STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525556	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKSIDE CARE CENTER	**3506 WASHINGTON RD KENOSHA, WI 53144**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0686

Level of harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, record review, and interview, the facility did not thoroughly assess and provide services consistent with professional standards of practice for pressure injuries for 2 (R116 and R25) of 3 residents reviewed with pressure injuries. * R116 was admitted to the facility with a Stage 2 pressure injury that developed into an unstageable pressure injury with slough. Documentation was conflicting as to the Stage of the wound and the description of the wound base. * R25 had mutiple pressure injuries/skin conditions. The facility did not accurately monitor and document the status of pressure injuries. The facility's assessments were not always completed weekly, there was inconsistent identification of the wounds and their locations. The location of the wounds were identified in different anatomical locations and it was unclear if areas mentioned in the medical were new wounds or if staff was referencing the same wounds using different identified locations such as; coccyx versus inner buttock versus left buttock, left heel having 2 DTIs, and the right heel having a DTI and a Stage 1. In addition, Surveyor noted the facility did not always contact the physician for treatment orders, nor did the Treatment Administration Record (TAR) reflect treatments as being done. The MD was not always contacted when pressure injuries/wounds worsened such as when the right outer heel stage 1 increased in size on 12/30/19. Findings include: The facility policy and procedure entitled Skin Care Management and Pressure Injury dated 12/21/2016 states: POLICY: Each resident will have a skin assessment and a treatment plan for the maintenance of skin integrity and wound management if required. The purpose of skin and wound management is to: 1. Identify residents at risk for skin breakdown. 2. Promote comfort and mobility. 3. Reduce or relieve pressure and maintain skin integrity. 4. Provide appropriate interventions to manage pressure ulcers and minimize infection. 5. Provide learning opportunities. 6. Monitor and evaluate resident outcome. PROCEDURE: . Monitoring: 1. Staff will perform routine skin inspections daily with cares and as needed notifying the nurse of any skin changes. 2. Nurses will conduct a weekly skin assessment to identify changes. 3. Identify cause and contributing factors such as friction, shear, pressure, malnutrition, dehydration, trauma, immobility, medications, disease, and moisture/incontinence. 4. If resident is diabetic, the nrse will observe feet. 5. If wound present, assess after cleansing for: location, size (length x width and depth in centimeters), color of wound bed (red, yellow, black), undermining/sinus tracts, amount/type color of drainage/exudate (serous, serous sanguineous, sanguineous, green, purulent), odor, tissue bleeding, wound edges (maceration, rolled), condition of surrounding skin (induration, redness, temperature, [MEDICAL CONDITION]), duration of wound, and pain. Notification: 1. MD (Medical Doctor). 2. Family/HCPOA (Health Care Power of Attorney). 3. Wound Certified Nurse: a. Wound nurse or designee to place resident on weekly wound rounds. b. Wound nurse or designee in collaboration with the MD will make recommendations for the treatment of [REDACTED]. Wound nurse or designee will maintain weekly measurements, description of each wound that has been identified documenting and updating MD as needed. 1.) R116 was admitted to the facility on [DATE] after hospitalization for a cardiovascular accident with left sided [MEDICAL CONDITION]. R116 had the following Diagnoses: [REDACTED]. R116's admission Minimum Data Set (MDS) assessment dated [DATE] coded R116 as needing extensive assistance with bed mobility, transfers,

toileting, and hygiene and a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. On 12/11/2019 in the Patient Discharge Instructions from the hospital, R116's skin was documented as having a reddened area to the buttocks/coccyx with [MEDICATION NAME] in place. [MEDICATION NAME] is a foam border dressing used to treat wounds with exudate or potential pressure areas that need protection. On 12/11/2019 at 8:14 PM in the progress notes, nursing charted R116 had a wound to the sacrum/coccyx measuring 8 cm x 1.5 cm x 0 cm and was beefy red. No cause of the wound was given such as excoriation or pressure and no staging was done if it was considered a pressure injury. The treatment from the discharge orders from the hospital was to cleanse the open area with normal saline and apply Orange Remedy to the open area every shift. Orange Remedy is a protectant paste with zinc oxide used to prevent skin breakdown due to moisture or to treat superficial skin breakdown. an order for [REDACTED].