STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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** - 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, staff interview and facility document review it was determined that staff failed to accurately assess a pressure ulcer; and failed to conduct weekly wound measurements and assessments until the wound has resolved for one of one sampled residents; Resident #1. The findings included: Resident #1 was admitted to the facility on ,[DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 7/9/20. Resident #1 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status exam). Resident #1 was coded in Section G (Functional Status) as requiring extensive assistance from two plus persons with bed mobility, dressing, eating and personal hygiene; and total dependence on staff with toileting. Review of Resident #1's weekly wound assessments revealed on 6/16/20 she developed stage one (1) pressure ulcers to her bilateral heels. The following in part was documented on the wound assessments: Left Heel: Date first observed: 6/16/20. Stage: 1 .4.5 x 6.0 CM (centimeters). Depth: 0. Drainage: small bright red drainage. Odor: none. Granulation: none. Right Heel: Date first observed: 6/16/20. Stage: 1 .3.2 x 4.5 CM. Depth: 0. Drainage: none. Granulation: none. The following orders were put into place on 6/16/20: Skin prep wipes apply to left heel every shift .Skin prep wipes apply to rt heel every shift for DTI (Deep tissue injury) (2). an order for [REDACTED].#1 had DTI's to her bilateral heels. The following was documented: Site: right heel. Size: 3.0 x 4.4 . Stage: DTI T/P (Turning and Repositioning Q (every) one to two hours .protective devices: Heels float. Left Heel 4.4 x 6.0 .Stage: DTI .T/P (Turning and Repositioning) Q (every) one to two hours .protective devices: Heels float. There were no further weekly wound assessment for Resident #1's bilateral heels after 6/22/20. There was no weekly wound assessment documenting that the areas on Resident #1's heels were resolved. There was also no clarification on what stage her wounds were to her bilateral heels (Stage 1 or DTI). On 9/10/20 at 11:15 a.m., an observation of Resident #1's skin was conducted with LPN (Licensed Practical Nurse) #1. Resident #1 was observed to have bilateral heel boots in place. Resident #1 had no open areas or any other skin concerns to her bilateral heels. On 9/11/20 at 11:00 a.m., a telephone interview was conducted with ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the Interim DON (Director of Nursing). When asked how often she expected staff to conduct wound assessments, ASM #2 stated that she expected staff to document weekly on wounds and to document the assessments into PCC (Point Click Care). When asked why nurses would document weekly on a wound, ASM #2 stated that the purpose was to determine the progression or deterioration of the wound and to see if the current treatment is effective. When asked if Resident #1's bilateral heels were stage one pressure ulcers or a DTI (Deep Tissue Injury); ASM #2 stated from what the orders state, she thought they were DTIs. When asked if LPN's were allowed to stage wounds, ASM #2 stated she didn't recommend LPN's to stage wounds, that she recommended RN's to be the wound assessors. When asked if an RN went behind the LPN who assessed Resident #1's heels on 6/16/20; ASM #2 stated they did not. ASM #2 did state that the LPN who conducted the initial wound assessment on 6/16/20 used to be a wound care nurse. ASM #2 stated that the facility did not currently have a wound care nurse. When asked where the rest of the weekly wound assessment sheets were for Resident #1's heels, ASM #2 stated the only other one she had was a wound assessment from 6/22/20. When asked when Resident #1's heels had healed, ASM #2 could not provide a date of when the heels had resolved. ASM #1 and ASM #2 agreed that they were lacking documentation regarding wound monitoring and that this has been an issue they had addressed in an AD HOC meeting on 9/1/20. ASM #2 stated that they did not yet start their plan of correction. When asked what was their root cause analysis for nurses not assessing wounds on a weekly basis; ASM #1 stated that she has mostly agency staff in the building and stated that there was an issue with staff compliance. During this meeting LPN #1, the unit manager stated that Resident #1's family also refused (Name of wound group) to see their mom because they were very particular on who treated their mom. On 9/14/20 at 12:03 p.m., ASM #1 provided evidence of the AD HOC meeting conducted on 9/1/20. The following was documented: Skin Assessments: Initial and Weekly documentation and measurements .Resolution: Agency and Facility Staff educated to policies and procedures and expectations. Calendar of Assigned days and shift .Monitoring Compliance by DON/designee weekly x 3 months, then quarterly to sustain compliance through 2021. Utilize (Name of Wound Group) and report to QAPI (Quality Insurance and Performance Improvement). Facility Policy titled, Pressure Ulcer Record Policy, documents in part, the following: To document the presence of a skin impairment. new skin impairment related to pressure when first observed and weekly thereafter. Procedure: Residents have a Pressure Ulcer Record completed for each skin impairment that is related to pressure .Enter the date first observed, enter the stage of the pressure ulcer, enter the size of the pressure ulcer .enter the granulation, enter the drainage, enter the odor of the ulcer .each week the ulcer to be assessed and the following information collected on the Pressure Ulcer Record form: A. Date. B. Stage. C. Length x Width. D. Depth E. Drainage. F. Odor. G. Progress/Remarks- i.e. changes in dressing type- schedule, etc. * Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155. (1) Stage One Pressure Ulcer-Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate at risk persons (a heralding sign of risk). This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (2) Deep Tissue Injury- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. Complaint deficiency.

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