| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455643 | A. Building<br>B. Wing | 09/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Matagorda House Healthcare Center | 700 12th St<br>Bay City, TX 77414 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37007<br><br>Based on observation, interview and record review, the facility failed to accommodate the needs and preferences of 3 of 6 residents (Resident #1, #2, and #3) reviewed for accommodation of needs.<br><br>The facility failed to place Residents #1, #2, and #3's call-lights within reach.<br><br>This failure could place residents at risk of not having their needs and preferences met and a decreased quality of life.<br><br>Findings include:<br><br>1. Record review of Resident #1's face-sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included pressure ulcer of unspecified heel, bipolar disorder, abnormalities of gait and mobility, muscle weakness, Type 2 diabetes, gastro-esophageal reflux disease, hemiplegia following cerebral infarction affecting left nondominant side, history of falling and unspecified dementia.<br><br>Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a Resident's cognitive skills for daily decision making was severely impaired. Further review revealed the resident was totally dependent on 2 persons for bed mobility and transfers, and Resident was totally dependent on 1 person for dressing, toilet use, personal hygiene and bathing.<br><br>Record review of Resident #1's care-plan (Problem onset: 5/26/20) revealed Problem/Need: I am at risk for falls related to impaired mobility and muscle weakness. Approaches: Call bell in reach.<br><br>Observation of Resident #1 on 8/17/21 at 10:30 AM revealed Resident #1 was asleep in bed. Further observation revealed the resident's call light was not within the resident's reach as it was placed on a chair next to the resident's bed.<br><br>2. Record review of Resident #2's face-sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included anemia, coronary artery disease, heart failure, peripheral vascular disease, hyperlipidemia, cerebrovascular accident, non-Alzheimer's dementia, hemiplegia and depression.<br><br>(continued on next page) |

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.

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

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. Further review revealed Resident #2 was totally dependent on 1 person for bed mobility, dressing and personal hygiene and totally dependent on 2 persons for transfers, toilet use and bathing.<br><br>Record review of Resident #2's care-plan (Start date 5/17/21) revealed Care Plan Description: At risk for falls related injury as evidenced by: Fall Risk Factors present as determined by Fall Risk Screen, hemiplegia related to cerebrovascular accident, weakness, impaired mobility and weakness. Intervention: safety measures to reduce fall risk.<br><br>Observation of Resident #2 on 8/17/21 at 10:40 AM revealed Resident #2 was asleep in bed. Further observation revealed the resident's call light was not within the resident's reach as it was on the floor.<br><br>3. Record review of Resident #3's face-sheet revealed an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included unspecified dementia, essential hypertension, muscle wasting and atrophy, dysphagia, cerebral infarction, pressure ulcer of right buttock, muscle weakness, history of falling, cognitive communication deficit and pain.<br><br>Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of 3 out of 15, which indicated severely impaired cognition. Further review revealed the resident required extensive assist of one person for bed mobility and transfers and was totally dependent on 1 person for dressing, toilet use, personal hygiene and bathing.<br><br>Record review of Resident #3's care-plan (problem onset date: 3/11/20) revealed Problem/Need: I am at risk for falls related to impaired mobility and cognitive impairment. Approaches: Call bell in reach.<br><br>Observation of Resident #3 on 8/17/21 at 10:43 AM revealed Resident #3 asleep in bed. Further observation revealed the resident's call light was not within the resident's reach and it was attached to the resident's over bed light.<br><br>Observation and interview with LVN-D on 8/17/21 at 10:47 AM, she observed the call lights of Resident #1, #2 and #3's and stated the call lights should have been within their reach while they were in bed. LVN-D proceeded to place the call lights in reach and stated all staff were responsible for answering call lights and were also to make sure the call lights were within the resident's reach when leaving the room.<br><br>In an interview with the facility's Administrator on 8/18/21 at 3:15 PM, she stated the expectation was for call lights to be within the resident's reach while in bed, and she would in-service staff.<br><br>Record review of facility's policy titled Answering the Call Light (revised September 2003) revealed in part . Purpose: The purpose of this procedure is to respond to the resident's requests and needs. General guidelines: 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37007<br><br>Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 10 residents (Resident #4) reviewed for pressure ulcers.