STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525662	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MORROW MEMORIAL HOME	**331 S WATER ST SPARTA, WI 54656**

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 observation, interview, and record review, the facility did not ensure that a resident having pressure ulcers received the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing for 1 of 2 residents (R) reviewed for treatment and prevention of pressure ulcers (R2). R2 had a significant change of condition placing R2 at increased risk for pressure injury (PI) development. The facility failed to revise R2's care plan or implement interventions to prevent PI. R2 developed bilateral PI's to the heel and worsened to a Stage 3 PI. R2 did not have a heel lift device in place or heels floated when in bed. There is also documentation that R2 attended a clinic visit for her wounds and a dressing was not in place as ordered at the time of that visit. Evidenced by: The facility policy entitled Nursing Procedures/Skin Care Protocols states in part; Standard Protocol for Skin Care: 1. Skin Inspection and Assessment: a. all residents will be assessed on admission, quarterly and with a change in resident's condition for risk factors. Minimize Skin Exposure and Injuries: h. Use pillows, foam wedges etc., to keep bony prominences (knees, ankles) from contat with one another. According to the National Pressure Ulcer Advisory Panel (NPUAP) standard of practice, .Repositioning for Preventing Heel Pressure Ulcers 1. Ensure that heels are free of the surface of the bed Use heel suspension devices that elevate and offload the heel completely in such a way as to distribute the weight of the leg along the calf . (NPUAP Heel Pressure Ulcers: 2014 International Pressure Ulcer Prevention & Treatment Guidelines, 2014). R2 was admitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. MDS assessments were as follows: - Annual assessment on 12/12/19 indicated R2 was independent with no set up with bed mobility. - A Quarterly assessment on 3/12/20 revealed R2 was at risk for developing pressure injuries, but had no unhealed pressure injuries or other skin or foot problems. - A Significant Change MDS assessment on 4/13/20 indicated R2 was at risk for developing pressure injuries, but had no unhealed pressure injuries or other skin or foot problems. - A Significant Change MDS assessment on 5/7/2020 indicated R2 had two stage two pressure injuries. - Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R2 had one Stage 3 pressure injury (PI) at the time the assessment. R2 also had a BIMS (Brief Interview of Mental Status) score of 9, indicating moderately impaired cognition. It is important to note that R2 was hospitalized with pneumonia on 4/4/2020 and returned to the facility on [DATE]. According to R2's Significant Change MDS assessment on 4/13/20, R2 now required extensive assistance of one staff with bed mobility. It is also important to note that when R2 returned from the hospital with decreased bed mobility and an increased risk for developing pressure injuries, the facility did not implement any new interventions to prevent PIs from developing. R2 did develop PIs on bilateral heels, the right heel worsening to a Stage 3. Interventions to prevent PI to the heels were not put into place until after R2 developed a PI. The weekly skin assessment done on 4/23/2020 indicated at that time, R2 has had no foot problems. A review of the Nurse's Notes indicates the facility discovered R2 had developed bilateral heel blisters on 4/28/2020. Nurse's Notes on 4/28/2020 regarding right heel blister reads, 5cm round, boggy. Red with areas of grey and black, intact. The left heel blister was noted as, 2.5cm round, grey, boggy, intact. On 4/29/2020, R2's Care Plan was updated with the intervention to Provide me with my heel lift cushion in my bed/recliner/chair when my heels may potentially come in contact with any surface. R2's Care Plan also states, Know that I am independent with bed mobility and have decided not to utilize the heel lift, place an air mattress on my bed, utilize a pressure redistribution cushion on any surface I sit on, despite the Significant Change MDS done on 4/13/20 that shows, R2 required extensive assistance of one staff with bed mobility. R2 has