STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and text message documentation the facility failed to provide privacy and confidentiality by sending unencrypted text messages with personal health information for one (Resident #1) of one resident reviewed for privacy of health information. Finding included: Documentation in the admission Medicare 5-day minimum data set assessment dated [DATE] revealed Resident #1 was severely cognitively impaired. Documentation in a 7/20/20 wound care follow-up progress note written by a nurse practitioner revealed Resident #1 had acquired pressure ulcers on her left heel, right heel, right medial foot, right medial ankle, right buttock, and left buttock. A phone interview was conducted on 8/26/20 at 9:57 AM with Nurse #1. Nurse #1 stated that she notified the physician for Resident #1 on 7/20/20 with a phone call that the pressure ulcers on Resident #1 were getting worse. The facility provided screen shots of text message communication dated 7/20/20 at 2:26 PM from the phone of Nurse #1 and the physician for Resident #1 as evidence of the communication regarding the resident's health. Documentation in the text message communication dated 7/20/20 at 2:26 PM revealed Nurse #1 wrote, (Resident #1) wounds are declining. She (now) has DTI (deep tissue injury) to bilateral heels and right buttock. Stage 2 to left buttock. Do you think it would help to do ABI (ankle brachial index) study? The screen shot indicated Nurse #1 subsequently sent another text, (Resident #1) ABI study? The text message response from the physician stated, What ABI study? The text message response from Nurse #1 stated, Should we order one for (Resident #1)? Her wounds are deterioration. DTI bilateral heels, DTI right buttock, Stage 2 left buttock. The test message response from the physician stated, Sure can. Buttocks aren't vascular. And heels usually aren't either. The text message response from Nurse #1 stated, Ok well I won't bother if you think it's not necessary. We are trying to order (an) air mattress for her and will start supplements and vitamins. The wound nurse came today for her weekly assessment. The physician responded in text, Ok. Gotcha. There was no documentation in the electronic medical record for Resident #1 regarding communication Nurse #1 had with the physician on 7/20/20. An additional phone interview was conducted with Nurse #1 and the Director of Nursing on 8/27/20 at 10:03 AM. Nurse #1 indicated on 7/20/20 she had both a verbal conversation on the phone and a text message conversation with the physician for Resident #1. Nurse #1 acknowledged she did not put any documentation in the medical record regarding the telephone conversation or the text message conversation she had with the physician on 7/20/20. Nurse #1 acknowledged that she did routinely send text messages to the physician about residents' medical care. Nurse #1 indicated that she did not have the capability to send encrypted messages to the physician and she indicated she had not received encrypted messages from the physician. The Director of Nursing stated that text messages were the physician's preferred method of communication.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to accurately code the MDS (Minimum Data Set) in the areas of skin conditions and pain for 1 (Resident #1) of 1 resident reviewed for accurate minimum data set assessments. Findings included: Resident #1 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Documentation in an occupational therapy note dated 7/3/20 revealed precautions for the resident were a fall risk, cervical collar on always, spinal cord compression from C3-C5, and extensive pain in bilateral lower extremities. The documentation further stated, (Occupational therapy) assisted (with) repositioning of (lower extremities) in bed and noticed sock was crinkled at the top, so adjusted sock, but realized sock may be causing issues so (occupational therapy) removed (both) socks to allow skin to air out. (Occupational therapy) noticed skin issues (with) (bilateral lower extremities) and notified (Registered Nurse) immediately, notified (Director of Rehabilitation) as well. (Registered Nurse) came to room to check (patient's) skin. Documentation in a nursing progress note dated 7/3/20 stated, Resident has pressure sores to both heels and right inner ankle, and redness to some toes on both feet. Was brought to my attention by physical therapy. Her heels are necrotic with a blister surrounding both areas. With movement there is a lot of pain. Areas wiped with skin prep and cover with foam covering over heels and boots applied, Pain medication was given. Daughter and MD (medical doctor) made aware. Documentation on the physician orders [REDACTED]. Documentation in a physical therapy progress note for Resident #1 dated 7/4/20 revealed, Screams out in pain regardless of pain medication with (bilateral lower extremity) movement, co tx (simultaneous treatment with both therapists) recommended. Wounds to (right) medial ankle and