STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045135	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA HEALTHCARE LLC	**2642 NORTH DUDNEY ROAD MAGNOLIA, AR 71753**

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** Complaint # (AR 113) was substantiated, all or in part, with these findings: Based on observation, record review, and interview the facility failed to ensure body audits and pressure ulcer assessments were consistently documented to monitor wound progress for 1 (Resident #7) of 2 (Resident #6 and #7) sampled residents who had pressure ulcers. These failed practices had the potential to affect 2 residents who had pressure ulcers according to the roster matrix. The findings are: 1. Resident #7 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] documented the resident was severely impaired in cognitive status for daily decision making per a Staff Assessment for Mental Status (SAMS); and required extensive assistance with Activities of Daily Living (ADL's), was incontinent of bowel and bladder, was at risk for pressure ulcers and did not currently have a pressure ulcer. a. The Care Plan revised on 3/24/2020 documented, The resident has potential impairment to skin integrity r/t (related to) fragile skin. The resident will maintain or develop clean and intact skin by the review date. Weekly skin assessment per licensed nurse. Resident is at risk of skin breakdown r/t Incontinence (B&B)and impaired mobility. b. A body audit assessment dated [DATE] documented the resident had a Stage 2 pressure ulcer to the coccyx measuring 4 x (by) 2.5 x 0 cm. (centimeters). c. A physician's orders [REDACTED]. d. The July 2020 Treatment Administration Record (TAR) did not have initials for 7/2 (2020) and 7/4 (2020) indicating that the treatment had been done. e. A physician's orders [REDACTED]. every day shift for wound care. f. The July 2020 TAR did not have initial for 7/5 (2020) through 7/10 (2020) and 7/12 (2020) indicating that the treatment had been done. g. There was no wound assessment to include measurements, exudate, odor or other characteristics of the pressure ulcer documented in the clinical record from 6/30 until the resident went to the hospital on [DATE]. h. The Hospital History and Physical (H&P) dated 7/13/20 documented .Review of Systems. skin pos (positive) for ulcers . General: . Skin: stage 3 pressure ulcer on coccyx . i. On 7/17/2020 the resident returned from the hospital. There was no documented wound assessment completed. j. The July 2020 TAR did not have initials on 7/20 (2020), 7/21 (2020), and 7/26 (2020) indicating that the treatment had been done. k. A Skin and Wound Evaluation dated 7/23/2020 documented, A. Describe . 15. Pressure. 15a. Stage . 7. unstageable due to obscured full thickness skin and tissue loss. 15a7a due to slough and/or eschar 22. Location: sacrum. b. Wound Measurements Length 8.7 cm x width 10.8 . c. wound bed slough 3a. % (percent) of slough 90% (percent) of wound filled. D. Exudate: . Heavy Type: Serosanguineous. l. On 8/6/2020 at 1:51 p.m., the Director of Nurses (DON) was asked, Does the resident have a pressure ulcer (PU)? The DON stated, Yes. The DON was asked, Where is it located? The DON stated, Sacrum. The DON was asked, What interventions are used? The DON stated, Low air loss (LAL) mattress, Juven, and getting her a wound care consult now that she is no longer positive for COVID-19. The DON was asked, When did the current pressure ulcer develop? The DON stated, 6/30/20. The DON was asked, What caused it? The DON stated, Generalized decline in health, incontinence, not being turned and repositioned as she should have been. The DON was asked, What interventions were in place prior to the PU developing? The DON stated, Barrier Cream, weekly skin audits, pressure relieving mattress and cushion. The DON was asked, What is the current treatment? The DON stated, Normal Saline (NS) soaked Gauze to wound, turn and reposition every 2 hours. The DON was asked, Is the PU improving? The DON stated, Yes. The DON was asked, Does the resident have pain? The DON stated, Yes. She gets medicated prior to treatments. The DON was asked, Is the treatment effective? The DON stated, Yes. The DON was asked, How do you monitor progress of the PU? The DON stated, During the daily dressing changes, notice if peri-wound is red, has more drainage or an odor, measurements weekly. The DON was asked, Can you tell me why there was no documented wound assessments or body audits completed? The DON stated, The Week of July 6 - 10th, I was working nights on the COVID hall and my ADON (assistant director of nurses) was supposed to be doing them. She is no longer employed and I would not know where she would have kept the documentation since it is not in the record. The DON was asked, Can you tell me what the PU measurement was prior to going to the hospital? The DON stated, No. The DON was asked, Can you tell me why measurements were not taken when the resident returned from the hospital on [DATE]? The DON stated, The nurse should have measured the wound when she returned. 2. A form titled Wound Care Monitoring documented, Policy: To promote healing, prevent infections, and prevent new pressure ulcers from developing. Residents will receive appropriate treatment for [REDACTED]. General Information: A licensed nurse will assess the pressure ulcer weekly and keep the physician informed of progress with prescribed treatments. Procedure/Protocol: 1. The Wound Care Coordinator or licensed nurse that is responsible for the wound care will examine wounds weekly to assess and document findings. 2. The Wound Care Coordinator or license nurse will complete a weekly wound description in the resident's health record. 3. Documentation will reflect if dressing is intact, drainage noted, pain associated with the wound, any odor and condition of surrounding skin is visual around dressing. 4. Determine state of pressure ulcer, descriptions not limited to included information. 9. The Wound Care Coordinator or licensed nurse will document progress or digress of wound weekly. Treatments will be adjusted accordingly and after obtaining a physician's orders [REDACTED].

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