STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT RIVER POINTE LLC	**4142 BONNEY ROAD VIRGINIA BEACH, VA 23452**

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 staff interviews, facility documentation review, and clinical record review, the facility staff failed to notify the physician of a facility acquired pressure for 1 of 4 residents (Resident #2) in the survey sample. The facility staff failed to notify the physician until 08/10/20, of a pressure ulcer initially identified on 08/05/20 and failed to notify the physician of the Registered Dietitian's recommendations for vitamin supplements to promote wound healing. The findings included: Resident #2 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of 07/24/20 coded Resident #2 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The MDS coded Resident #2 requiring total dependence of two with toilet use and transfer, total dependence of one with personal hygiene, eating, bathing, dressing and extensive assistance of two with bed mobility. Under section G0400 - Functional Limitation in Range of Motion (ROM), coded Resident #2 with impairment on one side to his lower extremity (hip, knee, ankle, foot). Resident #2 was coded as having no mood, rejection of care or behavioral problems. The MDS with an ARD of 07/24/20 under section M (Skin Condition - M0100) was coded for the using a formal assessment instrument/tool (e.g., Braden, Norton or other) for the determination of Pressure Ulcer Risk. Under section (M0150) for Risk of Pressure Ulcers coded Resident #2 at risk for developing pressure ulcers and under section (M1200) for skin and treatments was coded for having pressure reducing device bed. Resident #2's person-centered comprehensive care plan revised on 08/13/20 documented Resident #2 with actual alteration in skin integrity acquired (Pressure Ulcer) to the left hip related to altered nutritional status, cognitive impairment, decreased mobility and urinary incontinence. The goal: resident's ulcer will be covered with [MEDICATION NAME] tissue or resurfaced with new skin even with possible discoloration. Some of the intervention/approaches to manage goal: Monitor/document/report to MD changes in skin status, appearance, color, wound healing, s/s of infection, wound size and stage. Review of Resident #2's Plan of Care Response History revealed the following information documented on 08/05/20 at approximately 10:31 p.m. by Certified Nursing Assistant (CNA) #1. Documented under skin observation was coded as having an open area. On 08/31/20 at approximately 4:00 p.m., a phone interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 was assigned to Resident #2 on 08/05/20 (3 PM-11 PM shift). The LPN stated, I was never told or recall Resident #2 having a pressure ulcer/open area to his left hip. A phone interview was conducted with (CNA) #1 on 09/01/20 at approximately 11:30 a.m. The CNA said while providing care to Resident #2, on 08/05/20 (3 PM-11 PM shift), I observed an open area to Resident #2's left hip; the area was open but did not have a dressing. The CNA stated, I documented the open area and reported the open area to his nurse. The CNA said she informed Resident #2's nurse right away because they are able to give a more detailed/specific report about the residents open area. Review of Resident #2's Weekly Pressure Wound Observation Tool completed by Registered Nurse (RN) #2 included the following documentation: -Date acquired - 08/07/20 Pressure Ulcer to the left hip - Suspected Deep Tissue Injury (sDTI). -Current wound stage III -Visible tissue -improving - slough tissue present (yellow, tan, white, stringy) -The extent (%) of necrosis and/or slough in the wound bed - 10% -Small amount of serous drainage with odor present -Wound measurements - .05 cm x .05 cm with 0 depth - Distribution of per-wound tissue - hyper pigments with intact wound edges -Under treatment - describe any changes to treatment pan in the last week - dry dressing applied to wound upon observation. -Nurse Practitioner (NP) made aware with a new order for Santyl ointment. -Evaluation- the site was noted on 08/07/20 at 3 cm x 4 cm and now is a 0.5 cm x 0.5 cm. A phone interview was conducted with RN #2 on 08/31/20 at approximately 1:20 p.m. She said on 08/10/20 (7 AM-3 PM shift), the CNA who was assigned to Resident #2 reported while providing ADL care, she noticed a patch to his left hip. She said that prompted her to do an assessment because she was not aware that Resident #2 had a wound to his left hip. The RN said upon her observation, there was a dressing to Resident #2 left hip with a date of 08/07/20 but there were no nurses' initials present. The RN said she removed the dressing to discover a stage III pressure ulcer. She said the peri area around the wound was red, non-blanchable and the wound observed with drainage, odor, and a plug of white/yellow green slough. The RN said she was unable to locate an order for [REDACTED].