STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HOUSE OF MARSHALL HEALTH & REHABILITATION	5915 ELYSIAN FIELDS ROAD MARSHALL, TX 75672

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 -** Actual harm **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 observation, interview, and record review, the facility did not ensure all treatment and care was provided to residents, based on the comprehensive assessment of the resident and in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 residents reviewed for quality of care. (Resident #1) The facility did not monitor an open wound on Resident #1's sacral area daily and did not accurately assess the resident's wound. The facility did not prevent the development and worsening of Resident #1's sacral wound. The resident developed an open moisture associated wound on her sacral area that was initially identified as pressure ulcers on 8/31/20. Staff noticed drainage and odor from the wound prior to the resident being discharged to the hospital. The resident had a stage 3 pressure ulcer on her sacral area upon admission to the hospital. This failure could place residents at risk for developing avoidable pressure injuries and the worsening of existing pressure injuries. Findings included: A face sheet dated 9/17/2020 indicated Resident #1 was [AGE] years old, admitted [DATE] with [DIAGNOSES REDACTED]. She was discharged [DATE]. An MDS assessment dated [DATE] indicated Resident #1 had moderate cognitive impairment, was dependent on two staff for bed mobility, transfers, dressing, and was dependent on one staff for toilet use. She was always incontinent of bowel and bladder. She was at risk for developing pressure ulcers and had no identified pressure ulcers present on this assessment. A departmental note dated 8/31/2020 written by LVN B indicated Resident #1 had a new wound identified as a stage 2 pressure ulcer on her coccyx and a stage 1 pressure ulcer on her right upper buttock. The note indicated the wound was staged by the MDS nurse (an RN) and the wound care nurse was made aware and assessed the wound. During an interview on 9/17/2020 at 5:25 p.m., RN G said she observed Resident #1's wounds on 8/31/2020. She said the wound on Resident #1's sacrum was small, and the wound bed had no top skin layer, which was why she staged it as a stage 2 pressure ulcer. She said the wound on Resident #1's buttock was small with intact skin and was red, non-blanchable, which is why she staged it at a stage 1 pressure ulcer. She said she did not document her measurements of the resident's pressure ulcers and that the treatment nurse was responsible for getting the treatment orders. During an interview on 9/18/2020 at 10:20 a.m., the DON said she expected wound measurements to be documented when obtained for new wounds or any reassessed wounds. She said measurements should have been documented on Resident #1's pressure injury when it was discovered on 8/31/2020. A departmental note written by the treatment nurse dated 9/1/2020 indicated Resident #1 had a new order for a wound care physician to evaluate and treat her wounds. The coccyx wound was noted to be pink and moist with over 80% yellow slough and moderate amount of serosanguinous drainage noted. A new treatment was ordered to apply calcium alginate to the wound bed and cover with a dry protective dressing. The right buttock wound was noted to be dry with yellow tissue to the center and was to be treated with zinc ointment daily and as needed after incontinent care. A care plan dated 9/2/2020 indicated Resident #1 had a moisture associated wound to her left upper buttocks and on 9/9/2020 it combined to her sacral wound. A care plan dated 9/2/2020 indicated Resident #1 had a moisture associated wound to her sacrum with interventions including treatment to the area per her physician orders, observe and document any signs of infection, and re-evaluate the wound at least every 2 weeks for appropriateness of treatment orders if no signs of healing was noted. The care plan indicated the resident would be turned and repositioned at least every 2 hours to alleviate pressure, use padding to prevent skin/skin contact, and incontinent care would be provided every 2 hours and as needed. The care plan indicated the resident would be referred to the wound care physician and the dietician. An initial wound evaluation and management summary report dated 9/2/2020 from the wound care physician indicated Resident #1 had a wound to her sacrum that was present over 3 days duration. It showed signs of healing and was 4.5cm x 3.5cm x 0.1 cm. It had light serous drainage with 70% dermis (skin) present (open wound, not intact skin). She had a wound to her left upper buttock that was