STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676309	A. BUILDING _____ B. WING _____	05/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYWOOD CROSSING REHABILITATION & HEALTHCARE CENTE	5020 SPACE CENTER BLVD PASADENA, TX 77505

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for 1 of 5 residents (CR #1) reviewed for quality of care. -The facility failed to transfer CR#1 to the hospital for wound care once informed the Wound MD was unable to enter the facility and after the residents' wound and lab results continued to rapidly deteriorate. -The facility failed to transfer CR#1 to the hospital after three sets of critical labs on three consecutive days indicating the resident had a severe infection resulting [MEDICAL CONDITION], acute [MEDICAL CONDITION]/injury, and death. -The facility failed to properly inform CR#1's RP of the severity of the critical lab results and wound infection. These failures resulted in an immediate jeopardy on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of isolated and severity of actual harm due to the facility requiring more time to monitor the plan of removal for effectiveness. These failures placed residents with critical lab values at risk of inadequate care, wound deterioration, decline in health, or hospitalization . Findings include: Record review of CR#1's face sheet revealed an [AGE] year-old-female admitted on [DATE] with [DIAGNOSES REDACTED]. She was discharged on [DATE] to an acute care hospital. Record review of CR #1's Care plan dated [DATE] read in part, The resident has shearing injury to right buttocks with an increased potential for pressure ulcer/pressure injury development and/or potential for worsening/additional pressure ulcer/pressure injury r/t disease process, Hx of pressure ulcers or pressure injury, Immobility, Incontinent of Bladder, Incontinent of Bowel, Non-compliance with turning/repositioning, Weight loss/weight gain/evidence of inadequate nutrition and/or hydration. The resident will show signs of healing and remain free from infection. The resident will have intact skin, free of redness, blisters or discoloration, administer medications, supplements and/or treatments as ordered. Encourage adequate intake of hydration and nourishment to aid in wound healing. Monitor/document for side effects and effectiveness. Refer to/consult with RD. Conduct a complete head-to-toe skin assessment on a weekly basis. Further record review of CR #1's Care plan dated [DATE] read in part, If new skin breakdown occurs, promptly inform the resident/resident representative, Physician, Director of Nursing, Treatment Nurse and Registered Dietician of any new area of skin breakdown. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Encourage and provide education to the resident/resident representative and staff to keep the bed as flat as possible to reduce shear and avoid positioning resident in a manner that allows additional pressure to affected area. Ensure a pressure reduction cushion is in the resident wheelchair. Further record review of CR #1's Care plan dated [DATE] read in part, Evaluate/record/monitor wound healing with each dressing change. Measure length, width and depth (where possible) at least one time per week. Evaluate and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Request consult with wound care specialist when necessary . Inform MD of efforts and outcomes. Keep skin clean and dry. Provide incontinent care as quickly as possible following episodes of voiding or bowel movement, dry gently and thoroughly after bathing, and/or if perspiration is prevalent ensure prompt changing of clothing/linen. Further record review of CR #1's Care plan dated [DATE] read in part, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated . Record review of CR#1's nursing progress notes dated [DATE] at 07:18am writer Treatment nurse read in part, Sacral excoriation has exacerbated; unstageable wound incorporated into right buttocks blister. Measurement 6.2x5.8x? Depth undeterminable due to 100% non-viable tissue. Minimal/serous drainage, no odor, light [DIAGNOSES REDACTED]. Will consult with NP upon arrival. Site dressed as ordered. Further record of CR#1's nursing progress notes dated [DATE] at 11:23am writer Treatment nurse read in part, Call placed to NP, for MD. Informed her of resident's current wound condition, interstitial fluid in right arm, decreased appetite and lower abdominal pain. Consulting with MD, at this time. Call placed to RP informed her of resident's current condition, same as reported to NP. Consent given for resident to be seen by wound care MD in the a.m.; consent also given for bedside debridement, if necessary. Record review of nursing progress notes dated [DATE] at 6:52 pm, [DATE] at 5:09 pm, [DATE] at 3:57 am revealed, critical labs showed CR#1 had an elevated WBC count, BUN level, and BUN/Creatinine ratio indicating acute [MEDICAL CONDITION]/injury, dehydration, and infection. Record review of CR #1's lab results dated [DATE] revealed, a critical elevated BUN level of 96, an elevated BUN/Creatinine level of 48, and an elevated WBC count of 20.8. Further record review of CR #1's lab results revealed, a decreased [MEDICATION NAME] level of 7.5. Record review of CR #1's lab results dated [DATE] revealed, a critical elevated BUN level of 104, a critical elevated BUN/Creatinine level of 52, and an elevated WBC of 25.6. Further record review of CR #1's labs revealed, a decreased total protein level of 4.6. Record review of CR #1's lab results dated [DATE] revealed, an elevated WBC count of 29.3. Record review of CR #1 lab results dated [DATE] revealed, a critical elevated BUN level of 103, and a critical elevated WBC count of 36.2. Record review of Gamma Healthcare Lab normal reference ranges revealed, a BUN range of ,[DATE]mg/dl, BUN/Creatinine ratio range of ,[DATE] mg/dl, WBC count range of 4XXX,[DATE].0 k/ul, Protein, total range of 6XXX,[DATE].9 g/dl, and a [MEDICATION NAME] range of ,[DATE] mg/dl. Record review of Medscape's BUN interpretation dated [DATE] read in part, Possible critical value: >100 mg/dl indicates seriously impaired renal function. Record review of ABC's of Interpretive Laboratory Data dated 2002 revealed, a BUN/Creatinine ratio of 15 to ,[DATE] indicative of dehydration, a ratio of >,[DATE] indicative of Prerenal/Postrenal azotemia (a condition that that is characterized by abnormally high levels of nitrogen waste products in the blood). Record review of Medscape's Leukocyte Count (WBC) interpretation dated [DATE] read in part, An elevated WBC count is seen in response to infection, stress, [MEDICAL CONDITION] disorders. Record review of Gamma Healthcare Lab [MEDICATION NAME] interpretation read in part, ,[DATE] mg/dl Severe protein depletion, ,[DATE] mg/dl Moderate protein depletion, ,[DATE] mg/dl Mild protein depletion. Record review of ABC's of Interpretive Laboratory Data dated 2002 read in part, The main clinical use of [MEDICATION NAME] levels is for monitoring nutritional status. Record review of ABC's of Interpretive Laboratory Data dated 2002 revealed, causes of decreased total protein levels include; [MEDICAL CONDITION], nephroti[DIAGNOSES REDACTED], malnutrition, malabsorption, chronic debilitating disease. Record review of nursing progress notes dated [DATE] at 7:29 am writer LVN A revealed, a new order from the NP to send CR#1 to the ER due to elevated WBC count of 29.3 Further record review of nursing progress notes dated [DATE] at 8:19 am writer LVN A revealed, the NP called the facility and stated the MD did not want CR #1 to go to the ER since she was just started on IV antibiotics, and to closely monitor and start IV [MEDICATION NAME] for 7 days. A CBC and BMP was ordered. Record review of CR #1's physician orders [REDACTED]. Further record review of CR #1's physician orders [REDACTED]. Further record review of nursing progress notes dated [DATE] at 7:25 am writer Treatment nurse read in part, Wound has changed: appearance is gray/yellow. Moderate/serous drainage, strong odor detected, light [DIAGNOSES REDACTED] noted to peri-wound. Size has increased to 7.2x8.0; unable to determine depth due to 100% non-viable 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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Cleaned and dressed as ordered. Floor nurse made aware; NP has been called about other conditions. Awaiting return call back. Further record review of nursing progress notes dated [DATE] at 7:41 am read in part, Nurse informed about a critical lab for resident, BUN 103, WBC 36.2. Informed on call for MD, new order given for BLOOD CULTURE X1, 0.9NS AT 70ML/HR, REPEAT CBC, BMP 24HRS AFTER LAST DRAW. Further record review of nursing progress notes dated [DATE] at 8:30 am revealed, CR #1 was sent to the ER after a change in condition and after the fourth set of critical lab results showed an elevated WBC count and BUN level. Record review of CR#1's SBAR Communication Form and progress note dated [DATE] writer LVN A revealed, the change in condition, symptoms, or signs included elevated WBC 36.2, Vital Signs Pulse: 115, Mental Status Changes 1d. Decreased consciousness (sleepy, lethargic) was checked. Further record review of CR#1's SBAR Communication Form and progress note dated [DATE] writer LVN A read in part, Nursing Notes (for additional information on the Change in Condition): resident noted decreased consciousness and elevated WBC 36.2, NP notified new order send to hospital, RP notified, arranged transportation . Interview on [DATE] at 9:21 am with LVN A, when asked if CR#1 had wounds that were being treated, she stated she was not working between [DATE] to approximately [DATE], she said when she came back, she had a wound on her sacrum stating she thought it was a St III or IV PU. She said the Treatment nurse was doing daily wound treatments. When asked if the Wound MD assessed and/or was treating the residents wound, she stated the wound MD had not seen the resident. She stated the wound MD was supposed to assess and complete wound debridement on ,[DATE] but he never entered the facility due to COVID exposure at a previous facility. She further stated he could not enter the facility for 14 days per CDC guidelines. Further interview on [DATE] at 9:21 am with LVN A, when asked if another Wound MD was contacted to treat CR#1's sacral wound, she stated, no the resident was not seen by another Wound MD. When asked if she noticed any changes to the residents' behavior or condition, she stated the resident wasn't eating much further stating she also had abnormal lab results. She said the treatment nurse called the MD and RP because the wound was deteriorating. She said the resident was started on [MEDICATION NAME] then [MEDICATION NAME] for a wound and UTI infection. She stated the resident was sent out because her renal function was declining, and she was not eating. Interview on [DATE] at 11:28 am with the Administrator, when the surveyor informed the Administrator there was no documentation in the progress notes showing wound care was completed on CR#1's right buttock blister ,[DATE]-,[DATE]. Then on ,[DATE] the Treatment nurse documented in a progress note a sacral excoriation which exacerbated measuring 6.2 x 5.8. When asked why CR#1 was not transferred out for wound care if the Wound MD could not treat/manage the infected wound when wound care was ordered and consent obtained for debridement? The Administrator stated she was under the impression the NP and MD were doing telemedicine visits and were aware of the residents wound. When asked if the resident had s/s of infection, malnutrition, critical labs, and a declining renal function, should she have been sent out for higher level of care if the facility was unable to manage the wound and infection, she said regardless of COVID if a resident has to be sent out then they would, but she thought the NP and MD knew the severity of the wound. She said the wound MD had a back log and just doesn't come to this facility. She then asked if a debridement would have made a difference. Telephone interview on [DATE] at 1:23 pm with the NP, she stated she did not remember how long the wound was present but stated she would ask how CR#1 was doing for several weeks. She said she knew the resident was battling poor appetite and depression for months stating her weight had stabilized and she was hanging in there and after speaking to the psychiatrist it was recommended to increase the residents [MEDICATION NAME] to better manage her depression. She stated when she spoke to the Treatment nurse, she said the resident had what she described as a blister that ruptured and stated there was no changes. She stated the resident did not like to turn, and was always flat on her back, stating staff would try to turn her and position her on pillows, but she would just turn back onto her back. She said on ,[DATE] the Treatment nurse informed her the wound had deteriorated and spread to her sacrum. She said she came into the facility on Monday after being informed, and she was told the resident was not eating even when the staff tried to feed her. She stated she ordered labs, a Wound MD consult, and consent for bedside debridement if necessary. Further telephone interview on [DATE] at 1:23 pm with the NP, she stated when the labs came back the next day, the resident had elevated WBCs and she still was not feeling great and not eating. She stated the resident also had a UTI and was dehydrated so she ordered IV fluids and [MEDICATION NAME] to treat the UTI and to recheck labs in the morning. She stated when those labs came back, more fluids were ordered because of her elevated BUN and she was still dehydrated, she stated she and the MD discussed transferring the resident but with the COVID risk they felt it was best to keep her at the facility. She further stated LVN A had informed her the resident was doing better and eating, so she felt clinically, the IV antibiotics may be kicking in so she did not think at that time the resident needed to be transferred. She said the Treatment nurse contacted her on ,[DATE] in the morning stating the wound wasn't looking good, so she and the MD decided to repeat labs in the morning and monitor the resident for another 24 hours. Further telephone interview on [DATE] at 1:23 pm with the NP, when asked if the RP was fully aware of the severity of the wound infection and the critical labs, she stated the RP was contacted to let her know they did not want to transfer the resident because of the COVID and she agreed to keep the resident at the facility. She stated the next day she received a call stating the resident had critical labs and her WBC count was in the 30s, so she and the MD had a discussion and they wanted to continue to monitor closely and repeat labs in the morning the following day. She stated the resident was transferred because of an elevated WBC count and change in mental status. When asked if the resident should have been transferred considering the resident had a severe infection, multiple critical labs, lab results showing possible malnutrition, and the wound MD could not treat or debride the infected wound, she stated the resident was in bad shape and at the time, because of the COVID they did the best they could and they kept her at the facility as long as they could given the situation. Telephone interview on [DATE] at 2:04 pm with CR #1's family member, when asked if the facility contacted her and informed her of the severity of the wound infection and critical lab results, she stated the Treatment nurse called her on [DATE] and told her they