-check skin weekly, -help with hygiene and general skin care, -avoid using hot water for washing and use moisturizer on the skin, -help reposition at least every 1-2 hours while in bed, -keep good padding around the bony areas, -use skin protective devices, -A and D cream, -use pillows for support, -keep clean and dry, -have dietary staff discuss nutrition needs, -and report any changes to the nurse. On 12/12/2019 at 5:56 AM in the progress notes, nursing charted this was the initial assessment of the coccyx wound that R116 was admitted with. The progress note stated the initial stage of the wound was unable to be staged, was a suspected deep tissue injury with red and purple intact skin measuring 2 cm x 5 cm with tissue type of slough. Surveyor interviewed Director of Nursing (DON)-B on 3/3/2020 at 2:00 PM regarding the documentation of R116's initial wound assessment. DON-B agreed the charting was conflicting with the documentation of beefy red tissue on 12/11/2019 and then a deep tissue injury with slough on 12/12/2019; a deep tissue injury is closed skin and slough is found on an open wound. Surveyor stated it was difficult to determine what R116's skin looked like on admission with the two skin integrity entries. DON-B stated the wound charting was a mess. On 3/3/2020 at 11:57 PM in the progress notes, the nurse amended the charting to state the skin was intact on 12/12/2019. On 12/18/2019 in the progress notes, nursing charted R116 had a Stage 1 unblanchable area to the coccyx. No measurements were documented. On 12/18/2019, R116's skin integrity care plan was revised to state the skin injury to the coccyx area was a deep tissue injury. No interventions were revised. On 12/21/2019 in the progress notes, nursing charted R116 had a small area of blanchable purple/redness to the right side of the coccyx. No measurements were documented. On 12/23/2019 at 1:07 PM in the progress notes, nursing charted the coccyx wound measured 1 cm x 1.75 cm x < (less than) 0.1 cm with a pink base and no exudate. The wound was not staged. No documentation was found of notification of the physician with the open wound. No documentation of R116's coccyx wound was found for 14 days. On 1/6/2020 at 2:15 AM in the progress notes, nursing charted R116's coccyx wound was worsening and was now a Stage 2 pressure injury measuring 1.5 cm x 1.2 cm x 0.2 cm with pink [MEDICATION NAME] tissue in the base of the wound. After Surveyor discussed wound charting with DON-B on 3/3/2020 at 2:00 PM, the nurse appended the wound entry for 1/6/2020 on 3/4/2020 at 2:49 AM stating the wound was a suspected deep tissue injury with partial thickness skin loss in the center of the wound, which was pink in color. No measurements were given to denote the size of the deep tissue injury or the open area. On 1/7/2020 in the physician exam note, the physician documented: Possible sacral decubitus. Patient remembers the nurses saying (R116) had a pressure ulcer. I am unable to examine (R116) at this time as (R116) requires a Hoyer lift for transfers. Plan: I will check with the nurses if there is any evidence of a sacral decubitus ulcer. On 1/13/2020 at 1:57 PM in the progress notes, nursing charted the Stage 2 pressure injury to the coccyx measured 1 cm x 1.5 cm x < 0.5 cm with [MEDICATION NAME] tissue in the wound base which had pallor noted. On 1/15/2020, R116's skin integrity care plan was revised to state the skin injury to the coccyx area was a Stage 2 pressure injury. Apply Orange Remedy cream to the coccyx was added as an intervention. No documentation of R116's coccyx wound was found for 10 days. On 1/23/2020 at 11:05 PM in the progress notes, nursing charted the Stage 2 pressure injury to the coccyx measured 1.5 cm x 1 cm x 0.2 cm with [MEDICATION NAME] tissue in the wound bed and light drainage. After Surveyor discussed wound charting with DON-B on 3/3/2020 at 2:00 PM, the nurse appended the wound entry for 1/23/2020 on 3/4/2020 at 4:33 AM stating the suspected deep tissue was no longer present, but the partial thickness skin loss remained. On 1/23/2020, the treatment to the coccyx was changed to cleanse the open area to the coccyx with normal saline, apply collagen powder to the open area, and cover with a dry 2x2 secured with hypofix daily. On 1/29/2020 in the progress notes, a Licensed Practical Nurse (LPN) documented the open area to the coccyx was healing well with the wound tissue pink and edges moist and white. On 2/3/2020 at 3:37 PM in the progress notes, LPN-G charted R116's Stage 2 to the coccyx measured 1.8 cm x 1.5 cm with no depth documented. The wound had slough in the wound bed with pink tissue and white around the edges with light drainage. In an interview with LPN-G on 3/5/2020 at 9:53 AM, LPN-G stated LPN-G did R116's wound treatment every day. The wound was a small open area with pink to the wound base and it was probably a Stage 2, but as an LPN, she could not stage the wound. When asked if there was slough in the wound on 2/3/2020, LPN-G stated the wound did not have slough; slough is yellow and it was just pink. LPN-G stated the slough button may have been clicked on accident when charting and the computer system has limited choices to pick for the type of tissue present so you select whatever is closest. LPN-G stated if there had been slough present, LPN-G would have contacted DON-B for further instructions. On 2/10/2020 at 1:25 PM in the progress notes, LPN-D charted R116's Stage 2 to the coccyx measured 2 cm x 2 cm with no depth documented. The wound had slough in the wound bed with pink tissue and light drainage. In an interview with LPN-D on 3/5/2020 at 8:48 AM, LPN-D stated R116's wound was pink and smooth and flat. LPN-D stated the slough button must have been bumped when charting because there wasn't any yellow or white tissue. When Surveyor showed LPN-D their charting had slough documented twice, LPN-D stated the slough was put in the charting later because it was slough earlier in the charting. No documentation of a Registered Nurse assessing R116's coccyx wound was found for 22 days. On 2/14/2020 at 3:58 AM in the progress notes, nursing charted R116's coccyx wound was a suspected deep tissue injury with 75% pink [MEDICATION NAME] tissue and 25% deep purple and boggy with moderate drainage. The healing progress stated this was a worsened Stage 2 pressure ulcer becoming larger with tenderness present. The area