STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676366	A. BUILDING ______ B. WING _____	**07/31/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MELROSE	**1501 W 29TH ST TYLER, TX 75702**

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 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to ensure necessary care and services were provided to prevent the development of pressure ulcers and necessary treatment and services were provided to promote healing, prevent infection, and prevent new pressure ulcers from developing for 1 of 3 residents reviewed for pressure ulcers. (Resident #1)

Resident #1 developed 4 facility acquired avoidable pressure ulcers. The facility did not provide appropriate and accurate assessments of the pressure ulcers, did not implement new interventions to prevent the development of and worsening of the pressure ulcers, and did not request a dietary followup when the resident developed new pressure ulcers and the existing pressure ulcers worsened. The facility did not notify the physician at least 2 weeks after the resident's pressure ulcers worsened in appearance and developed a foul odor. Resident #1 was admitted to the hospital due to gangrene in his pressure ulcers and osteo[DIAGNOSES REDACTED] (infection in the bones) that required surgical intervention, and long term intravenous (IV) antibiotic therapy.

These failures contributed to the development and worsening of 4 new pressure ulcers for Resident #1.

An Immediate Jeopardy situation was identified on 7/31/15 at 8:30 a.m. The Immediate Jeopardy was removed on 7/31/15 at 3:01 p.m. The facility remained out of compliance at a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

This failure could place one resident with pressure ulcers and 2 residents in the bed most of the time at risk for developing new pressure ulcers, a decline in existing pressure ulcers, infections, and/or death.

Findings included:

A consolidated physician order [REDACTED].#1 was a [AGE] year old male admitted on [DATE]. His [DIAGNOSES REDACTED].

A Braden Scale for Predicting Pressure Sore Risk dated 4/13/15 indicated Resident #1 had a score of 14 indicating he was at high risk for pressure sores. The form indicated it would be updated quarterly and as needed. There were no other updates.

A Nutritional Evaluation dated 6/23/15 indicated Resident #1 received [MEDICATION NAME], a multi-vitamin, and vitamin C to aid in the maintaining of nutritional status and aid in skin repair. The dietician recommended the resident to continue a regular diet with additional supplements and add [MEDICATION NAME] (promotes wound healing) 1 package two times daily for 14 days. The previous consult was 1/21/15. There were no other dietician recommendations after 6/23/15.

A care plan dated 6/24/15 indicated Resident #1 had pressure ulcers: an unstageable on his coccygeal area, a Stage II on his left ischium (buttock), and an unstageable on his right ischium (buttock). The interventions included: daily/weekly skin assessments, documentation of assessments, notify physician of negative changes, monitor nutrition, notify physician of signs of progress in two weeks, low air mattress, and a television mounted on the wall to encourage repositioning, and consult wound care. A care plan problem indicated Resident #1 refused to bathe, but no care plan indicating a problem of refusal to stay off his bottom or to be repositioned.

The most recent MDS dated [DATE] indicated Resident #1 was moderately cognitively impaired and did not have any behaviors of rejection of care. He required total assistance with bed mobility with one person and was totally dependent on two staff for transfers. He was always incontinent of bowel and bladder. The assessment indicated his skin condition consisted of 1 Stage II pressure ulcer and 1 unstageable pressure ulcer.

Pressure Ulcer 1

A nursing note dated 5/28/15 indicated Resident #1 had a new Stage I pressure ulcer on his coccygeal area and the NP was notified.

A telephone physician order [REDACTED].#1's pressure ulcer on his coccygeal area with cleanser of choice, pat dry, then apply medi-honey to the wound bed, and cover with foam dressing, change daily and as needed.

A nursing note dated 6/1/15 indicated Resident #1's pressure ulcer on his coccygeal area measured 2.5 cm x 2 cm with 0.5 cm x 0.5 cm of necrotic tissue present. The DON was informed and the NP was called.

The June 2015 TAR indicated on 6/1/15 the pressure ulcer on Resident #1's sacrum/coccyx area was to be cleaned with wound cleanser, patted dry, and medi-honey applied to the wound bed.

There were no other measurements or assessments in between 6/1/15 and 6/22/15.

A nursing note dated 6/22/15 at 4:00 p.m. indicated Resident #1's pressure ulcer on his coccygeal area measured 6 cm x 4 cm with light pink drainage and pink tissue surrounding the area and the center of the pressure ulcer was dark brown.

A wound consult report dated 6/22/15 indicated Resident #1 had an unstageable pressure ulcer on his coccygeal area measuring 6 cm x 7 cm. The treatment intervention was to cleanse the wound per facility protocol, and apply collagen fold to wound bed. Cover with foam dressing.

