STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045432**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **07/15/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANDALWOOD HEALTHCARE, LLC	**2600 JOHN BARROW ROAD LITTLE ROCK, AR 72204**

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 0309

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide necessary care and services to maintain the highest well being of each resident
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Complaint # (AR 408) was substantiated (all or in part) with these findings.
Based on observation, record review and interview, the facility failed to ensure staff consistently assessed, monitored, documented the condition of a diabetic ulcer and immediately consulted with the physician regarding deterioration for 1 of 1 (Resident #4) case mix resident who had a diabetic ulcer. The failed practice had the potential to affect 1 resident who had a diabetic ulcer according to a list provided by the Treatment Nurse on 7/15/15 at 2:30 p.m. The findings are:
Resident #4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an assessment reference date of 6/30/15 documented
the resident scored 7 (0-7 indicates cognitively impaired) on a Brief Interview for Mental Status and required extensive to total care of 2 persons for all activities of daily living.
a. The Care plan with a review date of 4/8/15 documented, .Resident is at risk for complications associated with hyper or [DIAGNOSES REDACTED] related to IDDM Approaches: .Provide meticulous foot care .
The hospital Summary of Care Report documented Resident #4 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. The Report documented, .Why you were hospitalized .Your primary [DIAGNOSES REDACTED].Arterial Doppler
ultrasound .Impression Bilateral [MEDICAL CONDITION], more marked on the right than the left .
The pathology report dated 5/16/15 documented, Taken 5/15/15 .Final Microscopic Pathologic Diagnosis .Great toe, right amputation: ulceration and marked acute and chronic inflammation with histological changes consistent with osteo[DIAGNOSES REDACTED] .
As of 7/12/15, the care plan had no updated information addressing the resident's (5/15/15) amputated toe and/or associated goals and/or approaches.
b. A Skilled Daily Nurses Notes dated 5/16/15 documented, .(11:00 p.m.) resident arrived to facility via stretcher and 2 (ambulance) attendants. R (resident) alert and oriented x (times(3. Abdomen soft and non-tender. G (gastric) tube site intact , skin warm and dry to touch, dressing to right heel .wrapped with kerlix .to continue nursing home meds (medication) and antibiotics as ordered .
c. A physician order [REDACTED].
1) A Skilled Daily Nurses Notes dated 5/18/15 documented, Assess R great toe amputation-wrap (with) kerlix QOD per T.O. (telephone order).
Skilled Daily Nurses Notes dated 5/18/15, 5/21/15, 5/22/15, 5/25/15, and 5/26/15, documented, .Wound Care/ Dressings (checked as provided) . There was no documented assessment of the wound size or surrounding tissue area.
Skilled Daily Nurses Notes dated 6/4/15, 6/5/15, 6/12/15, 6/15/15, 6/23/15, 6/24/15, 6/25/15, documented .Wound Care/ Dressings (checked as provided) . There was no documented assessment of the wound size or surrounding tissue area.
2) The June 2015 Treatment Administration Record (TAR) documented, Assess right great toe amputation and rewrap QOD. The TAR
documented initials indicating assessment performed on 6/2, 6/4, 6/8, 6/10, 6/12, 6/16, 6/18, 6/22, and 6/24. According to the TAR the right great toe was not assessed on 6/6, 6/14, and 6/20.
3) On 7/14/15 at 10:30 a.m., when asked why the resident's treatments (assessment of great toe every other day) to her amputation site had not been done as ordered, the treatment nurse (LPN #3) stated she was pulled to (work) the floor 5/22/15 through 5/29/15 and was unable to complete the treatments and was pulled to the floor on 6/1/15 through 6/8/15.
d. A nurse's note dated 6/23/15 documented, Assessed resident great toe amputation. Site has redness noted to peri wound with slough noted to wound bed under the stitches. No odor noted. Dr. (physician #1) notified of changes, awaiting return call.
On 6/24/15, Dr. (#1) paged again this am, concerning resident's toe, no response. Dr. (#2) paged also, awaiting return call.
On 6/24/15, Dr. (#2) returned call at (1:19 p.m.). Stated that he will be at facility later to look and assess area.