<br><br>1. The facility failed to identify unstageable pressure sores on both of Resident #4's heels which developed into necrosis of the bone (the death of bone tissue due to a lack of blood supply).<br><br>2. The facility failed to effectively assess and put interventions in place for Resident #4 to prevent pressure ulcers from further developing After hospital care, Resident #4 was readmitted back to the facility where he developed a stage II pressure sore to the sacral area which was identified by the wound physician three days after readmission,<br><br>An Immediate Jeopardy (IJ) was identified on 9/2/21. While the IJ was removed on 9/6/21, the facility remained out of compliance at a scope of isolated and severity of actual harm that is not immediate jeopardy due to the facility continued to evaluate their plan of removal for effectiveness .<br><br>These failures could place residents at risk of wound development, wound deterioration, a decline in health, possible hospitalization and infection.<br><br>Findings include:<br><br>Record review of Resident #4's, undated, face sheet revealed an [AGE] year-old male, initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: unstageable pressure ulcer of left heel, cerebral infarction, constipation, hypothyroidism, anemia, metabolic encephalopathy, chronic kidney disease, muscle weakness, unspecified lack of coordination, mild cognitive impairment, dysphagia, cerebral infarction due to embolism of unspecified cerebral artery, history of falling, vascular dementia, essential hypertension and peripheral vascular disease.<br><br>Record review of Resident #4's Quarterly Minimal Data Set (MDS) assessment, dated 7/21/21, revealed the resident's cognitive skills for daily decision making was severely impaired, the resident was totally dependent on 1 staff for bed mobility, dressing, toilet use and personal hygiene. Resident #4 was at risk of developing pressure injuries, but had no unhealed pressure injuries.<br><br>Record review of Resident #4's care plan revealed:<br><br>* (Problem Onset: 8/13/21). Problem: Impaired skin integrity as evidenced by unstageable pressure ulcer injuries to right and left heel due to eschar with additional risks related to need for extensive assist with ADL's especially bed mobility, malnutrition, incontinence and peripheral vascular disease (Problem Onset: 8/17/21). Problem: Open area to coccyx.<br><br>Approaches: weekly skin checks, Report signs of infections (odor, increase drainage, pain or redness).<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * (Problem onset: 4/15/21). Problem: At risk for impaired skin integrity as evidenced by need for assistance with bed mobility, decreased ADL function . Approaches: weekly skin checks, promote adequate nutrition and hygiene, incontinent care as needed, skin assessment quarterly and as needed.<br><br>Record review of Resident #4's Departmental notes, dated 7/2/21 - 7/29/21, revealed no documentation of skin concerns.<br><br>Record review of Resident #4's Treatment Administration Record, dated July 2021, revealed:<br><br>* Skin hydration with A&D ointment to BLE daily. Start date 7/15/21. Review revealed skin hydration administered 7/15/21 - 7/31/21.<br><br>* Weekly Skin inspection to be performed Q Monday. Start date: 7/15/21. Review revealed skin inspection competed on 7/19/21 by LVN B and on 7/26/21 by LVN D.<br><br>Record review of Resident #4's Skin Inspection report, dated 7/20/21 and completed by LVN B, revealed Skin Status: Skin intact.<br><br>Record review of Resident #4's Skin Inspection report, dated 7/27/21 and completed by LVN B, revealed Skin Status: Skin intact.<br><br>Record review of Resident #4's Treatment Administration Record, dated August 2021, revealed:<br><br>Weekly skin inspection to be performed Q Monday. Start date: 7/15/21. Review revealed assessment completed 8/2/21 by LVN B.<br><br>Record review of Resident #4's Skin Inspection report, dated 8/3/21 and completed by LVN B, revealed Skin Status: Skin intact.<br><br>Record review of Resident #4's Departmental notes, dated 8/6/21 written by LVN C, revealed .Resident was vomiting, percutaneous endoscopic gastrostomy (PEG) tube feeding was put on hold. This nurse was informed that Resident showing change in condition. This nurse went to resident's room, resident not responsive, eyes open, moderate amount of light brown colored emesis on resident's gown. Loose stools, dark colored down to resident's knees. Resident's vitals checked. Blood pressure 87/79, Pulse 88, Temperature 98.7. Respiration 22 even and unlabored. Notified Physician to send to ER .<br><br>Record review of Resident #4's hospital clinical record, dated 8/6/21, revealed:<br><br>* History and physical: Chief complaint - Patient is an [AGE] year old gentleman, came to the hospital with sepsis .Patient has a necrotic wound to the right heel. Patient also has severe UTI.<br><br>* General appearance: Musculoskeletal: necrotic wound to the right heel.<br><br>* Diagnosis, Assessment and Plan: (1) Septic shock. Status: acute. (2) Acute Kidney Injury. Status: Acute. (3) Urinary Tract Infection. Status: Acute. (6) Foot ulcer with necrosis of bone.