measured 2 cm x 2.5 cm and unable to determine depth with necrotic tissue. After Surveyor discussed wound charting with DON-B on 3/3/2020 at 2:00 PM, the nurse made a late wound entry for 2/14/2020 on 3/4/2020 at 6:48 AM stating the wound was a suspected deep tissue injury with partial thickness skin loss. The healing progress of a worsened Stage 2 pressure ulcer from the original entry was removed; the wound becoming larger and tenderness present was retained. The measurements remained the same and the necrotic tissue documentation was replaced with [MEDICATION NAME] tissue. On 2/14/2020, the treatment order was changed from daily to twice daily. On 2/19/2020 in the progress notes, an LPN charted the open area to the coccyx remains; a small amount of dark skin was noted to the left side of the wound while the remaining area was pink and the surrounding tissue was white. No documentation of measurements, an RN assessment, or of physician notification was found. On 2/23/2020 at 7:09 PM in the progress notes, nursing charted R116's coccyx wound measured 2 cm x 1.5 cm with a pink wound bed and moderate drainage. The wound was not staged. On 2/24/2020, R116's skin integrity care plan was revised to state the skin injury to the coccyx area was a suspected deep tissue injury and has proven difficult to heal. The treatment was removed as an intervention while assess prevention strategies, elevate heels when in bed, and offer toileting were added interventions. On 2/27/2020 at 11:41 PM in the progress notes, nursing charted R116's coccyx pressure wound was unable to be staged due to slough in the wound bed. The wound measured 1 cm x 2.6 cm with no depth documented. The wound had moderate drainage and the healing progress was noted to be improving due to becoming smaller, even though the wound now had slough. After Surveyor discussed wound charting with DON-B on 3/3/2020 at 2:00 PM, the nurse made a late wound entry for 2/27/2020 on 3/4/2020 at 12:11 AM stating the wound was a suspected deep tissue injury with partial thickness skin loss with slough covering the wound base. The description stated the wound was becoming smaller and the original suspected deep tissue injury had healed with the partial thickness skin loss still noted with slough tissue to the wound bed. R116 no longer had complaints of pain with dressing changes. No documentation of physician notification of slough in the wound bed was found. On 3/2/2020 at 10:36 AM, Surveyor interviewed R116. R116 stated there is a sore on her backside and gets hot and burning if sitting in a chair too long. R116 stated the bandage is changed at least daily and R116 should lay down in bed, on the side to relieve the pressure. R116 had a cushion in the wheelchair and an air mattress on the bed. On 3/2/2020 at 1:12 PM in the progress notes, nursing charted R116's coccyx wound measured 1 cm x 2.1 cm x 0.1 cm with no exudate. No staging or description of the wound base was documented. On 3/3/2020, R116 was admitted to the hospital for [MEDICAL CONDITION]. Surveyor did not observe R116's wound or treatment. On 3/4/2020 at 10:20 AM, Surveyor interviewed DON-B regarding R116's wound documentation. DON-B stated the floor nurses do the initial assessment when a resident is admitted , but the policy is to not have the floor nurse stage a pressure wound until the wound certified

nurse looks at it the next day. The third shift nursing supervisor does wound rounds every Thursday and the floor nurses do all the measurements on Mondays so each resident should technically be charted on twice a week. Surveyor reviewed the skin charting with DON-B to show missing weeks of documentation. Surveyor reviewed R116's skin integrity care plan with DON-B showing how the care plan changed from a skin injury to the coccyx on 12/11/2019 to a deep tissue injury on 12/18/2019 to a Stage 2 on 1/15/2020 and back to a suspected deep tissue injury on 2/24/2020 and the interventions listed don't show limiting R116 sitting in the wheelchair which is a cause of the pressure injury. DON-B stated healing unstageable wounds is what the new terminology is so when a wound is unstageable and it starts to heal, it becomes a healing unstageable wound and that may be why the care plan terminology changed back and forth. DON-B stated the wound care team is responsible to change the care plan, but the nurses on the floor do go in and change things sometimes. DON-B agreed it was hard to determine the stage and status of R116's wound with the documentation as it was in the chart. DON-B stated the nurses that documented on R116's wound have been talked to about the conflicting charting. On 3/5/2020 at 2:00 PM, Surveyor reviewed the above findings with Nursing Home Administrator (NHA)-A, DON-B, and Director of Clinical Operations-F. R116 was admitted with a reddened area to the coccyx per hospital documentation that developed into a suspected deep tissue injury that opened up into an unstageable wound covered in slough. The wound was not documented on weekly and did not have accurate staging or descriptions of the wound or wound bed. After Surveyor showed DON-B the difficulty in following the wound progression, DON-B had some nurses amend their entries. The amended entries did not clarify the progression of the wound and with R116's admission to the hospital on [DATE], a current view could not be obtained. No further information was provided at that time. On 3/5/2020 via email at 3:50 PM after Surveyor exited the facility, Director of Clinical Operations-F forwarded the Admission Report Sheet taken by the nurse receiving R116 from the hospital, the admission body check form, and copies of the wound documentation