The physician progress notes [REDACTED]. [DIAGNOSES REDACTED], no drainage .Rt great toe amp (amputation) site: [MEDICAL
CONDITION] .Bactrim DS (Double Strength) .
e. A nurse's note dated 6/26/15 documented, (1:05 p.m.)- resident right great toe is necrotic with redness noted to periwound no drainage noted, sutures remain intact resident on antibiotic due to infection Bactrim DS 1 PO (by mouth) BID (twice a day) x (times) 10 days new order apply [MEDICATION NAME] cover dry gauze wrap with kerlix every day until follow up appt. (appointment) .
A physician order [REDACTED].
The physician progress notes [REDACTED].c/o (complaint of) pain .ischemic great toe .continue present tx (treatment) .ortho (orthopedic) appointment 7/1/15 .
f. Skilled Daily Nurses Notes dated 6/27/15, 6/28/15, 6/29/15 and 6/30/15 documented .Wound Care/ Dressings (checked as provided) . There was no documented assessment of the wound size or surrounding tissue area.
g. The physician progress notes [REDACTED]. Examination: .The right great toe has a distal eschar measuring 3 cm with some purulent drainage and marginal [DIAGNOSES REDACTED]. She has minimal pulses, flexes and extends the ankle .Impression: Right great toe amputation with worsening necrosis gangrene x (times) two weeks .
h. The nurse's notes dated 7/2/15 documented, resident had sutures removed on 7/1/15, area remains closed at this time. Small amount of drainage noted to site, continued treatment as ordered.
The nurse's notes dated 7/8/15 documented, Amputation to right great toe remains closed with moderate drainage noted. No s/sx (signs and symptoms) of infection noted .
i. The Physician's progress note dated 7/10/15 documented Resident #4's wound was stable.
j. On 7/14/15 at 11:45 a.m., the Treatment Nurse (Licensed Practical Nurse (LPN) #3) provided wound care for the resident. The LPN removed Kerlix wrap. Gauze was stuck to the wound so bad that she had to get sterile water to pour on it to loosen it. When it came loose, it revealed an area that measured 3cm (centimeters) x (times) 3cm x utd (unable to determine) (depth). The wound base was a mixture of eschar and yellow slough. The wound started bleeding after the dressing was removed. The resident stated the area was very painful. The surrounding area was red. The LPN was asked when she last saw the area. She stated, I saw it last Thursday, but it didn't look like that. There was a little black scab line and you could see where the stitches had been taken out. The LPN was asked if anyone had called the doctor over the weekend. She stated, I sure hope so. The LPN was asked if she had had any problems with coming in on Monday and the treatments weren't done on the weekend. She stated, Yes, quite often. That's been my biggest complaint here. The area was cleaned with [MEDICATION NAME] and 4x4 (gauze). [MEDICATION NAME] soaked 4x4 was placed on the wound and it was wrapped with kerlix. The
resident was asked how often her treatment was done. She stated, It's done every day. She was asked if it's done on the weekends. She stated, No, they don't do it on the weekends. A picture was taken of the wound.
k. The July 2015 Treatment Administration Record (TAR) documented the resident's great right toe amputation site was treated on 7/1, 7/2, 7/3, 7/4, 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/12, 7/13.

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.

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F 0309

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
According to the TAR the resident was not provided physician ordered treatment on 7/5/15.
l. On 714/15 at 1:40 p.m., LPN #2 was asked if she had ever changed the resident's dressing to her right great toe. She stated she had changed the resident's dressing on (Saturday) 7/11/15. LPN #2 stated she had to soak it to get the dressing off. It was stuck and took a while to get it off. The LPN stated she had never seen the area before and hadn't really seen how it was supposed to look. She indicated that the wound had some pink areas, no drainage, no dark areas, no slough. She stated, .around the outer edges, it kind a looked scabbed, no green or gray areas. It didn't look infected at all. The LPN was shown the picture that had been taken of Resident #4's wound. She was asked did the area look like this. LPN #2 stated, No, that's green!
m. On 7/14/15 at 2:55 p.m., LPN #1 was asked if she had changed the resident's dressing to her right great toe on (Sunday and Monday) 7/12/15 and 7/13/15. LPN #1 Stated, Yes. The bandage was stuck to the wound Sunday. There was a little slough. I don't really recall anything really bad with it. Monday it looked about the same. LPN #1 was asked if she reported the slough to anyone or call the doctor. She stated, I didn't write it down anywhere or tell anyone. It wasn't a lot to call the doctor on. LPN #1 was shown the picture of the wound taken earlier that day. LPN #1 stated, I don't remember seeing it look like that. It didn't look that bad, not to me. I remember a little yellow slough .
n. A nurse's note dated 7/14/15 (not timed) documented, Resident right great toe has [MEDICAL CONDITION] noted to periwound with redness and tenderness upon touch area is 3 x 3 x unstageable, pain med. given for pain . small amount of dark brown drainage present, Dr. (#2) paged awaiting return call .