<br><br>* Laboratory tests: [NAME] Blood Count 15.4 (normal range: 4.5 - 11.0), Urine [NAME] Blood Count (WBC) Too numerous to CNT/hpf.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * Problems: (1) Pressure injury of skin with infection.<br><br>Record review of Resident #4's Departmental notes, dated 8/14/21 written by LVN C, revealed .Resident arrived to facility via EMS .Assessment done at this time Respiration even and unlabored. Lung sounds clear in all lobes. Resident respiration even and unlabored .Resident has brief on, no redness noted to peri area. Resident skin warm and dry. Resident has dressing to bilateral feet with date 8/13/21.Both dressings removed, resident with unstageable to left heel, minimal drainage noted 10 X 9.5 X0 .Right heel noted to have dried blister, not open, no drainage .<br><br>Record review of Resident #4's Skin Inspection report, dated 8/13/21 and completed by LVN C, revealed Skin Status: Skin not intact - existing.<br><br>Record review of Resident #4's Braden Risk Assessment Report, dated 8/13/21, revealed:<br><br>* Risk score: 10<br><br>* Risk level: High<br><br>* Activity: Bedfast - confined to bed.<br><br>* Mobility: Very limited. Makes occasional slight changes in body extremity position but unable to make frequent or significant changes independently.<br><br>Record review of Resident #4's Wound Assessment Report, dated 8/13/21, revealed:<br><br>* Wound type: Pressure ulcer<br><br>* Wound location: bottom of left heel<br><br>* Date wound identified: 8/6/21<br><br>* Present upon admission: No<br><br>* Assessment Occasion: New wound<br><br>* Stage: Unstageable due to suspected deep tissue injury.<br><br>* Measurement: Length: 10 CM Width 9.5 CM<br><br>Record review of Resident #4's Wound Assessment Report, dated 8/13/21, revealed:<br><br>* Wound type: Pressure ulcer<br><br>* Wound location: Right pad of foot<br><br>* Date wound identified: 8/6/21<br><br>* Present upon admission: No<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * Assessment Occasion: Re-assessment<br><br>* Stage: Unstageable due to suspected deep tissue injury.<br><br>* Measurement: Length: 4 CM Width 2.2 CM<br><br>Record review of Resident #4's Physician's Orders, dated August 2021, revealed:<br><br>* Skin hydration with A&D ointment to BLE daily. Start date 8/13/21.<br><br>* Weekly Skin inspection to be performed Q Monday. Start date: 8/13/21<br><br>* Left heel - cleanse with normal saline. Pat dry. Apply betadine. Cover with xeroform and wrap with kerlix every day. Start date: 8/13/21.<br><br>* Right lateral foot. Cleanse with normal saline. Pat dry. Apply betadine and leave open to air daily. Start date: 8/13/21.<br><br>* Cefuroxime axetil 500 mg tablet (1) per Peg tube twice daily for 10 days. Start date: 8/13/21. Stop date: 8/23/21.<br><br>* Bactrim Double Strength Tablet (1) per Peg tube twice daily for 10 days. Start date: 8/13/21. Stop date: 8/23/21.<br><br>Record review of Resident #4's Treatment Administration Record, dated August 2021, revealed:<br><br>* Skin hydration with A&D ointment to BLE daily. Start date: 8/13/21. Review revealed Skin hydration completed.<br><br>* Left heel - cleanse with normal saline. Pat dry. Apply Betadine. Cover with xeroform and wrap with kerlix every day. Start date: 8/13/21. Review revealed treatment administered on 8/14/21 - 8/17/21.<br><br>* Right lateral foot - cleanse with normal saline. Pat dry. Apply betadine and leave open to air daily. Start date: 8/13/21. Review revealed treatment completed 8/14/21 - 8/17/21.<br><br>*<br><br>Record review of Resident #4's Medication Administration Record (MAR), dated August 2021, revealed:<br><br>* Cefuroxime axetil 500 mg tab (1) per Peg tube twice daily for 10 days. Start date: 8/13/21. Stop date: 8/23/21. Review revealed medication administered 8/14/21- 8/16/21.<br><br>* Bactrim Double Strength Tablet (1) per Peg tube twice daily for 10 days. Start date: 8/13/21. Stop date: 8/23/21. Review revealed medication administered 8/14/21- 8/16/21.<br><br>Record review of Resident #4's Wound Physician note, dated 8/16/21, revealed:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * Wound location: left heel. Wound type: Pressure. Stage: unstageable. Measurement: 5 X 7 X 0.1. Drainage: scant. Treatment: Collagen to surrounding open. Betadine to eschar. QD and PRN.<br><br>* Wound location: Right buttock. Wound type: Pressure. Stage: 2. Measurement: 0.5 X 1.0 X 0.1. Drainage: minimal. Treatment: Collagen. QD and PRN.<br><br>* Wound location: Right lateral foot. Wound type: Pressure. Stage: 2. Measurement: 3.5 X 2 X 0.1. Drainage: minimal. Treatment: Collagen. QD and PRN.<br><br>Observation of Resident #4 on 8/17/21 at 2:23 PM revealed resident in bed, dressing to right and left heels in place. LVN G present during observation and performed wound care as ordered on left heel and right lateral foot.<br><br>Record review of facility's Wound and Skin Status Report, dated 8/17/21, revealed in part:<br><br>* Name: [Resident #4]<br><br>* Date identified/Present upon admit: 8/6/21/No<br><br>* Date of last assessment and Length X Width X Depth: 8/13/21 and 4.10 X 2.20 X 0.00<br><br>* Location: Right pad of foot<br><br>* Stage: Unstageable - suspicious of DTI<br><br>* Treatment: right lateral foot cleanse with normal saline. Pat dry, apply betadine and leave open to air dry daily.