had found a wound two weeks prior and it was small. She said she was told over the weekend it blew up further stating she was trying to figure out how did it just, blow up. She stated she called them back the next day because she wanted to know why it took two weeks to notify her about the wound stating the Treatment nurse did tell her the wound was infected. She said she was not aware of the size of the wound until the resident went to the hospice center stating the wound was a size of a dinner plate. Further telephone interview on [DATE] at 2:04 pm with CR #1's family member. She stated she was not aware of the severity of the labs, stating she was told the labs came back and with an elevated WBC count and it was probably from the infection. She stated they were more interested in telling her (CR #1) was refusing to eat. Said she did not know about any other critical labs other than the WBC count. She said she was told they would try to get the Wound MD in, but he could not enter due to CDC guidelines. She stated the only time she had a sense of urgency was on Thursday morning when they told her they were going to take her to the hospital. She stated that same day, they called back and then said they weren't going to take her because they were going to see if the antibiotics were going to manage the infection and said she didn't know who made that decision. When asked if she was aware of the severity of the problems with the residents' kidneys, she said she was told she did have some changes to her kidneys. When asked if she spoke to the NP or MD regarding the residents' condition, she stated she spoke to the NP after multiple attempts of trying to contact her, but it was about something else. She said she never spoke to the NP or MD about the wound or infection. She stated she did not know the severity of the WBC count and infection until she looked it up herself. She stated CR#1 expired on ,[DATE] shortly after being placed on hospice. Interview on [DATE] at 8:54 am with the DON and Treatment nurse, when asked once notified the Wound MD was unable to enter the facility, was another Wound MD contacted to determine if he/she could assess and/or treat the resident, the DON stated the Wound MD works in a group and another Wound MD could have come out, but the Medical Director wanted to wait two weeks to see if the wound would heal first before sending someone out to assess and or treat the wound. Further interview on [DATE] at 8:54 am with the DON, when asked if any nursing staff responsible for the care of CR#1 requested the NP and/or MD transfer the resident when they were aware multiple labs results showed her WBC count and renal function were critical and not improving after interventions and her wound was deteriorating quickly, the DON said No, we did call the MD and he said to do this, & this, & this and if it doesn't' work, then we will take the next steps. The DON further stated, she did not ask the MD or NP ask why she was not being sent out. She further stated when the WBC count continued to increase, and the labs were not looking good the resident was sent out. Telephone interview on [DATE] at 9:57 am with the Wound MD, when asked if he ever saw and/or treated CR#1's wounds after an order for [REDACTED].#1 should have been transferred out of the facility for wound care and to manage the infection considering she had a series of critical labs, poor appetite with weight loss, diabetes, and a wound that was deteriorating rapidly, he stated based an educated case, if she was unstable, further stating he did not know what her vital signs were, but if her WBCs were rapidly elevating she would be transferred. He stated usually if a wound was significant and deteriorating quickly, sometimes he would refer for treatment at a higher level of care if there were concerns [MEDICAL CONDITION]. He stated he thinks she was a candidate to transfer earlier

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) because of the critical labs and co-morbid conditions, further stating if the wound was rapidly progressing he would have recommended she be sent out for more acute care. Record review of CR#1's Hospital Surgical Consultation Note dated [DATE] read in part, [AGE] year old lady with a medical history significant for diabetes, hypertension, [MEDICAL CONDITION], gastroparesis, dementia with Lewy bodies, previous [MEDICAL CONDITION], presents to hospital from nursing home for worsening sacral decubitus pressure ulcers. Apparently, there is been deterioration of the sacral decubitus pressure ulcers associated with fouls smell, necrotic tissue, as well as purulent drainage that has progressed and not improved despite medical management. Due to the frank infected nature of the wound, she was brought in here for further evaluation and work-up. Indeed, confirmed a necrotic purulent devitalized wound with foul smell prompting surgical intervention . Further record review of CR#'1s Hospital Surgical Consultation Note dated [DATE] read in part, Musculoskeletal: Necrotic foul-smelling sacral decubitus pressure ulcer measuring at least 15 x 20 cm with purulent discharge and drainage . Assessment: [AGE] year-old lady with: 1. Sacral decubitus pressure ulcer, 2.[MEDICAL CONDITION] 3. Urinary tract infection 4. Acute kidney injury . Record review of CR#1's Hospital Discharge Summary dated [DATE] read in part, Date of discharge [DATE]. Discharge Diagnosis: [REDACTED].Patient seen examined [DATE]. [MEDICATION NAME] in blood along with Proteus and E. Coli and [MEDICATION NAME] in the wound of the sacrum .Worsening leukocytosis noted, continue with current antibiotic regimen. Poor prognosis overall, bedridden status .Patient seen on [DATE] Patient with [MEDICATION NAME] bacteremia, sacral decubitus ulcer status [REDACTED]. Bedridden, not clinically improving. Worsening metabolic acidosis. Lactic acidosis seen today also. [MEDICATION NAME] drip started. [DIAGNOSES REDACTED]: Noted, replace now. Worsening renal function. Poor prognosis, overall not improving. [MEDICAL CONDITION]ly due to DIC [MEDICAL CONDITION]. Detailed in-depth conversation with (family member) today .Family expect patient to not suffer anymore and therefore will be aiming for hospice placement at this time . The facility Administrator, DON, and ADON were notified on [DATE] at 10:12 AM that an IJ situation had been identified due to the above failures. The IJ template was provided. A Plan of Removal was submitted by the Administrator on [DATE]. After several revisions, the final Plan of Removal was accepted on [DATE] at 9:06 AM. The plan of removal included the following: Facility Notified of the Immediate Jeopardy - [DATE] Date Removal Plan Developed - [DATE] Date All Tasks of the Removal Plan initiated - [DATE] Date Removal Plan planned to be fully implemented - [DATE] PLAN FOR REMOVAL OF IMMEDIATE JEOPARDY - [DATE] Task 1 - The facility shall conduct full skin assessments of the entire resident population. Any identified areas of pressure injury are identified and documented appropriately. Date of Task #1 initiated [DATE]. Task #1 completed [DATE]. Task 2 - Facility RN to complete head to toe assessment of all identified residents with Stage III and Stage IV wounds to assure that the resident is not experiencing immediate care needs. Date of Task #2 initiated [DATE]. Task #2 completed [DATE]. Task 3 - Facility RN to complete head to toe assessment of all other residents requiring wound care to assure that the resident is not experiencing immediate care needs. Date of Task #3 initiated [DATE]. Task #3 completed [DATE]. Task 4 - Upon completion of the assessment any identified immediate care needs, including but not limited to new or worsening skin conditions, abnormal lab values, changes in condition, changes in orders shall be presented