STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395273	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDENS AT SCRANTON, THE	**824 ADAMS AVENUE SCRANTON, PA 18510**

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 review of clinical records, select facility policy and facility wound tracking and staff interviews, it was determined that the facility failed to accurately identify and track pressure ulcers/injury for one out of eight residents sampled (Resident CR1). Findings include: According to the RAI (Resident Assessment Instrument) Manual a pressure ulcer/injury is defined as localized injury to the skin and/ or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. Review of the facility Skin and Wound Management System Policy last revised April 2017 defined a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. A review of the resident's clinical record revealed that Resident CR1 had diagnoses, which included COVID-19, [MEDICAL CONDITION] and [MEDICAL CONDITION] following [MEDICAL CONDITION] disease and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of muscle of multiple sites. An Annual Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated May 5, 2020, indicated that the resident's BIMS (brief interview for mental status- a tool to assess cognitive function) score was 9 (8-12 indicates moderately impaired cognition). Further review of the MDS revealed that the resident required extensive assist with two-person physical assist with bed mobility and toileting, was totally dependent on staff for bathing, and was at risk for pressure ulcers. Further review of the resident's clinical record revealed that on May 10, 2020, the resident was noted to have a small amount of sanguineous (bloody) drainage in his left groin, with further inspection revealing an open area measuring 1.3 centimeters (cm) in length x 3 cm in width x 1 cm in depth was identified. According to the documentation the area was difficult to visualize due to the contracture of the resident's left hip. Review of facility Wound Evaluation Form dated May 10, 2020, revealed that the resident's open wound was a non-pressure ulcer that measured 1.4 cm x 3 cm x 1 cm. Review of facility Wound Evaluation Flow Sheet dated May 18, 2020, revealed that Resident CR1's left groin open wound measured 3.3 cm x 3 cm x 6 cm, Stage IV (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer), had a moderate amount of serosanguineous (yellowish fluid mixed with blood) drainage, was tender to touch. Additional comments noted that the resident's tendon was exposed. A review of facility Wound Tracking for the month of May 2020 provided by the facility, revealed that Resident CR1 had a Stage II pressure ulcer identified on April 27, 2020, located on the back of his left hand and the wound was monitored weekly per facility policy. The May 2020 Wound tracking failed to include tracking of the resident's Stage IV pressure ulcer wound in his left groin. An END of PPS (Prospective Payment System) MDS dated [DATE], revealed that Resident CR1 had one Stage II pressure ulcer, the wound identified on April 27, 2020. No further pressure ulcers were identified on this assessment. Interview with Nursing Home Administrator and Director of Nursing on June 29, 2020, at approximately 10:30 a.m. confirmed that Resident CR 1 had developed a pressure injury in the left groin, the contracted hip area, and the facility failed to identify and track the resident's groin pressure ulcer. 28 Pa. Code 211.5 (f)(g)(h) Clinical records Previously cited 7/7/17 28 Pa Code 211.10 (a)(d) Resident care policies 28 Pa code 211.12 (a)(c)(d)(3)(5) Nursing services Previously cited 7/7/17

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.