present over 3 days duration. It showed signs of a healing moisture associated skin damage and was 0.4cm x 0.6cm x 0.1cm with light serous drainage. A wound healing progress report for Resident #1 completed by the treatment nurse indicated on 9/2/2020 her moisture associated wound on her sacrum was identified and measured 4.50cm x 3.50cm. On 9/9/2020, her wound measured 4.0cm x 5.0cm. During an interview on 9/16/2020 at 1:24 p.m., the wound care physician said Resident #1 had a macerated moisture associated wound to her bottom/sacral area. She said when she last observed it on 9/9/20, the wound did not show any signs of infection and she described it as wet skin with rivers or folds in the skin. A departmental note written by the treatment nurse dated 9/3/2020 indicated Resident #1 was seen by the wound care physician and the current treatment to the resident's wounds were discontinued. The note indicated a new treatment for [REDACTED]. Both areas were noted with light serosanguinous drainage with the peri-wound skin intact. Resident #1's sacrum wound was noted with 70% dermis skin and the left upper buttocks was noted with 100% dermis skin. A skin inspection report dated 9/4/20 for Resident #1 indicated on 9/4/2020 her skin was not intact with an existing wound. No other description of the wound was noted. A wound evaluation and management summary report dated 9/9/2020 from the wound care physician indicated Resident #1's wound to her sacrum was present over 10 days duration. It showed signs of healing and was 4.0cm x 5.0cm x 0.1 cm. It had light serosanguinous drainage with 70% dermis present. Her wound to her left upper buttock was combined with her sacrum wound presenting as one wound. A departmental note dated 9/10/2020 indicated Resident #1 was seen by the wound care physician. The note indicated the wound to her left upper buttock combined with the sacral wound to present as one wound. A treatment was ordered to cleanse the wound with wound cleanser, pat dry, and apply a foam silicone border dressing 3 times a week and as needed. The note indicated the moisture associated wound to Resident #1's sacrum had deteriorated in size since last assessment. Physician orders [REDACTED].#1 had an order started 9/11/2020 to cleanse a moisture associated wound on her sacrum with wound cleanser, pat dry, and apply a silicone foam border dressing 3 times a week and as needed. A weekly skin inspection report for Resident #1 dated 9/1/2020-9/17/2020, indicated on 9/4/2020 her skin was not intact with an existing wound. On 9/11/2020 her skin was not intact with an existing wound. No other details were present on the report. The 24-hour reports for 200 hall on 9/11/2020 indicated Resident #1 moved from the 400 hall to the 200 hall. The 24-hour reports for 200 hall from 9/11/2020-9/14/2020 did not indicate Resident #1 had wounds. The treatment records for September 2020 indicated Resident #1 received her ordered treatment of [REDACTED]. A Transfer Summary Report [REDACTED]. The report indicated she was receiving preventative skin care, but the report did not describe the resident's current wound status. During an interview on 9/16/2020 at 2:41 p.m., LVN A said she was the nurse taking care of Resident #1 when the resident was sent to the hospital. She said she sent her to the hospital because of her change of status in respirations and cognition. She said she had not been eating or drinking well. She said she was not aware Resident #1 had wounds. During an interview on 9/16/2020 at 1:30 p.m., the treatment nurse said she performed Resident #1's treatment prior to her being sent to the ER. She said the wound was not open like a pressure ulcer would be. During an interview on 9/17/2020 at 1:59 p.m., CNA E said Resident #1's wound had an odor coming from it. She said the treatment nurse was aware of the odor. She said she assisted the treatment nurse

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) with the wound change on 9/14/2020 and there was drainage on the dressing. She said she was not able to see the wound during the treatment. During an interview on 9/17/2020 at 1:50 p.m., CNA D said she took care of Resident #1 on the day she was transferred to the ER. She said she knew Resident #1 had a small wound on her bottom but had never seen the wound because of it being covered with a dressing. She said they were in-serviced to keep Resident #1 off her back unless she was eating. A hospital record dated 9/15/2020 indicated Resident #1 had a sacral stage 3 pressure ulcer that was present on admission. A wound care consult was ordered. A hospital wound care consult dated 9/16/2020 indicated Resident #1 had a 5 to 6 cm unstageable sacral pressure ulcer with eschar present. A plan was initiated for the consulting physician to be notified when Resident #1 was more stable to undergo surgery for [REDACTED].