STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375463	A. BUILDING _____ B. WING _____	10/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PAULS VALLEY CARE CENTER	1413 SOUTH CHICKASAW PAULS VALLEY, OK 73075

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	**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, it was determined the facility failed to ensure treatment and services necessary to prevent infection and/or prevent new pressure ulcers were provided for one (#4) of three residents reviewed for pressure ulcers. Findings: A facility policy titled Wound Care, documented the purpose of the policy was to provide guidelines for the care of wounds to promote healing. The policy documented nursing was to verify a physician's orders [REDACTED]. The policy documented the facility was to review the resident's care plan to assess for any special needs of the resident. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An annual assessment, dated 11/15/19, documented the resident had cognitive impairment. The assessment documented the resident required extensive to total assistance with activities of daily living (ADL). The assessment documented the resident had no pressure areas. A Braden Scale for predicting pressure sore risk, dated 05/25/20, indicated the resident was at high risk for pressure sores. On 06/26/20, the resident was admitted to hospices services for [DIAGNOSES REDACTED]. The initial plan of care did not list any areas of altered skin integrity. A quarterly assessment, dated 08/17/20, documented the resident had cognitive impairment. The assessment documented the resident required extensive to total assistance with ADL. A nurses progress note, dated 08/19/20, documented the resident had a reddened area to left hip, no open area. A nurses progress note, dated 08/26/20, documented a new physician's orders [REDACTED]. The wound measured 3 x 2.2 [MEDICAL CONDITION] cm. The note documented the wound would be dressed as ordered. A physician's orders [REDACTED]. Order end date 9/28/20. A physician's orders [REDACTED]. Order end date 9/30/20. A nurse's progress note, dated 09/30/20, documented the resident was seen by the wound care physician via telemedicine. The note documented the wounds to bilateral hips were evaluated. The note documented the right hip wound measured 7.5 x 7.0 x 0, moderate serous drainage, 90% eschar, 10% necrotic tissue. The note documented the wound to left hip measured 8 x 7 x 0.1 with moderate serous drainage, 80% eschar and 20% necrotic tissue. The note documented new orders were obtained for wound care to both pressure areas. A physician's orders [REDACTED]. A physician's orders [REDACTED]. On 10/06/20, a nurse's progress note documented a telemedicine visit with wound care physician. The note documented the right hip wound measured 7.5 x 7 x 0.3 with [DIAGNOSES REDACTED] to periwound, heavy serous drainage and odor. The note documented left hip wound measured 7.25 x 7.75 x 0.1 with heavy serous drainage. The note documented physician recommended turning side to side and front to back in bed every one to two hours if able, and to off load wound. A wound care telemedicine follow up evaluation, dated 10/06/20, documented wound measurements to right hip as 7.5 x 7 x 0.3cm with 90% eschar and 10% necrotic tissue, no change in progress. The evaluation documented the measurements to the left hip as 7.25 x 7.75 x 0.1cm with 80% eschar and 20% necrotic tissue, no change in progress. A physician's orders [REDACTED]. A physician's orders [REDACTED]. On 10/12/20, a nurse's progress note documented the wound care physician evaluated and debrided bilateral hip wounds. The note documented the wounds had deteriorated. A wound evaluation and management summary, dated 10/12/20, documented the right hip had 90% eschar, and 10% necrotic tissue. The summary documented the wound was in an [MEDICAL CONDITION] stage, unable to progress to a healing phase because of the presence of biofilm. The summary documented the left hip had 80% eschar, and 20% necrotic tissue. The summary documented addition of hypochlorite gel ([MEDICATION NAME]) daily to both wounds. The addition of the [MEDICATION NAME] was not found in the current physician's orders [REDACTED]. The wound care treatment record contained one blank for wound care to left hip and one blank for skin check for September, 2020. The wound care treatment record contained one blank for wound care to right hip for October, 2020. The resident's care plan contained no updated interventions to address active wounds or wound care. On 10/14/20 at 10:00 a.m., resident #4 was observed to be lying in bed on his back, slightly positioned to the left side. The resident was observed to have both knees drawn upward toward torso. Foul odor was noted in resident room. At 12:58 p.m., the resident was observed to be in bed on his back, slightly positioned to the left side with both knees drawn upward toward his torso. At 1:05 p.m., CNA #1 and CNA #2 were observed repositioning the resident to his right side. CNA #1 reported the resident was repositioned every two hours. Dressings to bilateral hips were observed and dated 10/14/20. At 2:55 p.m., the resident was observed lying on his back, slightly positioned to the right side. At 3:00 p.m., RN (registered nurse) #1, who was working as the charge nurse, was asked about frequency of repositioning. The RN reported the resident should be turned and repositioned at least every two hours but felt it should be done more frequently due to status of wounds. On 10/15/20, at 11:05 a.m., the hospice nurse reported both wounds had occurred within a week. The nurse reported their agency had increased the skilled nurse visits from two times a week to five times a week. The nurse reported their agency had increased the resident's bathing from three times weekly to five times weekly approximately one month ago to help keep an eye on the resident. On 10/15/20, at 11:30 a.m., LPN #2 reported the facility had been short staffed and the resident had not been turned every two hours. The LPN reported she had notified the previous DON (Director of Nursing) and the previous ADM. The LPN reported the wound care physician had been in the facility on 10/12/20 to debride both wounds. The LPN reported the dressings that were removed prior to debridement had excessive brown exudate. The LPN reported the resident should be turned at least every two hours. On 10/15/20 at 1:30 p.m., the ADM (administrator) and RC (regional consultant) reported the facility had experienced previous staffing problems. The RC reported staffing and education were a priority for the facility. The RC reported she and the ADM had addressed staffing and quality of care in QA (quality assurance) meetings.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, it was determined the facility failed to implement their infection control program to prevent the potential spreading of Covid-19 infection for all staff and residents. Findings: The facility identified a census of 26 residents. On 10/14/20 at 10:00 a.m., multiple residents were observed in the common area. None of the residents were observed to be wearing face masks. The residents were congregated in a small space in close proximity to one another. At 10:50 a.m., the administrator (ADM) reported the facility had no positive Covid-19 cases in residents or staff. The ADM reported testing had been performed weekly. The facility administrator (ADM) reported the Infection Preventionist (IP) was not in the facility. The ADM reported outside visits with residents and family had been allowed with residents and family masked and social distance required. After the noon meal, staff was observed taking several residents from dining room to the common area. None of the residents were observed to be wearing face masks. The residents were observed to be in close proximity to one another. On 10/15/20 at 8:55 a.m., four residents were observed in common area in close proximity to one another. None of the residents were observed to be wearing face masks. One resident was observed to be ambulating in common area, leaning down to speak to the other residents. The ADM and regional consultant reported the facility had been following guidelines of the critical element pathway that defined guidelines. The ADM and regional consultant reported the residents should have been wearing masks when not in their rooms.

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.