#2's left hip with a new order to start Santyl ointment. When asked, What type of ointment is Santyl she replied, A debridement, since the wound has slough, the wound need to be debrided. When asked if she completed the Weekly Pressure Wound Observation Tool dated 08/10/20, she replied Yes. The RN stated she put the date the pressure ulcer was acquired for 08/07/20 because that was the date on the dressing; so someone know it was there. The RN said she put the original pressure ulcer stage as a STDI because of the outer appearance of the wound being red and non-blanchable but the wound as of 08/10/20 was a stage III, again because the wound bed was with noted with slough. Review of Resident #2's progress notes under nutrition included the following recommendation made by the Registered Dietitian: -07/24/20 -Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days. -08/07/20-Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days. -08/14/20-Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days. -08/28/20 - Registered Dietitian (RD) reviewed Resident #2 related to (r/t) skin breakdown. Vitamins and minerals in place that will aid in wound healing. Medications include but not limited to: Vitamin C and Zinc. Review of Resident #2's Medication Administration Record [REDACTED]. Review of Resident #2's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A phone interview was conducted with the Registered Dietitian on 8/31/20 at approximately 1:30 p.m. She said the recommendations made on 07/24/20, 08/07/20 and 08/14/20 for Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days was emailed to the Administrator, (DON) and Unit Manager. The dietitian said the recommendation for Vitamin C and Zinc was to assist with wound healing. The Dietitian said she was not aware of the pressure ulcer to Resident #2's left hip until 08/28/20. She said Resident #2 had other areas prior to the left hip and that is why the Vitamin C and Zinc was first recommend on July 24, 2020. On 09/01/20 at approximately 1:15 p.m., a pre-exit phone conference was held with the (Administration Team) Administrator, DON, Staff Development Coordinator, MDS Coordinator and LPN #1 (House Supervisor). The Administration team was asked, if a nurse identifies a pressure ulcer, What is your process. LPN #1 (House Supervisor) said the nurse should have assessed the area, called the MD/NP to make him/her aware, get an order, make sure the treatment is carried out. When asked, Should the nurse put a dressing to a wound without a physician order, she replied, No. When asked, What is your process for the RD's recommendations? The DON stated the recommendations are first verified against the resident's current order and changes are made according to the recommendation. The DON said if medications were recommended; the physician must approve it. When asked, if the MD was made aware of the dietitian recommendation for Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days on 07/24/20 and 08/07/20. The DON replied, I'm not seeing orders saying he was notified, the questions was asked again, if the MD was made aware of the dietitian recommendation, the DON replied, No.
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**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT RIVER POINTE LLC	4142 BONNEY ROAD VIRGINIA BEACH, VA 23452

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and clinical record review the facility staff failed to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment to include pressure ulcer interventions for 1 of 4 residents in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on [DATE] and expired on [DATE]. [DIAGNOSES REDACTED]. Resident #1's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of [DATE] was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #1 as requiring extensive assistance of 1 for bed mobility and eating and total dependence of 1 for toilet use, personal hygiene and bathing. On [DATE] Resident #1's clinical record was reviewed and revealed the following: Review of Admitting Daily Skin Assessment revealed the following: Date: [DATE] 16:05 Signed: [DATE] 23:39 Head To Toe Skin Checks 1. Skin Integrity 1p. Describe new or existing other issues: Open area to left heel. 3. Site: 50) Left heel Type: open area. Review of Braden Scale For Predicting Pressure Sore Risk revealed the following: Date: [DATE] Score: 11.0 Category: HIGH RISK; Date: [DATE] Score: 10.0 Category: HIGH RISK: Date: [DATE] Score: 12.0 Category: HIGH RISK. Review of Resident #1's Admission MDS assessment with an Assessment Reference Date of [DATE] revealed the following: Section M - Skin Conditions M0150. Risk of Pressure Ulcers - Question asks - Is this resident at risk of developing pressure ulcers? 1. Yes. M0210. Unhealed Pressure Ulcer(s) - Question asks - Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 1. Yes. M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - B. 1. Number of Stage 2 Pressure Ulcers - 3. B. 2. Number of these Stage 2 Pressure Ulcers that were present upon admission/reentry - 3. C. 1. Number of Stage 3 Pressure Ulcers - 0. D. 1. Number of Stage 4 Pressure Ulcers - 0. F. 1. Number of Unstageable Pressure Ulcers due to coverage of wound bed by slough and/or eschar - 0. M1200. Skin and Ulcer Treatments B. Pressure reducing device for bed. C. Turning / repositioning program. E. Pressure Ulcer Care. Review of Weekly Pressure Wound Observation Tools revealed the following: Effective Date: [DATE] 14:37 B. OBSERVATIONS/DATA: 1. Location: Left Heel 4. PRESSURE ULCER STAGE: Original: III Current: III 8. WOUND MEASUREMENTS: Length (mm): 24 Width (mm): 25 Depth (mm): 1 Effective Date: [DATE] 17:43 B. OBSERVATIONS/DATA: 1. Location: Left Heel 4. PRESSURE ULCER STAGE: Original: II Current: II. 8. WOUND MEASUREMENTS: Length (mm): 25 Width (mm): 24 Depth (mm): 1 Effective Date: [DATE] 09:28 B. OBSERVATIONS/DATA: 1. Location: Left Heel 4. PRESSURE ULCER STAGE: Original: SDTI (suspected deep tissue injury) Current: IV. 8. WOUND MEASUREMENTS: Length (mm): 100 Width (mm): 80 Depth (mm): 0 On [DATE] received copy of Skin Wound Note dated [DATE] 16:22. Review of note revealed the following: Late Entry: Note Text: #1 wound left heel PrU (Pressure