#1's family member indicated she was transferred to the local ER because of a change in condition. He said the ER staff changed Resident #1's brief within an hour of her arriving to the hospital where they discovered she had a large open wound on her bottom. He said he was not aware of the wound or when it started. He said the hospital was wanting to do surgery on the wound but was not sure if she could survive the surgery. During an interview on 9/16/2020 at 3:28 p.m., the COTA said Resident #1 had a change of condition that started 9/11/2020. She said the treatment nurse had come in on 9/14/2020 and told her she needed to document on the wound, so she could notify the wound doctor of some changes, but she was unsure if she treated the wound. She said she reported to CNAs who were present (but she could not recall who) that the wound was smelling but staff told her they were handling it. During an interview on 9/17/2020 at 10:33 a.m., CNA C said she cared for Resident #1 when she was on 400 hall, and she had not noticed an odor to the wound but had seen the dressing saturated with drainage before. She said the dressing had obvious drainage on it and it was not urine or feces. During an interview on 9/17/2020 at 11:15 a.m., the treatment nurse said she was never notified of Resident #1's wound having any odors. She said the wound had gotten bigger but was not open like a pressure ulcer or showing signs of infection. During an interview on 9/17/2020 at 2:32 p.m., the DON said she expected any changes in wounds to be documented and reported to the resident's physician and responsible party. She said if a resident had an odorous wound it should be documented and followed up on. During an interview on 9/17/2020 at 3:04 p.m., RN F said she was the charge nurse the weekend before Resident #1 was sent out. She said she did not remember Resident #1's wounds being reported to her and did not know Resident #1 had wounds. She said she did not observe Resident #1's skin over the weekend. She said she performs wound care if the nurses ask her to, otherwise the nurses are responsible for performing scheduled wound care. During an interview on 9/17/2020 at 4:24 p.m., CNA D said she provided Resident #1 with a bed bath on 9/14/2020. She said the dressing was intact to Resident #1's sacral region. She said the nurse did tell her they changed the dressing later that day. She said the CNAs were not told if a resident had any wounds. During an interview on 9/17/2020 at 4:30 p.m., LVN A said she was not told Resident #1 had a wound and it was not on the 24-hour report sheet the staff used to communicate needs on. She said she expected to be informed of any resident wounds by the treatment nurse. She said if she would have known about Resident #1's wound, she would have observed the wound and the dressing during her shifts. During an interview on 9/17/2020 at 4:39 p.m., the treatment nurse said she was not responsible for staging pressure injuries (ulcers) because she was an LVN. She said a facility RN staged Resident #1's original pressure ulcer on 8/31/2020. She said the wound care physician saw Resident #1 on 9/2/2020 and changed the wound on her coccyx from a pressure injury to MASD because it was not on a pressure point. She said the staff originally put zinc on it, which was why the wounds were not open or yellow when observed by the wound care physician. She said she documented wound changes on the day of the scheduled skin assessment and not when new areas developed. She said during the second week of September, Resident #1's wounds on her sacral area and buttock came together on the sacrum because of deterioration. She said Resident #1's skin was moist and had small cracks in it from being moist. She said the facility did not initiate a low air loss mattress because the wound was not a pressure wound. She said on 9/14/2020, Resident #1's wound had open cracks in it, but nothing alarmed her, and she did not see any signs of it being a pressure wound. She said if a resident had wounds they were to stay on the 24-hour report and be documented on until it was resolved. During an interview on 9/17/2020 at 5:05 p.m., the DON said she expected documentation on the 24-hour report to be continued for 72 hours for new wounds. She said she expected the direct care staff assigned to the residents to be aware of any wounds and be observant of those issues. She said she expected the treatment nurse to understand the sacrum area was a pressure area. She said the treatment nurse was trained in wound care. She said if an area was identified on the skin