<br><br>Record review of facility's Wound and Skin Status Report, dated 8/17/21, revealed in part:<br><br>* Name: [Resident #4]<br><br>* Date identified/Present upon admit: 8/6/21/No<br><br>* Date of last assessment and Length X Width X Depth: 8/13/21 and 10.0 X9.5 X 0.0<br><br>* Location: Left bottom of heel<br><br>* Stage: Unstageable - suspicious of DTI<br><br>* Treatment: left heel - cleanse with normal saline. Pat dry. Apply betadine. Cover with xeroform and wrap with kerlix every day.<br><br>Record review of Resident #4's Departmental notes, dated 8/18/21, revealed .Resident lying in bed with eyes closed .continues on antibiotics X 2. Ceftin for Methicillin-resistant Staphylococcus aureus (MRSA) to wound and Bactrim for UTI .<br><br>Record review of Resident #4's Bath/Shower Completion Form, dated 8/18/21, revealed an open area.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #4's Bath/Shower Completion Form, dated 8/23/21, revealed no skin conditions were checked off.<br><br>Record review of Resident #4's Bath/Shower Completion Form, dated 8/25/21, revealed no skin conditions were checked off.<br><br>Record review of Resident #4's Bath/Shower Completion Form, dated 8/26/21 and 8/27/21, revealed an open area.<br><br>Record review of facility's Wound and Skin Status Report, dated 9/5/21, revealed in part:<br><br>* Name: [Resident #4]<br><br>* Date identified/Present upon admit: 8/6/21/No<br><br>* Date of last assessment and Length X Width X Depth: 8/30/21 and 6.00 X 7.5 X 0.0<br><br>* Location: Left bottom of heel<br><br>* Stage: Unstageable - Slough/Eschar<br><br>* Wound bed/Drainage: 10% granulation<br><br>* Treatment: cleanse wound to left heel with wound cleanser. Pat dry with gauze. Apply betadine to eschar and collagen to surrounding.<br><br>Record review of facility's Wound and Skin Status Report, dated 9/5/21, revealed in part:<br><br>* Name: [Resident #4]<br><br>* Date identified/Present upon admit: 8/6/21/No<br><br>* Date of last assessment and Length X Width X Depth: 8/30/21 and 2.5 0 X 0.5 X 0.10<br><br>* Location: Right pad of foot<br><br>* Stage: 3<br><br>* Wound bed/Drainage: 100% granulation<br><br>* Treatment: cleanse wound to right lateral foot with wound cleanser. Pat dry with gauze. Apply collagen and calcium alginate.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview with the ADON on 8/17/21 at 3:05 PM, she stated on 8/6/21, LVN C was assigned to Resident #4, however; LVN E identified Resident #4 had a wound to the heel and asked LVN C about the treatment. LVN C then stated she was unaware of a wound, and there was no treatments for a wound. The nurses proceeded to observe the resident and identified a dressing to the left heel. The ADON further explained she was subsequently made aware of the wounds to Resident #4's heel, and immediately began an investigation to determine when the wound developed and why there were no treatment orders in place. She further stated Resident #4 was sent to the hospital on 8/6/21 due to low BP. The ADON explained during the facility's investigation, LVN B was terminated upon discovering LVN B documented that Resident #4's skin was intact, when the resident did have open areas.<br><br>In an interview with LVN E on 8/18/21 at 12:22 PM, she stated on 8/6/21 she was on the hall and was approached by a CNA (could not recall which CNA) letting her know of a bandage to Resident #4's heel. LVN E proceeded to look at the resident's heel, removed the bandage and saw it was an open wound which was pretty nasty. LVN E described the wound as purulent drainage and foul odor, which she proceeded to clean up. The nurse assigned to Resident #4 that day was LVN C, she informed LVN C about the wound, and LVN C stated she knew nothing about it, she did not know how the bandage got on the heel, and there were no orders to treat the wound at the time of the discovery. LVN C further stated she would take care of the Resident.<br><br>In an interview with the ADON on 8/18/21 at 3:10 PM, she stated she was not aware of Resident #4's heels until it was brought to her attention on 8/6/21, and on that day a skin assessment was completed, and there was no sacral wound. Resident #4 was sent to the hospital on 8/6/21 and returned to the hospital on 8/13/21. ADON further explained that it was not until 8/16/21 when the resident was seen by the Wound Physician, a sacral would was identified and measured at a Stage 2, 0.5 X 1 X 0.1.<br><br>In an interview on 9/1/21 at 11:40 AM with the ADON, Resident #4's shower sheets for July and August 2021 were requested. At 2:46 PM ADON provided shower sheets dated 8/18/21, 8/23/21, 8/26/21 and 8/27/21. At 3:33PM the ADON stated facility staff were unable to locate Resident #4's shower sheets for July and part of August.