Ulcer) - 4.5 x 3 x 0- came from hospital with ulcer. Unstageable. Tx - clean, [MEDICATION NAME] gauze, wrap with kerlix - QD, PRN. Pt. (Patient) is Hospice. On [DATE] review of Resident #1's comprehensive care plan revealed the following: Focus: Actual alteration in skin integrity (Pressure Ulcer) stage 2 left heel. Date initiated: [DATE] Revision on: [DATE]. Goal: Wound will be free of infection. Date initiated: [DATE] Target Date: [DATE] Interventions/Tasks: Heels off loaded when in bed. Date initiated: [DATE]; Institute Weekly Pressure Ulcer Condition Report (refer to document for size and staging) Date initiated: [DATE]; Provide meals per physician order. Date initiated: [DATE]; Provide medical food supplement per physicians order. Date initiated: [DATE]; RD (Registered Dietician) will monitor and evaluate nutritional intake and condition of wound and make recommendations as indicated. Date initiated: [DATE]. Review of care plan, Stage 2 Pressure Ulcer on the Left Heel, does not reflect Stage 4 Pressure Ulcer on Left Heel as evidenced on the Weekly Pressure Wound Observation Tool dated [DATE]. Unable to locate pressure ulcer care plan initiated within 7 days after completion of the comprehensive assessment and prior to [DATE]. On [DATE] at 11:55 a.m., a telephone interview was conducted with MDS Coordinator. When asked when Resident #1 was admitted to the facility, the MDS Coordinator stated, [DATE]. When asked what was the Assessment Reference Date for the Admission MDS, MDS Coordinator stated, [DATE]. When asked when was the comprehensive careplan completed, MDS Coordinator stated, [DATE]. When asked if Resident #1 had a Stage 3 Pressure Ulcer on his left heel on admission, MDS Coordinator stated, I see he had an open area on his left heel on admission. MDS Coordinator stated, Actual Alteration in Skin Integrity Care Plan was initiated on [DATE]. MDS Coordinator stated, Another nurse did the MDS, she is retired now. MDS Coordinator stated, He had Stage 2's on the MDS. Reviewed the Weekly Pressure Wound Observation Tool dated [DATE] with the MDS Coordinator. Review of the tool revealed documentation that Resident #1 had a Stage 3 on the Left Heel. When asked, Is it documented on the Observation Tool that Resident #1 had a Stage 3 on his left heel? MDS Coordinator stated, Yes, I see it. When asked if the careplan for Alteration in Skin Integrity should have been initiated prior to [DATE], MDS Coordinator stated, Yes. MDS Coordinator stated, The care plan should be reflective of what is going on with the resident. On [DATE] at approximately 5:25 p.m., the exit meeting was conducted over the telephone and the Administrator and Director of Nursing was informed of the findings. No further information was provided by the facility staff.
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 observations, staff interviews, clinical record review and facility documentation review the facility failed to ensure 2 residents (Resident #2, #1) of 4 residents in the survey sample, were provided treatment and services to prevent the development of, promote the healing of, and prevent the decline of, a pressure ulcer, resulting in harm for Resident #2. The findings included: 1. For Resident #2, the facility staff failed to implement measures to prevent a left hip pressure ulcer and failed to identity the ulcer until it had advanced to a Stage III. The newly identified left hip pressure ulcer was first observed on [DATE] with no treatment put in place. On [DATE] there was a dressing covering the pressure ulcer to the left hip but no physician notification nor routine wound care treatment was put in place. On [DATE], the wound had advanced to a stage III pressure ulcer and presented with slough resulting in harm. Resident #2 was originally admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The current Minimum Data Set (MDS), an annual assessment with an Assessment Reference Date (ARD) of [DATE] coded Resident #2 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The MDS coded Resident #2 requiring total dependence of two with toilet use and transfer, total dependence of one with personal hygiene, eating, bathing, dressing and extensive assistance of two with bed mobility. Under section G0400 - Functional Limitation in Range of Motion (ROM) coded Resident #2 with impairment on one side to his lower extremity (hip, knee, ankle, foot). Resident #2 was coded as having no mood, rejection of care or behavioral problems. The MDS with an ARD of [DATE] under section M (Skin Condition - M0100) was coded for the using a Formal Assessment Instrument/tool (e.g., Braden, Norton or other) for the determination of Pressure Ulcer Risk. Under section (M0150) for Risk of Pressure Ulcers coded Resident #2 at risk for developing pressure ulcers and under section (M1200) for skin and treatments was coded for having pressure reducing device bed. Resident #2's person-centered comprehensive care plan revised on [DATE] documented Resident #2 with actual alteration in skin integrity acquired (Pressure Ulcer) to the left hip related to altered nutritional status, cognitive impairment, decreased mobility and urinary incontinence. The goal: resident's ulcer will be covered with [MEDICATION NAME] tissue or resurfaced with new skin even with possible discoloration. Some of the intervention/approaches to manage goal: administer multivitamin with mineral per physician order, institute Weekly Pressure Ulcer Condition Report, monitor for S/S of infection and report to physician for care and treatment or debride, Registered Dietitian (RD) will