inspection report, then an assessment on the visual body map and the wound assessment report should be made on the same day. The DON said she did not see the wound. During an interview on 9/18/2020 at 10:05 a.m., the treatment nurse said she did not go through formal training when she took the treatment nurse position last month. She said she had resources she could refer to if she needs them for wounds. She said the facility would refer a resident to the wound care physician if a wound was believed to be a pressure injury. An undated facility policy titled Charting and Documentation indicated: .1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records .6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment An undated facility policy titled Prevention of Pressure Ulcers/Injuries indicated: .4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries .b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc,); Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e/ Reposition resident as indicated on the care plan . An undated facility policy titled Pressure Ulcers/Injuries Overview indicated: .Pressure ulcer/injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. Pressure ulcer/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue . Eschar is dead or devitalized tissue that is hard or soft in texture; usually black, brown or tan in color; and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist; can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed . Stage 2 pressure ulcer: Partial-thickness skin loss with exposed dermis .granulation tissue, slough and eschar are not present . Stage 2 Pressure Ulcer: full-thickness skin loss- the stage 3 pressure ulcer appears as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or escar may be visible but does not obscure the depth of tissue loss The National Pressure Injury Advisory Panel (NPIAP) accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf on 9/29/2020 indicated: .Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury The NPIAP form titled Pressure Injury Prevention Points accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a._pressure-injury-preventi.pdf on 9/30/20 indicated: .Inspect the skin at least dailyfor signs of pressure injury, especially nonblanchable [DIAGNOSES REDACTED] .
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure treatment was provided, consistent with professional standards of practice, to promote healing and prevent new pressure injuries from developing for 1 of 6 residents reviewed for pressure injuries (ulcers). (Resident #1) The facility did not prevent the development and worsening of an open wound on Resident #1's sacral area. The resident developed an open moisture associated wound on her sacral area that was initially identified as pressure ulcers on 8/31/20. Staff noticed drainage and odor from the wound prior to the resident being discharged to the hospital. The facility was not monitoring the area daily to ensure the prevention of a stage 3 pressure ulcer. The resident had a stage 3 pressure ulcer on her sacral area upon admission to the hospital. The facility did not monitor the resident's sacral wound and did not accurately assess the resident's wound. This failure could place residents at risk for developing avoidable pressure injuries and the worsening of existing pressure injuries. Findings included: A face sheet dated 9/17/2020 indicated Resident #1 was [AGE] years old, admitted [DATE] with [DIAGNOSES

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) REDACTED]. She was discharged [DATE]. An MDS assessment dated [DATE] indicated Resident #1 had moderate cognitive impairment, was dependent on two staff for bed mobility, transfers, dressing, and was dependent on one staff for toilet use. She was always incontinent of bowel and bladder. She was at risk for developing pressure ulcers and had no identified pressure ulcers present on this assessment. A departmental note dated 8/31/2020 written by LVN B indicated Resident #1 had a new wound identified as a stage 2 pressure ulcer on her coccyx and a stage 1 pressure ulcer on her right upper buttock. The note indicated the wound was staged by the MDS nurse (an RN) and the wound care nurse was made aware and assessed the wound. During an interview on 9/17/2020 at 5:25 p.m., RN G said she observed Resident #1's wounds on 8/31/2020. She said the wound on Resident #1's sacrum was small, and the wound bed had no top skin layer, which was why she staged it as a stage 2 pressure ulcer. She said the wound on Resident #1's buttock was small with intact skin and was red, non-blanchable, which is why she staged it at a stage 1 pressure ulcer. She said she did not document her measurements of the resident's