An undated weekly Pressure Ulcer Progress Report indicated Resident #1's unstageable pressure ulcer on his coccygeal area was 6 cm x 4 cm x 1 cm and identified on 5/28/15.

The weekly Pressure Ulcer Progress Report for Resident #1's pressure ulcer on his coccyx area indicated the following:

* 7/6/15 - it had a foul odor, serosanguinous drainage (consisting of serum and blood), red and gray, no progress, no decrease in size, no decrease in depth, and no decrease in drainage. The physician was not notified.
* 7/14/15 - the area had a strong odor with no other changes. There was no other documentation.

Pressure Ulcer 2

A nursing note dated 6/1/15 indicated Resident #1 had a Stage I on his left buttock measuring 2 cm x 1 cm. The DON was informed and the NP was called.

A wound consult report dated 6/22/15 indicated Resident #1 had a Stage II pressure ulcer on his left ischium (buttock) measuring 2.3 cm x 3 cm. The treatment intervention was to cleanse the wound per facility protocol, apply collagen fold to wound bed and cover with a foam dressing.

An undated Weekly Pressure Ulcer Progress Report indicated Resident #1's Stage II pressure ulcer on his left ischium (buttock) measured 1 cm x 1.5 cm and identified on 6/1/15.

The weekly Pressure Ulcer Progress Report for Resident #1's pressure ulcer on his left buttock indicated the following:

*7/6/15 - the pressure ulcer was the same size with red drainage.
* 7/14/15 - no changes. There were no other assessments after 7/14/15.

Pressure Ulcer 3

A nursing note dated 6/23/15 at 8:20 a.m. indicated Resident #1 was identified with another new open area identified as a Stage I on his right ischium (buttock) measuring 1.8 cm x 1 cm with a pink wound bed and no drainage. The NP was notified

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **676366**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **07/31/2015**

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and ordered zinc 220 mg for 30 days. The note indicated the DON wrote an order to encourage the resident to go back to bed after breakfast and lunch.