monitor, evaluate nutritional status and condition of wound and make recommendations as indicated and specialty mattress (air-loss)-applied on [DATE]. Prior to the left hip pressure Resident #2's comprehensive care plan initiated on [DATE] with a revision date of [DATE] documented Resident #2 as high risk for skin breakdown related to generalized weakness, dementia, incontinence and [MEDICAL CONDITIONS]. The goal: the resident will be free of skin breakdown through [DATE] (target date). Some of the intervention/approaches to manage goals included to assess Resident #2's skin weekly and as needed and to administer dietary supplements as ordered. A Braden Risk Assessment Report was last completed on [DATE]. A Braden Risk Assessment is used for predicting pressure sore risk. Resident #2 scored a 20 indicating not at risk for the development of pressure ulcers. On [DATE] at approximately 2:44 p.m., a phone interview was conducted with the Director of Nursing (DON) and LPN #1 (House Supervisor). The DON and LPN #1 were asked how often should the Braden Scale Assessment be completed and they replied, On a quarterly basis. The LPN said the Braden Scale Assessment is used to predetermine if the resident is at risk for the development of pressure ulcers along with their nutritional value. Review of Resident #2's Plan of Care Response History revealed the following information documented on [DATE] at approximately 10:31 p.m., by Certified Nursing Assistant (CNA) #1. Documented under skin observation was coded as having an open area. A phone interview was conducted with (CNA) #1 on [DATE] at approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT RIVER POINTE LLC	**4142 BONNEY ROAD VIRGINIA BEACH, VA 23452**

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 2)

11:30 a.m. The CNA said while providing care to Resident #2, on [DATE] (,[DATE] shift.) I observed an open area to Resident #2's left hip; the area was open but did not have a dressing. The CNA stated, I documented the open area and reported the open area to his nurse. The CNA said she informed Resident #2's nurse right away because they are able to give a more detailed/specific report about the residents open area. On [DATE] at approximately 4:00 p.m., a phone interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 was assigned to Resident #2 on [DATE] (,[DATE] shift). The LPN stated, I was never told or recall Resident #2 having a pressure ulcer/open area to his left hip. Review of Resident #2's Weekly skin review revealed the following: [DATE] - not completed [DATE] - not completed [DATE] - completed with the following information included but not limited to: (open area to left hip.) An interview was conducted with LPN #1 (House Supervisor) on [DATE], who stated, We were behind on completing our weekly skin reviews. She said Resident #2's weekly skin review was missed on [DATE] and [DATE] but completed on [DATE]. Review of Resident #2's Weekly Pressure Wound Observation

Tool dated [DATE] completed by Registered Nurse (RN) #2 included the following documentation: Date acquired - [DATE] Pressure Ulcer to the left hip - Suspected Deep Tissue Injury (sDTI). Current wound stage III Visible tissue -improving - slough tissue present (yellow, tan, white, stringy) The extent (%) of necrosis and/or slough in the wound bed - 10% Small amount of serous drainage with odor present Wound measurements - 0.5 cm x 0.5 cm with 0 depth Distribution of per-wound tissue - hyper pigments with intact wound edges Under treatment - describe any changes to treatment pan in the last week - dry dressing applied to wound upon observation. Nurse Practitioner (NP) made aware with a new order for Santyl ointment. Evaluation- the site was noted on [DATE] at 3 cm x 4 cm and now is a 0.5 cm x 0.5 cm. Review of Resident #2's Skin/Wound Notes completed by RN #2 included the following documentation: [DATE] - left hip noted with a 3 cm x 4 cm hyperpigmented sited with a 0.5 cm x 0.5 cm with a pale white/green plug of slough in it, site cleaned with normal saline, dried, covered with Xeroform. The (NP) made aware with a new order for Santyl ointment and dressing daily. [DATE] - left hip noted with some non-viable tissue present and requested to change treatment from Alginate to Santyl ointment. Review of Resident #2's Treatment Administration Record (TAR) for [DATE] included the following left hip wound care order: [DATE]- Santyl ointment - apply to left hip - clean wound with wound cleanser, pay dry, apply Santyl to wound bed and cover with a saline moist gauze and cover what composite dressing - starting on [DATE]. [DATE] - D/C Santyl - start Alginate and boarder composite dressing - clean wound with dermal wound cleanser, pat dry, cut and fit Alginate and skin prep to peri wound skin and cover with boarder composite dressing every other day starting on [DATE]. [DATE] -D/C Alginate dressing - start Santyl ointment - apply to left hip - clean wound with wound cleanser, pay dry, apply Santyl to wound bed and cover with a saline moist gauze and cover what composite dressing starting on [DATE]. Review of Resident #2's (TAR) for [DATE] also included the following order: [DATE] - Low Air Loss Mattress every shift for Preventative Care. A phone interview was conducted with RN #2 on [DATE] at approximately 1:20 p.m. She said on [DATE] (7 AM-3 PM shift), the CNA who was assigned to Resident #2 reported while providing ADL care, she noticed a patch to his left hip. She said that prompted her to do an assessment because she was not aware that Resident #2 had a wound to his left hip. The RN said upon her observation, there was a dressing to Resident #2 left hip with a date of [DATE] but there were no nurses' initials present. The RN said she removed the dressing to discover a stage III pressure ulcer. She said the peri area around the wound was red, non-blanchable and the wound observed with drainage, odor, and a plug of white/yellow green slough. The RN said she was unable to locate an order for [REDACTED].