A nurse's note dated 7/14/15 at (1:00 p.m.) documented, Dr. (#2) returned call, order received and noted: Set up an appointment for wound clinic as soon as possible for great toe. Wound clinic appointment scheduled 7/15/15 at 9:00 am . At 1800 - Dr. (#2) here to see resident, he ask me to inform day nurse that he would be admitting resident to hospital (7/14/15). Dr. (#2) removed dressing to exam right great toe.

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
Complaint # (AR 408) was substantiated (all or in part) with these findings.
Based on observation, record review and interview, the facility failed to consistently assess, monitor and document the condition of pressure ulcers for 2 (Residents #1 and #3) of 4 (Residents #1, #2, #3 and #5) case mix residents who had pressure ulcers. The facility failed to relieve pressure to an existing pressure ulcer and failed to obtain a new treatment order when the wound did not improve for 1 (Resident #3) of 4 (Residents #1, #2, #3 and #5) case mix residents who had pressure ulcers. The facility failed to notify the physician of signs of wound infection for 1 (Resident #1) of 4 (Residents #1, #2, #3 and #5) case mix residents who had pressure ulcers.
These failures resulted in immediate jeopardy which caused or could have caused serious harm, injury or death to Residents #1 who had pressure ulcers that subsequently led to the resident being hospitalized and expiring due wound [MEDICAL CONDITION] and to #3 who had a recurrent pressure sore that deteriorated from stage II to unstageable. These failures had the potential to cause more than minimal harm for 5 residents who had pressure ulcers according to a list provided by the Administrator on [DATE] at 1:32 p.m. The facility was informed of the immediate jeopardy on [DATE] at 11:00 a.m.
The findings are:
1. The facility's 'Pressure Ulcer Protocol' provided by the Administrator on [DATE] documented, .Assess the resident. Wounds should be assessed upon admission and weekly thereafter . Monitor resident daily for signs/symptoms of infection (periwound, [DIAGNOSES REDACTED], induration, malodorous drainage, increase in non-viable tissue, and/or fever or increased WBC count) . Pressure redistribution - Float heels from the bed surface to provide pressure relief. Standard foam elbow/heel protectors do not provide sufficient pressure reduction .
2. Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The 5 Day Minimum Data Set (MDS) with an
Assessment Reference Date (ARD) of [DATE] documented the resident was moderately impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; was totally dependent on 1 staff for bed mobility, dressing, eating, personal hygiene, toileting and bathing; required 2 staff for transfers; had a feeding tube for nutrition; was always incontinent of bowel and bladder and was at risk for developing pressure ulcers.
a. The Plan of Care dated [DATE] documented, .Problem: Resident has a need for use of a feeding tube due to dysphagia related [MEDICAL CONDITION].Approach: Dietician to monitor adequacy of tube feeding formula and free-water flushes at least quarterly, also PRN (as needed) with any change of status .Problem: Resident is at risk for skin breakdown and/or alterations in skin integrity related to incontinence, impaired mobility and dependency on ADL care .Approach: .Report changes in skin status (i.e.: s/s infection, non-healing, new areas) to physician .
b. A Physician order [REDACTED]. May be off one hour per day for ADL care.
c. A Nurse's Note dated [DATE] (,[DATE] shift) and signed by LPN #3 documented, .Clean coccyx with wound cleanser, pat dry. Apply Duoderm every 3 days until resolved (shearing) .
d. A Nurse's Note dated [DATE] (,[DATE] shift) and signed by LPN #3 documented, Resident has a DTI (deep tissue injury) .noted to coccyx area. Area is discolored, dark purple 10 x 8 x (centimeters) US (unstageable) .