by facility staff on 12/11/2019 and 12/12/2019 as already recorded by Surveyor. The Admission Report Sheet, undated and unsigned, stated R116 had a Stage 2 to the coccyx with a treatment of [REDACTED]. The Admission Body Check form, undated and unsigned, indicated a wound measuring 8 cm x 1.5 cm to the coccyx area. 2.) On 3/2/20 at 10:32 AM the survey team was provided with a wound list dated 2/14/20. The wound list included R25 with the following information wound type: stage 2, location: coccyx, upon admission . On 3/5/20 at 11:25 AM, surveyor observed wound care to R25's coccyx performed by Licensed Practical Nurse (LPN)-H. Surveyor observed R25's coccyx with 2 stage 2 pressure ulcers. R25's feet were observed. R25's left heel was observed with dark brown eschar (dead skin tissue). On 3/5/20 at 11:36 AM, Surveyor conducted an interview with LPN-H. LPN-H informed surveyor that R25 was not initially on their unit at facility but that LPN-H had treated R25's wounds since moving from the rehab unit. Surveyor asked LPN-H how staff know how to provide care to a resident with pressure injuries. LPN-H replied they would be directed by the resident care plan and their Treatment Administration Record (TAR) when to provide skin treatments to residents. Surveyor asked how wounds are monitored in facility. LPN-H responded that nursing staff monitors wounds by performing measurements to see if the treatment is working. LPN-H stated that wound progress is communicated to nursing staff via email. Surveyor asked how often wounds should be assessed by nursing staff. LPN-H replied that wounds should be charted upon with an assessment and measurements on a weekly basis. Surveyor reviewed R25's medical record and noted the following: R25 was admitted to the facility 12/5/2019 with [DIAGNOSES REDACTED]. R25's Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/10/19 indicates a Brief Interview of Mental Status (BIMS) score of 14, indicating resident is cognitively intact and able to participate in daily decision making. Section G of R25's MDS indicates that resident requires extensive assist on two staff for bed mobility. R25 Requires total assistance of 2 staff for transfers with a mechanical lift. R25 requires extensive assist of 1 for personal hygiene and dressing. Section H of R25's MDS indicates resident is frequently incontinent of bowel and bladder. On 3/4/20 at 1:16 PM, surveyor reviewed R25's care plan 12/18/19 which states as follows: I have a skin injury, Deep Tissue Injury to my left heel, Stage 1 to Right outer heel (red), Moisture associated skin damage (MASD) to my tailbone .Because I can't move around well on my own. I show this by requiring daily skin treatment and ongoing preventative skin care. I need my nurses to provide wound care .I need everyone to make sure I change positions frequently and report any changes to my nurse. Per R25's admission skin assessment and medical record documentation R25 was with multiple pressure injuries which consisted of the following; Left Heel: Per review of initial skin admission assessment performed on 12/5/19, R25 was admitted to the facility with 2 suspected deep tissue pressure injuries (DTIs) to the left heel, measuring 2.0 x 4.5 cm and the other DTI measuring 1.0 x 1.0 cm. R25's Admission MDS indicated R25 has 1 Suspected DTI while the initial skin admission assessment indicates 2 suspected DTIs to the left heel and 1 suspected DTI to the right heel. Surveyor noted the discrepancy between the MDS which indicated 1 suspected DTI whereas the initial skin admission assessment dated [DATE] indicated 2 suspected DTIs to the left heel. From 12/9/19 to 3/3/20, there is wound documentation and measurements for the 1 suspected DTI to the left heel measuring 2.0 X 4.5 cm. There is no measurements for the 2nd suspected DTI measuring 1.0 X 1.0 cm. On 12/9/19, there is documentation of a suspected DTI measuring 2.0 x 4.5 cm. This suspected DTI is documented as noted upon admission. This wound's location on the left heel is not described, such as the actual location of this wound, tissue description, drainage etc. There is no physician notification related to the 2 DTIs or of the area's measurements. On 12/16/19, documentation notes left heel DTI 4.5 x 2.5 cm. There is no documentation in the medical record of physician notification of the increased size of the DTI to the left heel. On 3/4/20 at 10:05 AM, Surveyor reviewed R25's Treatment Administration Record (TAR) for December 2019 to March 4, 2020. Surveyor did not observe any treatments signed out by staff for suspected DTIs to the bilateral heels from 12/5/19 to 1/22/20. On 1/23/20, an order on the TAR was initiated. The order reads as follows: Apply skin prep to left heel wound daily HS (hours of sleep). On 3/5/20 at 11:25 AM, surveyor observed R25's feet, R25's left heel was observed with dark brown eschar (dead skin tissue). Right heel: Per the admission skin assessment dated [DATE], a suspected DTI noted to the Right heel measuring 0.5 x 0.5 cm On 12/9/19, documentation was noted of a Stage 1 pressure injury to R25's right outer heel measuring 1.5 x 1.0 cm. Documentation on 12/9/19 indicates stage 1 pressure injury to right outer heel was present upon admission to the facility. Surveyor noted there was no documentation found on the 12/5/19's admission skin assessment indicating a Stage 1 pressure injury to R25's right outer heel, only that R had a suspected DTI to the right heel. It was not clear to the surveyor if the DTI noted on the right heel and the stage 1 pressure injury to the right outer heel were the same injuries or if they were 2 separate areas. On 12/16/19, documentation states follow up assessment of