to the attending physician by the facility RN for further guidance, direction, and orders. Date of Task #4 initiated [DATE]. Task #4 to be completed [DATE]. Task 5 - The facility shall assure that any identified wounds are appropriately documented in the Skin and Wound module by the facility. This module includes a photograph and measurements of the wound that the attending physician or the wound care physician can review remotely and provide further guidance, direction and, orders. Date of Task #5 initiated [DATE]. Task #5 to be completed [DATE]. Task 6 - Upon completion of the assessments any identified care needs, including but not limited to new or worsening skin conditions, abnormal lab values, changes in condition, changes in orders shall be presented to the Resident Representative. Date of Task #6 initiated [DATE]. Task #6 completed [DATE]. Task 7 - Communication to Wound Care physician group regarding onsite visitation during COVID. An alternate physician shall be available to evaluate residents in the event the assigned physician has been exposed to COVID. The facility and physician also have Telemedicine and Skin and Wound module of the electronic health record to communicate. Date of Task #7 initiated [DATE]. Task #7 completed [DATE]. Task 8 - Communication to the attending physicians that the facility shall accommodate the Wound Care physician group regarding onsite visitation during COVID. An alternate physician shall be available to evaluate residents in the event the assigned physician has been exposed to COVID. The facility and physician also have Telemedicine and Skin and Wound module of the electronic health record. Date of Task #8 initiated [DATE]. Task #8 completed [DATE]. Task 9 - Licensed nursing staff shall be immediately inserviced regarding use of clinical judgement regarding concerns to transfer a resident to a higher level of care. Licensed nursing staff shall be trained before returning to work or assuming job responsibilities. Concerns may be presented to a member of nursing management, the facility Administrator, the Corporate Compliance line, and/or one of the facility Medical Directors. This inservice shall begin immediately and continue until all licensed nursing staff have been properly inserviced. Date of Task #9 initiated [DATE]. Task #9 to be completed [DATE]. Task 10 - Wound care nurse RN, WOCN, consultant to review Skin and Wound Module in the electronic medical record compared to Weekly Skin Report for accuracy. Any identified areas of concerns shall be addressed with the Director of Nurses, or Assistant Director of Nurses for further communication to the attending physician and/or wound care physician. Date of Task #10 initiated [DATE]. Task #10 to be completed [DATE]. Task 11 - Licensed nursing staff shall be inserviced the wound care nurse, RN, WCON, regarding identification and treatment to residents with pressure injuries [DATE]. Licensed nursing staff shall be trained before returning to work or assuming job responsibilities. This inservice shall begin immediately and continue until all licensed nursing staff have been properly inserviced. Date of Task #11 to be scheduled. Task 12 - Licensed nursing staff shall be immediately inserviced regarding communicating to the physician, and the family or Resident Representative regarding new or worsening skin conditions, abnormal lab values, changes in condition, and/or changes in orders. This inservice shall begin immediately and continue until all licensed nursing staff have been properly inserviced. Licensed nursing staff shall be trained before returning to work or assuming job responsibilities. Date of Task #12 initiated [DATE]. Task #12 to be completed [DATE]. Task 13 - Licensed nursing staff shall be immediately inserviced regarding the facility policy Pressure Ulcers/Skin Breakdown - Clinical Protocol. This inservice shall begin immediately and continue until all licensed nursing staff have been properly inserviced. Licensed nursing staff shall be trained before returning to work or assuming job responsibilities. Date of Task #13 initiated [DATE]. Task #13 to be completed [DATE]. Task 14 - Certified Medication Aides and Certified Nurse Aides were trained regarding reporting skin observation and reporting skin conditions to the charge nurse immediately. This inservice shall begin immediately and continue until all Certified Medication Aides and Certified Nurse Aides have been properly inserviced. Certified Medication Aides and Certified Nurse Aides shall be trained before returning to work or assuming job responsibilities. Date of Task #14 initiated [DATE]. Task #14 to be completed [DATE]. Task 15 - The Director of Nurses, or designee shall review lab values on a daily basis and will ensure that the attending physician is notified. Date of Task #15 initiated [DATE]. Task #15 to be ongoing. Task 16 - The Director of Nurses, or designee shall complete wound rounds with the Treatment nurse. This shall begin immediately and on a weekly basis. Date of Task #16 initiated [DATE]. Task #16 to be ongoing. The surveyor monitored the POR and included the following: Record review of Task #1 resident full skin assessments dated [DATE] revealed, skin assessments completed on all residents along with documentation of new and/or old PU wounds or skin concerns. Record review of Task #2 head-to-toe assessments dated [DATE] of residents with St III and IV PU revealed, head-to-toe assessments completed by the DON on 11 residents with no immediate needs identified in the residents assessed. Record review of Task #3 head-to-toe assessments of remaining residents requiring wound care dated [DATE] revealed, the remaining residents assessed by the DON did not have any immediate care needs identified. Record review of Task #4 resident RP and physician notification for further guidance for all residents assessed with [REDACTED]. Record review of Task #5, documentation of the Treatment nurses notes for identifiable wounds revealed, wound appropriately documented in the Skin and Wound Module, including pictures and measurements completed on [DATE]. Record review of Task #6, RP notified of resident immediate care needs (new or worsening skin conditions, abnormal lab values, changes in condition, changes in orders) revealed, documentation stating assessments were completed and there were no immediate care needs identified, RP were not notified since there were no immediate needs identified. Record review of Task #7 Communication to Wound Care physician group MD regarding onsite visitation during COVID, and Telemedicine and Skin and Wound module of the EHR for the facility physician revealed, on ,[DATE] the Wound MD, the facility Medial Director and facilities physicians were all notified of onsite visitation during COVID and the need for an alternate physician will be assigned in the event the assigned wound MD is exposed to COVID. Further record review of the communication revealed, all facility physicians notified of Telemedicine and the Skin and Wound module of the EHR to communicate with. Record review of Task #8 Communication to the attending physicians that they shall accommodate the Wound MD group if the assigned MD is unable to visit the facility due to COVID exposure revealed on ,[DATE] the facility Medial Director and attending physicians were all

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) notified of onsite visitation during COVID and an alternate physician will be assigned in the event the assigned wound MD is exposed to COVID. Further record review of the communication revealed, all facility physicians notified of Telemedicine and the Skin and Wound module of the EHR to communicate with. Record review of Task #9 in-service with licensed nursing staff Transfer of a resident to a higher level of care revealed, licensed nurses were in-serviced on [DATE] by the ADON and discussed the use of clinical judgement regarding concerns to transfer residents to a higher lev