<br><br>In a phone interview with LVN C on 9/1/21 at 12:31PM, she stated she worked with Resident #4 on the day he was sent to the hospital (8/6/21). LVN C explained prior to 8/6/21 she had not seen any skin issues with Resident #4 and had not been informed of anything new skin issues. Earlier in the day on 8/6/21 the resident was identified to have a wound to the heel, and a skin assessment was completed. Later in the day, she was called by a CNA and informed Resident #4 was throwing up. She proceeded to assess the resident, his BP was about 80/70, the ADON was made aware and EMS was called. When EMS arrived at the facility, the resident's BP was 50/40, and the resident was transported to the hospital. LVN C stated she later contacted the hospital to follow up on the resident's status and was informed the resident was septic. LVN C explained when Resident #4 readmitted from the hospital, he had no open areas or wounds, only the areas to the left and right heels. She stated there was nothing on the resident's back, bottom or his elbows. She stated she did not see anything on the coccyx and knew nothing about it.<br><br>(continued on next page) |

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| | 455643 | A. Building<br>B. Wing | 09/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a phone interview with LVN D on 9/1/21 at 12:51 PM, she stated she worked with Resident #4 a few times, but could not recall if she did Resident #4's skin assessment in July and could not recall if he had any skin issues. She further stated she could not remember if the resident had any issues with the heels prior to going to the hospital, and no CNA's mentioned any skin issues to her. LVN D explained when Resident #4 readmitted to the facility from the hospital on 8/13/21, he had a bandage on the sacrum, she removed the bandage and saw there was nothing under it. She stated she guessed the bandage was there as a preventative measure.<br><br>In an interview with CNA F on 9/1/21 at 4:33 PM, she explained during the early part of July, she went in to give Resident #4 a bed bath and saw he had a band-aid on his heel, she removed the band-aid, wiped the area to clean it and saw it was a red opened area, but it was not bleeding. She explained when she wiped the area, a red substance smeared on the towel. CNA F stated she proceeded to tell LVN B about her observation of Resident #4's heel and the nurse stated she would take a look at it. CNA F stated when Resident #4 readmitted to the facility from the hospital, he had a bandage to his bottom, the nurse removed it, but there was nothing under the bandage, and she saw no issues with his skin.<br><br>In a phone interview with the Wound Physician on 9/1/21 at 4:25 PM, she explained she was unaware of the process the facility had in place for identifying wounds. The Wound Physician explained 8/16/21 was the first time she saw Resident #4 when she identified the wound to the buttock, she also stated she was unsure if the wound to the buttocks could have been identified earlier. She was not aware of any skin issues to Resident #4's heels until the resident readmitted to the facility from the hospital.<br><br>In an interview with the facility DON on 9/2/21 at 1:49 PM, she stated she first started working in the facility on 7/26/21, however; did not have computer access for the first 2 weeks of hire, and was unable to go into the electronic medical records to review resident records. On 8/6/21, the ADON informed her of Resident #4's heels, and immediately started a skin sweep of the entire facility and did not identify any new pressure ulcers. She further explained that the expectation was for CNA's to inform the nurses of any changes they identify during showers or care, and for the nurses to follow up and make the ADON and DON aware of any new findings, however, she was not made aware of any skin issues with Resident #4 prior to 8/6/21.<br><br>In an interview with the facility's Previous Administrator on 9/2/21 at 2:10 PM, she stated during her time at the facility (4/13/21 - 7/2/21) morning meetings were held every morning, and the IDT would discuss skin issues. She stated she could not recall Resident #4 being discussed with any skin concerns. She further explained per the DON at the time (Previous DON), the facility was down to only 3 wounds and Resident #4 was not one of them. She stated wounds improved and she had no knowledge of anything else.<br><br>In an interview with the Administrator on 9/2/21 at 2:30 PM, she stated she was made aware of Resident #4's heels and the resident was subsequently sent to the hospital, LVN B was immediately terminated because she failed to document a change in Resident #4's skin condition, and failed to follow up. The Administrator further stated a skin sweep was completed of all residents in the facility and no new pressure ulcers were identified. She explained on 8/25/21, the failure was addressed in a QA meeting with all department heads, and the wound physician, and staff in-services were initiated.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview with the facility's Previous DON on 9/2/21 at 3:15 PM, she stated she worked in the facility from June 2020 until July 22, 2021. She explained during her time at the facility she was responsible for overseeing the nurses and for making sure skin issues were addressed. She explained every day, she would pull a report from the EMR to review for any new skin concerns which were documented and followed up with the nurses to assure follow up had been completed. She stated she stayed on top of wounds and was never made aware of any wound concerns regarding Resident #4.