#2's left hip with a new order to start Santyl ointment. When asked what type of ointment Santyl was, she replied, A debridement, since the wound has slough, the wound need to be debrided. When asked if she completed the Weekly Pressure Wound Observation Tool dated [DATE], she replied Yes. The RN stated she put the date the pressure ulcer was acquired for [DATE] because that was the date on the dressing; so someone know it was there. The RN said she put the original pressure ulcer stage as a STDI because of the outer appearance of the wound being red and non-blanchable but the wound as of [DATE] was a stage III, again because the wound bed was with noted with slough. Review of Resident #2's Telehealth -Integrated Wound Care Forms included but not limited to the following: On [DATE], the wound care specialist documented a stage II pressure ulcer to the left hip. The wound measured 0.5 cm x 0.3 cm x 0.1 cm with small amount of serous drainage. The wound care specialist documented that the wound improving with hyperpigmentation. Wound treatment - clean: wound cleaning spray -apply Santyl daily - might change to skin prep since would improving for protection. On [DATE], the wound care specialist documented the left hip with excoriation. Note; initially looked like pressure ulcer but now looks more like excoriation. Left hip wound noted with granulation tissue forming. Wound treatment - clean: wound cleaning spray-apply Venelex-put on today due to pressure ulcer last week, assess and change treatment as needed. On [DATE], the wound care specialist documented the left hip measuring 3.4 cm x 3.9 cm x 0 with 100% slough, macerated edged, no odor or drainage per DON. Wound treatment changed-clean: wound-apply Santyl, cover with border gauze daily and as needed. A phone interview was conducted with wound care specialist on [DATE] at approximately 10:54 a.m. She said at the time Telehealth was done on [DATE], the wound had improved and was definitely a stage II on [DATE]. She stated with my visit on [DATE], the wound continued to improve and at that point looked more like excoriation than a stage II pressure ulcer. On [DATE] at approximately 5:10 p.m., a phone interview was conducted with the wound nurse who said she had just finished her wound assessment on Resident #2 and the wound has deteriorated since my last telehealth visit on [DATE]. She said the wound is now covered with 100% slough, so the current treatment is being is discontinued and the new treatment is going to be Santyl ointment. Review of Resident #2's progress notes under nutrition included the following recommendation made by the Registered Dietitian: -[DATE] -Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days. -[DATE]-Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days. -[DATE]-Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days. -[DATE] - Registered Dietitian (RD) reviewed Resident #2 related to (r/t) skin breakdown. Vitamins and minerals in place that will aid in wound healing. Medications include but not limited to: Vitamin C and Zinc. Review of Resident #2's Medication Administration Record [REDACTED]. Review of Resident #2's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. A phone interview was conducted with the Registered Dietitian on [DATE] at approximately 1:30 p.m. She said the recommendations made on [DATE], [DATE] and [DATE] for Vitamin C 500 mg once daily x 14 days and Zinc 220 mg once daily x 14 days was emailed to the Administrator, (DON) and Unit Manager. The dietitian said the recommendation for Vitamin C and Zinc was to assist with wound healing. The Dietitian said she was not aware of the pressure ulcer to Resident #2's left hip until [DATE]. She said Resident #2 had other areas prior to the left hip and that is why the Vitamin C and Zinc was first recommend on [DATE]. On [DATE] at approximately 3:45 p.m., during the pre-exit phone conference with the Administration staff. When asked if a Root Cause Analysis (RCA) or an investigation was completed on Resident #2's left hip pressure ulcer, the DON and LPN #1 (House Supervisor) both replied No. The facility's policy titled Prevention of Pressure Ulcers/Injuries with a revision date of ,[DATE]. -Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment: -Assess the resident on admission for existing pressure ulcer/injury risk. Repeat the risk assessment weekly and upon any changes in condition. -Monitoring Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis. Definitions: *A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/). Pressure Injury - Stage 3 (Full-thickness skin loss) Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages.) *Santyl is used to help the healing [MEDICAL CONDITION] ulcers. [MEDICATION NAME] is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.) *Alginate Dressings are composed of calcium alginate, a gelatinous and water-insoluble substance. When in contact with a wound, the calcium alginate in the dressing reacts with sodium chloride from the wound. This turns the dressing into a [MEDICATION NAME] gel that maintains a moist environment for the wound (www.medicaldepartmentstore.com/Alginate-Dressings-s/286.htm.).