right heel, no area of pressure sore present. On 12/18/19, documentation states a stage 1 pressure injury is present to right heel measuring 0.3 x 0.2cm. On 12/23/19, documentation states that stage 1 pressure injury to right outer heel measures 0.3 x 0.2 cm. On 12/30/19, documentation states that stage 1 pressure injury to right outer heel measures 0.5 x 0.5 cm and that the ulcer status is improving. Surveyor noted the measurements on 12/30/19 to the stage 1 pressure injury to right outer heel had increased in size from 0.3 x 0.2 to 0.5 X 0.5. Surveyor noted there no other description or explanation as to why the facility thought the stage 1 pressure injury to the right outer heel was improving. On 1/6/20, documentation states that stage 1 pressure injury to right outer heel measures 0.5 x 0.5 cm and that the ulcer status is the same. On 1/13/20, documentation states that stage 1 pressure injury to right outer heel measures 0.5 x 0.5 cm and that the ulcer status is the same. There is no documentation of any physician notification related to increased measurements from 12/30/19 to 1/13/20. Surveyor noted there was no additional documentation for the monitoring of the stage 1 pressure injury to right outer heel from 1/13/20 to 2/3/20 (including measurements). On 2/3/20, documentation states right heel, no open noted (sic), only dry skin. On 3/4/20 at 10:05 AM, Surveyor reviewed R25's TAR for December 2019 to March 2020. Surveyor did not observe any treatments signed out by staff for the suspected DTI to bilateral heels from 12/5/19 to 1/22/20. On 1/23/20, an order on the TAR was initiated. The order reads as follows: Apply skin prep to left heel wound daily HS. On 3/5/20 at 11:25 AM, surveyor observed R25's feet, R25's right heel was observed with no DTIs and/or pressure injuries. Coccyx/inner buttock: On 3/4/20 at 10:05 AM, Surveyor reviewed R25's TAR for December 2019 to March 2020. On 3/4/20, an order was added to the TAR that read as follows: Cleanse open areas to coccyx and bilateral buttock, apply orange remedy cream followed by dry dressing to open areas every shift. Surveyor noted R25 was admitted to the facility on [DATE] with Moisture Associated Skin Damage (MASD) to their coccyx. There was no initial measurement of the MASD to the coccyx area performed upon admission to facility. On 12/5/19, MASD to inner buttocks was assessed as red, blanchable with no initial measurements documented. Surveyor noted it was unclear if the MASD to the coccyx area and to the inner buttocks were the same areas or if these were 2 separate areas. On 12/9/19, measurements of MASD to R25's coccyx were performed and documented as 0.5 x 0.5 cm. On 12/23/19, measurements of MASD to R25's coccyx were performed, measuring 2.25 x 0.75 cm with an assessment stating area is denuded, not a stageable wound. Surveyor noted this measurement and assessment of R25's MASD to the coccyx was performed 14 days after the last documented assessment on 12/9/19, showing that R25's MASD to coccyx had increased in size and that there was no documented notification to R25's physician related to the change in the size of the wound. On 1/6/20, an assessment was performed to coccyx stating red excoriation noted. Ulcer status was documented as the same. Surveyor noted no measurements were documented for MASD to the coccyx on 1/6/20. On 1/13/20, an assessment was performed to coccyx stating ulcer status: improving. Surveyor noted no measurements were documented for MASD on 1/13/20. Surveyor noted there was no additional information as to why the facility concluded the area was improving. Measurements performed on 1/16/20 were documented as 0.4 x 0.3 cm. No depth was documented to this wound. Per documentation on 1/16/20, it is noted that R25 currently had 3 separate stage 2 pressure injuries documented to their coccyx and left buttock area. These areas were acquired while R25 resided in facility. On 1/16/20, an assessment was performed stating left buttock/coccyx, current stage: stage 2, healing progress: worsened from MASD. Surveyor noted there was no documentation regarding the date of onset if the documentation is referring to the left buttock as being a new and/or separate area from the coccyx and from the inner buttock. This is the first time Surveyor noted reference to the left buttock area. Measurements performed on 1/16/20 were documented as 1.5 x 0.4 x 0.2 cm. Surveyor noted the documentation did not include what area this measurement was for. On 1/16/20 documentation was noted to as follows: coccyx, current stage: stage 2, healing progress: worsened MASD. Measurements performed on 1/16/20 were documented as 0.4 x 0.4 x 0.1 cm. which was for the coccyx. On 1/20/20, an assessment was performed stating coccyx, 1.5 x 0.5 cm, wound type: stage 2. No depth was documented for the coccyx wound. Per documentation on 1/20/20, the area is no longer references as MASD associated. No further documentation was noted to address 2 other pressure injuries that were first documented upon on 1/16/20. On 1/27/20, an assessment was performed stating coccyx, 1.5 x 0.5 cm, wound type: stage 2. No depth was documented for this wound. No further documentation was noted to address 2 other pressure injuries that were first documented upon on 1/16/20. On 1/28/20, documentation was performed stating coccyx, small open red slit. No measurements were documented for this wound. Upon record review and staff interview, it is unclear if this area was a new pressure injury to the coccyx or if this was area referred back on 12/5/19 upon admission. On 2/3/20, documentation was performed stating coccyx, small open red slit. 0.5 x 0.2 x 0.1 cm. Additional documentation was noted stating coccyx, 1.2 x 0.3, open area noted. Upon record review and staff interview, it is unclear if this was a new pressure injury or a previously documented wound. No staging information was noted for these wounds on 2/3/20. On 2/10/20, documentation was performed stating coccyx, healing progress: improving. 0.5 x 0.3 x 0.1 cm. No staging information was noted for this wound on 2/10/20. On 2/21/20, documentation was performed stating coccyx has a small open slit, treatment done. No measurements or staging information was noted for this wound on 2/21/20. On 3/3/20, a late entry documentation dated for 2/27/20 was performed stating coccyx, onset: noted on admission, stage: 2. 0.6 x 0.2 x 0.1 cm. On 3/5/20 at 11:25 AM, surveyor observed R25's coccyx with 2 stage 2 pressure ulcers. Left buttock: On 1/16/20, an assessment was performed stating left buttock, current stage: stage 2, healing progress: worsened MASD. Measurements performed on 1/16/20 were documented as 0.4 x 0.3 cm. No depth was documented to this wound. Per documentation on 1/16/20, it is noted that R25 currently had 3 separate stage 2 pressure injuries documented to their coccyx and left buttock area. On 3/3/20, a late entry documentation date for 2/27/20 was performed stating left buttock, onset: noted on admission, stage: 2.1.1 x 0.5 x 0.1 cm. Surveyor noted the documentation for the left buttock started on 1/16/20 and not on admission which was 12/5/19. On 3/4/20 at 10:05 AM, Surveyor reviewed resident's TAR for December 2019 to March 2020. Surveyor did not observe any

	treatment orders on TAR related to R25's MASD for the coccyx, inner buttock and left buttock. Additionally, Surveyor did not observe any treatment orders on the TAR for the stage 2 pressure injuries to coccyx/left buttock. Surveyor did not observe any treatments signed out by staff related to R25's MASD or stage 2 pressure injuries from 12/5/19 to 3/4/20. On 3/4/20 the TAR read as follows: Cleanse open areas to coccyx and bilateral buttock, apply orange remedy cream followed by dry dressing to open areas every shift. On 3/5/20 at 11:25 AM, surveyor observed R25 did not have any MASD to the inner and left buttock. After Surveyor's review of R25's medical record and interview with staff, Surveyor identified the facility did not accurately monitor and document the status of pressure injuries. The facility's assessments were not always completed weekly, there was inconsistent identification of the wounds and their locations. The location of the wounds were identified in different anatomical locations and it was unclear if areas mentioned in the medical were new wounds or if staff was referencing the same wounds using different identified locations such as; coccyx versus inner buttock versus left buttock, left heel having 2 DTIs, and the right heel having a DTI and a Stage 1. Surveyor noted the facility did not always contact the physician for treatment orders and that the TAR reflected treatments being performed. The physician was not always consulted with when the wounds worsened, such as when the right outer heel stage 1 increased in size on 12/30/19. On 3/4/20 at 10:38 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor inquired about the process for wound monitoring and the documentation of the wounds. DON-B explained to surveyor that measurements are performed by both floor nurses and nursing supervisors on a weekly ba
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not ensure residents receive adequate supervision and assistance devices to prevent accidents for 1 (R57) of 9 residents reviewed for falls. R57 was transferred with a sit-to-stand lift and sustained a fall from the lift when the care plan stated R57 transfers with a Hoyer lift. The fall was never investigated by the facility. Findings include: The facility policy and procedure entitled Fall Prevention Program dated 9/19/2019 states: When a resident has a fall at (the facility) a fall report will be completed promptly by a licensed nurse. The fall scene investigation form will be used to help determine the reason for the fall. The form will be completed by the nurse and kept in the resident's chart. Notification of the fall will be made to the resident's primary care physician and to the resident's primary contact. . All falls will be reviewed by an Interdisciplinary fall team. R57 was admitted to the facility on [DATE] after hospitalization . R57's Activities of Daily Living Care Plan dated 1/14/2020 indicated R57 transferred with the use of a Hoyer lift with two people. On 1/15/2020 in the physical therapy notes, therapy charted due to R57's inconsistency in standing, the use of a Hoyer lift is recommended for safe transfers at this time. On 1/19/2020 at 4:15 PM, R57 was attempted to be transferred by a Certified Nursing Assistant using a stand lift from the

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

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	525556	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKSIDE CARE CENTER	3506 WASHINGTON RD KENOSHA, WI 53144

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) toilet to the recliner. R57 could not stand up during the transfer and was lowered to the floor. A Hoyer lift was then used to transfer R57 from the floor to the recliner. The progress note indicated the physician was not notified of the incident. On 3/2/2020 at 11:55 AM, Surveyor observed R57 in the dining room during lunch time. A Hoyer lift sling was noted under R57 while in the wheel chair. On 3/5/2020 at 11:54 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R57's incident with the stand lift on 1/19/2020. DON-B stated R57 has always been a Hoyer lift and was unaware of the incident on 1/19/2020. DON-B stated the nurse must not have clicked the fall button when charting. When the fall button is used, it alerts administrative staff that a fall has occurred and the fall team then meets to discuss the fall and determine the cause so interventions can be put in place to prevent future falls. DON-B stated the nurse clicked other instead of fall so the administrative staff was unaware of the fall and did not do an investigation or education on the fall. DON-B stated R57's care plan was not followed and therefore R57 sustained a fall from the stand lift. No further information was provided at that time.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure assessment and monitoring of fistula site after [MEDICAL TREATMENT] was provided and designation of where [MEDICAL TREATMENT] was provided with communication for 1 (R126) of 1 residents reviewed receiving [MEDICAL TREATMENT]. R126 did not have orders to monitor the fistula site after [MEDICAL TREATMENT], the [MEDICAL TREATMENT] center where R126 received [MEDICAL TREATMENT] was not in R126's records, and no communication between the facility and the [MEDICAL TREATMENT] center was found. Findings include: The facility policy and procedure entitled [MEDICAL TREATMENT] Policy dated 11/28/2018 states: the facility will work collaboratively with residents' [MEDICAL TREATMENT] center to ensure a unified coordination of services. . NURSING CONSIDERATIONS FOR SOMEONE RECEIVING [MEDICAL TREATMENT]: 1. Information relevant to the resident's care will be shared with the [MEDICAL TREATMENT] center as needed. This information may include but is not limited to: a. Assessments of the resident's access site, i.e. infection, thrill, bruit, dressings. b. Fluid status c. Vascular status d. Vital signs e. Weights f. Laboratory data g. Dietary assessments and overall nutritional health. . 3. Monitor fistula or catheter site for signs/symptoms of infection, dislodging, or clotting (per [MEDICAL TREATMENT] center guidelines) nursing is not to change the dressing if one exists, add meds, flush or manipulate the fistula in any way. 4. Communicate any abnormal findings or changes in condition to the resident's physician, [MEDICAL TREATMENT] center and the resident's representative. R126 was admitted on [DATE] for long term care. R126 has a [DIAGNOSES REDACTED]. The following care plans were last reviewed 2/19/2020 and include the following information regarding R126's [MEDICAL TREATMENT]: R126's Activities of Daily Living Care Plan indicates R126 receives [MEDICAL TREATMENT] at an unidentified center three times a week and requires more assistance on [MEDICAL TREATMENT] days. R126's At Risk for Dehydration Care Plan indicates R126 is on a 1,000 cc per day fluid restriction. R126's Increased Amounts of Protein Care Plan breaks down the amount of fluid given by nursing and dietary and indicates R126 is to be weighed monthly. R126's current orders state: -fluid restriction of 1000 cc/24 hours -when R126 goes out for [MEDICAL TREATMENT], send an extra oxygen tank; Tuesday, Thursday, and Saturday -per [MEDICAL TREATMENT], the physician does not want lab draws done in the facility for PT/INR -R126 is to leave for [MEDICAL TREATMENT] three times per week: Tuesday, Thursday, and Saturday. Please make sure R126 is ready to leave at 9:00 AM -R126 receives [MEDICATION NAME] 50 mg/ml=100 mg IV once a month with [MEDICAL TREATMENT], [MEDICATION NAME] 40 mcg IV once a month with [MEDICAL TREATMENT], [MEDICATION NAME] 1 mcg/ml=3.5 mcg IV Tuesday, Thursday with [MEDICAL TREATMENT], Parsabiv 2.5 mg three times a week with [MEDICAL TREATMENT] Review of R126's medical record did not reveal where R126 received [MEDICAL TREATMENT]. No communication sheets were found. No documentation of monitoring of R126's fistula was found. On 3/2/2020 at 9:14 AM, Surveyor interviewed R126 regarding [MEDICAL TREATMENT] services. R126 stated the facility provides transportation to the [MEDICAL TREATMENT] center at 9:00 AM on Tuesday, Thursday, and Saturday and back to the facility at approximately 4:30 PM on those days. Surveyor asked if a communication sheet went back and forth with R126 to [MEDICAL TREATMENT] and R126 said no. R126 stated blood test results are shared once a month that are drawn at the [MEDICAL TREATMENT] center. Surveyor asked if weights were taken at the facility or the [MEDICAL TREATMENT] center and R126 stated the [MEDICAL TREATMENT] center checks the weights before and after [MEDICAL TREATMENT] and the facility sometimes checks the weight. R126's weight was documented in the medical record on 11/2/2019 and 1/2/2020. No other weights were found. On 3/4/2020 at 2:48 PM, Surveyor met with Director of Nursing (DON)-B to discuss the above findings and requested R126's [MEDICAL TREATMENT] communication between the facility and the [MEDICAL TREATMENT] center. Surveyor shared the concerns that R126's fistula was not being monitored after [MEDICAL TREATMENT] and there is nothing in the chart to show where [MEDICAL TREATMENT] is being performed or contact information of the [MEDICAL TREATMENT] center if concerns arise. On 3/4/2020 at 3:18 PM, DON-B provided [MEDICAL TREATMENT] Treatment Information dated 2/25/2020, 2/27/2020, 2/29/2020, and 3/3/2020 that had been faxed and printed after information was requested by Surveyor. The information was not available to staff until this time. An order was placed in R126's Treatment Administration Record to monitor the fistula to the left arm with R126 returns from [MEDICAL TREATMENT] on 3/4/2020 after being brought to the facility's attention by Surveyor. No further information was provided at that time.

