STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. BUILDING _____ B. WING _____	**04/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAUFONT HEALTH AND REHABILITATION CENTER	**200 HIOAKS ROAD RICHMOND, VA 23225**

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, facility documentation review, the facility staff failed to develop an effective, resident-centered baseline care plan that met professional standards of quality care for one resident (Resident #5) in a sample of 6 residents. The findings included: For Resident #5, the facility staff failed to include a focus and goal with effective interventions for an unstageable sacral wound present on admission. Resident #5, a [AGE] year old male, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #5's most recent Minimum Data Set with an Assessment Reference Date of 04/01/2020 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 13 out of possible 15 indicative of intact cognition. Functional status for bed mobility, transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Current number of Stage 4 pressure ulcers was coded as 1 meaning one. Number of these Stage 4 pressure wounds that were present on admission/reentry was coded as 1 meaning one. On 04/21/2020, Resident #5's admission skin assessment was reviewed. A document entitled, (electronic health record software name) Skin & Wound - Total Body Skin assessment dated [DATE] at 1:30 PM documented the following sub-headers and selections under Section 1 entitled, Skin Assessment: Turgor: good elasticity Skin color: normal for ethnic group Temperature: warm (normal) Moisture: normal Condition: normal New wounds: 1 On 04/21/2020 at 5:50 PM, an interview with the unit manager, Registered Nurse B (RN B), was conducted. RN B stated that Resident #5 was admitted with an unstageable sacral pressure ulcer. On 04/22/2020 at approximately 10:45 AM, Registered Nurse B (RN B) provided a copy of Resident #5's baseline care plan. There was not a focus, goal, or interventions addressing the sacral pressure wound present on admission on 09/17/2019. When asked about the expectation for wounds on the baseline care plan, RN B stated that everything found on the admission skin assessment should be on the baseline care plan. The facility staff provided a copy of their Policy Number 2602 titled, Care Planning. Under the header, Policy, it was documented, A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. Under Section 1 of this policy, it was documented, The computerized baseline care plan is initiated and activated within 48 hours. An excerpt of Section 2 documented, .summary of the baseline care plan that includes but not limited to .any services and treatments to be administered by the Center and personnel acting on behalf of the Center. On 04/22/2020 at approximately 6:55 PM, the administrator and Director of Nursing (DON) were notified of findings and by the end of survey on 04/24/2020, the administrator and DON had no further information or documentation to offer.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and staff interview, the facility staff failed to develop and implement a comprehensive care plan for 1 Resident (#107) in a survey sample of 8 Residents. The findings include: For Resident # 107 the facility staff failed to develop and implement a care plan with clearly defined, measurable goals and interventions. Resident #107 a [AGE] year old woman admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #107's most recent MDS dated [DATE] codes the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. The Resident is also coded as requiring extensive assistance with all aspects of bathing, dressing, grooming, toileting with physical assistance of 1-2 persons. She is able to eat independently and she propels self in wheelchair as she is unable to walk. On 8/5/2020 during clinical record review it was noted that Resident # 107's care plan read as follows: Focus - Resident is Resistive to care, manipulative behaviors, attention seeking, refuses neb TX, refuses CPA, also hoarding items at bedside and around room, also keeps clutter all around room, increased complaints, false accusations, talks aggressively towards staff, refuses weights, putting items behind her in wheelchair (tissue, clothes, depends), places nebulizer machine in wheelchair and on beds, attempts to ambulate with walker against nursing/ theraphy (sic) advice then falls, refuses to use devices, refuses to use reacher, and rolls out of bed, yells out, hoards batteries from the office, states the vending machine has taken her money to get a refund, hanging legs off the bed, intentionally slides out of the wheelchair so she can get rehab services, noncompliant with wearing a mask, (educated on importance) eats excessively, continues to ask different members for food. Date Initiated - 1/16/20 Created on 2/13/19 Revision 7/23/20. Goal - Clutter Free Environment through next review - Date initiated - 9/16/2019 Created on 2/13/2019 Revision 7/16/2020 Target date 10/12/2020. Interventions - Caregivers provide opportunity for positive interaction, attention, stop and talk with him/her as passing by. (non Pharmacological) Date Initiated: 09/26/2019 Created on 5/20/2019, Revision on 9/26/2019 Encourage to wear mask while out of room. Date Initiated- 7/24/2020 Created on 7/24/2020. Explain all procedures to the resident before starting and allow the resident 10 to adjust to change - Date Initiated: 09/26/2019 Created on 5/20/2019, Revision on 9/26/2019 Offer assistance with organizing items around room, education regarding safety measures r/t clutter - Date Initiated: 09/26/2019 Created on 2/13/2019, Revision on 9/26/2019 PT evaluation for wheelchair positioning - Date initiated 11/4/2019 Created on 11/4/2019 Focus - Resident uses [MEDICAL CONDITION] at night r/t ineffective gas exchange - Date initiated 4/23/20 Created on -4/23/20 Revision on 4/23/20 Goal - The resident will have no s/sx of poor oxygenation absorption through the review date. Date initiated 4/23/20 Created on -4/23/20 Revision on 4/23/20 Interventions - Encourage or assist with ambulation as indicated - Date initiated 4/23/20 Created on -4/23/20. Give Medications as ordered by physician -Date initiated 4/23/20 Created on -4/23/20. Monitor for s/sx of respiratory distress and report to MD as needed - Date initiated 4/23/20 Created on -4/23/20. On 8/7/2020 at approximately 2:30 PM an interview was conducted with Employee B who was asked about the Care Plan. When asked the purpose of the care plan she stated that it was to direct the care of the Resident. When asked if the care plan item listed as having Goal - Clutter free environment through next review appeared accurate she responded no. When asked what was wrong she stated this is just too much in the FOCUS. She said The focus should have been on hoarding/ [DIAGNOSES REDACTED] up room. This focus has everything from hoarding to sliding down in the wheelchair, non compliance with Bi Pap and other behaviors as well. When asked where I would find the information on the BI-Pap usage she pointed out Focus - Resident uses [MEDICAL CONDITION] at night r/t ineffective gas exchange. When asked if it appears correct she stated that it was not and elaborated that it should have included the time it is put on and off who is responsible for cleaning the equipment and any interventions needed for this resident who is documented as being non complaint with Bi-Pap. On 8/7/2020 during the end of day conference the

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

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Administrator was made aware of the issues with care plans and no further information was provided.