The (month) TAR indicated to cleanse Resident #1's pressure ulcer on his right buttock with normal saline and pat dry. There were no orders located.
A physician telephone order 7/6/15 indicated to cleanse Resident #1's pressure ulcer on his right ischium (buttock), pat dry, to apply fibrocol 2x2, and then cover with foam dressing.
An undated weekly Pressure Ulcer Progress Report indicated Resident #1's unstageable pressure ulcer on his right ischium (buttock) measured 6.3 cm x 5 cm and was identified on 6/23/15.
The weekly Pressure Ulcer Progress Report for Resident #1's pressure ulcer on his right ischium (buttock) indicated the following:
* 7/6/15 - the same measurements with gray drainage.
* 7/14/15 - with no changes.
Pressure Ulcer 4
During an interview on 7/28/15 at 1:24 p.m., LVN A said she identified a new pressure ulcer on Resident #1's buttock on 7/20/15. LVN A said the pressure ulcer was at least a Stage II, opened area, and measured about the size of a nickel. She indicated there was no documentation on this wound, no measurements, and the physician was not notified.
Weekly Skin Integrity Reviews signed by LVN D and dated 7/1, 7/8, and 7/14/15 were blank. They had open area checked and x on the picture of the buttock, but no assessment or description of the pressure ulcer.
During an interview on 7/28/15 at 2:56 p.m. LVN D said she worked the 2 p.m.-10 p.m. shift and had not completed any assessments or treatments for Resident #1's pressure ulcers since 6/15/15. She said she wrote an order on 7/6/15 for pressure ulcer # 3 at the DON's request; however, she did not contact the physician and did not assess the pressure ulcer. She said the last time she saw Resident #1's pressure ulcers or his bottom was 6/15/15, and it showed some healing. LVN D said the DON assigned Resident #1's treatments on the morning shift.
During an interview on 7/28/15 at 1:30 p.m., CNA B said she had worked with Resident #1 since the first of July. She said the resident had bad pressure ulcers on his buttocks when she first came. CNA B said the pressure ulcers smelled and had drainage. She said she informed the two charge nurses, LVN A and LVN E. She said Resident #1 did not refuse care, he would turn and reposition with assistance, and sometimes she assisted with dressing changes. CNA B said Resident #1 went to bed after lunch and gave her no problems with care.
A nursing note dated 7/20/15 at 3:00 a.m. indicated the resident had moderate amount of yellow drainage noted to his dressing and it was changed. (the note did not specify which pressure ulcer dressing)
During an interview on 7/28/15 at 3:13 p.m., LVN E said she had not worked with Resident #1 in about a week. She said the resident had three pressure ulcers the last time she provided treatment to his wounds which was around 7/20/15. She said the wound on the coccygeal area looked worse after a few days from when she first started on 7/6/15 and the other two looked about the same. LVN E said she did talk to the DON about the wound doctor looking at Resident #1's pressure ulcers, but she did not notify the physician about the resident's pressure ulcers worsening.
A nursing note dated 7/21/15 written by LVN A indicated the NP was called related to pressure ulcers on the Resident #1's buttocks. A new order was given to send to the wound clinic on 7/23/15.
During an interview on 7/28/15 at 1:24 p.m., LVN A said she worked with Resident #1 since 7/20/15 through to 7/24/15 when he went to the hospital. She said she talked to the DON and they got an order to send him to the wound clinic on 7/23/15 because his wounds smelled and looked so bad. She said Resident #1 had a large pressure ulcer on his coccygeal area that had yellow slough, black eschar, an odor, and drainage. LVN A said she did not complete any skin assessments on Resident #1 because they were supposed to be done on the 2 p.m-10 p.m. shift. She said the resident had two really bad pressure ulcers and two Stage II pressure ulcers on his buttocks.
A nursing note on 7/22/15 at 9:00 a.m. indicated Resident #1 ate less than 50 percent. The wound dressing was changed with moderate amount of yellow and brown drainage on the bandage. (The note did not specify which pressure ulcer).
A nursing note dated 7/24/15 at 8:30 a.m. indicated Resident #1 was sent to the wound care clinic.
An assessment from the Wound Care Clinic dated 7/24/15 identified the following 4 pressure ulcers:
1. Pressure Ulcer 1 identified on 5/28/15 - A Stage IV pressure ulcer on his coccyx measuring 5 cm x 4 cm x 1 cm, open with a large amount of purulent, yellow, brown, and green drainage, with an odor. The wound was surrounded by fibrotic scar, thicken tissue. A small amount of granulation noted less than 33 percent. The wound had a large amount of eschar, adherent slough more than 67 percent
2. Pressure Ulcer 2 identified on 6/1/15 - A Stage III pressure ulcer on his left ischium buttock measuring 0.5 cm x 0.5 cm x 0.1 cm, open with medium amount of serosanguineous drainage, red and brown drainage, no odor. The wound was surrounded by fibrotic scar, thicken tissue. A small amount of granulation noted less than 33 percent. The wound had a large amount adherent slough more than 67 percent.
3. Pressure Ulcer 3 - identified 6/23/15- A Stage IV pressure ulcer on his right ischium (buttock), measuring 6 cm x 6 cm x 2.5 cm, open with a large amount of purulent, yellow, brown, and green drainage, with an odor. The wound was surrounded by fibrotic scar, thicken tissue. A small amount of granulation tissue noted less than 33 percent. The wound had a large amount of eschar, adherent slough at more than 67 percent.
4. Pressure Ulcer 4 - (no date identified by facility) - A Stage III pressure ulcer on his right trochanter (hip) measuring 3 cm x 6 cm x 0.1 cm, open with a large amount of serosanguineous, red and brown drainage, no odor. The wound was surrounded by fibrotic scar, thicken tissue. A small amount of granulation noted less than 33 percent. The wound had a large amount adherent slough more than 67 percent.
A note from the wound care clinic dated 7/24/15 at 9:00 a.m. indicted Resident #1 had 4 pressure ulcers and he needed to be admitted to the hospital for surgical debridement.
A nursing note dated 7/24/15 indicated at 1:30 p.m. Resident #1 was back with orders to send to the hospital for surgical debridement. He was sent back to the hospital.
During an interview on 7/28/15 at 1:50 p.m., the DON said Resident #1 did not have a culture of his wound and was not on any antibiotics. The DON said on 6/23/15 he called the physician to get an order for [REDACTED]. He said until 7/21/15, he did not assess Resident #1's pressure ulcers and did not know they were not healing. The DON said on 7/21/15 he was walking down the hall and smelled a foul odor coming from Resident #1's room. He said at that time he saw the resident's pressure ulcers and was upset by how bad they looked and smelled. The DON said he was disappointed in his staff due to the miserable state of Resident #1's pressure ulcers. The DON said he called the NP and talked to her about getting an appointment at the wound clinic. He said there was a mix up with the dates, and Resident #1 was not seen at the wound clinic until 7/24/15. He said when Resident #1 was sent to the wound clinic, they wanted him sent to the hospital. The DON said he was not aware Resident #1 had four pressure ulcers when he left the facility and he was not aware when the fourth pressure ulcer developed. He said he was not aware the resident's pressure ulcers had an odor since at least 7/6/15. He said he was not aware the area on his ischium (buttock) worsened to an unstagable pressure ulcer. The DON said he had not seen the nursing documentation of the resident's pressure ulcers. He said the physician had not seen Resident #1's pressure ulcers and they only called to get a consult for the wound clinic. The DON said the Weekly Pressure Ulcer Progress report was given to him weekly for notification of pressure ulcer healing. He said he was not aware Resident #1 had two unstageable pressure ulcers. The DON said he must not have reviewed the documentation closely. He said the last time he saw Resident #1's pressure ulcers was 6/23/15. He said he was under the impression the resident's pressure ulcers were healing. The DON said Resident #1 had initially refused to lie down after breakfast and lunch and he loved to watch television. He said they got the resident's television mounted on the wall so he could watch it from bed and afterwards, there were no other issues with him lying down after meals.
During an interview on 7/30/15 at 12:50 p.m., the NP said she talked to so many facilities about residents with pressure ulcers, she could not say if she was informed of Resident #1's worsening of his pressure ulcers or not. She said she spoke to the DON about Resident #1 going to the wound clinic. She said at that time it was some mention of the drainage and the smell of the wound. The NP said she did not order wound cultures and she did not usually prescribe antibiotics. The NP said she did not give a stat order to send Resident #1 immediately because it usually took about 3 days to get an appointment.
During an interview on 7/28/15 at 1:14 p.m., the administrator said Resident #1 was admitted to the hospital because he had