F 0686 **Level of harm -** Immediate jeopardy **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, and record review, the facility failed to provide the necessary treatment and services, based on the comprehensive assessment and consistent with professional standards of practice to prevent development and worsening of pressure ulcers to 1 of 5 residents (CR#1) reviewed for pressure ulcers. -The facility failed to ensure CR#1 received appropriate and timely wound care once an unstageable infected sacral wound was identified on [DATE] resulting in [MEDICAL CONDITIONS], and subsequent death. -The facility failed to transfer CR#1 to the hospital for wound care once informed the Wound MD was unable to enter the facility due to COVID exposure and after the residents' wound and lab results continued to rapidly deteriorate. -The Treatment nurse failed to appropriately monitor and document CR#1's wound progression on the weekly Skilled Nurse Assessment, nurses progress notes, and Weekly Pressure Ulcer Reports. -The facility failed to transfer CR#1 to the hospital after three sets of critical labs were received on [DATE], [DATE], and [DATE] indicating the resident had a severe infection resulting [MEDICAL CONDITION], acute [MEDICAL CONDITION]/injury, and death. -The facility failed to properly inform CR#1's RP of the wound onset date and size and the severity of the critical lab results and wound infection. -The facility failed to ensure CNAs and/or Shower techs appropriately documented old and/or new skin changes on the Skin Monitoring: Comprehensive CNA Shower Review sheets. -The Treatment nurse failed to document completion of CR #1's wound care on the TAR on 6 dates between February and [DATE]. These failures resulted in an immediate jeopardy on [DATE]. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of isolated and severity of actual harm due to the facility requiring more time to monitor the plan of removal for effectiveness. These failures placed residents with wounds and/or pressure ulcers at risk of wound deterioration, a decline in health, possible hospitalization , and death. Findings include: Record review of CR#1's face sheet revealed an [AGE] year-old-female admitted on [DATE] with [DIAGNOSES REDACTED]. She discharged on [DATE] to a local hospital. Record review of CR#1's physician orders [REDACTED]. One time a day. Order date [DATE]-D/C Date-[DATE]. Record review of facility's Weekly Non-Pressure Ulcer Report week ending [DATE] revealed, documentation of a new facility acquired right buttock, open blister with an onset date of [DATE] measuring 1.4 x 1.1 X .1, moist, no odor, red wound bed, no slough, peri-wound normal. Record review of CR#1's February 2020 TAR revealed, no documentation showing wound care to the right buttock blister was completed on ,[DATE] and ,[DATE]. Record review of CR#1's nursing progress notes dated [DATE], writer Treatment nurse read in part, .Open blister to right buttock measures 1.0 x 1.0 x .2 (cm); 90% granulating tissue, 10% white non-viable tissue. Moist, no odor, no [DIAGNOSES REDACTED]. No change to treatment. Record review of CR #1's Care plan dated [DATE] read in part, The resident has shearing injury to right buttocks with an increased potential for pressure ulcer/pressure injury development and/or potential for worsening/additional pressure ulcer/pressure injury r/t disease process, Hx of pressure ulcers or pressure injury, Immobility, Incontinent of Bladder, Incontinent of Bowel, Non-compliance with turning/repositioning, Weight loss/weight gain/evidence of inadequate nutrition and/or hydration. The resident will show signs of healing and remain free from infection. The resident will have intact skin, free of redness, blisters or discoloration, administer medications, supplements and/or treatments as ordered. Encourage adequate intake of hydration and nourishment to aid in wound healing. Monitor/document for side effects and effectiveness. Refer to/consult with RD. Conduct a complete head-to-toe skin assessment on a weekly basis. Further record review of CR #1's Care plan dated [DATE] read in part, If new skin breakdown occurs, promptly inform the resident/resident representative, Physician, Director of Nursing, Treatment Nurse and Registered Dietician of any new area of skin breakdown. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Encourage and provide education to the resident/resident representative and staff to keep the bed as flat as possible to reduce shear and avoid positioning resident in a manner that allows additional pressure to affected area. Ensure a pressure reduction cushion is in the resident wheelchair. Further record review of CR #1's Care plan dated [DATE] read in part, Evaluate/record/monitor wound healing with each dressing change. Measure length, width and depth (where possible) at least one time per week. Evaluate and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Request consult with wound care specialist when necessary . Inform MD of efforts and outcomes. Keep skin clean and dry. Provide incontinent care as quickly as possible following episodes of voiding or bowel movement, dry gently and thoroughly after bathing, and/or if perspiration is prevalent ensure prompt changing of clothing/linen. Further record review of CR #1's Care plan dated [DATE] read in part, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated . Record review of CR#1's [DATE] TAR revealed, no documentation showing wound care to the right buttock blister was completed on ,[DATE] and ,[DATE]. Record review of CR#1's nursing progress notes dated [DATE] through [DATE] writer Treatment nurse revealed, no documentation showing progression of the right buttock blister and/or wound care completion. There was no documentation showing development of an excoriation or sacral wound until [DATE]. Record review of CR#1's Skin Monitoring: Comprehensive C.N.A. Shower Review sheets dated [DATE], [DATE], [DATE], [DATE] revealed, no documentation showing any changes new or old to the residents' skin. Further record review of CR#1's Skin Monitoring: Comprehensive C.N.A. Shower Sheet dated [DATE] revealed, an X marked on the groin area of the anatomical figure with Bed sore documented. Further record review of CR#1's Skin Monitoring: Comprehensive C.N.A Shower Review sheets dated [DATE], [DATE], [DATE], [DATE] revealed, documentation of refusal. Interview on [DATE] at 9:06 am with CNA B, when asked if she completed the showers and/or bed baths on CR#1, she stated yes, further stating CR#1's shower days were scheduled on Tuesday, Thursday, and Saturday. When asked if she noticed any changes to CR#1's skin, she stated she always bruised easily, and had skin tears. When asked if she had any wounds, she said she had one on her left arm and it was covered and she had a bed sore on her butt stating it was red. When asked if there was any dressing on the sacral area, she stated no, she said she applied the pink cream on the red area. Further interview on [DATE] at 9:06 am with CNA B, when asked what the facility's policy is if a wound is identified during a shower or bed bath, she stated she we complete the shower sheets and label where the wound is located and what we see and notify the nurse immediately. She stated every resident has a shower sheet completed by the shower tech and/or CNA and it is given to the nurse to review before the end of shift and the nurse must check the sheets. She stated the shower tech must report changes to a resident's skin immediately. When asked if she noticed any changes to CR#1's behavior within the past month, she stated about 7 months ago, the resident