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 staff interview, clinical record review and facility documentation the facility staff failed to review and revise care plan for 3 Residents (#1, #2, & #4) in a survey sample of 6 residents. The findings include: 1. For Resident #1 the facility staff failed to revise the care plan and add new wounds as they occurred. Resident # 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident # 1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/23/2020 coded Resident # 1 with a BIMS (Brief Interview of Mental Status) score of 8 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #1 requiring total dependence, on staff for Activities of Daily Living care. On 4/20/2020 a clinical record review was conducted. A review of the Progress Notes revealed that LPN H documented that Resident #1 was admitted with a pressure ulcer to her sacrum measuring 1.5 cm (centimeters) x 0.5 cm X 0.2 cm. Progress notes from the wound care physician revealed the following: Resident #1's sacral wound deteriorated and required surgical debridement by the wound doctor on 2/3/20, 2/10/20, 2/17/20, 2/24/20 and 3/2/20. On 2/3/20, she was found to have an unstageable pressure area to her Left Elbow requiring surgical debridement occurring, to the wound doctor notes, on 2/10/20, 2/17/20, 2/24/20 and 3/2/20. On 2/7/20 she was found to have and a Right hip pressure area requiring surgical debridement, occurring to the wound doctor notes, on 2/10/20, 2/17/20, 2/24/20 and 3/2/20. A review of the entire care plan revealed that the care plan was not updated to reflect new wounds and was only updated once after admission. The care plan revision on 1/30/20 was as follows: Treatment as ordered - Date initiated - 1/30/20 - Created on 1/30/20. Turning and positioning - Q 2 hrs. As tolerated Date initiated -1/30/20 created on 1/30/20. On 4/21/20 at approximately 2PM, an interview was conducted with the DON who stated Care plans are to be reviewed and revised as changes in condition occur. The care plan should be reviewed to see if the interventions in place are effective. If they are not effective you change it. When asked if the care plan in question should have been updated more than just once in the 2 months Resident #1 was at the facility, she stated Each time a new wound developed it should have been placed on the care plan with a new intervention for that wound. On 4/22/20, the facility submitted policy # 2602 Care Planning excerpts read: 6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. On 4/24/20 the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #2 the facility staff failed to (A) revise the care plan to add a pressure area to left heel found at unstageable on 2/8/20, (B) failed to care plan the use of Podus Boot and (C) failed to care plan PICC line placement for administration of antibiotics related to UTI (urinary tract and use of skin tear found on 4/16/20. Resident #2, was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #2's most recent MDS with an ARD of 4/2/20, a Quarterly assessment, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicated no cognitive impairment. (A) A review of Resident #2's progress notes revealed that on 2/8/20, Employee J (former DON) discovered an unstageable left heel wound during a skin assessment. On 4/21/20 at 9:25 AM, this surveyor observed Resident #2's wounds with the Nurse Practitioner (NP). The Resident was in bed laying and there was observed a necrotic wound to left heel. A review of the care plan revealed the care plan was not updated to include the left heel wound. (B) On 4/20/20 at 3:30 PM, an observation was made of Resident #2 lying in bed feet not on a pillow and no PODUS boot on the left foot. There was an IV Pole with pump beside bed with empty Intravenous (IV) Antibiotic bag and tubing still attached. A review of the progress notes revealed a noted dated 2/12/20 at 8:15 PM. excerpts of the Nurse Practitioner's notes read: 1. [MEDICATION NAME] paint twice daily. PODUS boot in place, will follow for risk of further breakdown. Patient was seen in Physical therapy today and staff found a wound to the left posterior heel. A review of the care plan revealed the care plan was not updated to include the PODUS boot. (C) On 4/20/20 at 3:37 PM, an interview with Licensed Practical Nurse (LPN) B was conducted and she was asked when the Resident had last received a dose of antibiotics. LPN B she indicated the last dose was given yesterday afternoon. She stated She had her last dose and I took the PICC out around 3:00 PM A review of the care plan revealed the care plan was not updated to reflect the PICC line and IV antibiotic use for UTI, A Care plan meeting was held on 2/14/20 at 8:10 AM excerpts from the interdisciplinary notes are as follows: Patient's care plan was reviewed and discussed with no changes made. Patient's care plan remains appropriate at this time. On 4/21/20 at approximately 12:00 PM, an interview was conducted with the DON. When asked what her expectation was for documenting and updating the care plan she responded It is my expectation that the nurses update the care plans with change in condition and quarterly. If there are new wounds, and or treatments or adaptive equipment, splints and boots all of that needs to be care planned. The DON submitted the Policy for care planning excerpts are as follow 6. Computerized care plans will be updated by each discipline on and ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. On 4/24/20 during the end of day conference, the Administrator was made aware of the concerns and no further information was provided. 