<br><br>Surveyor attempted to reach LVN B for a phone interview on 8/17/21, 8/18/21, 9/1/21 and 9/2/21. All attempts were unsuccessful, and no calls were returned.<br><br>Record review of the facility's policy titled Skin System Policy and Procedure, revised 11/17, revealed in part . Policy: 1. Residents who enter the facility without a pressure sore will not develop a pressure sore unless the individual's clinical condition demonstrates it was unavoidable .Procedure: 8. Upon identification of skin/wound impairment the nurse will: complete the SBAR (situation, background, assessment and recommendation tool) and obtain orders from the physician for care in accordance with the formulary guidelines for the identified wound as approved by the physician .<br><br>Record review of the facility's policy titled Change in a Resident's Condition or Status, revised May 2017, revealed in part .Policy Interpretation and Implementation: . 2: A significant change of condition is a major decline or improvement in the resident's status that: A. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. B. Impacts more than one area of the resident's health status . 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition/status<br><br>This was determined to be an Immediate Jeopardy (IJ) on 09/02/21 at 12:31 PM. The Administrator was notified. The Administrator was provided with the IJ template on 09/02/2021 at 12:31 PM.<br><br>The following Plan of Removal submitted by the facility was accepted on 09/03/21:<br><br>The plan of removal included the following:<br><br>Allegation of Credible Compliance<br><br>09/03/2021<br><br>Immediate Interventions:<br><br>1. Notification made to Medical Director, of Immediate Jeopardy on [DATE] 11:18am<br><br>2. Quality Assurance and Assessment Meeting conducted with action plan developed. This occurred at [DATE].<br><br>3. A complete skin sweep of the entire building was completed on [DATE] by charge nurses from each hallway under the direction of DON and ADON. No new skin alterations were identified.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4. Residents that have altered skin integrity have been re-reviewed by the Interdisciplinary Team (IDT) to ensure appropriate interventions were in place and that and care plans are updated to reflect current interventions. Completed on [DATE].<br><br>The Interdisciplinary Care Team consists of:<br><br>a. Administrator<br><br>b. Director of Nursing<br><br>c. Director of Rehab Services<br><br>d. Assistant Director of Nursing<br><br>e. Infection Preventionist<br><br>f. Activities Director<br><br>g. Dietary Manager<br><br>h. Social Services<br><br>i. Medical Director<br><br>j. Nurse Practitioner<br><br>5. Resident skin alterations and interventions will be monitored by visual observations 1 time daily by Director of Nursing, and/or ADON and/or Infection Preventionist for 4 weeks. The Wound Physician will round weekly on residents identified by the IDT team with skin alterations and provide timely documentation to the facility, with consultation as needed.<br><br>Training:<br><br>1. An immediate in-service was initiated on by Nurse Management Team on the importance of skin assessment, interventions and supporting documentation to be completed by [DATE].<br><br>Steps for Wound Documentation Inservice<br><br>Upon admission, readmission, return from hospital, or ER observation a complete head to toe skin assessment will be completed.<br><br>* Notify the DON and Administrator immediately<br><br>* Document the identified altered skin integrity in the wound care module<br><br>* Call the physician and notify of wound, obtain wound care treatment orders<br><br>* Obtain a wound physician consult order and obtain consent<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * Write a telephone order for treatment and consult<br><br>* Notify the family of wound, treatment, and facility plan of care.<br><br>* Identify probably cause of and possible other risk factors<br><br>* Identify areas of prevention and put in place such as float heels, air mattress, w/c cushion, other protective devices<br><br>* Initiate a care plan<br><br>* Assigned nurse will follow the Skin Inspections Schedule located in the 24-hour book and document weekly skin inspection in the wound module.<br><br>* Known altered skin integrity will be assessed weekly by assigned nurse and documented in the wound module following the weekly wound calendar in American Health Tech. Nurse Managers will use Skin Inspection Schedule and AHT wound assessment calendar as audit tools. Nurse Manager will place initials next to each completed task to signify compliance.<br><br>When you find a newly identified alteration on current residents in skin integrity including skin tears, bruises, open areas, the following steps will be completed.