e. A Nurse's Note dated [DATE] at 7:05 a.m. documented, Called to resident room by CNA (Certified Nursing Assistant), found resident unresponsive, clammy and cool to touch .B/P (blood pressure) ,[DATE], BS (blood sugar) 426 . 7:15 a.m. resident taken to (hospital) ER (emergency room) .
f. A Hospital History and Physical dated [DATE] (not timed) documented, .In ER pt (patient) was noted to be [MEDICAL CONDITION] tachypnea with leukocytosis and admitted to ICU for [REDACTED].
g. A Nurse's Note dated [DATE] at 7:50 p.m. documented, Readmit to (facility) .Resident has a sacral decubitus with [MEDICATION NAME] dressing present, and left plantar with black eschar area present . There was no documented assessment for the areas.
The Physician Readmission orders [REDACTED].
h. A Dietary Progress Note dated [DATE] and signed by the Registered Dietician documented, Weight ,[DATE] 170.6, ,[DATE] 167, ,[DATE] 172.6. Resident was on TF (tube feeding) of [MEDICATION NAME] 1.5 at 60 ml/hr cont . 2070 Kcal, 80 gm (gram) Pro (protein) . She was hospitalized and returned on TF of [MEDICATION NAME] 1.5 at 40 ml/hr . This regimen supplies 1380 Kcal, 59 gm Pro . Estimated needs for healing of her two unstageable wounds ~ 2352 Kcal, 109 gm Pro . Current TF may not be meeting needs for wound healing. Rec (recommend) increasing TF per tolerance to goal rate of 68 ml/hr x 23 hours. If she is unable to tolerate this increase, please call me for additional recommendations.
The [DATE] Weight Tracking form documented the resident's weight as 171.2 pounds.
i. A Physician order [REDACTED].
On [DATE] at 9:52 a.m., the Registered Dietician (RD) was asked about her Dietary Progress Note dated [DATE] and if she remembered getting a call from the facility telling her that the resident could not tolerate a higher tube feeding rate. She stated, No.
On [DATE] at 2:05 p.m., the APN was asked if she remembered why the resident's tube feeding was increased by only 5 ml/hr on [DATE] instead of following the RD recommendations from [DATE]. She stated, What may have happened is the nurse called him (physician) ,[DATE] about the RD recommendation, and he is a stickler about gradually increasing tube feeding, and then she went back to the hospital. And when a resident comes back from the hospital, we don't go back and look at the RD recommendation. We would approve what the readmit order is. That is more than likely the scenario.
As of [DATE] at 1:30 p.m., there was no documentation provided to verify the facility had contacted the RD with concerns about the resident's inability to tolerate a higher tube feeding rate.
j. A Nurse's Note dated [DATE] at 10:45 a.m. documented, CBC (complete blood count) results received. White blood cell 21.0. APN (Advanced Practice Nurse) for (physician) notified. Order received and noted to send patient to (hospital) ER for further evaluation related to elevated WBC (white blood count) .
A Hospital History and Physical dated [DATE] documented, .Present for abnormal lab with WBC of 30,000 . ED (emergency department) workup indicated possible [MEDICAL CONDITION] and UTI (urinary tract infection) and is to be admitted to ICU .
k. A Nurse's Note dated [DATE] at 1:30 p.m. documented, Resident readmitted . Multiple wounds noted to both lower

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F 0314

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
extremities. Sacral wound also noted .4:00 p.m . Glucerna 1.5 cal infusing at 45 ml/hr .
l. A Nurse's Note dated [DATE] at 2:30 p.m. and signed by LPN #3 documented, Resident readmitted to facility [DATE]. Upon readmission, resident has multiple wounds and multiple fluid filled blisters. Wound to sacral area is 13 x 13 x US (unstageable). Wound bed is necrotic, moderate brown drainage noted, wound edges are intact. Wound to right buttocks is 14 x 8 x US, wound bed is necrotic with some pink tissue noted, small amount of drainage noted. Wound to left heel 4 x 2 x US, half of wound is necrotic and half is red pink tissue noted .Wound to left plantar foot is 4 x 2 x US, wound bed is eschar, hard to touch, wound edges are dry and intact, peri wound is dark purple and fluid filled . right plantar foot has a fluid filled dark purple blister 8 x 5 x US. Right great toe is dark purple, no open areas. Right heel 3 x 1 x US . right lateral leg has an open blister 4 x 1 x 0.2 . left leg fluid filled blister closed 6 x 1.5 x US .