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a bad pressure ulcer on his buttocks. She said they sent the resident to the wound clinic and the clinic sent him to the hospital. She said she did not know about the resident's pressure ulcers until the day before he went to the hospital on [DATE].

The hospital emergency room History dated 7/24/15 at 3:11 p.m. completed by the hospital physician indicated Resident #1 had increasing altered mental status for the past three weeks. He had potentially Stage 4 deep pressure ulcers, which suggested he was left in the same spot for days or weeks.

A Subjective Hospital report dated 7/26/15 indicated Resident #1 was wheelchair bound and fairly active until about 8 days ago with prostration (complete mental or physical exhaustion) and decreased activity level was observed. Resident #1 has had several [MEDICAL CONDITION] and unable to ambulate or speak. The report indicated Resident #1's active problem list were: pressure ulcer, osteo[DIAGNOSES REDACTED], dehydration, protein-calorie malnutrition, history of stroke, and motor [MEDICAL CONDITION] (the inability to speak or to organize the muscular movements of speech). The impression and recommendations indicated: Severe pressure ulcerations on the sacrum area and right buttock and the resident needed surgical debridement. The physician's impression indicated He will likely require bone debridement which should be sent for culture to help direct antibiotic therapy. He will require long course therapy. Resident #1 also had protein associated malnutrition. The patient indicated a recent decrease in intake and weight loss per the nursing home staff. We will need to consider feeding tube and protein supplementation. Due to the extensive nature of these ulcers we will consider diverting to [MEDICAL CONDITION].

The hospital Surgical Procedure Report dated 7/27/15 for Resident #1 indicated a Stage IV pressure ulcer with frank gangrenous changes, exposed sacrum, coccyx completely separated, and osteo[DIAGNOSES REDACTED]. Right ischium stage IV decubitus ulcer, right ischium and inferior public ramus with fragile to the bone. Stage IV right trochanteric pressure ulcer with gangrenous tissue and murky fluid. The coccyx was removed. The coccyxgectomy was performed and great care was taken to avoid the wall of the rectum. According to the report, at the completion of the debridement the coccygeal wound measured 11 cm x 9 cm, the debridement of the right ischium (buttock) decubitus ulcer measured 15 cm x 8 cm. The trochanteric (hip) wound measured 10 cm x 5 cm. The hospital also noted possible elder neglect. The hospital impression indicated the resident would require 6-8 weeks of IV antibiotic therapy, possible flap reconstruction later, and a [MEDICAL CONDITION].