heel significant NO weight bearing of any kind to heel. Nurse #5 was interviewed on 8/25/20 at 2:57 PM. Nurse #5 stated that on 7/5/20 Resident #1 was in a lot of pain and cried out in pain as he moved her. Nurse #5 said he rolled the resident over and saw that she had excoriation on her buttocks but no open skin. Nurse #5 stated that he did not look at the heels of Resident #1 on 7/5/20 because the resident was in so much pain. Nurse #5 stated that the resident had soft boots on her feet on 7/5/20. Documentation on the admission Medicare 5-day MDS dated [DATE] coded Resident #1 as having severely impaired cognition requiring extensive to total assistance with all activities of daily living. The documentation revealed that based on clinical assessment and a formal assessment tool, Resident #1 had no pressure ulcers/injuries but was at risk for pressure ulcers/injury. The documentation coded the resident as receiving scheduled pain medication and as needed pain medication with no pain expressed by the resident upon interview. Resident #1 was assessed as having a range of motion impairment on one side of her upper extremity and no range of motion impairment on her lower extremities. An interview was conducted with the MDS coordinator (Nurse # 8) on 9/2/20 at 1:26 PM. Nurse #8 explained that she did not have a documentation or assessment to confirm the pressure ulcers on the heels and feet of Resident #1 at the time of the MDS assessment on 7/6/20. Nurse #1 explained that the documentation of the pressure sores was too vague and there were no measurements, so she did not put the information on the MDS assessment on 7/6/20. Nurse #8 stated that Resident #1 was on scheduled pain medication and received as need pain medication at the time of the assessment. Nurse #8 stated that she interviewed Resident #1 regarding her pain and the resident stated that she was not in pain. Nurse #8 stated that the scheduled pain medication was managing the pain Resident #1 was experiencing. Nurse #8 revealed she looked at the pain assessment and the daily skilled notes for which Resident #1 was not documented as being in any pain. An interview was conducted with the Director of Nursing (DON) on 9/2/20 at 4:47 PM. The DON indicated that it was her expectation that the MDS nurse look at the documentation in the chart, talk to the staff, and observe the resident before completing the MDS documentation. The DON also indicated that for a resident who was cognitively impaired a facial scale for pain assessment be used as well as documentation review and staff interview to determine how to code an MDS for pain assessment.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, and physician interview the facility failed to implement a comprehensive approach to pressure ulcer care and services for a resident at risk for pressure ulcers for 1 (Resident #1) of 2 residents reviewed for pressure ulcers in the facility. Eight pressure ulcers were identified after admission to the facility. Findings included: Resident #1 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Documentation on an admission daily

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) skin assessment dated [DATE] revealed Resident #1 had a cervical collar, a skin tear to her left forearm, and bruising to her right buttock. Documentation on a Braden Scale for predicting pressure sore risk completed by Nurse #2 and dated 6/29/20 revealed Resident #1 scored a 14 or a moderate risk. Documentation under the sensory perception revealed no impairment, under moisture revealed occasionally moist, under activity revealed bedfast, under mobility revealed very limited, under nutrition revealed adequate, and under friction and shear revealed no apparent problem. Documentation on a physician's progress note dated 6/30/20 revealed Resident #1 was admitted to the facility from the hospital after a fall and was thought to have a C3-C5 compression. (The C3, C4, and C5 vertebrae form the midsection of the cervical spine, near the base of the neck. A cervical vertebrae injury is the most severe of all the spinal cord injuries because the higher up in the spine an injury occurs, the more damage that is caused to the central nervous system.) Documentation on the care plan for Resident #1, initiated on 6/30/30 and dated as last revised on 7/16/20, did not have a focus area for pressure ulcers or wound care. Documentation in an occupational therapy note dated 7/3/20 revealed precautions for the resident were a fall risk, cervical collar on always, spinal cord compression from C3-C5, and extensive pain in bilateral lower extremities. The documentation further stated, (Occupational therapy) assisted (with) repositioning of (lower extremities) in bed and noticed sock was crinkled at the top, so adjusted sock, but realized sock may be causing issues so (occupational therapy) removed (both) socks to allow skin to air out. (Occupational therapy) noticed skin issues (with) (bilateral lower extremities) and notified (Registered Nurse) immediately, notified (Director of Rehabilitation) as well. (Registered Nurse) came to room to check (patient's) skin. The occupational therapist who wrote the 7/3/20 note was not available for interview. Documentation in a nursing progress note dated 7/3/20 stated, Resident has pressure sores to both heels and right inner ankle, and redness to some toes on both feet. Was brought to my attention by physical therapy. Her heels are necrotic with a blister surrounding both areas. With movement there is a lot of pain. Areas wiped with skin prep and cover with foam covering over heels and boots applied, Pain medication was given. Daughter and MD (medical doctor) made aware. Documentation on the physician orders [REDACTED]. Documentation on the July MAR (medication administration record) revealed this order was not documented as completed on 7/5/20, 7/8/20, 7/9/20, 7/15/20, 7/18/20, 7/19/20, and 7/29/20 on the day shift as well as the evening shift on 7/30/20. Documentation in a physical therapy progress note for Resident #1 dated 7/4/20 revealed, Screams out in pain regardless of pain medication with (bilateral lower extremity) movement, co tx (simultaneous treatment with both therapists) recommended. Wounds to (right) medial ankle and heel significant NO weight bearing of any kind to heel. Documentation on a weekly skin assessment completed by Nurse #5 dated 7/5/20 revealed the resident's skin was intact with no open areas at that time. Nurse #5 was interviewed on 8/25/20 at 2:57 PM. Nurse #5 stated that on 7/5/20 Resident #1 was in a lot of pain and cried out in pain as he moved her. Nurse #5 said he rolled the resident over and saw that she had excoriation on her buttocks but no open skin. Nurse #5 stated that he did not look at the heels of Resident #1 on 7/5/20 because the resident was in so much pain. Nurse #5 stated that the resident had soft boots on her feet on 7/5/20. Documentation on the admission Medicare 5-day minimum data set assessment dated [DATE] coded Resident #1 as having severely impaired cognition requiring extensive to total assistance with all activities of daily living. Resident #1 was coded as frequently incontinent of bowel and bladder. The documentation revealed that based on clinical assessment and a formal assessment tool, Resident #1 had no pressure ulcers/injuries but was at risk for pressure ulcers/injury. Resident #1 was coded as having an infection of the foot, skin tears, on a turning and repositioning program, application of ointments/medications, and oxygen therapy. The documentation coded the resident as receiving scheduled pain medication and as needed pain medication with no pain expressed by the resident upon interview. Resident #1 was assessed as having a range of motion impairment on one side of her upper extremity and no range of motion impairment on her lower extremities. Resident #1 was assessed as being 5 foot 4 inches tall and weighed 151 pounds. Documentation on a Braden Scale for predicting pressure sore risk completed by Nurse #5 and dated 7/6/20 revealed Resident #1 scored a 13 or a moderate risk. Documentation under the sensory perception revealed very limited, under moisture revealed occasionally moist, under activity revealed bedfast, under mobility revealed very limited, under nutrition revealed adequate, and under friction & shear revealed potential problem. Documentation in the wound care consultant progress notes by Nurse Practitioner (NP #1) dated 7/6/20 revealed Resident #1 had an initial assessment of wounds and treatment recommendations. Wound #1, a left distal heel deep tissue pressure injury, was 5 cm (centimeters) in length, 5.5 cm in width, and 0 cm in depth. Wound #1 was described as, central heel black, surrounding skin beefy red in color, no swelling. Wound #2, a right distal heel deep tissue pressure injury, was 5 cm in length, 9 cm in width, and 0 cm in depth. Wound #2 was described as, central heel black, surrounding skin red, no [MEDICAL CONDITION]. Wound #3, a right medial foot deep tissue pressure injury, was 1.5 cm in length, 1 cm in width, and 0 cm in depth. Wound #3 was described as bunion area deep red minimal blanching. Wound #4, a right medial ankle, deep tissue injury, was 1.5 cm in length, 1.5 cm in width, and 0 cm in depth. The treatment recommendations for Wounds #1, #2, #3, and #4 were, pressure relieving boots at all times, turn side to side per protocol. Monitor carefully (every) shift. The documentation of the pressure relief/off loading recommendations were to follow the facility pressure ulcer prevention protocol. After the 7/6/20 wound care assessment, there was no documentation of an assessment of the mattress on the bed, no care plan was created, and nutrition and hydration was not assessed other than food preferences without the input of the resident or her family. Documentation in an Admission Nutritional assessment dated [DATE] revealed the Registered Dietitian (RD #1) made the recommendation for Resident #1 to have daily weights taken out of concern for [MEDICAL CONDITION] and