue injury) is a persistent, dark discoloration on intact or non-intact skin that can have a dark wound bed or present as a blood-filled blister. This injury results from intense and/or prolonged pressure . (The National Pressure Injury Advisory Panel website at www.npiap.com accessed on 8/14/20) Review of the hospital Wound/Ostomy Progress Note (Inpatient) dated 7/06/20 revealed resident #2's wounds were present on admission. The sacrum/buttocks wound measured 14.5 x 13 x 0.1 centimeters (cm) and had a small amount of drainage. The right heel had an intact blood-filled blister that measured 6.2 x 3.0 cm and the left heel also had an intact blood-filled blister that measured 4.0 x 3.0 cm. On 8/05/20 at 11:33 AM, Certified Nursing Assistant (CNA) D stated during care she noted resident #2 had redness on her bottom. CNA D could not recall the date, but she remembered telling the assigned nurse, Licensed Practical Nurse (LPN) B that he should check resident #2's skin. CNA D stated LPN B told the wound nurse at that time. On 8/05/20 at 12:18 PM, LPN B stated he was regularly assigned to resident #2. He explained he attempted to complete her weekly skin assessments, but it was sometimes difficult because resident #2 was very modest. LPN B explained he would have to encourage resident #2 to allow him to do a full skin check and he often had to ask other nurses or CNAs to assist him. He recalled CNA D asked him to evaluate an area of concern she identified on resident #2's buttocks. LPN B stated the area was red, but he did not recall an open area, so he instructed CNA D to apply a protective barrier cream. He could not recall the date but thought the incident occurred during resident #2's last week in the facility. LPN B explained resident #2 was usually continent and used the bathroom even though she wore disposable briefs. However, due to her illness that week she was in bed and incontinent. LPN B said, I didn't document the skin problem. I told the wound nurse . LPN B acknowledged he should have notified the physician and documented the new area of skin concern. On 8/05/20 at 3:45 PM, Registered Nurse (RN) E stated she completed a full skin assessment on resident #2 prior to the hospital transfer. RN E said, I had to coax her into a skin assessment. She's very private but she allowed me to do a full body assessment . I would have seen an open area on her bottom even if there was barrier cream on it. RN E stated she did not assess resident #2's heels because she refused to remove her shoes. She explained resident #2's skin was assessed while she was in bed. RN E stated resident #2 was wearing her shoes in bed at that time. On 8/05/20 at 4:30 PM, the Director of Nursing (DON) stated her expectation was nurses would document on and report any newly identified areas of skin breakdown to the physician and wound nurse, who would consult the wound physician if indicated. She stated her expectation was nurses would use a change in condition form and a progress note to record any skin issues. She confirmed a family member or representative should be notified of any change in skin condition and treatments ordered. The DON explained CNAs should inspect their assigned residents' skin during care every shift and update nurses on their findings. The DON was informed resident #2's weekly skin check forms showed nurses identified areas of skin breakdown but there was no documentation of physician or family notification and no treatments were implemented. She acknowledged the importance of completing weekly skin check forms and explained the wound nurse reviewed them in the daily clinical meeting. The DON stated all aspects of wound prevention and healing should be addressed by interdisciplinary team once they were made aware. Review of the Skin System Policy & Procedure revised in September 2004, revealed all residents would have weekly skin assessments to identify areas of concern. The procedure included at least weekly meetings of the skin committee attended by the wound nurse, a nurse manager and a nurse administrator . to discuss changes, complex wounds, or problems related to skin . Staging and measurements were to be done by the wound nurse. The policy read, On admission and when observed skin is compromised, the Nurse finding the problem will initiate a treatment using formulary product . as approved by the physician, refer to the wound nurse and document on the 24 hour report. The document indicated the physician and family must be notified at the time of discovery, and notification must be documented in the medical record.