2. For Resident #1, the facility staff failed to accurately assess and ensure treatment orders were obtained and implemented timely. Resident #1 was admitted to the facility on [DATE] and expired on [DATE]. [DIAGNOSES REDACTED]. Resident #1's Admission Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of [DATE] was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT RIVER POINTE LLC	**4142 BONNEY ROAD VIRGINIA BEACH, VA 23452**

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)

Minimum Data Set coded Resident #1 as requiring extensive assistance of 1 for bed mobility and eating and total dependence of 1 for toilet use, personal hygiene and bathing. On [DATE] at 11:05 a.m., wound care to Resident #1's left heel was observed performed by Registered Nurse (RN) #3. Resident #1 was observed lying in bed on a low air loss mattress. RN #3 performed hand hygiene, donned clean gloves and removed the wound dressing from the residents left heel revealing a dark eschar plate covering the wound. When RN #3 was asked how she would describe the resident's wound on the left heel, RN #3 stated, It's a necrotic cap, unstageable. RN #3 performed hand hygiene, donned clean gloves and continued to perform wound care, cleaned left heel with Dakins Solution, applied gauze 4x4 dressing with [MEDICATION NAME] Solution to eschar plate and covered [MEDICATION NAME] dressing with ABD (Abdominal) Pad and wrapped left heel with kerlix. RN #3 removed dirty gloves and performed hand hygiene. On [DATE] Resident #1's clinical record was reviewed and revealed the following: Review of Admitting Daily Skin Assessment revealed the following: Date: [DATE] 16:05 Signed: [DATE] 23:39 Head To Toe Skin Checks 1. Skin Integrity 1p. Describe new or existing other issues: Open area to left heel. 3. Site: 50) Left heel Type: open area. Review of Weekly Pressure Wound Observation Tools revealed the following: Effective Date: [DATE] 14:37 B. OBSERVATIONS/DATA: 1. Location: Left Heel 4. PRESSURE ULCER STAGE: Original: III Current: III (stage 3) 5. VISIBLE TISSUE:
5c. Granulation tissue present (beefy red) 5i, Describe the extent (%) of necrosis and/or slough in the wound bed: 0. 8. Wound Measurements Length (mm): 24 Width (mm): 25 Depth (mm): 1 9. PERI-WOUND TISSUE: Normal 9b. Describe wound edges and
shape: Well Defined C. TREATMENT: 1. Describe any changes to treatment plan in the last week: Medi-honey 2. Current treatment plan: [REDACTED]. Effective Date: [DATE] 17:43 B. OBSERVATIONS/DATA: 1. Location: Left Heel 4. PRESSURE ULCER
STAGE: Original: II Current: II (stage 2). 5. VISIBLE TISSUE: 5c. Granulation tissue present (beefy red). 8. WOUND MEASUREMENTS: Length (mm): 25 Width (mm): 24 Depth (mm): 1 Effective Date: [DATE] 09:28 B. OBSERVATIONS/DATA: 1. Location:
Left Heel 4. PRESSURE ULCER STAGE: Original: SDTI (suspected deep tissue injury) Current: IV (stage 4). 5. VISIBLE TISSUE: 5a. Overall Impression: d. Worsening. 5i. Describe the extent (%) of necrosis and/or slough in the wound bed: 75. 6. DRAINAGE: 6a. Type: Serosanguinous 6b. Amount: Moderate 8. WOUND MEASUREMENTS: Length (mm): 100 Width (mm): 80 Depth (mm):
0 9. PERI-WOUND TISSUE: 9a. Description of peri-wound tissue: ethic color. 9b. Describe wound edges and shape: Intact approx (Approximately) 50 (Fifty) % (Percent) and rolled 50%. C. TREATMENT: 1. Describe any changes to treatment plan in the last week: The site has been noted since admission and resident continues with treatment per hospice. 2. Current treatment plan: [REDACTED]. EVALUATION: Wound Progress: Noted the site has greatly deteriorated and has a faint odor. Review of Resident #1's Admission MDS assessment with an Assessment Reference Date of [DATE] revealed the following: Section M - Skin Conditions M0150. Risk of Pressure Ulcers-Question asks - Is this resident at risk of developing pressure ulcers? 1. Yes. M0210. Unhealed Pressure Ulcer(s) - Question asks - Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 1. Yes. M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - B. 1. Number of Stage 2 Pressure Ulcers - 3. B. 2. Number of these Stage 2 Pressure Ulcers that were present upon admission/reentry - 3. C. 1. Number of Stage 3 Pressure Ulcers - 0. D. 1. Number of Stage 4 Pressure Ulcers - 0. F. 1. Number of Unstageable Pressure Ulcers due to coverage of wound bed by slough and/or eschar - 0. M1200. Skin and Ulcer Treatments B. Pressure reducing device for bed. C. Turning / repositioning program. E. Pressure Ulcer Care. Review of Braden Scale For Predicting Pressure Sore Risk revealed the following: Date: [DATE] Score: 11.0 Category: HIGH RISK; Date: [DATE] Score: 10.0 Category: HIGH RISK: Date: [DATE] Score: 12.0 Category: HIGH RISK. Review of Weekly Skin Review revealed the following: Date: [DATE] SKIN