diuretic medication as well as Ensure 237 ml (milliliters) to be given twice a day due to low intake. RD #1 was interviewed on 9/2/20 at 2:50 PM. RD #1 stated that when she did the initial assessment on 7/7/20 she was not aware Resident #1 had any wounds. RD #1 stated that she looked at the 6/30/20 admission skin assessment and the Braden scale pressure ulcer risk assessment dated [DATE] which did not reveal evidence of wounds. RD #1 did not know why the nutritional recommendations she made on 7/7/20 were not implemented because she e-mailed her recommendations to all the risk team members. Documentation in the nursing notes for Resident #1 on 7/10/20 revealed, Resident has open area to right buttock, greenish slough is present in wound. Wound bed is well-defined and no signs of infection. Area was cleansed with normal saline and calcium alginate applied and covered with dressing. Documentation in the treatment orders, dated as initiated on 7/11/20 and discontinued on 7/21/20, revealed Resident #1 had an order for [REDACTED].#1 was not documented as receiving this treatment on 7/15/20, 7/19/20, and 7/21/20. Documentation in the treatment orders, dated as initiated on 7/11/20 and discontinued on 7/21/20, revealed Resident #1 had an order for [REDACTED].#1 was not documented as receiving this treatment on 7/15/20, 7/19/20, and 7/21/20. Documentation in the nursing notes on 7/12/20 revealed Nurse #1 obtained treatment orders for Resident #1 for the resident's right buttock. There was no documentation on 7/12/20 indicating Nurse #1 notified the physician for Resident #1 about the open area on the resident's right buttock on 7/12/20. Nurse #1 was interviewed on 8/26/20 at 9:57 AM. Nurse #1 stated that she notified the physician about the open area on the resident's right buttock when she called to verify treatment orders but did not document the notification in the medical record on 7/12/20. Documentation in the physical therapy progress note for Resident #1 dated 7/13/20 revealed, (Patient) needing noting to have more spasms this date through out (upper extremities) (complained of) discomfort with movement. Staff education on positioning completely on side for off loading due to wound on (right) buttock and starting on coccyx. Documentation in the wound care consultant notes by NP #1 for Resident #1 dated 7/13/20 revealed an initial assessment and recommendations for the wound to the right buttock and reassessments of Wounds #1, #2, #3, and #4. Wound #5, a right buttock pressure ulcer, was a Stage 3 upon the initial exam. Wound #5 was 9 cm in length, 6 cm in width, and 0.2 cm in depth. It was described as 80% [MEDICATION NAME] and 20% slough. Treatment recommendations for pressure wounds #1, #2, #3, and #4 were to use pressure relieving boots, monitoring, and turning from side to side. The treatment recommendation for Wound #5 was to cleanse with normal saline, Santyl applied to slough, calcium alginate, dry sterile dressing every day and as needed. The treatment recommendations for pressure relief/off-loading were to follow the facility pressure ulcer prevention protocol and facility pressure redistribution mattress protocol. Documentation on a Braden scale for predicting pressure sore risk completed by Nurse # 2 dated 7/13/20 revealed Resident #1 scored a 15 or at risk. The resident was documented as improving her activity to being chairfast and improving her mobility to being slightly limited. Documentation in a risk meeting note dated 7/15/20 stated Resident #1 had new wounds to her bilateral feet, right buttock, and sacrum. The risk meeting note dated 7/15/20 did not note any additional interventions for the resident's wounds other than an upcoming appointment with a neurologist. There was no documentation of an assessment of the mattress on the bed or the need for a care plan. Interview with the DON on 8/25/20 at 1:30 PM revealed the risk meeting documentation was incorrect in that Resident #1 did not have a sacrum pressure wound at the time of the 7/15/20 risk meeting. The DON explained that the staff members documenting in the risk meeting possibly looked at the wrong resident's documentation or made human error. Documentation in a nutrition meeting note dated 7/16/20 for Resident #1 recommended the addition of Ensure 237 ml