On [DATE] at 3:46 p.m., the Treatment Nurse was asked to provide any additional wound assessments conducted on Resident #1 after the [DATE] nurse's notes and prior to the [DATE] wound clinic assessment.
As of [DATE] at 1:30 p.m., the Treatment Nurse was unable to provide any additional wound assessments until the resident went to the wound clinic on [DATE].
n. A Nurse's Note dated [DATE] at 11:00 a.m. documented, Resident left the facility at 9:00 a.m. via facility van for wound clinic appointment. No signs and symptoms of distress noted at this time .
Wound Clinic notes dated [DATE] at 10:17 a.m. documented, (Wound #1) Right lat (lateral)- 6 x 1XXX,[DATE].4 x 0.3 eschar; (#2) Right ankle - 1.6 x 1 x eschar; (#3) Right ant (anterior)- 0.7 x 0.3 x eschar; (#4) Right medial lower leg - 0.5 x 1; (#5) Right great toe - 7.2 x 1.5 x eschar; (#6) Right plantar - 4 x 7.4; (#7) Left lateral - 4.5 x blister; (#8) Left heel - 4.3 x 4 x eschar .
Wound care orders dated [DATE] at 12:48 p.m. documented, Please keep dressing clean, dry and intact. Please change dressing's daily, zinc to periwound, santyl to wound bed (.only to eschar), [MEDICATION NAME], secure with webril, kerlix, tape to lower ext (extremities), secure buttocks wounds with abd (abdominal) pads and tape. Please rotate patient every hour, keep heels off loaded at all times, please call with any questions are concerns.
o. A Dietary Progress Note dated [DATE] and signed by the Registered Dietician documented, Weight 162. Resident down 10 pounds x 2 months. She is currently NPO (nothing by mouth) and gets TF of Glucerna 1.5 at 45 ml/hr cont (continuous) (23 hrs (hours)) . This supplies ~ 1553 Kcal, 85 gm Pro . Resident's estimated needs for wound healing ~ ,[DATE] Kcal, 110 gm Pro . Due to her continued weight loss and slow healing wounds, rec try 2 Cal HN (high nutrition) at 57 ml/hr continuous .
A Physician order [REDACTED].
On [DATE] at 9:52 a.m., the Registered Dietician (RD) was asked about her Dietary Progress Note dated [DATE] and if she remembered getting a call from the facility telling her that the resident could not tolerate a higher tube feeding rate. She stated, No.
As of [DATE] at 1:30 p.m., there was no documentation provided to verify the facility had contacted the RD with concerns about the resident's inability to tolerate a higher tube feeding rate.
p. A Nurse's Note dated [DATE] at 9:30 a.m. documented, Resident left facility at 9:30 a.m. for wound clinic appointment. No signs and symptoms of distress upon leaving the facility .
Wound clinic notes dated [DATE] at 10:49 a.m. documented assessments and measurements with care provided and/or required on 15 wounds. The notes did not document any signs or symptoms of infection.
q. Wound clinic notes dated [DATE] at 12:05 p.m. documented assessments and measurements with care provided and/or required for 15 resident wounds. The notes did not document any signs or symptoms of infection.
r. A Nurse's Note dated [DATE] at 7:30 p.m. and signed by LPN #1 documented, Resident moaning out loud, found resident perspiring profusely, front of resident clothing, arms and chest wet, noted resident's back and lower extremities dry. Resident repositioned to right side. BS (blood sugar) 119 at this time.
A Nurse's Note dated [DATE] at 6:00 p.m. and signed by LPN #1 documented, No apparent problems noted . Dressing to buttock area dry and in place. Noted odor from wounds. Skin warm and dry to touch. Totally dependent on all needs. Foley patent with yellow clear urine draining. V/S (vital signs) ,[DATE], 100, 18. There was no documentation the physician was notified of the wound odor.
A Nurse's Note dated [DATE] at 9:30 a.m. and signed by LPN #1 documented, Lying quietly, skin warm and dry to touch. V/S (blank) . Dressing intact to buttocks area. Foul odor from wounds noted. Foley patent with yellow urine draining with sediment. There was no documentation the physician was notified of the wound odor.