3. For Resident #4, the facility staff to timely revise the care plan to include individualized focus, goal, and interventions associated with 2 pressure injuries on the left heel and one pressure injury on the right heel. Resident #4, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #4's most recent Minimum Data Set with an Assessment Reference Date of 03/11/2020 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as a 99 indicative the interview could not be completed. Cognitive Skills for Daily Decision-Making were coded as severely impaired - never/rarely made decisions. Functional status for bed mobility was coded as requiring extensive assistance from staff with a one-person physical assist for support. Transferring was coded as 7 meaning it only occurred once or twice during the 7-day look-back period. On 04/21/2020 at approximately 11:15 AM, Resident #4 was observed sleeping in her bed with the head of the bed elevated and covers on. On 04/21/2020 at approximately 11:30 AM, LPN D and this surveyor entered Resident #4's room for a wound observation. Resident #4 was awake lying supine on a regular pressure-reducing mattress (not an air mattress) with the head of the bed elevated. LPN D pulled back the covers to inspect Resident #4's heels. There was a heel lift in place and Resident #4's heels were floated. There was a discolored area on the lateral, posterior portion of Resident #4's right heel. There was a discolored area on the lateral region of Resident #4's left heel and a discolored area on the medial region of Resident #4's left heel. LPN D stated she would have to go get something to measure them. The care plan was reviewed. A focus created on 08/15/2014 and revised on 04/20/2020 documented, Resident has an actual skin impairment to heel with potential for further skin impairments r/t (related to) decreased mobility, incontinence. Interventions initiated on 08/24/2016 associated with this focus documented, Keep skin clean and dry; Pressure reduction mattress; Weekly skin assessments. This revision occurred 26 days after the Suspected Deep Tissue Injury (SDTI) on left heel was discovered and does not address the Deep Tissue Injury (DTI) on the right heel. A focus created on 05/26/2014 and revised on 10/18/2016 documented, The resident has an ADL (activities of daily living) self-care performance deficit MS ([MEDICAL CONDITION]). An intervention created and initiated on 04/18/2020 documented, Heel lift-prevention. This revision occurred 24 days after the SDTI on the left heel was discovered and does not address which heel or both heels. On 04/22/2020 at approximately 11:10 AM, an interview with the unit manager Registered Nurse B (RN B), was conducted. When asked about the expectation for revising the care plan if a wound is discovered, RN B stated that the care plan should be revised on the day the wound is discovered. On 04/22/2020 at approximately 6:55 PM, the administrator and DON were notified of findings and by then end of survey on 04/24/2020, they had no further documentation or information to offer.

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 interview, clinical record review and facility documentation the facility staff failed to ensure Residents were provided goods and services to treat existing pressure areas and prevent the development of new pressure areas, for 4 Residents (#1, #2, #5, and #6) in a survey sample of 6 Residents. This resulted in physical harm for Resident #1. The findings included: 1. For Resident # 1, the facility staff failed to provide treatment and services that would promote healing and prevent new 3 pressure areas from forming. This is harm. Resident # 1 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident # 1's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 1/23/2020 coded Resident # 1 with a BIMS (Brief Interview of Mental Status) score of 8 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #1 requiring total dependence, on staff, for Activities of

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Daily Living. A clinical record review was conducted and it was found that on 1/13/2020 on admission to the facility Resident # 1 had an admission assessment, a Braden Scale assessment and conducted by LPN H. The Braden Scale score on admission was 10 indicating that the Resident is at HIGH RISK for development of pressure ulcers. A review of the Progress Notes dated 1/13/2020 revealed that LPN H documented that Resident #1 was admitted with a pressure ulcer to her sacrum measuring 1.5 cm (centimeters) x 0.5 cm X 0.2 cm. She also states bilateral lower limbs starting to contract. A review of Resident #1's baseline care plan read as follows: Focus -Resident has an actual skin impairment (stage III to sacrum) - Date initiated 1-14-20 Created on 1-14-20 Revision on 1-30-20. Goal - Residents wound will improve through next review-Date initiated 1-14-20- Created on 1-14-20 Revision 1-30-20. Interventions - Keep skin clean and dry - Date initiated 1-14-20- Created on 1-14-20. Pericare with incontinence episodes - Date initiated 1-14-20- Created on 1-14-20. Weekly skin assessments - Date initiated 1-14-20- Created on 1-14-20. A review of the care plan revealed that the care plan was updated on 1/30/20 was as follows: Treatment as ordered - date initiated - 1/30/20 - created on 1/30/20 Turning and positioning - Q 2 hrs. as tolerated 1/30/20 created on 1/30/20 On 1/14/2020 a progress note written by the Nurse Practitioner (NP) describes the sacral wound as Unstageable sacral wound 100% covered in slough yellow- the periwound is moist with scattered breaks in the skin due to the moisture. The NP also documented Sacral ulcer-skin prep the periskin and apply [MEDICATION NAME] to the wound itself cover with Allevyn. A review of clinical record revealed the NP order dated 1/14/2020 was not implemented as written. The Skin prep was omitted from the order. Excerpts from the Wound Care Doctor's notes from the 2/3/20 are as follows: Initial wound Evaluation & Management Summary Focused wound exam (site 1) - Stage 4 Pressure wound Sacrum Etiology - Pressure - Wound Size - 1.2 x 0.5 x 0.1 - Thick adherent devitalized necrotic tissue 75% Granulation tissue - 25%. Surgical excisional debridement procedure Indication for procedure- Remove Necrotic Tissue and Establish the Margins