pressure ulcers and that the treatment nurse was responsible for getting the treatment orders. During an interview on 9/18/2020 at 10:20 a.m., the DON said she expected wound measurements to be documented when obtained for new wounds or any reassessed wounds. She said measurements should have been documented on Resident #1's pressure injury when it was discovered on 8/31/2020. A departmental note written by the treatment nurse dated 9/1/2020 indicated Resident #1 had a new order for a wound care physician to evaluate and treat her wounds. The coccyx wound was noted to be pink and moist with over 80% yellow slough and moderate amount of serosanguinous drainage noted. A new treatment was ordered to apply calcium alginate to the wound bed and cover with a dry protective dressing. The right buttock wound was noted to be dry with yellow tissue to the center and was to be treated with zinc ointment daily and as needed after incontinent care. A care plan dated 9/2/2020 indicated Resident #1 had a moisture associated wound to her left upper buttocks and on 9/9/2020 it combined to her sacral wound. A care plan dated 9/2/2020 indicated Resident #1 had a moisture associated wound to her sacrum with interventions including treatment to the area per her physician orders, observe and document any signs of infection, and re-evaluate the wound at least every 2 weeks for appropriateness of treatment orders if no signs of healing was noted. The care plan indicated the resident would be turned and repositioned at least every 2 hours to alleviate pressure, use padding to prevent skin/skin contact, and incontinent care would be provided every 2 hours and as needed. The care plan indicated the resident would be referred to the wound care physician and the dietician. An initial wound evaluation and management summary report dated 9/2/2020 from the wound care physician indicated Resident #1 had a wound to her sacrum that was present over 3 days duration. It showed signs of healing and was 4.5cm x 3.5cm x 0.1 cm. It had light serous drainage with 70% dermis (skin) present (open wound, not intact skin). She had a wound to her left upper buttock that was present over 3 days duration. It showed signs of a healing moisture associated skin damage and was 0.4cm x 0.6cm x 0.1cm with light serous drainage. A wound healing progress report for Resident #1 completed by the treatment nurse indicated on 9/2/2020 her moisture associated wound on her sacrum was identified and measured 4.50cm x 3.50cm. On 9/9/2020, her wound measured 4.0cm x 5.0cm. During an interview on 9/16/2020 at 1:24 p.m., the wound care physician said Resident #1 had a macerated moisture associated wound to her bottom/sacral area. She said when she last observed it on 9/9/20, the wound did not show any signs of infection and she described it as wet skin with rivers or folds in the skin. A departmental note written by the treatment nurse dated 9/3/2020 indicated Resident #1 was seen by the wound care physician and the current treatment to the resident's wounds were discontinued. The note indicated a new treatment for [REDACTED]. Both areas were noted with light serosanguinous drainage with the peri-wound skin intact. Resident #1's sacrum wound was noted with 70% dermis skin and the left upper buttocks was noted with 100% dermis skin. A skin inspection report dated 9/4/20 for Resident #1 indicated on 9/4/2020 her skin was not intact with an existing wound. No other description of the wound was noted. A wound evaluation and management summary report dated 9/9/2020 from the wound care physician indicated Resident #1's wound to her sacrum was present over 10 days duration. It showed signs of healing and was 4.0cm x 5.0cm x 0.1 cm. It had light serosanguinous drainage with 70% dermis present. Her wound to her left upper buttock was combined with her sacrum wound presenting as one wound. A departmental note dated 9/10/2020 indicated Resident #1 was seen by the wound care physician. The note indicated the wound to her left upper buttock combined with the sacral wound to present as one wound. A treatment was ordered to cleanse the wound with wound cleanser, pat dry, and apply a foam silicone border dressing 3 times a week and as needed. The note indicated the moisture associated wound to Resident #1's sacrum had deteriorated in size since last assessment. Physician orders [REDACTED].