<br><br>* Initiate a SBAR and notify the DON and Administrator immediately<br><br>* Initiate an Incident/Accident Report for any newly identified skin tears or bruises<br><br>* Document the identified altered skin integrity in the wound care module<br><br>* Call the physician and notify of wound, obtain wound care treatment orders<br><br>* Obtain a wound physician consult order and obtain consent<br><br>* Write a telephone order for treatment and consult<br><br>* Notify the family of wound, treatment, and facility plan of care.<br><br>* Identify probably cause of and possible other risk factors<br><br>* Identify areas of prevention and put in place such as float heels, air mattress, w/c cushion, other protective devices<br><br>* Initiate care plan<br><br>* Assigned nurse will follow the Skin Inspections Schedule located in the 24-hour book and document weekly skin inspection in the wound module.<br><br>* Known altered skin integrity will be assessed weekly by assigned nurse and documented in the wound module following the weekly wound calendar in American Health Tech.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | * Nurse Managers will use Skin Inspection Schedule and American Health Tech. wound assessment calendar as audit tools. Nurse Manager will place initials next to each completed task to signify compliance.<br><br>2. A post-test and return demonstration will be completed by all licensed nursing staff to ensure competency. Continued in-servicing will be conducted if needed based on test score. Test scores will be accepted when employee gets 100% of questions correct.<br><br>3. New staff will receive in-servicing prior to orientation on the floor to include agency staff. PRN staff will not be allowed to work in the facility until they have completed in-service training and have a score of 100% on the post-test and return demonstration upon their next scheduled shift.<br><br>4. A listing of current employees will be used to track in-service completion.<br><br>5. The Certified Nurse Aides have been receiving ongoing training on newly implemented shower sheets and the importance of identifying new skin alterations and notifying charge nurses and re-training on the stop and watch process which identifies any changes in condition by the DON and ADON to be completed by 9/5/2021. The certified nurse aides will be provided with applicable interventions via shift change and the certified nurse aide care guide.<br><br>Monitoring:<br><br>1. The Charge nurse will notify Nursing Administration (DON/ADON/ Infection Preventionist (IP) when a new skin alteration is identified to determine if the appropriate process have been followed.<br><br>2. Administrator, or appointed designee, will review this process in the Abbreviated Quality Assurance Meeting scheduled 5 times per week (Monday through Friday) to monitor for compliance, to assess the appropriateness of the intervention, and to make changes based on the interdisciplinary team's decisions. (Sign in Sheet) In the abbreviated Quality Assurance Meeting, the process will be reviewed for any new alteration in skin integrity and if any additional clarification is needed this will be completed. The Nurse Aids, Medication Aides, and nurses will be notified of any intervention changes once the meeting has ended. DON, ADON will be responsible for communicating this information to the staff providing direct care to the resident discussed in the daily meeting.<br><br>3. An audit log will be utilized to track that planned interventions for Residents with skin alterations that are currently in place through visual observation. Nurse Managers will use Skin Inspection Schedule and AHT wound assessment calendar as audit tools. Nurse Manager will place initials next to each completed task to signify compliance. This will be conducted by Director of Nursing Assistant Director of Nursing, and Infection Preventionist.<br><br>4. The Shower Sheets and the Stop and Watch documentation provided from the Certified Nurse Aides will be reviewed in the Abbreviated Quality Assurance Meeting which occurs daily Monday through Friday and documentation and interventions will be reviewed by the DON and ADON.<br><br>The Medical Director will be involved through the Quality Assurance and Performance Improvement (QAPI) process with ongoing training as needed.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | [The Facility]will have all aspects of the plan implemented by [DATE] and the Administrator will be responsible for this implementation.<br><br>Monitoring:<br><br>The Plan to lower the Immediate Jeopardy had been implemented by:<br><br>Interviews and observations of 3 residents with pressure ulcers were made on 9/3/21 - 9/5/21 between the hours of 9:00 AM - 6:30 PM. The observations revealed the residents had pressure reducing mattresses, staff were turning and repositioning them, and using other pressure reducing devices such as pillows, positioning wedges, etc. Interviews with the residents revealed they received appropriate wound care and were assisted timely with repositioning.