utilized an air mattress in bed since prior to 2020. The Care Plan was updated again on 5/10/2020 to add I often decline my heel lift knowing the risks. Offer me pillows as an alternative. Encourage use. There is no evidence in the record to indicate that R2 was educated on the risks and benefits of refusing to use a heel lift or that she was indeed offered to have one in place. On 5/4/2020, R2 had a telehealth visit with provider. Visit notes written by the Nurse Practitioner (NP), read, She is sitting more which has caused bilateral heel pressure sores with skin that is currently intact. Staff have implemented treatment measures with floating her heels and offloading pressure. Nurse's Notes on 5/4/20 note the right heel to have a 4 cm x 5 cm brown dry soft blister and the left heel to have a 2 cm x 2 cm soft blister. Nurse's Notes indicate R2, does now float her heels. On 5/11/2020, Skin Assessment Nurse's Notes describe the right heel as a 4 cm x 4 cm blister and a small open area of 1 cm x 1 cm x 0.1 cm with small serosanguineous drainage. The left heel is described as 08.0 cm x 03 cm and a 0.5 cm round flesh colored bump noted. The note states left heel fluid has reabsorbed and heel is soft in the area around the bump. The Nurse's Notes states, in part . She is to be floating her heels in her chair and in bed with heel lift cushion . Floating heels is important. There is no indication that resident has refused to float heels. On 5/18/2020, there are no measurements on the heels. The right heel is described as black in color with tiny pinpoint area stuck to [MEDICATION NAME] and bed one drop of bright red blood. Left heel has a discolored area that is soft and has no fluid in it. Skin intact . can be OTA (open to air) just keep it floating . She does lay down more in bed and is now using the heel lift cushion in bed as her heels do bother her some. She is frequently repositioned by staff as she doesn't move much on her own anymore. On 5/26/2020, Skin Assessment Nurse's Notes describe R2's left heel as a 5 cm x 5 cm dark brown area dry, 1.5 cm x 1.5 cm thicker dark scab almost black in color, 0.5 cm x 2 cm pink area wet with some serous fluid, tender. R2's left heel is described as dark brown dry thicker skin 1.5 cm x 1.5 cm, OTA. Nurse's Notes state, She does float her heels on the heel lift cushion. On 6/1/2020, R2's Skin Assessment Nurse's Notes state, Right heel as a 3 cm x 3 cm dried skin area that looks like it is peeling off slowly. This is OTA and resident denied any pain here. Left heel has a 2.5 cm x 2 cm dark brown area in the center of the wound bed. This portion is dry. Around this area is a red ring with a 0.5 cm white macerated ring around the entire area. Almost involves the whole heel. The rest of the skin around it is red but not swollen or hot. Area is very wet . provider was notified and request for order change to [MEDICATION NAME] suggested. Left heel tender. Notes indicate, She lays does (sic) in bed on an air mattress in bed and floats her heels on the heel lift cushion. On 6/3/2020, R2 was seen in the general surgery clinic for possible abscess of buttock and wound of right heel. Under physical examination notes from the visit, the provider documents, Right foot heel posterior aspect there is a 4 by 3 cm stable eschar that is present today there is tenderness to palpation. Underlying tissue does not feel boggy. There is no surrounding [DIAGNOSES REDACTED]. There is no discharge . The provider notes in the Assessment and Plan an unstageable pressure injury of right heel and that it is Important to keep pressure off the right posterior heel. Patient should be utilizing offloading . On 6/8/2020, R2 had a follow up visit which consisted partly of debridement of the right heel, along with treatment for [REDACTED]. Assessment and plan from this visit indicate R2 has a Pressure injury of right heel, Stage 3 and orders to monitor for infection, daily dressing changes, continue offloading the right heel, float heels when in bed, and follow up in one week. Skin Assessment Nurse's Notes on this day state, The right heel has a 1.5 cm x 1.4 cm black eschar area noted. Around this area from 2:00 o'clock to 10:00 o'clock is an open ring measuring 0.5 cm wide rim around the eschar. This area is pink and moist. The left heel is noted as healed with dry skin. Notes indicate R2 does lay in bed on an air mattress in bed and floats her heels on the heel lift cushion. On 6/15/2020, the Skin Assessment Nurse's Notes read, Late entry for 6/14/2020 Did assess her skin last pm at 1900 . On her right heel she had a 1 cm round eschar area and a rim of red tissue