#1 had an order started 9/11/2020 to cleanse a moisture associated wound on her sacrum with wound cleanser, pat dry, and apply a silicone foam border dressing 3 times a week and as needed. A weekly skin inspection report for Resident #1 dated 9/1/2020-9/17/2020, indicated on 9/4/2020 her skin was not intact with an existing wound. On 9/11/2020 her skin was not intact with an existing wound. No other details were present on the report. The 24-hour reports for 200 hall on 9/11/2020 indicated Resident #1 moved from the 400 hall to the 200 hall. The 24-hour reports for 200 hall from 9/11/2020-9/14/2020 did not indicate Resident #1 had wounds. The treatment records for September 2020 indicated Resident #1 received her ordered treatment of [REDACTED]. A Transfer Summary Report [REDACTED]. The report indicated she was receiving preventative skin care, but the report did not describe the resident's current wound status. During an interview on 9/16/2020 at 2:41 p.m., LVN A said she was the nurse taking care of Resident #1 when the resident was sent to the hospital. She said she sent her to the hospital because of her change of status in respirations and cognition. She said she had not been eating or drinking well. She said she was not aware Resident #1 had wounds. During an interview on 9/16/2020 at 1:30 p.m., the treatment nurse said she performed Resident #1's treatment prior to her being sent to the ER. She said the wound was not open like a pressure ulcer would be. During an interview on 9/17/2020 at 1:59 p.m., CNA E said Resident #1's wound had an odor coming from it. She said the treatment nurse was aware of the odor. She said she assisted the treatment nurse with the wound change on 9/14/2020 and there was drainage on the dressing. She said she was not able to see the wound during the treatment. During an interview on 9/17/2020 at 1:50 p.m., CNA D said she took care of Resident #1 on the day she was transferred to the ER. She said she knew Resident #1 had a small wound on her bottom but had never seen the wound because of it being covered with a dressing. She said they were in-serviced to keep Resident #1 off her back unless she was eating. A hospital record dated 9/15/2020 indicated Resident #1 had a sacral stage 3 pressure ulcer that was present on admission. A wound care consult was ordered. A hospital wound care consult dated 9/16/2020 indicated Resident #1 had a 5 to 6 cm unstageable sacral pressure ulcer with eschar present. A plan was initiated for the consulting physician to be notified when Resident #1 was more stable to undergo surgery for [REDACTED].#1's family member indicated she was transferred to the local ER because of a change in condition. He said the ER staff changed Resident #1's brief within an hour of her arriving to the hospital where they discovered she had a large open wound on her bottom. He said he was not aware of the wound or when it started. He said the hospital was wanting to do surgery on the wound but was not sure if she could survive the surgery. During an interview on 9/16/2020 at 3:28 p.m., the COTA said Resident #1 had a change of condition that started 9/11/2020. She said the treatment nurse had come in on 9/14/2020 and told her she needed to document on the wound, so she could notify the wound doctor of some changes, but she was unsure if she treated the wound. She said she reported to CNAs who were present (but she could not recall who) that the wound was smelling but staff told her they were handling it. During an interview on 9/17/2020 at 10:33 a.m., CNA C said she cared for Resident #1 when she was on 400 hall, and she had not noticed an odor to the wound but had seen the dressing saturated with drainage before. She said the dressing had obvious drainage on it and it was not urine or feces. During an interview on 9/17/2020 at 11:15 a.m., the treatment nurse said she was never notified of Resident #1's wound having any odors. She said the wound had gotten bigger but was not open like a pressure ulcer or showing signs of infection. During an interview on 9/17/2020 at 2:32 p.m., the DON said she expected any changes in wounds to be documented and reported to the resident's physician and responsible party. She said if a resident had an odorous wound it should be documented and followed up on. During an interview on 9/17/2020 at 3:04 p.m., RN F said she was the charge nurse the weekend before Resident #1 was sent out. She said she did not remember Resident #1's wounds being reported to her and did not know Resident #1 had wounds. She said she did not observe Resident #1's skin over the weekend. She said she performs wound care if the nurses ask her to, otherwise the nurses are responsible for performing scheduled wound care. During an interview on 9/17/2020 at 4:24 p.m., CNA D said she provided Resident #1 with a bed bath on 9/14/2020. She said the dressing was intact to Resident #1's sacral region. She said the nurse did tell her they changed the dressing later that day. She said the CNAs were not told if a resident had any wounds. During an interview on 9/17/2020 at 4:30 p.m., LVN A said she was not told Resident #1 had a wound and it was not on the 24-hour report sheet the staff used to communicate needs on. She said she expected to be informed of any resident wounds by the treatment nurse. She said if she would have known about Resident #1's wound, she would have observed the wound and the dressing during her shifts. During an interview on 9/17/2020 at 4:39 p.m., the treatment nurse said she was not responsible for staging pressure injuries (ulcers) because she was an LVN. She said a facility RN staged Resident #1's