of Viable Tissue Procedure Note: The wound was cleansed with normal saline anesthesia was achieved using topical [MEDICATION NAME]. Then with a clean surgical technique a size 15 blade was used to surgically excise necrotic muscle and surrounding facial fibers were removed at a depth of 0.3 cm and healthy bleeding tissue was observed. Dressing treatment plan - Primary dressing -[MEDICATION NAME] dressing apply every three days for 30 days. Plan of care reviewed and addressed - OFF LOAD WOUND Reposition per facility protocol. (emphasis added) There was no record of any intervention to off load the wound. A review of the clinical record revealed that Resident #1's sacral wound deteriorated and required surgical debridement by the wound doctor on 2/3/20, 2/10/20, 2/17/20, 2/24/20 and 3/2/20. Excerpts from the Wound Care Doctor's notes from the 2/3/20 are as follows: Focused wound exam (Site 2) wound of left elbow - Wound size 1 x 1 x not measurable Dressing treatment plan-Primary dressing- Hydrogel gel w/silver apply three times a week for 30 days. Secondary dressing - dry protective dressing apply three times per week for 30 days. A review of the physician orders [REDACTED]. Nurses Progress notes do not document date (Site II - Elbow wound) was found or notification of development of second wound to the Resident Representative as the Resident was not her own responsible party. On 2/7/20 at 6:01 PM progress notes read: CNA reported an area to resident's right hip during am care. Upon entering room and open area was observed to resident's right hip. Area was cleansed with NS (Normal Saline). , applied Santyl to eschar area with surrounding slough 80% of wound bed is beefy red. No foul odor noted. Continue tx as ordered. Continue to turn and position Q 2 hrs. (Every 2 hours). (NP name redacted) notified. (RP name redacted) notified. Resident #1 Right hip pressure area required surgical debridement on 2/10/20, 2/17/20, 2/24/20 and 3/2/20. In addition, on 2/10/20 the wound doctor gave the following orders which were also not implemented. Dressing/ Treatment Plan Discontinue Hydrogel gel w/silver Add- [MEDICATION NAME] Add - Calcium Alginate and continue dry protective dressing. [MEDICATION NAME] (lab) On 2/17/20, the wound doctor gave new orders for [MEDICATION NAME] with calcium alginate and dry dressing. However, a review of the physicians order sheet and the treatment administration record revealed the new orders were not on the physicians order sheet or the treatment administration record. On 4/21/20 at approximately 1:30 PM an interview was conducted with the NP who stated As a general rule when the wound doctor is consulted I step back and let him make the treatment decisions. When asked about her expectations for interventions for pressure wounds prevention and treatment, she stated she would expect an air mattress. When asked if she had ordered an air mattress on admission for Resident #1 she said Well that is usually an order I give verbally. 4/21/20 at approximately 2:00 PM an interview was conducted with wound doctor. When asked his expectations were for interventions for sacral and hip pressure areas he stated that I would expect an air mattress for someone with a sacral wound. When asked if he ordered an air mattress he stated he was not certain. His Physician note read: Support Surface Bed- Group 1, Chair - Pressure Reduction, Feet -Pillow. When asked what the term Group 1 refers to he stated It's a regular mattress, a Group 2 refers to an air mattress. On 4/21/20 at approximately 2:25 PM, an interview was conducted with the Director of Nursing (DON) who stated anyone with a stage 3 or worse sacral ulcer and comorbidities like poor nutrition and limited mobility should have an air mattress. On 4/24/20 during the end of day conference the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #2, an unstageable wound on the left heel was found by the facility staff on 02/08/2020. The facility staff failed to provide pressure-reducing interventions at that time. On 02/12/2020, the NP was made aware of the wound and ordered a Podus boot which was not implemented until 04/20/2020. Resident #2, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #2's most recent MDS with an ARD of 4/2/20 coded as a Quarterly assessment coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. Resident is her own responsible party and makes all her own decisions. She has her right leg amputated below the knee has just gotten her prosthesis and is working with physical therapy on walking. She still uses a wheel chair for mobility. On 4/20/20 Resident #2's clinical record was reviewed. The review found that on 2/8/20, Employee J (former DON) discovered Resident #2 had an unstageable left heel wound found during a skin assessment. The progress notes did not document notification of physician or NP, therefore no treatments were ordered. A review of the progress notes shows that the wound is not mentioned until 2/12/20 at 8:15 PM. excerpts of the Nurse Practitioner's notes read: Chief Complaint: Left heel wound Patient was seen in Physical therapy today and staff found a wound to the left posterior heel. Skin warm and dry, Left heel open red/purple superficial appearance with surrounding blistered skin. 1. [MEDICATION NAME] paint twice daily. PODUS boot in place, will follow for risk of further breakdown. On 4/20/20, an observation was made of Resident #2 lying in bed feet not on a pillow no PODUS boot on. An interview was conducted with LPN B who stated No she doesn't wear any boot she puts a pillow under her foot sometimes. On 4/21/20 at 9:35 AM, an interview was conducted with Resident #2 and she stated I don't wear a boot at night I just put a pillow under my foot . On 4/21/20 at 9:45 AM, an interview was conducted with the Unit manager RN B who stated Resident #2 has a boot she wears at night to protect her heel. On 4/21/20 around 12:00 noon, an interview was conducted with the DON. When asked when the wound on Resident #2 was discovered she stated that she was new to the facility and from what she knew the wound had been found on 2/8/20 by the former DON who did not document on it properly. When asked what her expectation was for documenting wounds she stated, It is my expectation that the nurse who finds it should measure and stage it notify the MD and or RP (Responsible Party), update the care plan and put some interventions in place and document all you have done in the nurses notes. When asked was she aware there was no order for a Podus boot and nothing in the care plan about it she stated that she was aware now and she would get it fixed. On 4/24/20, during the end of day conference the Administrator was made aware of the concerns and no further information was provided. 