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 0.5 cm at the weidest part around the edge of the eschar. Today (wound clinic physician's assistant) did debride it and cleaned it with NS and applied skin prep and [MEDICATION NAME] and covered with a foam patch . She does float her heels on the heel lift cushion. On 6/23/2020, Skin Assessment Nurse's Notes describe the right heel as having A 3 cm by 3 cm open area on the back of the right heel. In the center is a layer of white tissue and is adhered yet. Around the island is pink tissue and it is moist. Surrounding skin intact . lays on ain air mattress at night. She is using the heel lift cushion as well to float heels at night. On 6/26/2020, R2 had follow up visit with general surgery clinic. Provider notes reads Still have concern that she is putting pressure on her heel. It has been ordered that the (sic) float the heels to keep pressure off these areas. Notes under physical examination today read Skin: Right heel wound there is no dressing in place today there is only the patient's sock to protect the wound there is the 2.5 x 3 x 0.2 cm wound with a 70% slough 30% granulation tissue. Slough will be debrided today. Assessment and plan notes for the Pressure injury of right heel, stage three states, Discussed the importance of off-loading the heel, discussed floating the heel. Current treatment and dressing order at the time of this visit when no dressing was in place reads, Cleanse right heel wound w/safeclens or similar and pat dry. Apply [MEDICATION NAME] to wound bed and skin prep to edges. Cover with 10 x 10 [MEDICATION NAME] or similar daily until healed. On 6/29/2020, the Skin Assessment Nurse's Notes indicate R2's right heel has a 3 cm x 3 cm open area yet. Most of this is white fibrous tissue with some black in the center. No mention of heel lift, floating heels, or refusals. On 7/6/2020, R2's clinic visit notes state, Vital to keep pressure offloading the heel. Important to float the heels. Nurse's skin assessment notes on this day describe the right heel as open area 1 cm x 1 cm x <0.1 cm and is pink and healing. Moist. No undermining, tunneling, odor, little pain, and not draining. Edges are defined and attached. Surrounding skin is intact. No mention of heel lift, floating heels, or refusals. On 7/13/2020, R2 was seen in the clinic. Clinic documentation states the right heel has a 1 x 1.2 x 0.2 cm wound with 90% healthy granulation tissue. There is some slough in the superior aspect at the 12 o'clock position that will be debrided today. There is no tunneling or undermining. There is no significant periwound [DIAGNOSES REDACTED]. There is no induration. There is no significant tenderness to palpitation. Skin Assessment Nurse's Notes indicated the treatment was not done tonight, as it was done by the provider in the clinic this afternoon. Will try to get it done later in the week. No mention of heel lift, floating heels, or refusals. On 7/22/2020, Skin Assessment Nurse's Notes read, Did get to see this resident's wounds tonight. The right heel measures 2.2 cm x 2 cm x 0.4 cm wound bed is pink and wet 75% of wound and the other 25% on the upper edge is firmly adhered yellow slough. No undermining or tunneling. Very wet with some yellow to brown drainage. No odor, wound edge is yellow and wet. Surrounding skin intact . She lays in bed on an air mattress. She does float her heels with heel lift cushion. On 7/27/2020, Skin Assessment Nurse's Notes indicate R2's right heel to have a 2 cm x 1.5 cm x 0.2 cm open area with pink wound bed that looks a bit dry. Note states, She sits on a cushion and lays in bed at night and is floating heels and is laying side to side . On 8/3/2020, Skin Assessment Nurse's Notes states the right heel wound measures 1.4 cm x 1.6 cm x 0.2 cm. Wound bed is pink with a small island of firmly adhered slough noted. No undermining, or tunneling is seen. On odor, and there is a small amount of yellow drainage but some of that is probably warm medi