On [DATE] at 2:56 p.m., Licensed Practical Nurse (LPN) #1 was asked about the Nurse's Notes she wrote on [DATE], [DATE] and [DATE] addressing the resident's status; change in condition and wound odor. When asked if she had notified the physician of the resident's change in condition, especially the wound odor. She stated, I don't think so. I don't want to tell you something I can't remember.
s. The [DATE] Treatment Administration Record (TAR) documented, Clean left lower extremity with wound cleanser, apply zinc to periwound, santyl to wound bed (only to eschar), [MEDICATION NAME], Kerlix and tape every day. Clean right lower extremity with wound cleanser; apply zinc to periwound and santyl to wound bed (only to eschar), [MEDICATION NAME], kerlix and tape every day. Clean buttocks with wound cleanser, zinc to periwound, santyl to wound bed (only to eschar), cover with ABD pads and secure with tape every day.
The TAR documentation indicated the resident was not provided wound care as ordered on ,[DATE] (Sunday), ,[DATE] (Saturday), ,[DATE] (Sunday), ,[DATE] (Saturday), and ,[DATE] (Sunday).
On [DATE] at 3:46 p.m., LPN #3 (facility treatment nurse) was asked why there were blanks on the resident's [DATE] TAR, specifically on the weekends. She stated, Because the treatments weren't done. She was asked if she specifically remembered coming in on Mondays and Resident #1's treatments had not been done. She stated, Yes.
t. A Nurse's Note dated [DATE] at 8:00 a.m. documented, Received lab report of WBC of 29.4. Notified (APN). New order given, send to ER .
A Hospital ED Note dated [DATE] documented, .Wounds uncovered and assessed by MD. Unstageable wounds noted to bilat (bilateral) LE (lower extremities) and buttocks. Draining noted and foul odor present . Physical Exam: .Multiple decubiti of the lower extremities and buttocks/sacral area . Assessment/Plan: .Pt with multiple severe decubiti, she is septic and she also has UTI .
A Hospital Progress Note dated [DATE] documented, Consult received, pt with multiple severe decubiti, gangrene of limbs. Has PEG (percutaneous endoscopic gastrostomy tube) . Pt has massive wounds to hips and connecting to sacrum with black eschar. Some small areas open with foul drainage. Bilat LE with multiple arterial wounds and gangrenous and to heels and plantar foot .
A Hospital Discharge Summary dated [DATE] documented, Discharge Diagnosis: [REDACTED]. care discussed with family and patient discharged to hospice care.
u. On [DATE] at 10:36 a.m., the resident's daughter was asked when the resident expired. She stated her mother was discharged from the hospital on [DATE] to Hospice and died a couple of hours later on [DATE] due to wound [MEDICAL CONDITION].

3. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of [DATE] documented the resident scored 9 (,[DATE]
indicates moderately impaired) on a Brief Interview for Mental Status; required 2 staff physical assistance with bed mobility, transfers and toileting, 1 person assistance with set up for eating, bathing and dressing, had impairment in range of motion (ROM) 1 side upper and lower extremities; was always incontinent of bowel and bladder; and was at risk for developing pressure ulcers, had stage I and Stage III pressure ulcers, had 1 [MEDICAL CONDITION], and used pressure relieving devices and received application of dressings to feet.
a. The Care plan dated [DATE] documented, . Problem [DATE] - (Resident #3) has wounds and is at risk for pressure ulcers r/t (related to) incontinence, immobility, late effects of [MEDICAL CONDITION], and needing total care with ADLs and transfers. Approaches: Report changes in skin status (ie: s/s infection, non-healing, to physician primary risk factors prevention treatment. Float heels when in bed.
b. A wound clinic report dated [DATE] documented, There is complete [MEDICATION NAME] of the right lateral ankle ulcer. There is a small area of ecchymosis present. No maceration. Ulcer: is closed .
c. The facility's Weekly Skin Report dated [DATE] documented, .right ankle, Stage II, size 2 x 2 x 0.2 cm (centimeter) . sera-sanguineous drainage .

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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	(continued... from page 3) d. A physician's orders [REDACTED]. (treatment) to right ankle and start clean with wc (wound cleanser), pat dry, apply calcium alginate cover with dry dressing every other day until resolved. As of [DATE] at 2:15 p.m., the treatment regimen for the resident's right ankle had not been changed according to the treatment nurse. e. The facility's Weekly Skin Report dated [DATE] documented, .Right ankle; Stage III, size 2 x 2 x 0.2 cm with sera-sanguineous drainage . f. On [DATE] at 2:55 p.m., Resident #3 was lying in bed on his back. The resident's right ankle was resting directly on the mattress and his heel was not off-loaded. At 4:36 p.m., Resident #3 was in bed lying on his back his right ankle was resting directly on the mattress and his heel was not off-loaded. g. On [DATE] at 10:10 a.m., Resident #3 was in bed. The treatment nurse peeled back the resident's dressing to his right lateral ankle. The area was unstageable due to a small section of black eschar in the wound bed. The area measured 4 x 2.5 x UTD (unable to determined). There was moderate amount of brownish colored drainage noted, no odor. Periwound was pink. The ankle has a foam boot, but when resident's foot is on the bed, the ankle is not offloaded. The treatment nurse was asked if the area was worse this week than last. She stated, Yes. h. On [DATE] at 12:38 p.m., the Director of Nursing provided the following documentation, [DATE] - Treatment nurse brought resident to therapy room to consult with PTA/COTA (Physical Therapy Assistant/Certified Occupational Therapy Assistant) pressure relief for resident's right ankle.PTA also checked resident's room for off-loading bolster to be used when resident is in bed to float feet and consulted with hall nurse regarding proper placement of bolster . 4. The immediate jeopardy was removed on [DATE] at 1:40 p.m. and the scope and severity lowered to an H when the facility initiated the following plan of removal: a. All LPNs and RNs were in-serviced beginning on [DATE] by the Corporate Nurse and the Director of Nursing/Designee addressing completing ordered treatments, completing body audits, weekly documentation of wounds. b. All LPNs and RNs in-serviced by Corporate Nurse/Director of Nursing/Designee beginning [DATE] on notification of the resident physician on any change of condition to ensure that the physician is aware of all changes in the resident. c. All residents found to be at risk of skin breakdown, as determined by an MDS review, were assessed beginning [DATE] and completed on [DATE]. Assessments were completed by the Charge Nurses after being in-serviced by the Corporate Nurse and the Director of Nursing on [DATE]. All skin areas were properly documented on a body audit form. These forms were reviewed by the Director of Nursing/Designee to ensure that all concerns were addressed, properly documented, and that the physician was notified to ensure that orders for treatment were in place. d. The Treatment Nurse was individually in-serviced on [DATE] by the Corporate Nurse and the Director of Nursing/designee to ensure that she is following the Treatment Plan for those residents with pressure ulcers, that weekly documentation is to be completed, that the physician is notified of any change of condition or and lack of response by a wound to the current treatment. The treatment nurse will complete a weekly skin report of all pressure ulcers. A copy of this weekly report will be provided to the Administrator and Director of Nursing for follow-up. e. Director of Nursing/RN designee will observe all pressure ulcers at least one time weekly to ensure that the documentation is accurate and that the current treatment is effective, or if there is a need for a change in treatment. f. A specific Nurse has been assigned to the weekend Treatment Nurse position. The nurse will be in-serviced prior to [DATE] to ensure that he/she is aware of the requirement of accurate documentation, following the current plan of treatment, preventative nursing interventions, and notification of the physician of any change of condition. g. All CNAs in-serviced [DATE] by the ADON/Designee on preventative measures to avoid skin breakdown, offloading of pressure points to reduce risk of breakdown. h. DON/Designee will monitor residents requiring offloading twice daily for 2 weeks to ensure that proper offloading is being done beginning [DATE]. i. DON/CDM/Designee in-serviced by the corporate nurse on [DATE] regarding completing RD dietary recommendations within 48 hours of receiving the recommendation. The CDM will address all issues not requiring a physician's orders [REDACTED]. A copy of the completed dietary recommendation form will be provided to the Administrator and Corporate Nurse within 48 hours of receiving. j. All in-services will be continued until all off duty employees have been in-serviced prior to returning to the floor to provide resident care.