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	676187	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HOUSE OF MARSHALL HEALTH & REHABILITATION	**5915 ELYSIAN FIELDS ROAD MARSHALL, TX 75672**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) original pressure ulcer on 8/31/2020. She said the wound care physician saw Resident #1 on 9/2/2020 and changed the wound on her coccyx from a pressure injury to MASD because it was not on a pressure point. She said the staff originally put zinc on it, which was why the wounds were not open or yellow when observed by the wound care physician. She said she documented wound changes on the day of the scheduled skin assessment and not when new areas developed. She said during the second week of September, Resident #1's wounds on her sacral area and buttock came together on the sacrum because of deterioration. She said Resident #1's skin was moist and had small cracks in it from being moist. She said the facility did not initiate a low air loss mattress because the wound was not a pressure wound. She said on 9/14/2020, Resident #1's wound had open cracks in it, but nothing alarmed her, and she did not see any signs of it being a pressure wound. She said if a resident had wounds they were to stay on the 24-hour report and be documented on until it was resolved. During an interview on 9/17/2020 at 5:05 p.m., the DON said she expected documentation on the 24-hour report to be continued for 72 hours for new wounds. She said she expected the direct care staff assigned to the residents to be aware of any wounds and be observant of those issues. She said she expected the treatment nurse to understand the sacrum area was a pressure area. She said the treatment nurse was trained in wound care. She said if an area was identified on the skin inspection report, then an assessment on the visual body map and the wound assessment report should be made on the same day. The DON said she did not see the wound. During an interview on 9/18/2020 at 10:05 a.m., the treatment nurse said she did not go through formal training when she took the treatment nurse position last month. She said she had resources she could refer to if she needs them for wounds. She said the facility would refer a resident to the wound care physician if a wound was believed to be a pressure injury. An undated facility policy titled Charting and Documentation indicated: .1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records .6. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment An undated facility policy titled Prevention of Pressure Ulcers/Injuries indicated: .4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries .b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc,); Wash the skin after any episodes of incontinence, using pH balanced skin cleanser; d. Moisturize dry skin daily; and e/ Reposition resident as indicated on the care plan . An undated facility policy titled Pressure Ulcers/Injuries Overview indicated: .Pressure ulcer/injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. Pressure ulcer/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue . Eschar is dead or devitalized tissue that is hard or soft in texture; usually black, brown or tan in color; and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist; can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed . Stage 2 pressure ulcer: Partial-thickness skin loss with exposed dermis .granulation tissue, slough and eschar are not present . Stage 2 Pressure Ulcer: full-thickness skin loss- the stage 3 pressure ulcer appears as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or escar may be visible but does not obscure the depth of tissue loss The National Pressure Injury Advisory Panel (NPIAP) accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf on 9/29/2020 indicated: .Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury The NPIAP form titled Pressure Injury Prevention Points accessed at https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a._pressure-injury-preventi.pdf on 9/30/20 indicated: .Inspect the skin at least dailyfor signs of pressure injury, especially nonblanchable [DIAGNOSES REDACTED] .