honey. It is still tender to touch. Edges are defined and attached. Surrounding skin intact. Little macerated around the edges . She does lay on an air mattress and float her heels on the heel lift cushion. On 8/10/2020, R2 was seen again in the clinic, with clinic visit notes stating, Continue offloading buttock and heel. Measurements of right heel at clinic were 0.9 x 1.2 x 0.1 cm with 100% granulation tissue. There is no tunneling or undermining. No periwound [DIAGNOSES REDACTED], induration, tenderness to palpation, or calor. The wound was cleansed using SAF-Clens and then blotted dry. [MEDICATION NAME] was placed in the base of the wound. Skin prep was placed on the periwound, then a [MEDICATION NAME] 10 x 10 cm dressing was placed, followed by roll gauze to secure the dressing and then a compression stocking and sock were replaced. Skin Assessment Nurse's Notes on this day read, . On her right heel this area appears to have been debrided today too as the drainage on the dressing was light pink in color. Measures 1.4 cm x 1.3 cm x 0.2 cm. Wound bed is pink in color and moist. Cleaned with NS and blotted dry. Applied [MEDICATION NAME] and [MEDICATION NAME] and covered with a foam dressing and kling wrap. This is changed daily . She does float her heels on heel lift cushion in bed. Does not mention use of heel lift in recliner or refusals to use heel lift in recliner. On 8/17/2020, Skin Assessment Nurse's Notes indicate R2's right heel wound is 1 cm x 1 cm and covered with a thin layer of light yellow slough and a scant amount of brown drainage in the old dressing. Note states, She does float her heels on heel lift cushion in bed. On 8/19/2020 at 11:48 AM, Surveyor observed R2 resting in bed. Resident was covered with blanket, but legs and feet did not appear to have anything between mattress and legs - heels did not appear to be floated. At 12:07 PM, Surveyor observed CNA C deliver meal tray to R2's room. CNA C assisted R2 from bed to wheelchair. Surveyor did not observe any heel lift or pillows in place on bed for use in floating heels. R2 was wearing gripper socks and appeared to have dressing under right gripper sock. On 8/19/2020 at 12:15, Surveyor spoke with CNA C regarding interventions used with R2 to reduce pressure. CNA C stated that for R2's heels, she uses a blue cushion when in the chair or in the bed. Surveyor asked if she had it in place this morning. CNA C stated she thought it might have needed washing. Surveyor asked CNA C what is usually done when a resident has a heel lift that is temporarily unavailable, and she stated, We would use a pillow or something until it is back. CNA C stated she thought R2 should have a pillow in bed for her heels since the blue heel lift was not available, but stated there were no pillows or pressure relieving devices in use for R2 while in bed prior to lunch today. Surveyor made another observation of bed and floor and did not note any pillows in the vicinity other than what was used at R2's head. Surveyor asked CNA C how to know what R2's pressure relieving device needs are, and CNA C showed Surveyor the CNA care card, which indicated Provide me with my heel lift cushion in my bed/recliner/chair when my heels may potentially come in contact with any surface. I often decline my heel lift knowing the risks. Offer me pillows as an alternative. Encourage use. Surveyor asked if R2 had heels floated while in bed prior to lunch today, and CNA C stated, No. Surveyor asked if R2 should have had her heels floated while in bed, and CNA C stated, Yes. On 8/19/2020 at 4:12 PM, Surveyor spoke with DON B and NHA A. Surveyor asked DON B what would be a key intervention she would expect to see for a resident with pressure injuries or risk for pressure injuries on the heels. DON B replied, The standard of care is a heel lift cushion. DON B stated that R2 had a heel lift cushion available up until last night as far as she can tell and was not sure if it got sent to laundry overnight. Surveyor asked what would be expected in a situation such as that when the pressure relieving device is unavailable, and DON B stated, Float heels with pillow. Surveyor was unable to locate, nor did the facility provide, any documentation of refusal or education on risks and benefits of refusal to using heel lift in R2's medical record.