| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675722 | A. BUILDING _____ B. WING _____ | 04/14/2017 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| FORT STOCKTON LIVING & REHABILITATION | 501 N SYCAMORE FORT STOCKTON, TX 79735 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0274<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Review or revise the resident's care plan after any major change in a resident's physical or mental health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to conduct a comprehensive assessment within 14 days after a significant physical change in condition for 2 of 16 (Resident #1 and #3) residents reviewed for assessments.<br>a) Resident #1 had a fall resulting in a fractured knee on 1/30/17 and was readmitted to the facility on [DATE] on hospice services.<br>b) Resident #3 had a fall resulting in a fractured leg and he had a decrease in his Activities of Daily Living (ADL status). No Significant Change MDS was completed.<br>This failure could place the 4 resident receiving hospice and the 46 residents receiving preventive skin care at risk for unidentified significant changes, and interventions not implemented in a timely manner.<br>The findings included:<br>RESIDENT #1<br>Review of Resident #1's face sheet dated 1/31/17 documented she was [AGE] years of age admitted on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #1's MDS assessment dated [DATE] documented in part:<br>-She scored 3 of 15 on the mental status exam (indicating severe cognitive impairment).<br>-She showed no signs of [MEDICAL CONDITION].<br>-She rejected care.<br>-She was dependent on staff for all Activities of Daily Living (AD's).<br>-She was incontinent of bowel and bladder.<br>-She was checked for at risk for pressure injuries.<br>Review of Resident #1's Care Plan updated 2/19/17 documented:<br>-Resident #1 Death and dying issues related to terminal condition, as evidenced by care is being coordinated with the hospital hospice.<br>Review of Resident #1's Physician order [REDACTED].<br>2/01/17-Admit to hospice: DX (diagnosis): [MEDICAL CONDITIONS].<br>There was no documentation of hospice on the 2/03/17 Minimum Data Set (MDS) Assessment and there was no other MDS's for Resident #1.<br>During an interview on 4/13/17 at 1:25 p.m. the MDS Coordinator initially said Resident #1 did not have a change in condition because she had been on Hospice Services and had a slow decline since the Coordinator had been working at the facility. When asked if the fractured knee should have triggered a Significant Change MDS Assessment, the Coordinator acknowledged it should have.<br>RESIDENT #3<br>Review of Resident #3's Resident Face Sheet printed 4/11/17 documented he was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #3's 5 Day MDS assessment dated [DATE] documented he was not at risk for pressure sores and did not have any.<br>Review of Resident #3's care plan dated 4/27/16 documented Resident #3 was at risk for skin breakdown related to incontinence, [MEDICAL CONDITION], limited mobility, over-weight, refuses care, and impaired cognition. The identified goal was Resident #3 will continue to have 0 breakdown through review period. Identified approaches included:<br>- Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible.<br>- Avoid shearing resident's skin during positioning, transferring, and turning.<br>- Conduct a systematic skin inspection weekly, pay particular attention to bony prominence's.<br>- Report any signs of skin breakdown (sore, tender, red, or broken areas.)<br>There was no care plan for Resident #3's actual pressure injury that occurred on 3/27/17.<br>Review of Resident #3's 3/30/17 Skin Assessment by the Treatment Nurse documented in part: Resident continues with abrasion/ sheared area to Rt buttock, measures 1.5 x 0.6x 0.1cm. Open area in between buttocks, measures 7.0 x 0.5 x 0.1 cm almost abraded area.<br>During an interview on 4/13/17 at 1:25 p.m. the MDS Coordinator said a significant change would be triggered by a decline or improvement in the resident's status. She defined a declined as if a resident did not want to get out of bed; got sick and did not want to eat, started refusing medications; had an increase in confusion - anything that was not the resident's normal. She continued a decline in function and any skin issues would also trigger a significant change MDS. The MDS Coordinator said Resident #3 was shipped out to the hospital after a fall, the hospital sent him back and he did not feel good so the facility sent him back to the hospital for two days, and he was sent out again which was when they discovered he had a fractured leg. She acknowledged she was aware he did not want to get out of bed and had a decrease in appetite. When asked if this would trigger a significant change MDS Assessment she acknowledged it would. The MDS Coordinator acknowledged all she did was a 5-day admission MDS on Resident #3 when he returned. She said I missed it.<br>DEFINITIONS (taken from State Operations Manual guidance on Pressure Ulcers, revised on 5/01/15):<br>Shearing - the interaction of both gravity & friction against the surface of the skin. Friction is always present when shear force is present. Shear occurs when layers of skin rub against each other or when the skin remains stationary & the underlying tissue moves & stretches & angulates or tears the underlying capillaries & blood vessels causing tissue damage.<br>While pressure ulcers on the sacrum remain the most common location, pressure ulcers on the heel are occurring more frequently, are difficult to assess & heal, & require early identification of skin compromise over the heel.<br>Review of the facility's policy for Minimum Data Set (MDS) Assessment Completion and Submission Timeframe's dated revised October 2010 documented in part:<br>Policy Statement<br>Our facility will conduct and submit resident assessments in accordance with current federal and state submission Timeframe's.<br>Policy Interpretation and Implementation.<br>-Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted to CMS (centers for medicare and medicaid services)Assessment Submission and Processing system in accordance with current federal and state guidelines. |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0274<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>-Significant Change in Status:<br>Assessment Reference Date:<br>14th calendar day after determination of significant change in status.<br>MDS Completion Date:<br>14th calendar day after determination that significant error in prior comprehensive assessment occurred.<br>CAA (care area assessment) Completion Date:<br>14th day after determination of significant change in status.<br>Care Plan Completion Date:<br>CAA Completion Date + 7 calendar days.<br>Transmission Date:<br>Care Plan completion date + 14 calendar days.<br>Review of CMS-672 dated 4/11/17 documented 4 resident on hospice services and 46 resident receiving preventive skin care. |
| F 0279<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to develop and implement a comprehensive person centered care plan that ensured residents practicable physical, mental, and psychosocial well-being for 1 of 16 residents reviewed for care plans. (Resident #3).<br>a) The facility failed to have a care plan that addressed Resident #3's right buttock and inner buttocks abrasion/sheer on 3/27/17 a fracture to his femur fracture due to a fall on 1/13/17.<br>This failure could place the 3 residents documented with fractures, the 13 residents with pressure sores at risk of not receiving care and services to meet their needs.<br>Findings included:<br>RESIDENT #3<br>Review of Resident #3's Resident Face Sheet printed 4/11/17 documented he was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #3's 5 Day MDS assessment dated [DATE] documented:<br>- He scored a 1 of 15 (indicating severe cognitive impairment);<br>- He was dependent on one staff for all ADL care including transfers, dressing, eating, hygiene, and bathing;<br>- He had lower range of motion impairment on both sides and used a wheelchair;<br>- Falls had one fall in the review period with a major injury.<br>- There were no pressure injuries.<br>Review of Resident #3's Physician order [REDACTED].<br>- 3/27/17 Pureed diet with honey thick liquids<br>Review of Resident #3's care plan dated 4/27/16 documented Resident #3:<br>-Pressure Ulcer: was at risk for skin breakdown related to incontinence, [MEDICAL CONDITION], limited mobility, over-weight, refuses care, and impaired cognition. The identified goal was Resident #3 will continue to have 0 breakdown through review period. (There was no care plan for Resident #3's actual pressure injury).<br>-Fall: at risk for falls related to poor safety awareness, daily confusion. Resident uses furniture and walls for support while attempting to ambulate.<br>- Dehydration: had potential or actual dehydration related to being dependent on staff, diuretic therapy, dx of dementia/ cognitive impairment, resident may not perceive the need to accept hydration. (There was nothing about the need for thickened liquids)<br>- Nutritional Status: Resident #3 was at risk for potential nutritional problem as evidenced by: related to poor dentin. (There was nothing about Resident #3 being on a pureed diet).<br>There was no care plan for Resident #3's actual pressure shearing.<br>During an interview on 4/13/17 at 1:25 p.m. the MDS Coordinator said she was responsible for care plans. She acknowledged she did not change Resident #3's care plan. The MDS Coordinator said she was unaware that Resident #3's diet texture had changed. She acknowledged Resident #3's actual fall with a fracture should have been care planned and was not. She said I didn't do it. The MDS Coordinator said the care plan needed to reflect the resident because it determined what was put on the resident's profile. She said she was typically made aware of an issue during stand up meeting when they went over significant events. She acknowledged she was aware of the resident having a fall and a significant change in the need of services. She said she was overloaded but should have found it. The MDS Coordinator said there was a communication problem and it the process was ineffective. She said when she was trained on how to do the MDS's she was not trained on how to do the care plans.<br>DEFINITIONS (taken from State Operations Manual guidance on Pressure Ulcers revised on 5/01/15)<br>Shearing - the interaction of both gravity & friction against the surface of the skin. Friction is always present when shear force is present. Shear occurs when layers of skin rub against each other or when the skin remains stationary & the underlying tissue moves & stretches & angulates or tears the underlying capillaries & blood vessels causing tissue damage.<br>Assessment - An admission evaluation helps identify the resident at risk of developing a pressure ulcer, & the resident with existing pressure ulcer(s) or areas of skin that are at risk for breakdown. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified & have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care approaches.<br>Review of the facility's policy for Goals and Objectives, Care Plans dated revised April 2011 documented in part:<br>Policy Statement:<br>Care Plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence.<br>Policy Interpretation and Implementation:<br>-Care plan goals and objectives are defined as the desired outcome for a specific resident problem.<br>-When goals and objectives are not achieved, the resident's clinical record will documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly.--Care plan goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved.<br>-Goals and objectives are reviewed and/or revised:<br>When there has been a significant change in the resident's condition:<br>When the desired outcome has not been achieved;<br>When the resident has been readmitted to the facility from a hospital/rehabilitation stay; and,<br>At least quarterly.<br>-The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident clinical records in accordance with established policies.<br>Review of the form CMS 672 Resident Census and Conditions of Residents completed by RN E on 4/11/17 documented there were 13 residents with pressure ulcers in the building.<br>Review of the facility's 802 printed on 4/11/16 documented 3 fractures. |
| F 0314<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure 5 of 6 residents (Resident #1, #3,#4, #17 |

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| F 0314<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 2)<br>and #18) with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The facility failed to:<br>a) Perform skin assessments every shift per Resident #1's care plan dated 2/19/17 and to identify Resident #1 suspected deep tissue injury (SDTI)<br>b) Accurately assess Resident #3 for pressure injuries. The assessments indicated he was a moderate risk for pressure injuries after he already had one. Resident #3 was assessed with [REDACTED].<br>c) Accurately assess Resident #4 for pressure injuries. The assessments indicated he was at moderate risk for pressure injuries after he already had one. Resident #4 was assessed with [REDACTED].<br>d) Accurately assess Resident ##17 for pressure injuries. The assessments indicated she was at risk for pressure injuries after she already had one.<br>e) Accurately assess Resident #18 for pressure injuries. The assessments indicated he was at risk for pressure injuries after he already had one.<br>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 4/6/17. While the IJ was lowered on 4/11/17 the facility remained out of compliance at a level of actual harm with a scope identified as a pattern because they had not had time to monitor for effectiveness.<br>This deficient practice placed 13 residents at risk of not receiving wound care treatments, skin assessments or interventions and put them at risk of life threatening complications.<br>Findings include:<br>RESIDENT #1<br>Review of Resident #1's face sheet dated 1/31/17 documented she was [AGE] years of age admitted on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #1's MDS assessment dated [DATE] documented in part:<br>-She scored 3 of 15 on the mental status exam (indicating severe cognitive impairment).<br>-She showed no signs of [MEDICAL CONDITION].<br>-She rejected care.<br>-She was dependent on staff for all Activities of Daily Living (AD's).<br>-She was incontinent of bowel and bladder.<br>-She was checked for at risk for pressure injuries.<br>Review of Resident #1's Care Plan updated 2/19/17 documented:<br>-Resident #1 had actual functional loss in transfers/bed mobility, used wheelchair and needed assistance with locomotion. Identified approaches included attempt to alleviate barriers to self performance of ADL's (activities of daily living), provide assistance with ADL's necessary to complete task.<br>-Resident #1 had self care deficit and required total assistance with showers, hygiene, and dressing. Identified approaches were Resident #1 required total dependence assistance with hygiene and showering.<br>-Resident #1 required a splint to her left leg (due to fracture). Identified approaches included to inspect skin to left leg, observe and report any red or broken areas.<br>-Resident #1 was expected to have skin breakdown or/and pressure ulcers related to end stage. Identified approaches included to utilize heel protectors; position with pillows to elevate pressure points, turn and reposition every 2 hours or as needed, skin assessment and inspection every shift with close attention to heels. There was no documentation of skin assessments done every shift.<br>Review of Resident #1's 2/2017 Physician order [REDACTED].<br>-Start date 5/23/14-heel protectors in place.<br>Review of Resident #1's Braden Scale dated 4/04/17 documented she scored a 12 indicated she was high risk for developing a pressure ulcer.<br>Review of the Weekly Wound Tracking Worksheet dated 3/10/17 documented in part:<br>-Resident #1 had an acquired in house trauma injury that measured 0.7 x 0.3 x 0.2 centimeters (cm) on her left thigh with granulation tissue (pink or red with shiny moist granular appearance) identified on 2/14/17. Nutrition measures: Vitamin C , zinc every day, arginade twice a day, liquid protein 30 ml (milliliters) twice a day, super-cereal with breakfast and 60 ml of 2 cal three times a day. Braden Score 12 (high risk for pressure injuries). Support measures: Clean with normal saline, dry, apply abd pad everyday and as needed until healed. Splint left leg at all times. Heel protectors in place while in bed.<br>Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her right coccyx that measured 1.3 x 0.3 x 0.1 with granulation tissue. Nutrition measures: Vitamin C, zinc every day, arginade twice a day, liquid protein 30 ml (milliliters) twice a day, super-cereal with breakfast and 60 ml of 2 cal three times a day. Support measures: apply [MEDICATION NAME].<br>(http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages: Persistent non-blanchable deep red, maroon or purple discoloration).<br>Review of the Weekly Wound Tracking Worksheet dated 3/17/17 documented in part:<br>-Resident #1 had an acquired in house pressure injury that measured 1.5 x 0.5 x 0.1 centimeters (cm) on her coccyx area with granulation tissue (pink or red with shiny moist granular appearance) identified on 2/14/17. Braden Score 12 (high risk for pressure injuries). Support measures: Clean with normal saline, dry, apply collagen and dry dressing every of day and as needed until healed.<br>-Resident #1 had an acquired in house trauma injury that measured 0.7 x 0.3 x 0.2 centimeters (cm) on her left thigh with granulation tissue (pink or red with shiny moist granular appearance) identified on 2/14/17. Braden Score 12 (high risk for pressure injuries). Support measures: Clean with normal saline, dry, apply abd pad everyday and as needed until healed. Splint left leg at all times. Heel protectors in place while in bed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her right coccyx that measured 0.7 x 0.5 x 0.1 cm. with [MEDICATION NAME] tissue (new skin or growing can be pink and shiny). Support measures: apply [MEDICATION NAME] twice a day and as needed until healed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/07/17 to her coccyx left that measured 0.7 x 0.3 x 0.1 cm. with [MEDICATION NAME] tissue (new skin or growing can be pink and shiny). Support measures: apply [MEDICATION NAME] twice and as needed until healed.<br>Review of the Weekly Wound Tracking Worksheet dated 3/31/17 documented in part:<br>Apply [MEDICATION NAME] to peri-area as needed until healed. DX (diagnosis): Stage 2 to left coccyx.<br>Clean wound to left knee with Normal saline, dry apply to TAO (triple antibiotic ointment), abd pad until healed. DX: Wound to left knee.<br>Clean unstageable to coccyx with normal saline, dry, with 4 x 4's, apply collagen and dry dressing every other day until healed.<br>-Resident #1 had an in house acquired trauma injury identified on 2/14/17 to her right coccyx that measured 1.7 x 0.6 cm. with granulation tissue (pink or red with shiny moist granular appearance). Support measures: Clean with normal saline, dry, apply abd pad everyday and as needed until healed. Splint left leg at all times. Heel protectors in place while in bed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her coccyx (right and left coccyx pressure injury merged across the coccyx identified on 3/21/17) that measured 2.25 x 5.2 cm. with necrotic tissue (eschar, black, brown or tan tissue). Support measures: Clean with normal saline, dry, apply dry dressing every other day and as needed until healed.<br>Review of Resident #1's 4/2017 Physician order [REDACTED].<br>Start date 4/04/17-Clean unstageable to right heel with [MEDICATION NAME], leave open to air every day and heel protectors in place at all times. DX (diagnosis) unstageable to right heel. (discontinued on 4/05/17)<br>Review of the telephone physician orders [REDACTED]. DX: SDTI.<br>Review of the Weekly Wound Tracking Worksheet dated 4/07/17 documented in part:<br>-Resident #1 acquired in house deep tissue injury to her right heel that measured 4 x 2.5 cm. identified on 4/04/17. Support measures: Support measures: Clean with [MEDICATION NAME], dry, apply [MEDICATION NAME], heel dressing wrap with kling and<br>secure with tape every other day and as needed. Heel protectors in place at all times. |

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| F 0314<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 3)<br>-Resident #1 had a deep tissue injury on her left posterior lower leg identified on 4/04/17 that measured 2 x 2. Support measures: Clean with normal saline, dry, apply foam dressing, change every three days and as needed until healed. Knee immobilizer to remain in place.<br>-Resident #1 acquired an in house deep tissue injury to the top of her 2nd right toe that measured 0.6 x 0.7 cm. identified on 2/28/17. Support measures: Clean with [MEDICATION NAME] and lota every day or as needed.<br>-Resident #1 acquired in house deep tissue injury to the top of her 3rd left toe that measured 0.6 x 0.6 cm. identified on 4/04/17. Support measures: Clean with [MEDICATION NAME] and lota every day or as needed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her coccyx (right and left buttock pressure injury merged across the coccyx on 3/21/17) that measured 5 x 5 cm. with necrotic tissue (eschar, black, brown or tan tissue. Support measures: Clean with dakins 0.25%, dry, apply aginate moistened with hydrogel and pack into wound. Apply [MEDICATION NAME] to peri-wound. Apply charcoal dressing and alleveyn dressing every day.<br>During an observation on 4/04/17 at 11:38 a.m. Resident #1 was lying in bed and 2 hospice aides had just finished giving Resident #1 a bed bath. The surveyor asked them if Resident #1 had any skin issues. An aide lifted up Resident #1's right heel and said she has this and she also has one area on her buttock but it had a dressing on it. The right heel had a large dark purple black area (approximately the size of a large egg). The hospice aide said Resident #1 did not have any type of dressing on the heel. The hospice aides did not make the facility staff aware of Resident #1's right heel (SDTI) or the hospice nurse. The surveyor requested the facility's treatment nurse assess the right heel on 4/04/17 at 4:40 p.m.<br>During an observation during wound care on 4/04/17 at 4:09 p.m. the treatment nurse got her supplies ready to do wound for Resident #1. The treatment nurse took off Resident #1's leg immobilizer and raised Resident #1's leg up to do a skin assessment of the leg. The treatment nurse changed the dressing to Resident #1's left knee and changed the dressing to the unstageable pressure injury on Resident #1's coccyx area. She said that was the only pressure injury resident #1 had at this time (indicating the wound to Resident #1's coccyx). While positioning Resident #1 in bed the treatment nurse had to put Resident #1's heel protectors back on. She raised the right lower leg and placed the heel protector on. The treatment nurse pointed out that Resident #1 had areas on her right 2nd and 3rd toe which she said they just cleansed the area but did not put dressing on them. The treatment nurse did not assess Resident #1's heels when she put the heel protectors back in position. The treatment nurse had finished her treatment and was walking out of Resident #1's room when the surveyor asked her to check Resident #1's right heel. The treatment nurse went to her medication cart and got out a measuring tape and re-entered Resident #1's room. The treatment nurse said she was unaware Resident #1 had anything to her right heel. She measured the area at 4 x 2.5 cm. She wrote the size on and appearance of the area on a scrap piece of paper and turned it into the Director of Nurses (DON) at 4:55 p.m. The treatment nurse said the said the DON would be the one to go in and stage the area.<br>During an interview on 4/05/17 at 8:51 a.m. the DON said she first learned about Resident #1's right heel injury the day before (4/04/17) when the treatment nurse informed her around 5:00 p.m. She said she was not sure when Resident #1 acquired the pressure injury. She said she had talked to the hospice nurse to see if anyone had reported it to her and she said the hospice aides did not report any new issues to her. The DON said the hospice nurse informed her that she asked the hospice aides if there was any thing she needed to know about Resident #1 and the aides told her no. She said the hospice nurse did not assess Resident #1's heels when she came in yesterday because Resident #1 was asleep and she didn't want to wake her. The DON said if there are any changes the charge nurse for that resident was informed. She said the charge nurse for Resident #1 was not informed of any new issues. She said she did not do a full body skin assessment of Resident #1 on 4/04/17 but would get the treatment nurse and do it now. The DON said she would have to get the hospice aides notes faxed to her.<br>During an interview on 4/06/17 at 9:48 a.m. hospice aides Q and R said they had just noticed Resident #1's right heel on Monday (4/04/17). They said they were supposed to report any resident changes to their hospice nurse. They said they did not report Resident #1's heel so they had to go to an in-service on reporting resident changes. The hospice aides said they had to report any thing different with the resident, like that resident's heel. They said they report changes immediately.<br>During an interview on 4/06/17 at 11:07 a.m. the treatment nurse said skin assessments were to be done weekly. She said she did medication pass on Monday's and then Tuesday's she had to go to wound care in Midland with one of the residents so she did not do treatments or skin assessments on those days. She said she did skin assessments on what ever day the aides were giving showers so she could be in the shower room while the residents were showered. She said she would look to see where the shower aides were giving the showers and that would be the hall she would do skin assessments on that day. She said she does not know if that was the way skin assessments are supposed to be done but that was how it had been done since she had been there. She said the charge nurses were to do wound care on their halls when she got pulled off treatments.<br>Review of a written statement dated 4/12/17 by the DON documented she spoke to the Hospice Director on 4/04/17. She said she made rounds (to see the hospice residents) on 4/04/17 and said the hospice aides did not report any new skin issues for Resident #1 to her. The Hospice Director said she did not assess Resident #1's heels on 4/04/17 because the resident seemed comfortable. The DON said she interviewed the facility staff regarding Resident #1's deep tissue injury and the staff denied observing any new areas of skin breakdown during their shift. Some of the staff members verbalized that Resident #1 tended to remove her heel protectors at times. Staff reported putting Resident #1's heel protectors back on, however they said they did not look at her heels.<br>RESIDENT #3<br>Review of Resident #3's Face Sheet printed 4/11/17 documented he was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #3's 5 Day MDS assessment dated [DATE] documented he was not at risk for pressure sores and did not have any.<br>Review of Resident #3's MDS's assessment 4/03/17 documented in part:<br>-He scored 1 of 15 on his mental status exam (indicating severe cognitive impairment).<br>-He showed signs of [MEDICAL CONDITION].<br>-He required extensive assist from staff for transfers, dressing, eating and personal hygiene. He was dependent on staff for bathing.<br>-He was incontinent of bowel and bladder.<br>-He was checked to be not at risk for pressure ulcers.<br>Review of Resident #3's care plan revised on 1/30/17 documented Resident #3 was at risk for skin breakdown related to incontinence, [MEDICAL CONDITION], limited mobility, over-weight, refuses care, and impaired cognition. The identified goal was Resident #3 will continue to have 0 breakdown through the review period. Identified approaches included:<br>- Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible.<br>- Avoid shearing resident's skin during positioning, transferring, and turning.<br>- Conduct a systematic skin inspection weekly, pay particular attention to bony prominence's.<br>- Report any signs of skin breakdown (sore, tender, red, or broken areas.)<br>Review of Resident #3's 3/27/17 Braden Scale documented he scored a 14 which was indicated he was a moderate risk. The nurse documented he had an open area to the left inner coccyx (5 x 1 cm), right buttocks (7 x 2), and an unstageable to the right heel 2 x 0.<br>Review of Resident #3's 3/30/17 Skin Assessment by the Treatment Nurse documented in part: Resident continues with abrasion/ sheared area to Rt buttock, measures 1.5 x 0.6 x 0.1 cm. Open area in between buttocks, measures 7.0 x 0.5 x 0.1 cm almost abraded area. Resident has SDTI to Rt heel measures 5 x 6 cm, wound intact without drainage, redness or odor. Cushion applied to foot of bed to provide BLE(bilateral lower extremities) support and float heels. Resident encouraged to reposition q2 hours and prn to off load pressure/wt and use pillows to assist.<br>Review of Resident #3's 4/06/17 Skin Assessment documented he had an SDTI/unstag (unstageable) to the Right Heel measuring 4.5 cm long by 5.5 cm width. The Treatment Nurse documented the tissue type was intact, bruised blister.<br>Review of Resident #3's Braden Scale completed by the treatment nurse on 4/07/16 documented he scored a 14 which indicated he was at Moderate Risk for developing a pressure injury.<br>During an observation on 4/05/17 at 3:21 p.m. the treatment nurse entered Resident #3's room and did wound care for an incision to Resident #3's left leg. The nurse had the certified nurse aide (CNA) hold up Resident #3's right and left heels. After the wound care the Treatment had the aides hold the both heels so golf ball sized purple/black areas on |

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| F 0314<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 4)<br>Resident #'#3 heels could be observed. Heels were floated off the bed. Resident #3 was only identified as a moderate risk for pressure ulcers.<br>RESIDENT #4<br>Review of Resident #4's Resident Face Sheet dated 1/23/17 documented he was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #4's 3/31/17 quarterly MDS documented:<br>-He scored 7 of 15 on his mental status exam (indicating severe cognitive impairment).<br>-He showed no signs of [MEDICAL CONDITION].<br>-He was dependent on staff for all ADL's.<br>-He had a catheter and was incontinent of bowel.<br>-He had one Stage I pressure ulcer and one Stage II pressure ulcer.<br>Review of Resident #4's Care Plan updated 4/03/17 documented: Resident #4 had a pressure ulcer stage 2 (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) to right heel and stage I (npuap-pressure-injury-stages: intact skin with a localized area of non-blanchable [DIAGNOSES REDACTED]) to left heel. Area measures 4.2 x 4.5 cm with soft boggy tissue from blister. Red 0.5 x 0.5 red area, stage I to Lt (left) heel. Wound care clean stage II (intact blister) with [MEDICATION NAME], dry apply heel protector et (and) wrap with kerlix qd (every day) until healed.<br>Resident #4 identified goal was Resident #4's pressure ulcers to both heels will heal without complications.<br>Identified approaches included use padding on foot steps on wheelchair for pressure reduction when resident is in chair; use pillow and heel protectors to relieve pressure on the heels; Assess and record the condition of the skin surrounding the pressure ulcer; Assess the pressure ulcer for location, stage, size (length, width, and depth) presence/absence of granulation tissue and [MEDICATION NAME] daily and during treatment/dressing changes; conduct a systematic skin inspection daily. Report any signs of further skin breakdown; keep bony prominence's from direct contact with one another with: pillows, foam wedges etc.<br>Review of Resident #4's Braden Scale dated 4/06/17 documented he scored a 15 indicating he was at moderate risk for developing a pressure ulcer.<br>Review of Resident #4's 2/2017 Physician order [REDACTED].<br>1/12/17 Stage I left heel - clean with [MEDICATION NAME], dry, apply heel protector, wrap with Kerlix until healed.<br>Review of Resident 4's Physician order [REDACTED].<br>- 3/18/17 air mattress to bed<br>- 3/18/17 clean unstageable open wound to right heel with normal saline, pat dry, apply santyl ointment to wound bed cover with tefla, secure with kerlix, change every day and PRN.<br>- 3/18/17 clean unstageable open wound to left heel with normal saline, pat dry, apply santyl ointment to wound bed, cover with Tefla, secure with kerlix, change every day.<br>- 1/12/17 Float heels in bed<br>Review of Resident #4's Measurements (taken from the skin report) documented in part:<br>Right Heel: 1/18/17 - no measurements; 1/19/17 6 x 5 right heel, intact, fluid filled blister; 1/23/17 Stage II 5.7 x 6 cm; 1/31/17 Stage II 5.2 x 5.5; 2/7/17 5.7 x 6 cm; 2/12/17 2 x 12 unstageable; 2/22/17 1.5 x 11 x 0.1; 3/06/16 1.8 x 1.1 x 0.1; 3/19/17 3 x 3 (unstageable); Stage III 3 x 2 x 0.2<br>Left Heel: 1/19/17 Stage I 0.5 x 0.5; 1/23/17 0.5 x 0.5; 1/31/17 Stage I 0.3 x 0.3; 2/7/17 .04 x 0.4; 2/12/170.4 .0.4. 4/06/17 unstageable 2 x 2.<br>Blister lower right arm: 2/28/17 - 2 x 3 x 0.1; 3/06/17 - 2 x 1 x 0.1.<br>During an observation on 4/04/17 at 5:00 p.m. the treatment nurse did wound care for Resident #4's unstageable to his left heel. The wound wound was the size of a baseball with a slight odor. Resident#4 had no other known skin issues at the time of observation.<br>RESIDENT #17<br>Review of Resident 17's Face Sheet printed 4/04/17 documented she was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #17's 2/03/17 annual MDS assessment documented<br>-She had long and short term memory impairment with severely impaired decision making abilities.<br>-She was dependent on staff for all ADL care.<br>-She was incontinent of bowel and bladder.<br>-There were no skin issues identified.<br>Review of Resident #17's 1/02/17 Care Plan documented Resident # 17 had an 1 x 1 unstageable to her left toe, bunion area. The identified goal was Resident #7 will show healing within the review period. Identified approaches was: clean with [MEDICATION NAME], allow to dry, cover with foam dressing QD.<br>Review of Resident # 17's 1/02/17 Care Plan documented Resident #17 was at risk for pressure ulcers due to moisture, required assistance, chair bound, and sensory deficit. Identified goal was intact skin without evidence of redness, irritation, maceration, or open areas through next quarter. Identified approaches included skin assessment and inspection every shift with close attention to heels per licensed staff. CNA to report any skin issues to charge nurse immediately.<br>Review of Resident #17's 3/01/17 - 4/04/17 Physician order [REDACTED].>3/07/17 Clean Stage II to left outer heel with NS (normal saline), dry, apply collagen to wound et dry dressing qod (every other day) until healed.<br>3/07/16 Clean Stage II to right outer heel with NS, dry, apply collagen to wound et dry qod until healed.<br>Review of Resident #17's 3/13/17 Pressure Ulcer Documentation documented she had an unstageable pressure ulcer (npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) with necrotic tissue to her right heel measuring 1.7 x 1.4 x 0.1.<br>Review of Resident #17's 3/13/17 Braden Scale assessment documented she scored a 15 an indicated she was at low risk to develop a pressure ulcer.<br>During an interview on 4/06/17 at 8:40 a.m. the treatment nurse informed the surveyor Resident #17's wound care had just been done. She said Resident #17 had a deep tissue injury on the right heel and a blister on the left heel.<br>RESIDENT 18<br>Review of Resident #18's Face Sheet printed 4/04/17 documented he was a [AGE] year old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #18's 3/29/17- 5 day MDS Assessment documented:<br>He had long and short term memory impairment with severely impaired decision making skills<br>-He was dependent on staff for ADL care.<br>-He had no skin breakdown<br>Review of Resident #18's 3/22/16 Care Plan documented a problem of potential for pressure ulcer or altered skin integrity related to incontinence, abnormal gait, and [MEDICAL CONDITION]. The identified goal was will have intact skin with minimal redness, blisters, or discoloration through review date. Identified approaches included: body audits at least weekly by licensed staff, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathe or daily care; turn, reposition at least every 2 hours, more often as needed or requested.<br>Review of Resident #18's Braden Scale dated 1/16/17 documented he scored a 15 an indicated he was at low risk of developing a pressure ulcer.<br>Review of Resident #18's 4/06/17 Skin assessment documented he had a stage II pressure ulcer on his left great toe measuring 1.1 x 1 cm, a suspected deep tissue injury on the right second toe measuring 0.4 x 0.7.<br>During an interview on 4/6/17 at 11:54 a.m. the Administrator was informed of the Immediate Jeopardy. She said she was not informed of Resident #1's unstageable pressure injury or that the surveyor had found it. The Administrator said the facility talked about skin issues every morning in stand-up meeting and she was not informed of Resident #1's new pressure injury. She said she received a copy of the facility's skin report and did not realize that 6 new pressure injuries had developed (close to 10% of the facility's census) in 2 months. She said that's too much. |

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| F 0314<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 5)<br>During an interview on 4/6/17 at 1:58 p.m. the Treatment Nurse said she had been the treatment nurse off and on for several years. She said this time she had been the treatment nurse for over a year. She said she got pulled treatments to do other jobs because of staffing issues. She said her Corporate Office had said she was not to be pulled. She said last week she had to go to wound care Monday and Friday and then Wednesday she was pulled to work the floor which gave her 2 days to do treatments and skin assessments. She said this week (4/3/17 - 4/7/17) she was pulled to the floor on 4/3 to be the medication nurse and 4/04/17 she had to transport a resident to wound care. She said she had talked to the DON about sending one resident with just two aides to wound care. She said she physically counted the number of wounds in the building when she did the skin report and was very aware of the number of residents with pressure injuries. She said the numbers seem up there. She said the aides were usually very good about reporting changes to her. The Treatment Nurse said she tried to do skin assessments on one hall a day.<br>During an interview on 4/06/17 at 2:55 p.m. the Administrator said she was not informed of Resident #1's pressure injury until the next day. She said unstageable was the most explanation she got. The Administrator was informed that no full body assessment was completed until after 9 a.m. the day after the unstageable was discovered on Resident #1. The Administrator acknowledged the system had broken down. She said it appeared the problem started with the Hospice aides and not telling any of the staff. She said once the Treatment Nurse was notified she should have done a full assessment. The Administrator said the facility CNA's provided incontinent care and as needed bed baths. She said they provided care like repositioning and putting on the heel protectors that everyone kicks off. She said as they were repositioning Resident #1 she would think they would see the unstageable pressure injury.<br>Review of the Certified Nursing Assistant Job Description (undated) documented, in part:<br>Summary: Provide nursing care to the residents according to established policies and procedures and to ensure that the highest degree of quality of care is maintained at all times.<br>Safety and Sanitation: Report all incidents and accidents immediately.<br>Review of the facility's February 2014 Policy and Procedure on Pressure Ulcer Risk Assessment documented, in part:<br>Purpose: The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers.<br>Preparation: Review the resident's care plan to assess for any special needs of the resident.<br>Once a pressure ulcer develops, it can be extremely difficult to heal.<br>Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor.<br>Assessment:<br>Skin Assessment: Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated.<br>Review of the facility's February 2014 policy and procedure on Prevention of Pressure Ulcers documented, in part:<br>Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors.<br>General Guidelines: Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue.<br>Use pillows, wedges or other off-loading devices to keep bony prominence's such as knees or ankles from touching each other. Do not massage bony prominence's.<br>When in bed every attempt should be made to float heals (keep heels off the bed) by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician.<br>The facility's Plan of Removal Of Immediate Jeopardy was accepted on 4/04/17 and included the following:<br>Prevention of Pressure Sores<B |
| F 0371<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Store, cook, and serve food in a safe and clean way**<br><br>Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve foods under sanitary conditions for 1 of 1 kitchens.<br>The facility failed to ensure:<br>a) Staff effectively washed their hands in a manner that prevented cross contamination;<br>b) equipment was properly cleaned and sanitized<br>c) temperatures of food were taken to ensure they were within a safe serving temperature;<br>d) hand washing sink in the dirty dish area was maintained in working order;<br>e) plates were stored in a manner to prevent contamination.<br>This deficient practice could affect 76 residents receiving meals/snacks from the facility kitchen by creating conditions that could lead to food-borne illness.<br>Findings included:<br>Observation on 4/10/17 at 10:15 a.m. showed three of five stacks of dishes by the serving area. The dishes were stored face up with the eating surface exposed. The hand washing sink in the dish washer area was blocked by a tray and unable to be used.<br>Observation made on 4/12/17 between 3:00 p.m. and 5:00 p.m. showed:<br>- Three of five stacks of plates were still stored face up.<br>- The Food Service Supervisor (FSS) washed her hands and turned off the faucet with her bare hands.<br>- Cook A washed her hands and turned off the faucet with her bare hands<br>- Dietary Aide (DA) B washed her hands and turned the faucet off with her bare hands. She then threw the paper towel in the large garbage can by picking up the lid (contaminating her hands) and went to roll utensils in napkins.<br>- DA C turned off the faucet with her bare hands. She did this three times during the observation.<br>- DA D entered the kitchen at 4:00 p.m. washed her hands, turned off the faucet with her bare hands, threw away the paper towel in the large garbage can (touching the lid contaminating her hands), went into the dirty dish area, then went into the food preparation area with 2 loaves of bread and took some of the bread out of the bag for the supper meal.<br>- Cook A took the food processor and rinsed it in the food preparation sink. She did not wash or sanitize it but set it up for use for the next morning.<br>- During the temperature-taking process, Cook A took the temperature of the main meal with regular texture. Then, without cleaning the thermometer, she took the temperature of the main meal with mechanical soft texture. Cook A took the temperature of the regular/puree vegetables the same way without cleaning the thermometer in between pans. The puree vegetable was too cold and Cook A put it on the stove; she did not take the temperature of the pureed vegetables before serving them. Cook A did not take the temperature of the rice or the substitute meal (ham salad with potato salad) at all.<br>During an interview on 4/13/17 at 9:50 a.m. the FSS (Food Service Supervisor) said she expected her staff to wash their hands and turn off the faucets with the paper towel. She acknowledged using the large trash can with the non-step lid lead to cross contamination. She acknowledged she had seen DA D touch the garbage can lid and not re-wash her hands. The FSS said all of her staff had taken the Safe-Serv food handling classes and that hand washing was emphasized in it. She said the food processor should be washed out in the food preparation sink with soap and water. She said they used to run it through the dish washer but the manufacturer recommendations said not to. She was informed Cook A just rinsed the food processor and set it up for the next day and did not use soap. She was informed Cook A did not take temperatures of everything and immediately asked the substitute? She was shown the stacks of plates and acknowledged the possibility of contamination. The FSS said the hand-washing sink in the dishwashing area was frequently blocked because it had not worked for a while and the staff had to wash their hands in the 'clean' area of the kitchen. The FSS acknowledged the dishwashers would probably inadvertently contaminate something on their way to hand washing sink in the 'clean' area of the kitchen.<br>During an interview on 4/13/17 at 10:45 a.m. the Administrator was informed of the kitchen findings. She said the hand-washing was just bad practice and acknowledged the cross contamination with the garbage can lid.<br>Review of the facility's undated Training from 'The Safe Food Handler' documented to turn off the sink with a single-use paper towel or a hand dry. It documented If you are not careful, you can contaminate your hands after washing them. Consider using a paper towel to turn off the faucet. |

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| F 0371<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 6)<br>Review of the Serv-Saf Manager Book documented food that is being held for service is at risk for time-temperature abuse and cross-contamination. If your operation holds food, you must make policies that reduce these risks. Focus on the time and temperature control, but don't forget about protecting the food from contamination.<br>Hold cold food at 41 degrees F or lower. This will prevent pathogens from growing to unsafe levels.<br>Review of the form CMS 672 Resident Census and Conditions of Residents completed by Registered Nurse E on 4/11/17 documented there were 76 residents who ate from the facility's kitchen. |
| F 0465<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**<br><br>Based on observation, interview and record review, the facility failed to ensure the environment was safe, sanitary and comfortable for 3 of 4 resident halls (100, 300 and 400) in that:<br>a) Resident furniture was not maintained in a manner that was functional or sanitizable;<br>b) Resident-use equipment was not maintained a manner that was functional or sanitizable;<br>c) Resident bathrooms were lacking covebase or the lights did not work;<br>d) The resident's beds had foot boards that were scraped and exposing the bare wood;<br>e) The resident rooms toilets had caulking that was stained;<br>This failure could place the 66 residents residing in the affected rooms on halls 100, 300 and 400, staff and visitors at risk of living, working and visiting in an unsafe, unsanitary and uncomfortable environment.<br>Findings included:<br>HALL 100<br>During an observation on 04/12/17 at 10:00 a.m. in resident room 102, the drawer on the dresser was off the tracks and would not open and close. The foot boards on A and B beds were scraped and exposing the bare wood.<br>During an observation on 04/12/17 at 10:02 a.m. in resident room 103, the corner wall by the closet was scraped.<br>During an observation on 04/12/17 at 10:04 a.m. in resident room 104, the corner wall was scraped and the metal protector was exposed.<br>During an observation on 04/12/17 at 10:05 a.m. in resident room 105, the drawers on the A bed dresser were broken.<br>During an observation on 04/12/17 at 10:07 a.m. in resident room 106, the drawer on the A bed dresser was broken. The room door seal was bent and torn.<br>During an observation on 04/12/17 at 10:09 a.m. in resident room 107, the drawer on the B side closet was broken. Both foot boards were scraped and exposing the bare wood.<br>During an observation on 04/12/17 at 10:12 a.m. in resident room 108, the drawer on the B bed dresser was broken. The foot board B bed was scraped and exposing the bare wood.<br>During an observation on 04/12/17 at 10:14 a.m. in resident room 109, the drawer on the A bed dresser was broken. The foot board A bed was scraped and exposing the bare wood.<br>During an observation on 04/12/17 at 10:15 a.m. in resident room 110, the drawer on the A bed dresser was broken. The foot board A bed was scraped and exposing the bare wood.<br>During an observation on 04/12/17 at 10:16 a.m. in resident room 111, the drawer on the A bed dresser was broken.<br>During an observation on 04/12/17 at 10:17 a.m. in resident room 112, the drawer on the B bed dresser was broken. The handle on the drawer of the A side closet was loose.<br>During an observation on 04/12/17 at 10:19 a.m. in resident room 113, the drawer on the A bed dresser was broken.<br>During an observation on 04/12/17 at 10:20 a.m. in resident room 114, the drawer on the B bed dresser was broken. The wall in the room was scraped exposing the drywall.<br>During an observation on 04/12/17 at 10:22 a.m. the handle on the drawer of the closet was broken. Both foot boards were scraped and exposing the bare wood.<br>HALL 300<br>During an observation on 04/14/17 at 9:00 a.m. in resident room 301, the drawers on A and B bed dressers were broken.<br>During an observation on 04/14/17 at 9:02 a.m. in resident room 302, the drawers on A and B bed dressers were broken. The foot board on A bed was scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 9:03 a.m. in resident room 303, the caulking around the toilet was peeled and stained.<br>During an observation on 04/14/17 at 9:04 a.m. in resident room 304, the caulking around the toilet was peeled and stained. Both foot boards were scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 9:05 a.m. in resident room 305, the inner part of the toilet bowl was stained.<br>During an observation on 04/14/17 at 9:06 a.m. in resident room 306, the caulking around the toilet was peeled and stained. The drawer on the A bed dresser was broken. Both foot boards were scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 9:07 a.m. in resident room 307, the foot board on A bed was scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 10:40 a.m. in resident room 308, the foot board on A bed was scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 11:42 a.m. in resident room 309, both foot boards were scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 11:43 a.m. in resident room 310, the double receptacle cover plate was missing. The drawer handle on A side closet was missing.<br>During an observation on 04/14/17 at 11:44 a.m. in resident room 311, the drawer handle on B side closet was missing. The foot board on B bed was scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 11:46 a.m. in resident room 312, the foot board on A bed was scraped and exposing the bare wood.<br>During an observation on 04/14/17 at 11:48 a.m. in resident room 313, the drawer handle on B side closet was missing.<br>During an observation on 04/14/17 at 11:50 a.m. in resident room 314, the handle on A side bed dresser was broken. The drawer handle on A side closet was missing. Both foot boards were scraped and exposing the bare wood.<br>HALL 400 (The secure unit)<br>Observation on 4/10/17 at:<br>- 11:30 a.m. showed Room 411's bathroom light not working.<br>- 11:50 showed no covebase in Room 412's bathroom<br>Observation made on 4/12/17 between 8:15 a.m. and 8:45 a.m. showed Hall 400:<br>- 401 B - dresser was scratched up and drawers were off track.<br>- 402 window blind was missing 3 slats.<br>- 403 A bed - the headboard was worn to exposed wood leaving it unsanitizable. The foot board was also worn to exposed particle board.<br>- 404 A bed footboard was scraped to the exposed particle board. Window blind slats were bent.<br>- 406 A bed dresser drawers were off track, the headboard was worn to the exposed wood (leaving it unsanitizable).<br>- 408 B bed night stand was scraped to exposed particle board.<br>- 409 A bed's fall mat was cracking leaving the foam exposed (unable to be sanitized).<br>- 409 B bed dresser had a handle coming off the drawer.<br>- 409 bathroom There were rolled up briefs in 2 corners of the bathroom.<br>- 410 B bed nightstand had all three drawers with the edge off the drawers.<br>- 411 bathroom had no light, the trash was full so someone was using the bathroom.<br>- 412 B Bed had no night stand.<br>- 412 A and B bed had no light cover on the over-bed lights, there was no covebase in the bathroom.<br>- 414 B bed floor mats had corners that were broken leaving the foam exposed and unsanitizable, the headboard was worn to exposed wood. |

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| F 0465<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 7)<br>- 414 Curtain Rod was bent at a 45 degree angle.<br>- 416 window had slats missing.<br>- The day room/ dining room 8 chairs had finish that was worn off and the chairs were worn to the wood.<br>During an interview on 4/13/17 at 10:50 a.m. the Administrator said Hall 400's environment was crowded and institutional. She said there was a lot that could be done with the secured unit, but it was a matter of staff buy-in to get it done.<br>During an interview on 04/14/17 at 12:21 p.m. the Maintenance Supervisor was made aware of the issues observed. The Maintenance Supervisor said he would get the repairs done.<br>Review of the maintenance log showed none of these issues had been brought to the maintenance department's attention in the last 30 days.<br>Record review of the facility's undated Job description - Maintenance Director indicated in part:<br>- Keeps interior in good repair which includes drywall repair, painting cleaning carpets and miscellaneous other duties.<br>Review of the 4/10/17 census documented there were 24 residents residing on Hall 400 and 42 residing in the affected rooms on halls 100 and 300. |
| F 0490<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Be administered in an acceptable way that maintains the well-being of each resident .**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record reviews the facility Administrator and Director of Nurses (DON) failed to provide oversight in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for 1 of 6 residents identified with wounds (Resident #1).<br>A. The Director of Nurses (DON) failed to implement facility policies and procedures regarding pressure sore assessments and treatments when:<br>(1) Resident #1's Deep Tissue Injury was not identified by facility staff. Resident #1 did not receive a full body assessment for additional wounds until the next day (4/5/17) after surveyor request.<br>B. The Administrator failed to oversee the Director of Nurses to ensure she was monitoring the nursing staff on completing accurate and timely nursing assessments and treatments.<br>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 4/6/17 at 11:54 p.m While the IJ was lowered on 4/11/17 at 12:02 p.m., the facility remained out of compliance at a level of actual harm with a scope identified as a pattern because they did not have time to monitor for effectiveness.<br>This deficient practice affected the timely care and treatment of [REDACTED].#1 and could affect the other 12 residents with wounds by not providing therapeutic and timely treatments for wounds, and cause pain to residents during wound care.<br>Findings include:<br>RESIDENT #1<br>Review of Resident #1's face sheet dated 1/31/17 documented she was [AGE] years of age admitted on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #1's MDS assessment dated [DATE] documented in part:<br>-She scored 3 of 15 on the mental status exam (indicating severe cognitive impairment).<br>-She showed no signs of [MEDICAL CONDITION].<br>-She rejected care.<br>-She was dependent on staff for all Activities of Daily Living (AD's).<br>-She was incontinent of bowel and bladder.<br>-She was checked for at risk for pressure injuries.<br>Review of Resident #1's Care Plan updated 2/19/17 documented:<br>-Resident #1 had actual functional loss in transfers/bed mobility, used wheelchair and needed assistance with locomotion. Identified approaches included attempt to alleviate barriers to self performance of ADL's (activities of daily living), provide assistance with ADL's necessary to complete task.<br>-Resident #1 had self care deficit and required total assistance with showers, hygiene, and dressing. Identified approaches were Resident #1 required total dependence assistance with hygiene and showering.<br>-Resident #1 required a splint to her left leg (due to fracture). Identified approaches included to inspect skin to left leg, observe and report any red or broken areas.<br>-Resident #1 was expected to have skin breakdown or/and pressure ulcers related to end stage. Identified approaches included to utilize heel protectors; position with pillows to elevate pressure points, turn and reposition every 2 hours or as needed, skin assessment and inspection every shift with close attention to heels. There was no documentation of skin assessments done every shift.<br>Review of Resident #1's 2/2017 Physician order [REDACTED].<br>-Start date 5/23/14-heel protectors in place.<br>Review of Resident #1's Braden Scale dated 4/04/17 documented she scored a 12 indicated she was high risk for developing a pressure ulcer.<br>Review of the Weekly Wound Tracking Worksheet dated 3/10/17 documented in part:<br>-Resident #1 had an acquired in house trauma injury that measured 0.7 x 0.3 x 0.2 centimeters (cm) on her left thigh with granulation tissue (pink or red with shiny moist granular appearance) identified on 2/14/17. Nutrition measures: Vitamin C , zinc every day, arginade twice a day, liquid protein 30 ml (milliliters) twice a day, super-cereal with breakfast and 60 ml of 2 cal three times a day. Braden Score 12 (high risk for pressure injuries). Support measures: Clean with normal saline, dry, apply abd pad everyday and as needed until healed. Splint left leg at all times. Heel protectors in place while in bed.<br>Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her right coccyx that measured 1.3 x 0.3 x 0.1 with granulation tissue. Nutrition measures: Vitamin C, zinc every day, arginade twice a day, liquid protein 30 ml (milliliters) twice a day, super-cereal with breakfast and 60 ml of 2 cal three times a day. Support measures: apply [MEDICATION NAME].<br>Review of the Weekly Wound Tracking Worksheet dated 3/17/17 documented in part:<br>-Resident #1 had an acquired in house pressure injury that measured 1.5 x 0.5 x 0.1 centimeters (cm) on her coccyx area with granulation tissue (pink or red with shiny moist granular appearance) identified on 2/14/17. Braden Score 12 (high risk for pressure injuries). Support measures: Clean with normal saline, dry, apply collagen and dry dressing every of day and as needed until healed.<br>-Resident #1 had an acquired in house trauma injury that measured 0.7 x 0.3 x 0.2 centimeters (cm) on her left thigh with granulation tissue (pink or red with shiny moist granular appearance) identified on 2/14/17. Braden Score 12 (high risk for pressure injuries). Support measures: Clean with normal saline, dry, apply abd pad everyday and as needed until healed. Splint left leg at all times. Heel protectors in place while in bed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her right coccyx that measured 0.7 x 0.5 x 0.1 cm. with [MEDICATION NAME] tissue (new skin or growing can be pink and shiny). Support measures: apply [MEDICATION NAME] twice a day and as needed until healed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/07/17 to her coccyx left that measured 0.7 x 0.3 x 0.1 cm. with [MEDICATION NAME] tissue (new skin or growing can be pink and shiny). Support measures: apply [MEDICATION NAME] twice and as needed until healed.<br>Review of the Weekly Wound Tracking Worksheet dated 3/31/17 documented in part:<br>Apply [MEDICATION NAME] to peri-area as needed until healed. DX (diagnosis): Stage 2 to left coccyx.<br>Clean wound to left knee with Normal saline, dry apply to TAO (triple antibiotic ointment), abd pad until healed. DX: Wound to left knee.<br>Clean unstageable to coccyx with normal saline, dry, with 4 x 4's, apply collagen and dry dressing every other day until healed.<br>-Resident #1 had an in house acquired trauma injury identified on 2/14/17 to her right coccyx that measured 1.7 x 0.6 cm. with granulation tissue (pink or red with shiny moist granular appearance). Support measures: Clean with normal saline, dry, apply abd pad everyday and as needed until healed. Splint left leg at all times. Heel protectors in place while in bed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her coccyx (right and left coccyx |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 8)<br>pressure injury merged across the coccyx identified on 3/21/17) that measured 2.25 x 5.2 cm. with necrotic tissue (eschar, black, brown or tan tissue). Support measures: Clean with normal saline, dry, apply dry dressing every other day and as needed until healed.<br>Review of Resident #1's 4/2017 Physician order [REDACTED].<br>Start date 4/04/17-Clean unstageable to right heel with [MEDICATION NAME], leave open to air every day and heel protectors in place at all times. DX (diagnosis) unstageable to right heel. (discontinued on 4/05/17)<br>Review of the telephone physician orders [REDACTED]. DX: SDTI.<br>Review of the Weekly Wound Tracking Worksheet dated 4/07/17 documented in part:<br>-Resident #1 acquired in house deep tissue injury to her right heel that measured 4 x 2.5 cm. identified on 4/04/17. Support measures: Support measures: Clean with [MEDICATION NAME], dry, apply [MEDICATION NAME], heel dressing wrap with kling and<br>secure with tape every other day and as needed. Heel protectors in place at all times.<br>-Resident #1 had a deep tissue injury on her left posterior lower leg identified on 4/04/17 that measured 2 x 2. Support measures: Clean with normal saline, dry, apply foam dressing, change every three days and as needed until healed. Knee immobilizer to remain in place.<br>-Resident #1 acquired an in house deep tissue injury to the top of her 2nd right toe that measured 0.6 x 0.7 cm. identified on 2/28/17. