STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075070	A. BUILDING _____ B. WING _____	06/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB SAYBROOK	1775 BOSTON POST RD OLD SAYBROOK, CT 06475

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #1) reviewed for pressure ulcers, the facility failed to inform the physician and the resident representative when the resident's wound worsened and required a new treatment. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission MDS dated [DATE] identified Resident #1 had moderately impaired cognition required total 2-person assistance with transfers and extensive 2-person assistance with bed mobility, dressing, grooming and toilet use. Additionally, the MDS identified Resident #1 was at risk for developing pressure ulcers, had no pressure ulcers at the time of the assessment, and treatments included pressure relieving devices for bed and chair, and application of nonsurgical dressing. A physician's orders [REDACTED].#1's bilateral heels for protection, monitor every shift and change every 3 days. The Care Plan dated 4/14/20 identified Resident #1 was at risk for skin breakdown. Interventions included to encourage the resident to reposition side to side, offload pressure to both heels with a pillow, inspect skin when providing care, pressure redistribution mattress and provide pressure reduction cushion for chair/wheelchair. A Nurse's Note dated 4/19/20 at 10:53 PM, written by LPN #1, identified Resident #1 had a right heel blister with discoloration and no drainage. A physician's orders [REDACTED]. Change daily. A Nurse's Note dated 4/21/20 identified right heel blister that's drying noted, measuring 3.0cm by 2.0cm by 0.1cm. APRN and family aware. New order for skin prep and Allevyn heel noted. A Nurse's Noted dated 5/2/20 identified the treatment to right heel was done and a foul smell was noted, may need new treatment. No other description of the heel ulcer was documented. A physician's orders [REDACTED].#4, directed to cleanse right heel with soapy water, rinse with water and pat dry, apply [MEDICATION NAME] followed by Allevyn dressing and change every 2 days and as needed. Review of the Nurse's Notes failed to reflect that the resident's representative was updated when the wound condition deteriorated on 5/2/20 and the new order for [MEDICATION NAME] wound treatment was obtained. Skin Tracking Sheets completed by the ADNS identified the following: 5/5/20: right heel blister stage 2; 3.0cm by 2.0cm by 0.1cm, no drainage, improved; treatment: skin prep and allevyn heel dressing daily. 5/14/20: right heel blister stage 2: 2.0cm by 2.0cm by 0.1cm, no drainage, improved; treatment: skin prep and allevyn heel dressing daily. Review of the facility documentation and Resident #1's clinical record failed to reflect that any further wound tracking, description or measurements were obtained during the 16 day period from 5/14/20 through 5/30/20. Nurse's note dated 5/30/20 identified an order was obtained to send Resident #1 to the clinic for evaluation and treatment of [REDACTED]. Review of a Hospital Discharge Summary dated 6/14/20 identified Resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Interview with LPN #3 on 6/25/20 at 2:40 PM identified when changing the resident's right heel dressing on 5/2/20, she noted it smelled like a dirty foot. Other than the foul smell, LPN #3 could not describe what the wound looked like, indicating she informed the supervisor of her concerns. LPN #3 identified she had assumed RN #4 would update the family because he had obtained the new treatment order. Interview with RN #4 on 6/27/20 at 11:00 AM identified he was asked by LPN #3 to evaluate Resident #1's right heel wound on 5/2/20. RN #4 identified it was not necrotic, had a small yellowish opening at the center, with minimal drainage and did not look infected. RN #4 identified he notified the on-call APRN who gave the order to change the wound treatment. Although RN #4 identified his usual practice was to document in a nurse's note any assessments he performed and orders obtained, he indicated that it was extremely busy during this time and he must have forgotten to document. Additionally, RN #4 indicated he would sometimes offer to inform the resident representative of changes if the nurse was too busy, but usually it was the charge nurse's responsibility. Interview with the DNS on 6/29/20 at 10:10 AM identified that any nurse can update the resident representative of a change in condition or any new orders. Additionally, either the charge nurse or supervisor should have updated the family with Resident #1's pressure ulcer status and new treatment order. Interview with APRN #1 on 6/30/20 at 12:10 PM identified that she was aware of and had seen Resident #1's right heel pressure ulcer early on when it was identified as a blister, however she had not been informed of any worsening nor asked to assess the wound since that time. On 5/30/20, when she was called and informed that the heel now presented with eschar, redness and appeared infected, she was very surprised and shocked that it had deteriorated to this point and the she was not made aware. Additionally, APRN #1 indicated that a decline like that did not occur overnight and someone should have noticed it at least a week prior. Further, APRN #1 identified when nursing has a concern about a resident and wants them to be evaluated they write an entry in the APRN book with the resident's name and what issue or concern that needs to be addressed. APRN#1 indicated there were no entries pertaining to Resident #1's pressure ulcer. Review of the facilities Change in Resident Condition/Family/MD Notification policy identified when there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident, the family or responsible party shall be notified. The facility failed to notify the physician and the resident representative on 4/19/20 when Resident #1's right heel deteriorated to a blister with discoloration. Additionally, the facility failed to notify the physician and resident representative when Resident #1's heel continued to deteriorate and on 5/30/20, the resident required hospitalization for an infected right heel ulcer and osteo[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 review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #1) reviewed for pressure ulcers, the facility failed to ensure a thorough wound assessment was completed and a treatment immediately implemented at the time a new pressure ulcer was identified, failed to ensure weekly wound documentation was consistently performed, and failed to notify the Dietitian when a pressure ulcer developed, which subsequently led to the deterioration of the pressure ulcer and the eventual need for the resident to be hospitalized for [REDACTED].#1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Nutritional assessment dated [DATE] identified Resident #1 was eating well and was able to make needs known. Resident #1 had no pressure ulcers or other skin injuries at the time of the assessment. The documentation identified the resident gave reports of weight loss and had a recent fracture. Resident #1 was started on 8 ounces of milkshake with all meals for additional calories/protein and fluid. The Admission MDS dated [DATE] identified Resident #1 had moderately impaired cognition, required total 2-person assistance with transfers and extensive 2-person assistance with bed mobility, dressing, grooming and toilet use. Additionally, the MDS identified Resident #1 was identified at risk for developing pressure ulcers, had no pressure ulcers at the time of the assessment and had treatments including pressure relieving devices for bed and chair and application of nonsurgical dressing. A physician's orders [REDACTED]. The Care Plan dated 4/14/20 identified Resident #1 was at risk for skin breakdown. Interventions included to encourage the resident to reposition side to side, offload pressure to heels with a pillow, inspect skin when providing care, pressure redistribution mattress and pressure reduction cushion for

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) chair/wheelchair. A Nurse's Note dated 4/19/20 at 10:53 PM, written by LPN #1, identified Resident #1 had a right heel blister with discoloration, no drainage and the supervisor was notified. Further review failed to reflect an RN assessment was completed at that time, including a description of the wound, exact location on the heel, size, stage, appearance of the wound bed, any undermining/tunneling, surrounding skin condition, or drainage and exudate. Additionally, the clinical record failed to reflect that the physician/APRN was notified of the wound, or that a treatment was implemented at that time. The Skin Tracking Sheet dated 4/20/20, and completed by RN #1, identified Resident #1 had a facility acquired right heel blister, stage 2, measuring 3.0cm by 2.0cm by 0.1cm with 4/20/20 as the date of origin, (this date is in conflict with the Nurse's Note dated 4/19/20 when the blister was originally identified). The Tracking Sheet identified the treatment included skin prep followed by Allevyn heel and to change daily. A Nurse's Note dated 4/21/20 by RN #1 identified the right heel blister drying, measuring 3.0cm by 2.0cm by 0.1cm. Additionally, APRN and family were aware, new order for skin prep and Allevyn heel ordered and heels to be offloaded at all times when in bed. A physician's orders [REDACTED]. Change daily. A Skin Tracking Sheet completed by the ADNS identified the following: 4/27/20: right heel blister stage 2; 3.0cm by 2.0cm by 0.1cm, no drainage, improved; treatment: skin prep and allevyn heel dressing daily. A Dietitian progress note dated 4/30/20, identified resident had gradual weight loss since admission, was eating 75-100% of meals and the Dietitian recommended weekly weights for 4 more weeks. Although Skin Tracking dated 4/27/20 identified Resident #1 had a right heel blister stage 2, the dietitian note failed to reflect the right heel blister. Review of the clinical record failed to reflect documentation that the Dietitian was notified when Resident #1 was identified with a stage 2 right heel pressure ulcer on 4/19/20. Skin Tracking Sheets completed by the ADNS identified the following: 5/5/20: right heel blister stage 2; 3.0cm by 2.0cm by 0.1cm, no drainage, improved; treatment: skin prep and allevyn heel dressing daily. 5/14/20: right heel blister stage 2: 2.0cm by 2.0cm by 0.1cm, no drainage, improved; treatment: skin prep and allevyn heel dressing daily. Review of facility documentation and Resident #1's clinical record failed to reflect that any further wound tracking, description or measurements were obtained during the 16 day period from 5/14/20 through 5/30/20. Nurse's note dated 5/30/20 identified the physician ordered Resident #1 to be sent to the clinic for evaluation and treatment of [REDACTED]. Hospital Discharge Summary dated 6/14/20 identified Resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Interview with LPN #1 on 6/26/20 at 11:40 AM identified she checked the resident's heel on 4/19/20 because the resident had complained of right heel discomfort. Although LPN #1 indicated she informed the nursing supervisor (RN #2) about the blister, she could not explain why she (LPN #1) did not measure and describe the area or why there was no documentation by the RN supervisor to support that the area was thoroughly assessed including measurements and description. Interview with RN #2 on 6/26/20 at 3:30 PM identified although she usually writes a nurse's note when informed about a new resident concern, or completes an assessment and obtains new orders, she did not remember anything specific regarding Resident #1's new right heel blister which was identified on 4/19/20. RN #2 indicated it was extremely busy during that time due to the pandemic, she only works per diem and could not remember that long ago. Interview with the DNS on 6/29/20 at 10:10 AM identified that LPN's can assess and measure wounds but the RN needs to verify the assessment in order to notify physician/APRN with accurate information and obtain further directions/orders. The DNS identified that Resident #1's pressure ulcer/blister should have been assessed by the RN with a thorough description of the area. Additionally, the physician/APRN should have been notified and an appropriate treatment should have been initiated when the wound was identified. Additionally, the DNS indicated that because there was no infection control nurse/wound nurse during this time, she had delegated other RN's to do the weekly wound tracking. The DNS identified she was not aware Resident #1's pressure ulcer hadn't been tracked for over 2 weeks from 5/14/20 through 5/30/20, indicating the facility was so overwhelmed with the COVID-19 virus that it must have gotten overlooked. Additionally, the DNS indicated there should have been consistent weekly monitoring of Resident #1's pressure ulcer. Further, the DNS identified if there had been an infection control nurse/wound nurse working in the facility and Resident #1 had been receiving weekly consistent wound tracking of the right pressure ulcer, especially during the last 2 weeks (5/14/20 - 5/30/20) the wound deterioration could absolutely have been prevented. Further, the DNS identified that the Dietitian should be notified with any new skin or pressure injury. Additionally, that although the supervisor does most of the notifications, any nurse can update the dietitian of any new wounds/pressure ulcers. Further, the Dietitian should have been notified so the resident could have been evaluated and received nutritional support for wound healing if needed. Interview with LPN #2 on 6/26/20 at 11:00 AM identified she was the regular nurse for Resident #1 and had performed the right heel treatment on 5/27/20, 3 days prior to hospital transfer. LPN #2 identified that although the wound wasn't really improving, it wasn't worse either. LPN #2 identified the area was about quarter sized and the tissue was pinkish red without drainage. LPN #2 identified on 5/30/20, upon performing the dressing change, she found the heel wound to be much worse in appearance than it had been 3 days prior and summoned the supervisor, RN #4. LPN #2 identified the wound looked very black, with no drainage, no odor and resident had no complaints of pain. Interview with RN #4 on 6/27/20 at 11:00 AM identified when he was summoned by LPN #2 to assess Resident #1's right heel, he was shocked at how bad it looked. RN #4 indicated the heel was very black and he knew the resident needed transfer to the hospital for evaluation. Interview with APRN #1 on 6/30/20 at 12:10 PM identified that she was aware of and had seen Resident #1's right heel pressure ulcer early on when it was identified as a blister, however she had not been informed of any worsening nor asked to assess the wound since that time. On 5/30/20, when she was called and informed that the heel now presented with eschar, redness and appeared infected, she was very surprised and shocked that it had deteriorated to this point and that she was not made aware. Additionally, APRN #1 indicated that a decline like that did not occur overnight and someone should have noticed it at least a week prior. Further, APRN #1 identified when nursing has a concern about a resident and wants them to be evaluated they write an entry in the APRN book with the resident's name and what issue or concern that needs to be addressed. APRN #1 indicated there were no entries pertaining to Resident #1's pressure ulcer. Interview with the Dietitian on 6/27/20 at 4:00 PM identified she is only in the building 1.5 days per week. The Dietitian identified that besides the admission nutritional assessment completed on 4/3/20, she had last evaluated Resident #1 on 4/30/20. The Dietitian identified she was only evaluating the resident's weights at that time because she had not been informed that Resident #1 had a right heel pressure ulcer. Had she been notified, the Dietitian indicated she would have evaluated the resident to determine if there were any nutritional needs and made recommendations if needed at that time. If she had determined there were no nutritional deficits or needs, she would have documented her evaluation and findings in the clinical record. The Dietitian identified when the previous infection control/wound nurse was there, she would email her with any resident concerns including new wounds. She identified that any nurse can send her an email for updates, although none do. The Dietitian indicated the facility had not had an infection control nurse/wound nurse for several months and during this time she had not been receiving updates. Additionally, the Dietitian indicated she is unable to attend the At Risk meetings because they are held on a day she is not scheduled in the facility. Review of the Documentation policy identified a complete wound assessment and documentation will be done weekly on each area until healed utilizing the skin/wound tracking record. Include site/location; stage; size including length, width and depth measured in centimeters; appearance of the wound bed which describes the tissue present in the wound bed including color, drainage, odor and periphery; undermining/tunneling; surrounding skin which describes the condition of the surrounding skin noting if it is intact, [DIAGNOSES REDACTED]tous, indurated, [MEDICAL CONDITION], macerated and the temperature if abnormal; drainage/exudate which describes the amount, color, consistency and odor. Review of the facility's Wound Prevention/Interventions for All Residents, identified to encourage adequate nutrition including supplements as recommended by the dietitian. The facility failed to ensure a thorough RN assessment of a new heel blister on 4/19/20, physician notification and a treatment was implemented for Resident #1, who was admitted with intact skin and at risk to develop pressure ulcers. Additionally, the facility failed to notify the dietitian of the wound and complete weekly wound assessments and documentation from 5/14/20 through 5/30/20, at which point the wound had deteriorated and the resident had to be sent to the hospital for treatment of [REDACTED].