The policy on Skin Integrity Monitoring System revised March 2012 indicated .a system will be in place to assure residents are assessed and monitor for any type of skin breakdown, and preventive measures are in place. A Braden scale will be completed quarterly and with any significant change in condition. When pressure ulcers are identified, the assessment of the ulcer must be documented on the Skin Assessment Flow sheet. When a pressure ulcer is identified, treatment orders are obtained from the physician. Amend the residents care plan to reflect the treatment interventions for new pressure ulcer and updates as needed to communicate the changes to all nursing staff, inform the dietary for nutritional consult. If pressure causes changes in the resident's skin, it is the responsibility of the nursing staff to initiate guidelines for pressure ulcers per physician orders. If eschar or necrotic tissue is present, debridement may be indicated .

A Skin System policy dated March 2012 indicated a care plan will be completed for each pressure ulcer site.

On 7/31/15 at 8:30 a.m., the the administrator and DON were notified an Immediate Jeopardy situation was identified.

On 7/31/15 at 1:40 p.m., the facility's Plan of Removal was accepted and included the following:

PLAN OF REMOVAL

7/31/2015

I. Corrective Action Taken:

Resident was sent to local wound clinic on 7/24/2015 and then later to the local hospital. The wound clinic transferred resident to a local hospital.

Resident is not expected to return to the facility.

II. Identification of Resident Potentially Affected:

All residents that are bedfast or in wheelchairs have the potential to be affected by this alleged deficient practice.

III. System Changes To Be Made:

A. FULL IN HOUSE SKIN ROUNDS - COMPLETED ON 7/31/15
B. INSERVICE NURSING DEPARTMENT ON SKIN SYSTEM - COMPLETED BY 8/1/15
C. NURSING ASSISSTANT DAILY OBSERVATION FORM - FILLED OUT WHEN SHOWERING ALL RESIDENTS - WITH/WITHOUT AREAS OF CONCERN
D. GIVE TO CHARGE NURSE TO SIGN AND VERIFY- MAKE COPY FOR DIRECTOR OF NURSES & ADMINISTRATOR
E. NURSES WILL DO THE FOLLOWING AND THIS WILL BE ON-GOING FOR ANY RESIDENT:

· CALL PHYSICIAN REGARDING AREA OF CONCERN / SKIN STATUS AND OBTAIN ORDERS FOR THAT RESIDENT / TO INCLUDE THE FOLLOWING:
· AREA OF CONCERN
· DRAINAGE
· ANY ODOR
· PRODUCT FOR CLEANSING
· PRODUCT FOR TREATMENT
· TYPE OF DRESSING (IF NECESSARY)
· IF SPECIAL TAPE IS NEEDED
· FREQUENCEY OF DRESSING CHANGE
· THE DURATION OF THE TREATMENT
· MEASUREMENTS OF AREA
· IS IT WORSENING
· ANY IMPROVEMENT
· CHANGE ASSESSMENT
· IDENTIFY THE UNDERLYING CAUSE
· PUT IN PLACE (IF PRESSURE) PRESSURE RELIEVING DEVICES
· PUT THE RESIDENT ON A TURN SCHEDULE
· DOCUMENTED IN THE NURSE'S NOTES
· UPDATE CARE PLAN / MDS
· CALL PHYSICIAN REGARDING THE PROGRESS - DOCUMENT IN NURSE NOTES
· INFORM RESIDENT AND RESPONSIBLE PARTY - DOCUMENT IN NURSES NOTES
· CHECK FOR WEIGHT LOSS - DOCUMENT IN NURSES NOTES
· CALL DIETITICIAN FOR A CONSULT - DOCUMENT IN NURSES NOTS

F. CHARGE NURSE TURN IN OBSERVATION SHEET & SKIN ASSESSMENT PRESSURE / NON PRESSURE FLOW SHEET TO DON AND ADMINISTRATOR
G. WEEKLY SKIN ASSESSMENTS ON ALL RESIDENT - TURN A COPY IN TO DON & ADMINISTRATOR
· IF A RESIDENT DEVELOPS A PRESSURE SORE DAILY SKIN ASSESSMENTS ARE TO BE COMPLETED AND DOCUMENTED DAILY
H. NO OTHER RESIDENTS HAVE PRESSURE SORES. (sic)

The survey team determined the facility had implemented its Plan of Removal sufficiently to remove the Immediate Jeopardy, effective 7/31/15.

As of 7/31/15 at 2:45 p.m., interviews with two LVNs and 4 CNAs revealed they were trained on the facility plan of removal and were able to provide information of different situational events related to pressures sores and their policy.

On 7/31/15 at 3:01 p.m., the administrator and DON were informed the Immediate Jeopardy was lifted; however, the facility remained out of compliance a pattern of actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

The CMS 672 dated 7/28/15 indicated 1 resident had a pressure ulcer and 2 residents who were bedfast.