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An initial exam of Wound #6, a left buttock pressure ulcer, measured 7 cm in length, 4 cm in width, and 0.1 cm in depth. Wound #6 was described as friable (crumbly) and bleeds easily. Treatments recommendations for Wounds #1, #3, and #4 were revised to protect the wound with Abdominal pads and Kling, monitor twice a day, pressure relieving boots, and turning from side to side. The treatment recommendation for Wound #2 was to monitor and wear foam boots. The treatment recommendation for Wound #5 was to cleanse with normal saline, santyl applied to slough, calcium alginate, and a dry sterile dressing applied every day and as needed. The Treatment recommendations for Wound #6 were to cleanse with normal saline, calcium alginate applied, and a dry sterile dressing applied every day and as needed. The treatment recommendations for pressure relief/off-loading were to follow the facility pressure ulcer prevention protocol and pressure redistribution mattress per facility protocol. Documentation on a Braden Scale for predicting pressure sore risk completed by Nurse #1 and dated 7/20/20 revealed Resident #1 scored a 13 or a moderate risk. Documentation under the sensory perception revealed very limited, under moisture revealed occasionally moist, under activity revealed bedfast, under mobility revealed slightly limited, under nutrition revealed adequate, and under friction and shear revealed problem. Nurse #1 provided text messages she sent to the physician for Resident #1 on 7/20/20 at 2:26 PM. The text messages revealed the physician was notified of the deterioration of the wounds and recommendations were sought by Nurse #1. An interview was conducted with the charge nurse/MDS nurse (Nurse #1) on 8/26/20 at 9:57 AM. Nurse #1 revealed she had a conversation with the physician on 7/20/20 for Resident #1 regarding recommendations for wound care. Nurse #1 stated that it was discussed that the wounds for Resident #1 were getting worse and if an ABI (a simple test to compare blood pressure in the upper and lower limbs) study was necessary. Nurse #1 stated that the physician had no recommendations at that time. Nurse #1 confirmed the communication with the physician was both verbal and through text messages, but she had neglected to document the communication in the medical record. Documentation on the weekly pressure wound observation tools for Resident #1 dated 7/20/20 had assessments for the right buttock, right distal heel, right medial foot, and right medial ankle. Documentation on all the pressure wound observations tools dated 7/20/20 stated Resident #1 was on a pressure reducing mattress. Documentation on the weekly pressure wound observation tool for Resident #1 dated 7/24/20 had an assessment of the left buttock. Documentation on the pressure wound observation tool dated 7/24/20 stated Resident #1 was on a pressure redistribution mattress. There was no weekly pressure wound observation tool for the left distal heel of Resident #1 for the week of 7/20/20. Documentation on the physician orders [REDACTED]. Documentation on the July TAR revealed the physician orders [REDACTED]. Documentation in the physician's orders [REDACTED]. Documentation on the July TAR for Resident #1 revealed the order for the right buttock was not documented as completed on 7/21/20. Documentation in the treatment orders for Resident #1 revealed a treatment order initiated on 7/21/20 and discontinued on 7/27/20 for the left buttock to be cleansed with normal saline, patted dry, Calcium Alginate applied, and covered with a dry dressing one time daily. Documentation in the July TAR revealed Resident #1 was not documented as receiving a treatment for [REDACTED]. Documentation in a risk meeting note dated 7/21/20 stated Resident #1 had multiple pressure wounds to heels, hip, and bilateral buttocks and the resident was being followed by the wound care consultant. Interventions discussed at the meeting were an upcoming neurology appointment and the registered dietitian would evaluate her weights. There was no documentation of care plan creation, or a reevaluation of the resident's mattress. Interview with the DON on 8/25/20 at 1:30 PM revealed the risk meeting documentation was incorrect in that Resident #1 did not have a hip pressure wound at the time of the 7/21/20 risk meeting. The DON explained that the staff members documenting in the risk meeting possibly looked at the wrong resident's documentation or made human error. Documentation in the physician orders [REDACTED]. An interview with the facility Registered Dietitian (RD #1) on 9/1/20 at 1:57 PM revealed that she attended the weekly risk meeting via the telephone and had not been inside the facility since March. RD #1 revealed she saw in the electronic medical record Resident #1 had an admission weight of 151 pounds. RD #1 stated that the facility was supposed to do daily weights for 3 days and weekly weights for 4 weeks on every new admission. RD #1 stated that she sent numerous emails requesting weights be taken of Resident #1. RD #1 stated that she did not know why she could not get weights for Resident #1 until 7/15/20. RD #1 revealed that she was able to get a nurse to go down to the resident's room and ask her how much she usually weighs and if the weight of 151 pounds was correct. RD #1 stated that she was told by the nursing staff the resident stated that she had never weighed more than 128 pounds. RD #1 stated that on 7/15/20 the facility obtained another weight for Resident #1 of 135 pounds. RD #1 participated in the 7/15/20 risk meeting for Resident #1 and was aware of the wounds the resident had acquired. RD #1 revealed that she e-mailed the entire risk meeting team her recommendations for orders