<br><br>Facility staff were interviewed on 9/4/21 - 9/6/21 over completed in-services, new plans, new tools and new policies developed. Staff interviewed included the Administrator, DON, ADON, 4 nurses (2 from night shift 6PM - 6AM and 2 from day shift 6AM - 6PM) and 4 CNA's (2 from each shift). All staff interviewed voiced understanding of new policies and plan developed to monitor wound management program. Nursing staff were aware of their responsibilities in wound management, knowledge of assessment tools, and what to do and how to care for residents who develop new wounds or wounds worsen. Staff were also able to voice responsibility to review residents' records and orders and who to report any discrepancies or clarifications to.<br><br>Record review was completed for the 3 residents with pressure ulcers and revealed facility staff had assessed residents for wounds, completed updated Braden scales, completed updated weekly skin assessments, completed wound assessments and updated care plans with individualized interventions.<br><br>Record review of the facility's Assessment Schedule for September 2021 dated 9/3/21 revealed a tool created for the administrative staff to check off on once scheduled assessments are completed.<br><br>Record review of the facility's new Weekly Skin Inspection Schedule revealed room numbers of residents whose skin assessments were due each day and shift. Record review of Weekly skin review of completed 9/3/21 - 9/5/21 revealed assessments were completed per the schedule and documented.<br><br>Record review of in-services completed by nursing staff revealed: Steps for Wound Management (9/3/21), New shower sheets (9/3/21), Change of Condition (9/2/21), Return Demonstration of Comprehension of Wound Assessment Manager 9/6/21.<br><br>The Administrator and DON were notified the IJ was removed on 9/6/21 at 2:27 PM. The facility remained out of compliance at [TRUNCATED] |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37007<br><br>Based on observation, interview, and record review , the facility failed to maintain medical records on each resident which was complete and accurately documented for one (Resident #10) of five residents reviewed.<br><br>The facility failed to ensure Resident #10's MAR was accurately documented to reflect he did not receive supplemental oxygen.<br><br>This failure could place the residents at risk for nurses to inaccurately document medications and/or treatments.<br><br>Findings include:<br><br>Record review of Resident #10's face sheet, dated 09/01/21, revealed she was a [AGE] year old female and was admitted to the facility on [DATE] with diagnoses which included, muscle wasting, lack of coordination, dysphagia (difficulty swallowing), and unspecified psychosis.<br><br>Record review of the MDS assessment, dated 09/01/21, for Resident #10 revealed a BIMS score of '2,' which indicated severely impaired cognition .<br><br>Record review of the August 2021 TAR for Resident #10 revealed the staff initialed the resident received oxygen at 2 liters per minute via nasal cannula.<br><br>Record review of the September 2021 Physician Orders for Resident #10 revealed an order for oxygen to be administered via nasal cannula continuously at the rate of 2 liters per minute.<br><br>Observation on 08/27/21 at 3:05 p.m. revealed Resident #10 was not in her room. Observation revealed there was no oxygen concentrator or portable oxygen tanks visible in the room.<br><br>Observation on 08/27/21 at 4:20 p.m. revealed Resident #10 sat in the hallway in her wheelchair. There was no oxygen administered to the resident. The resident did not appear to be in distress or had difficulty breathing.<br><br>Observation on 08/31/21 at 9:45 a.m. revealed Resident #10 participated in activities in the lobby. Oxygen was not administered to the resident. The resident did not appear to be in distress or had difficulty breathing.<br><br>Observation on 08/31/21 at 10:18 a.m. revealed Resident #10 attended a birthday party in the activity room. Oxygen was not administered to the resident. The resident did not appear to be in distress or had difficulty breathing.<br><br>Observation on 08/31/21 at 12:15p.m. revealed Resident #10 was in her room. She was not receiving oxygen. There was no oxygen concentrator or portable oxygen cylinder in the room. The resident did not appear to be in distress.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 09/01/21 at 12:35 p.m. revealed Resident #10 was in the dining room. She was not receiving oxygen . She did not appear to be in any distress.<br><br>Observation on 09/02/21 at 9:30 a.m. revealed Resident #10 was in bed in her room. A family member was in the room . The resident was not receiving oxygen. There was no oxygen concentrator or portable oxygen cylinder in the room. The resident did not appear to be in distress.<br><br>Observation on 09/02/21 at 11:25 a.m. revealed Resident #10 laid in her bed, awake. The resident was not receiving oxygen. There was no oxygen concentrator or portable oxygen cylinder in the room. The resident did not appear to be in distress.<br><br>Interview with the ADON on 09/03/21 at 11:00 a.m. revealed the Physician Orders were computer generated based on the previous month and any updates. She said Resident #10 was administered the oxygen when she had COVID-19 last year, but has no respiratory issues now. She said she would call the physician to have the order discontinued . She said the nurses should not have been signing the TAR . |