was able to move, talk, and about three months ago, the resident was stiff, we had to turn her every two hours and she was total care. She stated the resident's appetite decreased, stating the past couple of months, she had decreased energy and refused to eat everything and refused her baths. Further record review of the facility's Weekly Non-Pressure Ulcer Report weeks ending [DATE], [DATE], [DATE], [DATE] revealed, documentation of the right buttock open blister as improving. Further record review of the facility's Weekly Non-Pressure Ulcer Report week ending [DATE] revealed, documentation of the right buttock open blister as unchanged. Further record review of the facility's Weekly Non-Pressure Ulcer Report week ending [DATE] revealed, documentation of the right buttock blister as deteriorated. Record review of the facility's Weekly Non-Pressure Ulcer Report week ending [DATE] revealed, documentation stating the right buttock open blister changed. Interview on [DATE] at 9:56 am with the DON and Treatment nurse, when asked where wound care was documented, the Treatment nurse stated she documented on the weekly PU reports and if the wound was not a pressure ulcer, it would be documented on the weekly Non-PU report. She further stated she documented daily wound care treatment in the nursing progress notes. When informed on [DATE] there was documentation in the nursing progress note showing wound care was completed on CR#1's right buttock blister, but there was no further documentation in the progress notes showing daily wound treatments were completed or the progression of the blister into a sacral wound/excoriation until [DATE]. The Treatment nurse could not state why wound care to the right buttock blister was not documented in the nurses' progress notes. Interview on [DATE] at 9:56 am with the Treatment nurse, when informed a St II PU is a defined as blister and asked if the right buttock blister should have been documented on the weekly PU report since a blister is a PU, she stated the resident scratched herself. She said because it was a scratch, not a PU, she documented the wound on the Non-PU report further stating, the wound deteriorated so fast over the weekend. She could not state why it was not documented on the Weekly PU report. Record review of Guidelines for Staging of Pressure Ulcers dated [DATE] read in part, Stage II Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed

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	676309	A. BUILDING _____ B. WING _____	05/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYWOOD CROSSING REHABILITATION & HEALTHCARE CENTE	5020 SPACE CENTER BLVD PASADENA, TX 77505

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F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) without slough. May also present as an intact or open/ruptured serum-filled blister . Record review of CR#1's Skilled Nurses Notes dated between [DATE] and [DATE] revealed, documentation showing no new changes to skin was checked in section G. Skin/Wound: 1. Skin Integrity. Further record review of section G. 2. Wound Care revealed, no documentation of treatable wounds, dressing changes per treatment orders, or notable skin changes documented. Interview on [DATE] at 9:21 am with LVN A, when asked who completes the Skilled Nurses Notes, she stated the nurse assigned to the hall completes them daily. When asked if section G. Skin/Wound should be completed by the nurse, she stated any treatments, new wounds would be entered in this section stating, further stating antibiotics and treatment orders would be documented as well. When asked if a resident has an old wound would this be documented, she said the wound nurse documents the measurements in her progress notes, but whatever is on her documentation would then be entered in section G by the nurse. When asked if the Skin/wound section should be left blank if a resident has a wound and/or skin changes, she stated that section should not be left blank. Interview on [DATE] at 9:56 am with the DON and Treatment nurse, when asked who completed the Skilled Nurses Notes and how often was this note completed, the DON stated the nurse on the skilled hall completed them daily. When asked if section G. Skin/Wound should be completed when a resident has a new and/or old wound, she stated most of the time the treatment nurse documents the wound treatment in her progress notes. When asked if there were no changes to an old wound and/or a new wound should section G be completed, the DON stated the nurse would check the appropriate boxes in that section and would document if the wound is new, old, any changes such as the color, odor, and location. When asked if that section should ever be left blank if a resident has a wound, she stated no, it should be completed by the nurse. Record review of CR#1's [DATE] TAR revealed, no documentation showing wound care to the right buttock blister was completed on [DATE] and [DATE]. Further interview on [DATE] at 8:54 am with the Treatment nurse and DON, when asked why there was no documentation showing wound care was completed on the right buttock blister and/or sacral wound on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] she stated, I have no answer as to why it was not documented. She stated the weekend nurse would be responsible for completing wound care on Saturday and Sunday, so she could not answer for those days. The DON stated they currently do not have a weekend treatment nurse stating the nurse on that hall would be responsible for completing the wound care. She stated the position has been opened for six months and it is hard to fill because its PRN and weekend position. Further interview on [DATE] at 9:49 am with the Treatment nurse, she stated there was no documentation on the TAR for [DATE], [DATE], and [DATE] stating when a new order is entered after 9:00 am, the wound treatment completed skips to the next day and will look like the treatment was not completed. After surveyor intervention, she further stated they have since fixed the problem. She could not account for the missing documentation on [DATE], [DATE], and [DATE]. Record review of CR#1's physician orders [REDACTED]. One time a day. Order Date-[DATE]-D/C Date-[DATE]. Record review of CR#1's nursing progress notes dated [DATE] at 07:18am writer Treatment nurse read in part, Sacral excoriation has exacerbated; unstageable wound incorporated into right buttocks blister. Measurement 6.2x5.8x? Depth undeterminable due to 100% non-viable tissue. Minimal/serous drainage, no odor, light [DIAGNOSES REDACTED]. Will consult with NP upon arrival. Site dressed as ordered. Further record of CR#1's nursing progress notes dated [DATE] at 11:23am writer Treatment nurse read in part, Call placed to NP, for MD. Informed her of resident's current wound condition, interstitial fluid in right arm, decreased appetite and lower abdominal pain. Consulting with MD, at this time. Call placed to RP informed her of resident's current condition, same as reported to NP. Consent given for resident to be seen by wound care MD in the a.m.; consent also given for bedside debridement, if necessary. Record review of CR#1's Braden Scale for Predicting Pressure Sore Risk dated [DATE] revealed, a score of 10 indicating high risk for developing a pressure sore. Record review of nursing progress notes dated [DATE] at 6:52 pm, [DATE] at 5:09 pm, [DATE] at 3:57 am revealed, critical labs showing CR#1 had an elevated WBC count, BUN level, and BUN/Creatinine ratio indicating acute [MEDICAL CONDITION]/injury, dehydration, and infection. Record review of nursing progress notes dated [DATE] at 7:29 am writer LVN A revealed, a new order from the NP to send CR#1 to the ER due to elevated WBC count of 29.3. Further record review of nursing progress notes