for nutritional supplements for Resident #1 on 7/15/20. RD #1 didn't know why the recommended orders for nutritional supplements for Resident #1 didn't get implemented until the next risk management meeting on 7/21/20. Documentation in a nursing progress note for Resident #1 dated 7/24/20 revealed, At (6:00 AM) this nurse was called to resident room by CNAs (certified nursing assistants). It was brought to the attention that resident had an area on left collar bone. This nurse assessed area and resident had a raised red bruise on left collar bone next to collar brace. (Physician name) was called and notified of this finding and he said to pad the area so that skin will be protected from collar brace. Area was padded and resident is now in the bed resting. Documentation in a wound care consultant note by NP#1 for Resident #1 dated 7/27/20 revealed there was an evaluation of the skin changes, worsening wounds on the buttocks, and a new area on the resident's neck. Wound #7, a left neck pressure wound, was a Stage 2 measuring 4 cm in length, 0.4 cm in width, and 0.1 cm in depth. The wound care orders changed. Wound #1 and #2 were to have skin prep to the area with a bulky dressing every day. Wound #3 and #4 were to be cleansed with normal saline and protected from rubbing on the sheets. Wound #5 was to be cleansed with normal saline, a dry sterile dressing applied every day and as needed. Wound #6 was to be cleansed with normal saline, Santyl applied to slough, and a dry sterile dressing applied every day and as needed. Wound #7 was to be cleansed with normal saline, silvasor gel applied, a dry sterile dressing applied every day and as needed along with protection from the hard collar. The treatment recommendations for pressure relief/off-loading were to follow the facility pressure ulcer prevention protocol and pressure redistribution mattress per facility protocol. Documentation on the weekly pressure wound observation tool for Resident #1 for 7/27/20 had an assessment of the left neck. The weekly pressure wound observation tools for Resident #1 did not have assessments of the right buttock, right distal heel, right medial heel, right medial foot, the left distal heel, or the left buttock for the week of 7/27/20. Documentation in a risk meeting for Resident #1 dated 7/28/20 recommended no additional interventions but noted she had wounds on bilateral lower extremities, bilateral buttock, and the left neck. The risk meeting did not document a discussion of care plan creation or updates, an evaluation of the mattress on the bed and cushion on the chair, or the completion of a pressure sore risk assessment. Documentation on the physician orders [REDACTED]. Documentation on the July and August TAR for Resident #1 revealed the physician's orders [REDACTED]. Documentation on the physician orders [REDACTED]. Documentation on the July and August TAR for Resident #1 revealed the physician's orders [REDACTED]. Documentation on physician orders [REDACTED]. Documentation on the July and August TAR for Resident #1 revealed the physician's orders [REDACTED]. Documentation in the treatment orders for Resident #1 revealed a treatment order initiated on 7/28/20 and discontinued on 8/4/20 for the left buttock to be cleansed with normal saline, patted dry, Santyl applied to slough, and covered with a dry dressing daily. Documentation in the July TAR for Resident #1 revealed the treatment order for the left buttock initiated on 7/28/20 was not documented as completed on 7/29/20 and 7/31/20. Documentation on the physician orders [REDACTED]. Documentation on the July and August TAR for Resident #1 revealed the physician's orders [REDACTED]. Documentation in the treatment orders for Resident #1 revealed an order, dated as initiated on 7/28/20 and discontinued on 8/4/20, for the right buttock to be cleansed with normal saline and a dry sterile dressing applied daily on the day shift. Documentation on the July TAR revealed Resident #1 was not documented as receiving this treatment on the day shift on 7/29/20 and 7/31/20. Documentation in an occupational therapy note for Resident #1 dated 7/30/20 stated in part, (Patient) found to have a new (left) scapular wound and significant odor coming (from) sacral wounds with sacral wound completely necrotic and unstageable at this time. Patient positioned to offset sacrum and left scapula to decrease pressure to allow healing and pillow use to decrease skin contact with bony prominences. Administrator approached for intervention including air mattress with administrator referred us with (Director of Rehabilitation) and (Director of Nursing) to address. Documentation on a weekly pressure wound