3. For Resident #5, the facility staff failed to assess and treat in timely fashion an unstageable sacral pressure wound present on admission (09/17/2019). Also, the facility staff failed to turn on the air mattress on 04/21/2020. Resident #5 had a Stage 4 sacral wound and was observed lying supine on his air mattress which was off (unplugged from the wall) and partially deflated. Resident #5, a [AGE] year old male, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #5's most recent Minimum Data Set with an Assessment Reference Date of 04/01/2020 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as 13 out of possible 15 indicative of intact cognition. Functional status for bed mobility, transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Current number of Stage 4 pressure ulcers was coded as 1 meaning one. Number of these Stage 4 pressure wounds that were present on admission/reentry was coded as 1 meaning one. Bowel continence was coded as always incontinent. The physician's orders [REDACTED]. An order entry dated 09/22/2019 documented, Clean sacral wound with normal saline apply allevyn patch every day shift for wound care. An order entry dated 09/24/2019 documented, Clean sacral wound with normal saline, apply santyl (enzymatic [MEDICATION NAME] agent), saline moistened gauze, dry gauze and cover with ABD (dressing) every day shift for wound care. An active order dated 01/23/2020 documented, Wound consult with (physician name). An active order dated 04/13/2020 documented, Clean sacrum area with NS (normal saline), pat dry apply medi-honey and dry dressing daily every day shift. The first Wound treatment orders were entered 4 days after admission. There were no orders for an

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F 0686

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 3)

air mattress. A document titled, PCC (electronic health record software name) Skin & Wound - Total Body Skin assessment dated [DATE] at 1:30 PM documented the following sub-headers and selections under Section 1 titled, Skin Assessment: Turgor: good elasticity Skin color: normal for ethnic group Temperature: warm (normal) Moisture: normal Condition: normal New wounds: 1 There was no further information about wound location, description, measurements, treatments, or pressure-reducing interventions in place in this document. A document titled, Braden Scale For Predicting Pressure Sore Risk dated 09/17/2019 documented a score of 17 in the header of the assessment. In Section 7 titled, Scoring, an excerpt documented, The Score and Category will appear in the header of this assessment as per the scoring below .AT RISK 15-18. The progress notes on 09/17/2019 were reviewed. A noted dated 09/17/2019 at 1:30 PM documented, An Admission Assessment has been completed. See the Assessment for details. The resident arrived from the hospital. The reason for the admission per the resident/POA (power of attorney) is . The entry was electronically signed by a registered nurse and a licensed practical nurse. The new wound documented on the skin assessment was not addressed in any nursing progress notes dated 09/17/2019. Excerpts of a progress note written by the nurse practitioner, Employee G, dated 09/18/2019 at 3:19 PM documented the following narratives under the selected headers: Interval History: (Resident #5) was admitted to rehab s/p (status [REDACTED]. ROS (review of systems) SKIN: Turgor normal; cap refill<3 sec (less than 3 seconds); no cyanosis; warm; dry, clean stump incision with staples in tact (sic) on the left. A sacral wound was not addressed in the progress note. An excerpt of a medical admission note written by the medical director dated 09/19/2019 at 7:27 PM under the sub-header titled, Skin documented, Turgor normal; cap refill <3sec (less than 3 seconds); no cyanosis; warm; dry. A sacral wound was not addressed in the admission note. An excerpt of a medical note written by the nurse practitioner dated 09/20/2019 at 7:54 PM under the sub-header titled, Skin documented, Turgor normal; cap refill <3sec (less than 3 seconds); no cyanosis; warm; dry, clean stump incision with staples in tact (sic) on the left. A sacral wound was not addressed in the note. An excerpt of a nurse's note written by LPN G dated 09/21/2020 at 10:05 PM documented, Wound care provided to sacrum wound and surgical wound. This note did not define what the wound care was; it did not contain a description of the wound, measurements, treatments, dressing, or pressure-reducing measures. There were no orders for sacral wound care on 09/21/2019. A document titled, PCC (electronic health record software name) Skin & Wound - Total Body Skin assessment dated [DATE] at 3:00 PM entered by LPN G, documented the following sub-headers and selections under Section 1 titled, Skin Assessment: Turgor: good elasticity Skin color: normal for ethnic group Temperature: warm (normal) Moisture: normal Condition: normal New wounds: 0 An excerpt of a medical note written by the nurse practitioner dated 09/24/2019 at 1:50 PM under the sub-header titled, Skin documented, Turgor normal; cap refill <3sec (less than 3 seconds); no cyanosis; warm; dry, sacral unstageable wound