CONDITION: 8a. Open Area Site - 53) Sacrum; Other (specify) - skin tears bilateral arms; 49) Right heel. Date: [DATE] SKIN CONDITION: 8a. Open Area 9. Other: Multiple skin tears bilateral upper arm, pressure ulcer left heel, paper thin skin bilateral arms and legs. Date: [DATE] SKIN CONDITION: 8a. Open Area 9. Other: Multiple skin tears bilateral upper arms, pressure ulcer left heel, paper thin skin bilateral arms and legs. Date: [DATE] SKIN CONDITION: 8a. Open Area 9. Other: Multiple skin tears bilateral upper arm, pressure ulcer left heel, paper thin bilateral arms and legs. Date: [DATE] SKIN CONDITION: 8a. Open Area Site - 50) left heel Description: tx (Treatment) in progress. Review of Resident #1's Order Summary Reports, Treatment Administration Records (TAR) and Medication Administration Records (MAR) for Periods [DATE] - [DATE] and [DATE] - [DATE] revealed the following treatment orders for the left heel: Cleanse left heel with wound cleanser and pat dry and apply dry dressing until healed q (every) day shift for measurements and monitoring as needed for wound care. Order Date: [DATE] Start Date: [DATE] D/C (Discontinued) Date: [DATE]. [MEDICATION NAME] Wound/Burn Dressing Gel
(Wound Dressings) Apply to left heel topically every day shift every other day for wound care. Cleanse with wound cleanser, pat dry, skin prep periwound, apply to wound bed, cover with gauze, wrap with kerlix. Order Date: [DATE] Start Date: [DATE] D/C Date: [DATE]. [MEDICATION NAME] Wound/Burn Dressing Gel (Wound Dressings) Apply to left heel topically every day shift every other day for wound care. Cleanse with wound cleanser, pat dry, skin prep periwound, apply to wound bed, cover with gauze, wrap with kerlix. Order Date: [DATE] Start Date: [DATE] D/C Date: [DATE]. Tx (Treatment) - clean left heel, [MEDICATION NAME] gauze, wrap with kerlix every day shift. Order Date: [DATE] Start Date: [DATE] D/C Date: [DATE]. Tx - clean left heel with Dakins 0.25%, [MEDICATION NAME] gauze, wrap with kerlix every day shift for wound to heal. Order Date: [DATE] Start Date: [DATE]. Low Air Loss Mattress every shift for PREVENTATIVE CARE. Order Date: [DATE] Start Date: [DATE].
Review of Order Summary Report for ORDER DATE RANGE: [DATE] - [DATE] did not evidence any wound treatment order for the
left heel prior to [DATE] or treatment to the left heel prior to [DATE]. On [DATE] at 12:45 p.m., a telephone interview was conducted with the Director of Nursing (DON), when asked when Resident #1 was admitted to the facility, the DON stated, [DATE]. When asked if he had an open wound on his left heel on admission, DON stated, Yes. When asked what stage the wound was on the left heel on admission, DON stated, Stage 3. When asked what were the wound measurements on admission, DON stated, 24 mm x 24 mm x 1 mm, tissue was normal, edges were defined. It was open. When asked if the resident had a treatment order for the left heel, DON stated, No, nothing came from the hospital. When asked when was the first treatment ordered for the left heel, DON stated, [DATE], the nurses got the order. When asked if Resident #1 should of had a treatment order prior to [DATE], DON stated, Yes, he should of had a treatment order. When asked why he didn't have a treatment order for the left heel prior to [DATE], DON stated, He was admitted by Hospice. I don't know why they didn't follow up with an order. When asked if the facility staff nurses check and follow up to ensure residents have orders as needed, the DON stated, Yes, but they didn't follow up. DON stated, (Resident name) was seen by the wound nurse on [DATE], that is when he got his order. When asked when Resident #1 should of had a treatment order for the left heel, DON stated, He should of had a treatment order on the date of admission. DON stated, We do not have a Wound Nurse and the Nurses on the units are doing wound care. When asked when Resident #1 was placed on the low air loss mattress, DON stated, [DATE]. When asked what type mattress Resident #1 was on prior to the low air loss mattress, DON stated, (Resident name) had been on a beige box egg crate overlay on the bed. The DON stated that staff are to off load Resident #1's heels with pillows and stated that Resident #1 could not have Prevalon Boots because his skin tears easily and he is a high bleeder. Reviewed left heel Weekly Pressure Wound Observation Tools with Effective Dates of [DATE] 14:37, [DATE] 17:43 and [DATE] 09:28 with the DON. Left heel pressure ulcer wound stages documented as follows: Stage 3 on [DATE], Stage 2 on [DATE] and a Stage 4 on [DATE]. The DON stated that she had wound measurements for the left heel dated [DATE] and the wound was unstageable. The DON stated, (Resident name) was referred to the Wound Doctor on [DATE]. When asked if the Wound Doctor was with (Name) Wound Care, DON stated, Yes. The DON stated that the last wound measurements available were done on [DATE]. A copy of wound measurements for [DATE] was requested from the DON. On [DATE] received and reviewed the Skin Wound Note dated [DATE] 16:22. Review of note revealed the following: Late Entry: Note Text: #1 wound left heel PrU (Pressure Ulcer) - 4.5 x 3 x 0- came