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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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) observation tool for the left scapula dated 7/30/20 revealed Resident #1 was on a pressure reducing mattress. An interview was conducted with the rehabilitation manager on 8/20/20 at 11:59 AM. The rehabilitation manager explained that Resident #1 was in the facility for rehabilitation services after a fall at home. The rehabilitation manager further explained that the resident was completely dependent at first and initially therapy revolved around staff education for touch, positioning, temperature sensitivity, and sensitivity to all stimuli. The rehabilitation manager revealed the resident was very prone to skin breakdown. The rehabilitation manager explained that the resident would cry out in pain and fear with all movement and would make spastic movements with any change in position. An additional interview was conducted with the rehabilitation manager on 8/21/20 at 12:28 PM. The rehabilitation manager revealed that an air mattress was obtained for Resident #1 at some point. The rehabilitation manager stated that she thought an air mattress was found in the facility and put on the bed of Resident #1 on the same day it was requested. Documentation in a physician's orders [REDACTED]. Documentation in a follow up note by the nurse practitioner (NP #2) dated 7/31/20 revealed the nurse practitioner expressed a concern for the worsening pressure ulcers on Resident #1. The plan stated in part, Needs optimized nutrition, low air loss mattress and offloading given her poor overall medical condition. Further recommendations following neurosurgery and vascular surgery follow up. Prognosis is poor overall. The wound consultant notes dated 7/27/20 were not available to NP #2 in the electronic medical record when she was reviewing the electronic medical record of Resident #1 on 7/31/20. NP #2, who wrote the 7/31/20 follow up progress note, was interviewed on 8/25/20 at 10:59 AM. NP #2 stated that on 7/31/20 she was at the facility doing a routine 30 day follow up for Resident #1, and she only came to the facility on ce every couple of weeks. NP #2 revealed that, in passing she was notified by a nursing staff member of the multiple pressure wounds on Resident #1 to include wounds on her left and right buttock. NP #2 stated that she looked to see if the wound care consultant was following Resident #1 and if treatment orders were in place. She stated that she did not observe the wounds but reviewed the documentation that was available. Documentation on a weekly pressure wound observation tool dated 8/3/20 for the left scapula revealed Resident #1 was on an air mattress and the wound progress was, worsening. Documentation in a wound care consultant note by NP #1 for Resident #1 dated 8/3/20 revealed NP #1 was asked to evaluate the wounds on her buttocks, heels, and a new blistered area on her left scapula, that came from lying on a gurney for many hours while at a neurology appointment. NP #1 made the recommendation the resident be seen at a wound clinic for suggestions for treatment. Wound #5, the right buttock pressure ulcer, was 8.5 cm in length, 5.5 cm in width, and 0 cm in depth. Wound #6, the left buttock pressure ulcer, was 8.5 cm in length, 5.5 cm in width, and 0.2 cm in depth. Wound #7, the left neck wound, was assessed as healed. Wound #8, a left scapula wound, was a Stage 2 measuring 5 cm in length, 5 cm in width, and 0.1 cm in depth. Documentation on a physician's follow-up progress note dated 8/5/20 revealed the physician thought an evaluation by a wound clinic for Resident #1 at her bedside would be beneficial. The physician noted her prognosis was poor given the rapid decline in her wounds and overall functional status. The wound care consultant notes from NP #1 dated 8/3/20 were not available in the electronic medical record on 8/5/20 for the physician to review. Documentation on physician orders [REDACTED]. Documentation on the August TAR for Resident #1 revealed the physician's orders [REDACTED]. Documentation on the physician orders [REDACTED]. Documentation on the August TAR for Resident #1 revealed Resident #1 was not documented as receiving the treatment for [REDACTED]. Documentation on a physician's orders [REDACTED]. Documentation in the physician orders [REDACTED]. Documentation in the physician orders [REDACTED]. An interview was conducted with the Director of Nursing on 8/24/20 at 3:30 PM. The DON revealed that the documentation for the completion of the treatment orders for the right and left buttock initiated on 8/5/20 were located on the MAR (medication administration record) instead of the TAR. The DON acknowledged that the treatments should be located on the TAR and not the MAR. Documentation in wound care consultant note by NP #1 for Resident #1 dated 8/10/20 revealed NP #1 recommended an evaluation at the local wound clinic for suggestions on treatment of [REDACTED]. NP #1 took wound cultures at the request of the resident's physician during her assessment of the wounds. Wound #6, increased in size to 12.8 cm in length, 8.5 cm in width, and 1 cm in depth but was documented as unchanged. Documentation in nursing notes on 8/10/20 revealed Resident #1 was sent out of the facility for a magnetic resonance imaging but while ret