F 0880

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review the facility did not ensure staff performed proper hand hygiene for 2 (R14, R72) of 4 sampled residents. * Registered Nurse (RN)-C was observed replacing a soiled drain gauze around R14's [MEDICAL CONDITION] with a clean gauze without washing his hands and without changing his gloves. Additionally, RN-C did not wash his hands and did not change his gloves after cleaning R14's right, lower back chest tube insertion area site and before placing a clean dressing. * Licensed Practical Nurse (LPN)-D was observed spilling pills from the medication cup onto a laptop, then LPN-D picked up the pills with her bare hands and administered them to R72. Findings include: On 03/04/20 the facility's policy entitled: Brookside's Hand Washing Policy (not dated) was reviewed and read: Some situations that require hand hygiene including but not limited to: when hands are soiled, before and after any resident contact, before and after assisting a resident with meals, before and after changing a dressing, when coming in contact with and after contact with a resident's intact skin (e.g. when taking a pulse or blood pressure and lifting a resident), after removing gloves. 1.) On 03/04/20 Surveyor reviewed R14's medical record which indicated R14 had medical [DIAGNOSES REDACTED]. Resident also had a cervical surgery and due to surgery complications R14 received a [MEDICAL CONDITION]. On 03/04/20 Surveyor reviewed R14's Admission Minimum Data Set (MDS) dated on 02/26/20 which indicated R14 had a medical [DIAGNOSES REDACTED]. On 03/04/20 Surveyor reviewed R14's plan of care dated 02/28/20 which indicated R14 had a spinal surgery with complications. R14's plan of care interventions dated 02/28/20 included: monitor R14's [MEDICAL CONDITION] and right and left chest tubes. R14's plan of care dated on 02/28/20 also indicated R14 had a right and left chest tube to remove excess fluid from R14's lungs. On 03/04/20 Surveyor reviewed R14's active Treatment Administration Record (TAR) dated on 02/20/20 which indicated R14's [MEDICAL CONDITION] cannula and dressing on the [MEDICAL CONDITION] needs to be changed 2 times per day in the am and pm. R14's active TAR dated 02/20/20 indicated R14's right and left pleurex drains are drained every 3 days in the mornings. R14's Pleurex drains are not to be emptied on the same day and the drains have to alternate days during R14's lung fluid removal. R14's TAR dated 02/20/20 also indicated R14's oxygen was to be titrated to keep R14's oxygen saturations above 90% via [MEDICAL CONDITION] oxygen administration. On 03/04/20 at 9:45 am, Surveyor observed Registered Nurse (RN)-C during [MEDICAL CONDITION] care, right lower back chest tube drainage and dressing change to R14. RN-C was observed washing his hands and then RN-C applied clean gloves. RN-C then opened a bottle of normal saline cleaning solution, a 1 pack of 4 x 4 gauze, and 1 new tracheotomy inner cannula number 4 replacement tube. RN-C opened a bottle of the Normal Saline cleaning solution and placed the bottle on the bed with the opening of the Normal Saline bottle touching R14's used bed linens. RN-C then removed R14's used [MEDICAL CONDITION] cannula from R14's [MEDICAL CONDITION] site. RN-C then did not wash his hands and did not change his gloves and used the same gloves to insert R14's new, clean [MEDICAL CONDITION] inner cannula into R14's [MEDICAL CONDITION] site. RN-C then did not wash his hands and did not change his gloves and removed R14's soiled [MEDICAL CONDITION] dressing. RN-C did not wash his hands, did not change his gloves and then took a clean 4 x 4 gauze pad and cleaned around R14's [MEDICAL CONDITION] opening site. RN-C continued to use the same gloves and then opened a drain gauze package and placed a clean drain gauze package onto R14's [MEDICAL CONDITION] site without changing gloves and without washing his hands throughout the entire procedure. When RN-C was completed with the [MEDICAL CONDITION] care, RN-C then removed his gloves and washed his hands. On 03/04/20 at 9:52 am, Surveyor observed RN-C removed R14's right arm from their shirt sleeve and opened the Pleurex sterile package. RN-C then applied a pair of sterile gloves from the Pleurex package. RN-C removed a soiled dressing from R14's right, lower back chest tube site. RN-C

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) then cleaned around R14's right lower back chest tube opening without changing his glove and without washing his hands. RN-C continued to use the same gloves and then took 1 alcohol wipe from the Pleurex drain opened package and used an alcohol wipe on R14's right lower back chest tube entrance port. RN-C then connected the pleurex drain connector to start draining the fluid from R14's right lung. RN-C indicated there was no drainage from R14's right, lung and removed the Pleurex drain. RN-C then removed his gloves and did not wash his hands. RN-C then used unwashed, bare hands to apply the foam dressing, open a pack of 4 x 4 gauze and 1 [MEDICATION NAME] cover onto R14's right, lower back chest tube insertion site. RN-C then washed his hands for about 5 seconds. On 03/04/20 at 10:05 am, Surveyor spoke with RN-C and RN-C indicated he should always wash his hands and change his gloves when handling soiled dressings and prior to applying clean dressings. On 03/04/20 at 1:00 pm, Director of Nursing (DON)-B indicated RN-C should have washed his hands and replace gloves after removing soiled dressings and prior to applying clean dressings. On 03/04/20 at 3:00 pm the Administrator-A and DON-B were made aware RN-C did not wash his hands and did not change his gloves after handling R14's soiled dressings and prior to applying clean dressing onto R14's [MEDICAL CONDITION] opening site and R14's right lower back chest tube site. 2.) On 3/4/20 at 7:28 AM, Surveyor observed Licensed Practical Nurse (LPN)-D administer medication to R72. LPN-D cut open R72's medication pouch with a scissors and attempted to pour the pills into a medication cup. The pills spilled onto the laptop keyboard on top of the medication cart. LPN-D picked up the pills with unwashed bare hands and placed the pills into the medication cup. LPN-D repeated this process for two more medication pouches for R72, each of them spilling onto the laptop keyboard on the medication cart. LPN-D picked up all the pills and placed them into the medication cup and administered the pills to R72. On 3/4/2020 at 2:48 PM, Surveyor discussed the above observation with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. DON-B agreed the medications should not have been administered after falling onto another surface and picked up with unwashed bare hands. No further information was provided at that time.