dated [DATE] at 8:19 am writer LVN A revealed, the NP called facility and stated the MD does not want CR #1 to go to the ER since she was just started on IV antibiotics, and to closely monitor and start IV [MEDICATION NAME] for 7 days. A CBC and BMP was ordered. Record review of CR #1's physician orders [REDACTED]. Further record review of CR #1's physician orders [REDACTED]. Record review of the facility's Weekly Pressure Ulcer Log week ending [DATE] revealed CR #1 had a new facility acquired unstageable sacral wound measuring 6.2 x 5.8cm depth undetermined with minimal serous drainage, no odor, 100% slough present, and peri-wound light red. There was no documentation on the weekly pressure ulcer logs showing documentation of a right buttock blister, or an unstageable wound or excoriation prior to [DATE]. Record review of nursing progress notes dated [DATE] at 7:25 am writer Treatment nurse read in part, Wound has changed: appearance is gray/yellow. Moderate/serous drainage, strong odor detected, light [DIAGNOSES REDACTED] noted to peri-wound. Size has increased to 7.2x8.0; unable to determine depth due to 100% non-viable tissue. Cleaned and dressed as ordered. Floor nurse made aware; NP has been called about other conditions. Awaiting return call back. Further record review of nursing progress notes dated [DATE] at 7:41 am read in part, Nurse informed about a critical lab for resident, BUN 103, WBC 36.2. Informed on call for MD, new order given for BLOOD CULTURE X1, 0.9NS AT 70ML/HR, REPEAT CBC, BMP 24HRS AFTER LAST DRAW. Further record review of nursing progress notes dated [DATE] at 8:30 am revealed, CR #1 was sent to the ER after a change in condition and after the fourth set of critical lab results showed an elevated WBC count and BUN level. Record review of CR#1's SBAR Communication Form and progress note dated [DATE] writer LVN A revealed, the change in condition, symptoms, or signs included elevated WBC 36.2, Vital Signs Pulse: 115, Mental Status Changes 1d. Decreased consciousness (sleepy, lethargic) was checked. Further record review of CR#1's SBAR Communication Form and progress noted dated [DATE] writer LVN A read in part, Nursing Notes (for additional information on the Change in Condition): resident noted decreased consciousness and elevated WBC 36.2, NP notified new order send to hospital, RP notified, arranged transportation . Interview on [DATE] at 9:21 am with LVN A, when asked if CR#1 had wounds that were being treated, she stated she was not working between [DATE] to approximately [DATE], she said when she came back, she had a wound on her sacrum stating she thought it was a St III or IV PU. She said the Treatment nurse was doing daily wound treatments. When asked if the Wound MD assessed and/or was treating the residents wound, she stated the wound MD had not seen the resident. She stated the wound MD was supposed to assess and complete wound debridement on ,[DATE] but he never entered the facility due to COVID exposure at a previous facility. She further stated he could not enter the facility for 14 days per CDC guidelines. Further interview on [DATE] at 9:21 am with LVN A, when asked if another Wound MD was contacted to treat CR#1's sacral wound, she stated, no the resident was not seen by another Wound MD. When asked if she noticed any changes to the residents' behavior or condition, she stated the resident wasn't eating much further stating she also had abnormal lab results. She said the treatment nurse called the MD and RP because the wound was deteriorating. She said the resident was started on [MEDICATION NAME] then [MEDICATION NAME] for a wound and UTI infection. She stated the resident was sent out because her renal function was declining, and she was not eating. Interview on [DATE] at 11:28 am with the Administrator, when asked why CR#1 was not transferred out for wound care if the Wound MD could not treat/manage the infected wound when wound care was ordered and consent obtained for debridement, the Administrator stated she was under the impression the NP and MD were doing telemedicine visits and were aware of the residents wound. When asked if the resident had s/s of infection, malnutrition, critical labs, and a declining renal function, should she have been sent out for higher level of care if the facility was unable to manage the wound and infection, she said regardless of COVID if a resident has to be sent out then they would, but she thought the NP and MD knew the severity of the wound. She said the wound MD has a back log and just doesn't come to this facility. She then asked if a debridement would have made a difference. Interview on [DATE] at 12:01 pm with CNA A, when asked what she would do if a resident refused a shower or bed bath, she said she would report to the nurse, so the nurse can go in and try to get the resident to shower. Further stating if the nurse can't get the resident to bed bath or shower, the RP would be notified. She stated she would keep trying if the resident refused on the scheduled day and would try to ask the next day. She said with CR#1 they could not continue to give her a shower she would vomit if they tried to get her up and sit in the chair. They said she was not eating well, and she wanted to stay in the bed. She said it was rough trying to get her to eat, stating she ate approximately ,[DATE]%. She stated the decrease appetite was going on for a while and the CNAs and nurses all said to try to go into the room and feed her because she could not feed herself. She said sometimes she would throw it up and it would not stay. When asked if she noticed any changes to CR#1's skin she said before she was transferred, her she had generalized discoloration. Said she didn't see any wounds, further stating she said she did see a s[REDACTED]e on her buttock and was told to put a topical barrier cream on the wound. Telephone interview on [DATE] at 1:23 pm with the NP, she stated she did not remember how long the wound was present but stated she would ask how CR#1 was doing for several weeks. She stated when she spoke to the Treatment nurse, she said the resident had what she described as a blister that ruptured and stated there was no changes. She stated the

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F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) resident did not like to turn, and was always flat on her back, stating staff would try to turn her and position her on pillows, but she would just turn back onto her back. She said on [DATE], the Treatment nurse informed her the wound had deteriorated and spread to her sacrum. She said she came into the facility on Monday after being informed, and she was told the resident was not eating even when the staff tried to feed her. She stated she ordered labs, a Wound MD consult, and consent for bedside debridement if necessary. Further telephone interview on [DATE] at 1:23 pm with the NP, she stated when the labs came back the next day, the resident had elevated WBCs and she still was not feeling great and not eating. She stated the resident also had a UTI and was dehydrated so she ordered IV fluids and [MEDICATION NAME] to treat the UTI and to recheck labs in the morning. She stated when those labs came back, more fluids were ordered because of her elevated BUN and she was still dehydrated, she stated she and the MD discussed transferring the resident but with the COVID risk they felt it was best to keep her at the facility. She further stated LVN A had informed her the resident was doing better and eating, so she felt clinically, the IV antibiotics may be kicking in so she did not think at that time the resident needed to be transferred. She said the Treatment nurse contacted her on ,[DATE] in the morning stating the wound wasn't looking good, so she and the MD decided