from hospital with ulcer. Unstageable. Tx - clean, [MEDICATION NAME] gauze, wrap with kerlix - QD, PRN. Pt. (Patient) is Hospice. On [DATE] (Name) Wound Care Progress Notes were reviewed and revealed the following: Date of Service: [DATE] Encounter: Initial, Progress: Improving #1 Left Heel Pressure Ulcer Treatment Recommendations: Clean: Dakin's Solution 0.25% (,[DATE] S) Freq(Frequency): Daily (QD) & PRN (As Necessary). Instructions: Clean with Dakins, [MEDICATION NAME] gauze, wrap with kerlix. Pressure Relief/Off Loading: Facility pressure ulcer prevention protocol; Pressure redistribution mattress per facility protocol; Turn and reposition per schedule protocol; Heel offloading per facility protocol; Misc (Miscellaneous) order: Incontinence care prn; Optimize nutrition. Date of Service: [DATE] Encounter: Subsequent, Progress: deteriorating #1 Left Heel Pressure Ulcer Unstageable - L 10 cm x W 8 cm x D 0 cm. Tissue Type: 100% Necrotic. Treatment Recommendations: Clean: Dakin's Solution 0.25% (,[DATE] S) Freq: Daily & PRN. Instructions: Clean with Dakins, [MEDICATION
NAME] gauze, wrap with kerlix. Pressure Relief/Off loading: Facility pressure ulcer prevention protocol; Pressure redistribution mattress per facility protocol; Heel offloading per facility protocol; Misc order: Incontinent care prn; Optimize nutrition. Date of Service: [DATE] Encounter: Subsequent, Progress: deteriorating #1 Left Heel Pressure Ulcer Unstageable L 10 cm x W 8 cm x D 0 cm Odor: Strong Tissue Type: 80% eschar 20% Necrotic Note: Left heel PrU (Pressure Ulcer) was obtained at hospital. Was found on admission to LTC (Long Term Care). Strong odor per DON (Director of Nursing).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT RIVER POINTE LLC	**4142 BONNEY ROAD VIRGINIA BEACH, VA 23452**

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 4) Says smalls like Burnt meat. Treatment Recommendations: Clean: Dakin's Solution 0.25% (,[DATE] S) Freq: Daily & PRN. Instruction: Clean with Dakins, [MEDICATION NAME] gauze, wrap with kerlix. Pressure Relief/Off loading: Facility pressure ulcer prevention protocol; Pressure redistribution mattress per facility protocol; Turn and reposition per schedule protocol; Heel offloading per facility protocol. Misc order: Incontinence care prn; Optimize nutrition. On [DATE] review of Resident #1's comprehensive care plan revealed the following: Focus: Actual alteration in skin integrity (Pressure Ulcer) stage 2 left heel. Date initiated: [DATE] Revision on: [DATE]. Goal: Wound will be free of infection. Date initiated: [DATE] Target Date: [DATE] Interventions/Tasks: Heels off loaded when in bed. Date initiated: [DATE]; Institute Weekly Pressure Ulcer Condition Report (refer to document for size and staging) Date initiated: [DATE]; Provide meals per physician order. Date initiated: [DATE]; Provide medical food supplement per physicians order. Date initiated: [DATE]; RD (Registered Dietician) will monitor and evaluate nutritional intake and condition of wound and make recommendations as indicated. Date initiated: [DATE]. There was no evidence that a pressure ulcer care plan was initiated prior to [DATE]. On [DATE] review of Resident #1's Medication Administration Record [REDACTED]. Cleanse with wound cleanser, pat dry, skin prep periwound, apply to wound bed, cover with gauze, wrap with kerlix. Start Date: [DATE] D/C Date: [DATE]. Review of the Medication Administration Record [REDACTED]. Review of the Treatment Administrative Record revealed that Resident #1 has an order for [REDACTED]. Review of the Treatment Administration Record revealed blank spaces on ,[DATE], ,[DATE], and [DATE]. On [DATE] at approximately 1:00 p.m., an interview was conducted with the DON. Reviewed findings with the DON and when asked what does a blank space on the MAR indicated [REDACTED]. Review of Hospice Visit Note Report on [DATE] revealed the following: Visit Date: [DATE] Heel, LT Unstage Onset Date: [DATE] - Wound Assessed - Yes, Measurements Taken - Yes, Length x Width x Depth (CM) 1.5 x 1.2 x 0.2, Depth Description - Necrotic, Granulation Tissue - None, Shape - Round, Exudate Type - Serous, Exudate Amount - Scant, Odor - None, Epithelization - < (Less Than) 25%, Necrotic Tissue Type - White, Necrotic Tissue Amount - 75 - <100%, Total Necrotic Tissue Slough - 75 - 100%, Total Necrotic Tissue Eschar - 0 - 25%. Wound Care Not Provided: Not Ordered This Visit. On [DATE] at approximately 8:00 a.m., reviewed CNA (Certified Nursing Assistant) Documentation Survey Report for [DATE] and [DATE], Treatment Administration Records for [DATE] and [DATE] and Medication Administration Records for [DATE] and [DATE]. There was no documentation evidencing Resident #1's heels off loaded when in bed. On [DATE] at 10:15 a.m., a telephone interview was conducted with the Director of Nursing and she was made aware of identification of harm due t