STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075438	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD GROVE SPECIALTY CARE CENTER, LLC	**5 RICHARD BROWN DRIVE UNCASVILLE, CT 06382**

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	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, and a review of the facility policies one of three sampled residents (Resident #2), who required total staff assistance with bed mobility, the facility failed to assess Resident #2's risk factors for the development of a pressure ulcer, and/or failed to conduct a comprehensive initial wound assessment, and/or failed to implement interventions to prevent pressure ulcers in accordance with the facilities policies and procedures. The findings include: Resident #2's [DIAGNOSES REDACTED]. The braden scale dated 9/6/19 identified Resident #2 was at low risk for the development of pressure ulcers. The Resident Care Plan dated 5/27/20 identified Resident #2 was at risk for skin breakdown related to impaired mobility and incontinence. Interventions included a pressure redistributing mattress (standard mattress). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified long and short term memory problems, severe cognitive impairment for daily decision making, total assistance of 2 staff members for bed mobility, transfers, dressing, toilet use, personal hygiene, and had a pressure reducing device for the chair and the bed. A physician's orders [REDACTED]. The nurse's note dated 7/24/20 at 9:08 PM identified breakdown to the left foot, heel and malleolus absent measurements or a comprehensive assessment of the wounds. A physician's orders [REDACTED]. An individualized resident assignment dated 7/24/20 identified Resident #2 had an open area to left foot, heel and malleolus and directed frequent turns, and to float the residents heel as much as possible. A nurse's note dated 7/25/20 at 2:47 PM identified Resident #2 was alert, skin prep was applied to left heel and lateral ankle wounds. The skin was intact with redness and a deep purple center to the left lateral ankle was noted. The resident's heels were red. Shoes were kept off, and heels were elevated. The nurse's note dated 7/30/20 at 12:33 PM identified Resident #2 had new red blanchable area to right heel, and treatment was in place. A physician's orders [REDACTED]. Additional orders included an air mattress to the bed, off loading boots at all times, and check skin integrity every shift. The wound tracking progress note dated 7/31/20 at 2:34 PM identified a new right heel stage 2 pressure ulcer that measured 2.0 centimeter (cm) by 3.5 cm, a left lateral ankle pressure area deep tissue injury (DTI) and left lateral foot pressure area DTI that measured 1.1 cm by 1.5 cm. The nurse's note dated 7/31/20 at 2:44 PM identified Resident #2 was seen by wound physician via face time with a registered nurse and a nurses aide present. The wound care specialist progress note dated 7/31/20 identified Resident #2 was seen as a consultation and evaluation for Resident #2's wounds. The right heel stage 2 pressure injury measured 2.0 cm by 3.5 cm, there was no drainage, granulation, slough, eschar or [MEDICATION NAME] present. The right heel stage 2 pressure ulcer presented as a collapsed intact blister. The left lateral ankle was an acute DTI, persistent non-blanchable deep red, maroon or purple discoloration measuring 1.1 cm by 1.5 cm. A physician's orders [REDACTED]. The right heel stage 2 pressure ulcer was to be cleansed with normal saline, pat dry, apply skin prep once daily for 14 days, the left lateral ankle deep tissue injury was to be cleansed with normal saline, pat dry, apply skin prep once daily for 14 days, and the left heel redness was to be cleansed with normal saline, pat dry, apply skin prep once daily for 14 days. The wound care specialist progress note dated 8/14/20 identified a right heel stage 2 pressure injury measuring 2.5 cm by 3.0 cm by 0.1 cm, there was a moderate amount of serous drainage without an odor, the wound bed had 1 to 25% [MEDICATION NAME] present, no granulation, no slough, no eschar. The left lateral ankle was an acute deep tissue injury (DTI), persistent, non-blanchable deep red, maroon or purple discoloration that had received an outcome of resolved. The left lateral foot DTI, was non-blanchable and deep red, maroon or purple discoloration measuring 1.0 cm by 1.0 cm. and the wound was improving. Interview with NA #1 on 8/18/20 at 4:30 PM identified Resident #2 was able to move his/her feet in the past, however since his/her fall on 7/8/20 Resident #2 did not move by him/herself anymore. NA #1indicated if the staff did not move the residents legs, he/she was not able to move it by him/herself. Interview with PT #1 on 8/18/20 at 4:55 PM identified Resident #2 cannot move his/her lower extremities significantly while in bed and needed assistance from staff to re-position in bed. PT #1 indicated Resident #1 had some movement to his/her lower extremities, however was not cognizant enough to change his/her position. Interview with NA #2 on 8/19/20 at 1:50 PM identified Resident #2 was able to move his/her legs minimally while in bed before the fall on 7/8/20. After the fall in July of 2020 Resident #2 was not able to move his/her legs unless the staff moved them for him/her. NA #2 indicated subsequent to the identification of the wounds Resident #2 had boots while in bed, however prior to that she would put a pillow under his/her legs while in bed. Interview with NA #3 on 8/19/20 at 2:08 PM identified when she walked by Resident #2's room or would feed Resident #2, she did not see his/her legs elevated off the bed. NA #3 indicated she did not see Resident #2's legs offloaded prior to the development of the wounds. NA #3 identified the lack of staffing caused the resident to stay in bed. Interview with RN #1 (Infection Preventionist) on 8/18/20 at 3:25 PM identified Resident #2 could move his/her upper and lower extremities while in bed, however for major body changes he/she needed assistance. RN #1 indicated interventions that were in place to prevent pressure sore development included, a standard pressure relieving mattress, body audits, encouragement of good nutrition and hydration, dietary consultation and the application of a moisturizing lotion however, the facility failed to conduct quarterly braden assessments in January of 2020, May of 2020, and on July 8th of 2020 when the resident had a change in condition to determine the residents skin integrity risk, so that appropriate interventions could be implemented to prevent the development of pressure ulcers. Furthermore, RN #1 indicated she was not trained to conduct wound assessments and waited for the wound care physician (seven days after the wound appeared) for a comprehensive assessment of the wounds with subsequent treatment modalities. Interview with the Director of Nursing (DON) and RN #2 on 8/20/20 at 1:35 PM identified the last braden scale assessment was completed on 9/6/19, and was overdue by seven months. The braden scale should have been completed quarterly, and when the resident experienced a change in condition to determine if he/she was at risk for pressure ulcer development, and was not. The DON also indicated when the resident required staff assistance for bed mobility, the expectation was to communicate the change in condition, conduct a braden skin assessment and develop individualized interventions to prevent pressure ulcer development. Further interview and review of the clinical record with the DON and RN #2 failed to identify Resident #2 was turned and repositioned every two hours. Moreover, the DON indicated the wounds should have be measured and assessed when they were first identified on 7/24/20 in accordance with the facility policy and were not. The facilities wound and skin care protocol directed that all residents would be assessed by the nurse for the risk of skin breakdown, utilizing the braden scale upon admission, readmission, every week for the first 4 weeks, upon a significant change in condition, and quarterly thereafter. The facilities policy further directed that a complete wound assessment would be conducted weekly and documented utilizing the wound tracking record. The interdisciplinary plan of care protocol would address resident problems, goals and interventions directed toward the prevention and/or treatment of [REDACTED]. The care plan would address preventative and treatment interventions for the impairment of skin integrity and pressure ulcers.

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