to repeat labs in the morning and monitor the resident for another 24 hours. Further telephone interview on [DATE] at 1:23 pm with the NP, when asked if the RP was fully aware of the severity of the wound infection and the critical labs, she stated the RP was contacted to let her know they did not want to transfer the resident because of the COVID and she agreed to keep the resident at the facility. She stated the next day she received a call stating the resident had critical labs and her WBC count was in the 30s, so she and the MD had a discussion and they wanted to continue to monitor closely and repeat labs in the morning the following day. She stated the resident was transferred because of an elevated WBC count and change in mental status. When asked if the resident should have been transferred considering the resident had a severe infection, multiple critical labs, lab results showing possible malnutrition, and the wound MD could not treat or debride the infected wound, she stated the resident was in bad shape and at the time, because of the COVID they did the best they could and they kept her at the facility as long as they could given the situation. Telephone interview on [DATE] at 2:04 pm with CR #1's family member, when asked if the facility contacted her and informed her of the severity of the wound infection and critical lab results, she stated the Treatment nurse called her on [DATE] and told her they had found a wound two weeks prior and it was small. She said she was told over the weekend it blew up further stating she was trying to figure out how did it just, blow up. She stated she called them back the next day because she wanted to know why it took two weeks to notify her about the wound stating the Treatment nurse did tell her the wound was infected. She said she was not aware of the size of the wound until the resident went to the hospice center stating the wound was a size of a dinner plate. When asked if she spoke to the NP or MD regarding the residents' condition, she stated she spoke to the NP after multiple attempts of trying to contact her, but it was about something else. She said she never spoke to the NP or MD about the wound or infection. She stated she did not know the severity of the WBC count and infection until she looked it up herself. She stated CR#1 expired on [DATE] shortly after being placed on hospice. Interview on [DATE] at 8:54 am with the DON and Treatment nurse, when asked, once notified the Wound MD was unable to enter the facility, was another Wound MD contacted to determine if he/she could assess and/or treat the residents wound, the DON stated the Wound MD works in a group and another Wound MD could have come out, but the Medical Director wanted to wait two weeks to see if the wound would heal first before sending someone out to assess and or treat the wound. Further interview on [DATE] at 8:54 am with the DON, when asked if any nursing staff responsible for the care of CR#1 requested the NP and/or MD transfer the resident when they were aware multiple labs results showed her WBC count and renal function were critical and not improving after interventions and her wound was deteriorating quickly, and she was showing s/s of malnutrition, the DON said No, we did call the MD and he said to do this, & this, & this and if it doesn't' work, then we will take the next steps. The DON further stated, she did not ask the MD or NP ask why she was not being sent out. She further stated when the WBC count continued to increase, and the labs were not looking good the resident was sent out. Telephone interview on [DATE] at 9:57 am with the Wound MD, when asked if he ever saw and/or treated CR#1's wounds after an order for [REDACTED].#1 should have been transferred out of the facility for wound care and to manage the infection considering she had a series of critical labs, poor appetite with weight loss, diabetes, and a wound that was deteriorating rapidly, he stated based an educated case, if she was unstable, further stating he did not know what her vital signs were, but if her WBCs were rapidly elevating she would be transferred. He stated usually if a wound is significant and deteriorating quickly, sometimes he would refer for treatment at a higher level of care if there are concerns [MEDICAL CONDITION]. He stated he thinks she was a candidate to transfer earlier because of the critical labs and co-morbid conditions, further stating if the wound was rapidly progressing he would have recommended she be sent out for more acute care. Interview on [DATE] at 2:03 pm with the DON, when asked what the facility policy was if a CNA and/or shower tech identifies a new and/or change to a resident's skin during a bath/shower or ADL care, she stated they are supposed to document what they observe on the shower sheet and report it to the resident's nurse immediately. When asked if the CNA and/or shower tech is supposed to document old wounds on the shower sheet, she stated yes, they should always document the old wound that is present and anything that is observed on the residents' skin so other CNAs or shower techs who shower the same resident will know that it is an existing wound and not a change to the residents skin. Record review of CR#1's Hospital Surgical Consultation Note dated [DATE] read in part, [AGE] year old lady with a medical history significant for diabetes, hypertension, [MEDICAL CONDITION], gastroparesis, dementia with Lewy bodies, previous [MEDICAL CONDITION], presents to hospital from nursing home for worsening sacral decubitus pressure ulcers. Apparently, there is been deterioration of the sacral decubitus pressure ulcers associated with fouls smell, necrotic tissue, as well as purulent drainage that has progressed and not improved despite medical management. Due to the frank infected nature of the wound, she was brought in here for further evaluation and work-up. Indeed, confirmed a necrotic purulent devitalized wound with foul smell prompting surgical intervention . Further record review of CR#'1s Hospital Surgical Consultation Note dated [DATE] read in part, Musculoskeletal: Necrotic foul-smelling sacral decubitus pressure ulcer measuring at least 15 x 20 cm with purulent discharge and drainage . Assessment: [AGE] year-old lady with: 1. Sacral decubitus pressure ulcer, 2.[MEDICAL CONDITION] 3. Urinary tract infection 4. Acute kidney injury . Record review of CR#1's Hospital Discharge Summary dated [DATE] read in part, Date of discharge [DATE]. Discharge Diagnosis: [REDACTED].Patient seen examined [DATE]. [MEDICATION NAME] in blood along with Proteus and E. Coli and [MEDICATION NAME] in the wound of the sacrum .Worsening leukocytosis noted, continue with current antibiotic regimen. Poor prognosis overall, bedridden status .Patient seen on [DATE] Patient with [MEDICATION NAME] bacteremia, sacral decubitus ulcer status [REDACTED]. Bedridden, not clinically improving. Worsening metabolic acidosis. Lactic acidosis seen today also. [MEDICATION NAME] drip started. [DIAGNOSES REDACTED]: Noted, replace now. Worsening renal function. Poor prognosis, overall not improving. [MEDICAL CONDITION]ly due to DIC [MEDICAL CONDITION]. Detailed in-depth conversation with (family member) today .Family expect patient to not suffer anymore and therefore will be aiming for hospice placement at this time . Record review of the facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol revised [DATE] read in part, Assessment and Recognition .2 the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active [DIAGNOSES REDACTED]. During resident visits, the physicians will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. 2. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions .a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. B. Current approaches should