covered in slough-some pink discoloration around the ulcer itself. Under the header, Assessment/Plan Section 2, it was documented, Unstageable sacral ulcer-begin santyl dressings, may be able to debrid (sic) it next week. He needs an air mattress. An excerpt of a dietary note dated 09/25/2019 at 1:19 PM under the header Skin documented, Unstageable pressure ulcer to sacrum 3.8 x 2.6 .per 9/24/19 Skin & Wound Evaluation. The most recent wound care evaluation via telemedicine evaluation by the wound care physician was dated 04/20/2020. The following sub-headers and input were documented under the header, Focused Wound Exam Stage 4 Pressure Wound Sacrum: Wound size: 3 x 2.3 x 0.3 cm (centimeters) Undermining: 4.4 cm at 12 o'clock Exudate: moderate serous Thick adherent devitalized necrotic tissue: 15% Granulation tissue: 85% Wound progress: improved Primary dressing: leptospermum honey apply once daily for 23 days Secondary dressing: foam with border apply once daily for 23 days; alginate calcium apply once daily for 23 days Recommendations: Off-load wound; reposition per facility protocol. On 04/21/2020 at approximately 2:00 PM, a telephone interview with the wound care physician, Employee F, was conducted. Employee F confirmed documentation on his most recent visit. When asked about his expectation for pressure-reducing measures, Employee F stated he expects an air mattress on Resident #5's bed and something to reduce pressure when (Resident #5) is up in his chair. On 04/21/2020 at 2:45 PM, Licensed Practical Nurse B (LPN B) verified she was the nurse caring for Resident #5. When asked if Resident #5 was cognitively able to make his needs known, LPN B stated, Yes. On 04/21/2020 at approximately 2:50 PM, Resident #5 was observed in his bed, awake, lying supine with the head of the bed slightly elevated. When asked when he first arrived to the facility, Resident #5 stated, Some months ago. Resident #5 was unable to state what month he arrived. When asked if he had a wound, Resident #5 stated he had a wound on his back. When asked if staff were caring for the wound and doing dressing changes, Resident #5 stated that when he first arrived they didn't change it like they were supposed to. Resident #5 also stated that he had to tell the doctor they weren't changing the dressing when he first arrived but they're getting better at it now. This surveyor also observed that the air mattress was off and partially deflated. The mattress appeared to be approximately 4 inches thick. On 04/21/2020 at approximately 2:55 PM, an interview with LPN B was conducted. When asked what the current treatment was for Resident #5's sacral wound, LPN B referred to the electronic health record and stated the treatment is [MEDICATION NAME] and a dry dressing daily. When asked how long he had the wound, LPN B stated she didn't know but she has been working at the facility for 6 weeks and it has been improving. On 04/21/2020 at approximately 3:00 PM, LPN B entered Resident #5's room with this surveyor to observe the sacral wound. This surveyor again observed that the air mattress was off and partially deflated. LPN B peeled back the dressing (dated 04/20/2020) to reveal the sacral wound. There was granulation tissue in the majority of the wound bed and no odor or purulent drainage was observed. After the wound observation, LPN B and this surveyor exited the room. When asked why the air mattress was off, LPN B stated that she saw it was off this morning. LPN B also so stated that she checked the orders and didn't see air mattress ordered, so she just left it off. When asked why he was on an air mattress, LPN B stated that (Resident #5's) wound used to be worse but now it is better and his dressing provides cushioning. LPN B stated that she will find out if he needs an air mattress or not. On 04/21/2020 at approximately 3:10 PM, an interview with LPN C (the nurse who makes rounds with the wound doctor), was conducted. When asked if Resident #5 had orders for an air mattress, LPN C stated that (Resident #5) is on an air mattress and it should be in the orders. When asked if an air mattress should ever be turned off, LPN C stated the air mattress should always be on, otherwise it will deflate down to the metal frame. LPN C and this surveyor then entered Resident #5's room to observe the air mattress. LPN C tried to turn the unit on but was unable to do so. LPN C then looked at the cord and stated, It came unplugged. LPN C then plugged it into the wall and turned the unit on. LPN C pushed down on the mattress and stated that she could not feel the metal frame with her fingers while pushing down on the mattress. Resident #5 stated, I feel it coming up now. On 04/21/2020 at 5:50 PM, an interview with the unit manager, Registered Nurse B (RN B), was conducted. When asked if the meaning of new wound on the total body skin assessment dated on 09/17/2019 was in reference to the left AKA incision or a pressure wound, RN B stated, We don't know what that means. RN B stated that she tried to find clarification in the chart but was unable to determine the meaning. RN B also stated that Resident #5 was admitted with an unstageable sacral pressure ulcer. When asked about what would be expected on the admission skin assessment if a pressure wound was present on admission, RN B stated she would expect to see a description of the wound and, I would stage it, put in some form of treatment, and put it on the care plan. When asked about the importance of performing skin assessments on admission, RN B stated it's important to make sure (residents) are getting appropriate care and treatment so no harm comes to the patient. RN B also stated that it's important to identify it (wound) quickly so can address it and turn things around and heal it. On 04/22/2019 at 8:57 AM, RN B provided a document titled, Richmond Market PCI Live for DQMDD. RN B verified this document was an excerpt from the Discharge Summary dated 09/16/2019 at 9:36 AM. Under the header, Category, it was documented Wound Healing Care Notes. Under the header, Assessment, it was documented, Coccyx - moist, black, now unstageable pressure ulcer, no drainage, odor, or induration noted. Periwound skin intact, delayed blanching red. Under the header, Recommendations, it was documented, Coccyx/sacrum - clean with comfort shield wipes, then with normal saline moisten gauze, allow to air dry, then cover with allevyn lift border. Change Q3DAYS and PRN soiled (change every 3 days and as needed when soiled). On 04/22/2020 at approximately 9:05 AM, Resident #5 was observed lying in bed, awake, leaning to his right side, and the head of the bed slightly elevated. The air mattress unit was on and the air mattress appeared to be approximately 10 inches thick. On the morning of 04/23/2019, the administrator provided an invoice for an air mattress for Resident #5 dated 10/10/2019. An expense log for the air mattress was also provided with a start bill date of 10/10/2019 up to current. The facility staff provided a copy of their Policy Number 3201 titled, General Wound Care/Dressing Changes. In Section 1, it was documented, Notify the physician and obtain orders for treatment(s) and dressing changes. In their Policy Number 2402 titled, Pressure Ulcer Monitoring & Documentation in Section 1, it was documented, A licensed nurse will assess patients for the presence of pressure ulcers/injuries; if a pressure ulcer/injury is present, the nurse will evaluate for complications. In their facility Policy Number 202 titled, Patient admitted , under the header, Procedure an excerpt of Section 14 documented, Complete the following assessments: Skin Assessment, Braden Scale for Prediction of Pressure Sore Risk . Section 15 documented, Document any unusual findings and follow-up interventions including notification of physician and responsible party in progress notes. In summary, Resident #5 was admitted to the facility with an unstageable sacral wound. The sacral wound was not described, measured, staged, treated, or documented in the nursing admission skin assessment. The wound was not addressed in the admission note by the nurse practitioner or the medical director. The first sacral wound treatment was ordered 4 days after admission. A nurse practitioner progress note 7 days after admission first documented about the sacral wound and indicated (Resident #5) needed an air mattress. An air mattress was not ordered and facility documentation provided by the administrator showed that Resident #5 was provided an air mattress 23 days after he was admitted with an unstageable sacral wound. Also, the facility staff failed to turn on the air mattress on 04/21/2020. Resident #5 had a Stage 4 sacral wound and was observed lying supine on his air mattress which was off (unplugged from the wall) and partially deflated. On 04/24/2020 by the end of survey, the administrator and DON had no further information or documentation to offer. 4. For Resident #6, the facility staff failed to promote wound healing and treat left heel wound present on admission until 3 days after admission. Resident #6, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #6's most recent Minimum Data Set with an Assessment Reference Date of 03/27/2020 was coded as a quarterly review. The Brief Interview for Mental Status was coded as 99 meaning the interview could not be completed. Cognitive Skills for Daily Decision-Making were coded as moderately impaired - decisions poor; cues/supervision required. Functional status for bed mobility, transfers, eating, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Number of Stage 4 pressure ulcers were coded as 1 meaning one. Number of these Stage 4 pressure ulcers that were present upon admission/reentry was coded as 1 meaning one. Number of Unstageable pressure ulcers with suspected deep tissue injury in evolution was coded as 1 meaning one. The physician's orders [REDACTED]. Every day shift for pressure ulcer. An order dated 12/16/2019 documented, Heel lift while in bed every shift for pressure ulcer. However, the physician's orders [REDACTED]. The Treatment Administration Record for December 2019 was reviewed. An entry dated 12/16/2019 at 3:30 PM titled, Heel lift while in bed every shift for pressure ulcer was signed off as administered initially on the night shift of 12/16/2019, three days after Resident #6 was admitted to the facility. The Medication Administration Record [REDACTED]. Every day shift for pressure ulcer was signed off as administered initially on 12/17/2019, four days after Resident #6 was admitted to the facility. The admission skin assessment was reviewed. A document titled, (electronic software name) Skin & Wound - Total Body Skin assessment dated [DATE] at 5:13 PM documented the following headers and selections: Turgor: good elasticity Skin color: normal for ethnic group Temperature: warm (normal) Moisture: normal Condition: normal New wounds: 2 Description, location, measurements, treatments, or interventions were not documented in this assessment. The progress notes for December 2019 were reviewed. A nursing Skin/Wound note dated 12/13/2019 at 5:13 PM documented, Skin assessment completed. Findings: Turgor: good elasticity Skin color: normal for ethnic group Temperature: warm (normal) Moisture: normal Condition: normal New wounds: 2 Left heel ulcer yellowSacral heel ulcer healing stage 2 (sic). There was no further description, measurements, treatment, or pressure-reducing intervention addressed in this narrative note. A nursing admission summary written by an LPN dated 12/13/2019 at 5:13 PM documented, An admission assessment has been completed. See the assessment for details. The Resident arrived from hospital. The reason for the admission per

resident/POA (power of attorney) is Weakness special care needs. A document titled, Admission assessment dated [DATE] at 5:13 PM was reviewed. The form did not have a header for skin assessment. An excerpt of the discharge summary titled, (hospital name) Discharge Summary dated 12/13/2019 at 11:06 AM under the header, Hospital Course documented, Left heel decub (decubitus) staph capitis infection. An excerpt of the physician's progress note titled, Physician's Admission Medical Care Plan dated 12/14/2019 at 6:31 AM under the header, Skin documented, Turgor normal; cap refill<3 sec (capillary refill less than 3 seconds); no cyanosis, warm; dry, left heel with dressing. Under the header, Assessment of acute and chronic conditions, it was documented, .left heel ulcer - wound care. An excerpt of the nurse practitioner note dated 12/16/2019 at 3:28 PM under the header, Skin documented, .left heel with black center, there is soft tissue around the edge, tender. An excerpt under the header, Assessment/Plan documented, Left heel ulcer - wound care, heel lift and consider an air mattress. A skin/wound note written by an RN dated 12/19/2019 at 2:21 PM documented, Patient admitted on [DATE] from the hospital with 2 pressure wounds #1- 3 x 5cm Unstageable pressure ulcer to left heel. Wound covered 100% with eschar tissue, scant amount of drainage noted on reassessment with mild [DIAGNOSES REDACTED] periwound and area is tender to touch. #2 - 1.5 x 1 cm stage 1 pressure area to R ankle. Bunny boots to both feet and floated as ordered. On 04/21/2020 at approximately 6:10 PM, Licensed Practical Nurse C was interviewed. LPN C (the nurse that rounds with the wound care physician) verified she was the nurse caring for Resident #6. When asked how long Resident #6 had the wounds, LPN C stated, Forever and a day. LPN C and this surveyor entered Resident #6's room for a wound observation. Resident #6's heels were floated and there was a kling outer wrap dressing dated 04/21/2020 to the left foot. LPN C unwrapped the dressing. The medial left heel wound bed was covered with eschar/necrotic tissue. LPN C stated that the wound is improving. The wound care evaluations by the wound care physician with dates ranging 01/24/2020 through 04/20/2020 were reviewed. The most recent wound care evaluation by the wound physician was dated 04/20/2020. Under the header, Focused Wound Exam (Site 1) Stage 4 Pressure Wound of the Left Medial Heel, the following sub-headers and input were documented: Wound size: 4 x 4.3 x not measurable cm Thick adherent black necrotic tissue (eschar): 90% Thick adherent devitalized necrotic tissue: 10% Wound progress: improved On 04/22/2020 at 1:10 PM, an interview with the unit manager, Registered Nurse B (RN B) was conducted. When asked about the expectation for initiating treatment and interventions for pressure wounds present on admission, RN B stated that it should be initiated that day, not three days after admission. The facility staff provided a copy of their Policy Number 3201 titled, General Wound Care/Dressing Changes. In Section 1, it was documented, Notify the physician and obtain orders for treatment(s) and dressing changes. In their Policy Number 2402 titled, Pressure Ulcer Monitoring & Documentation in Section 1, it was documented, A licensed nurse will assess patients for the presence of pressure ulcers/injuries; if a pressure ulcer/injury is present, the nurse will evaluate for complications. In their facility Policy Number 202 titled, Patient admitted , under the header, Procedure an excerpt of Section 14 documented, Complete the following assessments: Skin Assessment, Braden Scale for

F 0842

Level of harm - Potential for minimal harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, clinical record review, and facility documentation, the facility staff failed to document medications as ordered by physician for 1 Resident (# 106) in a survey sample of 8 Residents. The findings include: Resident #106, a [AGE] year old female, was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #106's Minimum Data Set with an Assessment Reference Date of 06/19/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 meaning intact cognition. Functional status for bed mobility, transfers, toilet use, dressing, and personal hygiene were coded as requiring extensive assistance from staff. Functional limitation in Range of Motion for lower extremity was coded as 2 meaning impairment on both sides. Mobility device was coded as C meaning wheelchair. For the Minimum Data Set with an Assessment Reference Date of 07/10/2020 coded as a discharge assessment, functional status for bed mobility, transfers, toilet use, dressing, and personal hygiene were unchanged and coded as requiring extensive assistance from staff. On 8/6/2020 a review of the clinical record was conducted and it was found among the medications that were ordered by the physician, Carvedilol 6.25 mg (used for blood pressure control) and [MEDICATION NAME] 100 mg (a [MEDICAL CONDITION] medication - used in this Resident for neuropathic pain). A Review of the MAR (Medication Administration Record) Revealed that on 6/13/20 and 6/20/2020 at 6:00 PM there were blank spaces where staff initials should be for [MEDICATION NAME] administration. A review of the MAR for Carvedilol 6.25 mg revealed a blank space on 6/13/2020 and on 6/20/2020 at 6:00 PM where staff initials should be for medication administration. On 8/7/2020 at approximately 1:00 PM an interview was conducted with the Administrator and Employee B and they were shown the MAR and asked what a blank spot means. Employee B stated Even if it was given the assumption must be made that it was not given since there is no documentation. Employee B was asked what a nurse should do if she does not have a medication and she responded First check the stat box and it can be taken from there. Both of these medications should have been in the stat box. On 8/7/2020 a copy of the Stat Box contents was provided and both medications were available in the stat box. On 8/7/2020 during the end of day conference the Administrator was made aware of the issues with medication administration and no further information was provided.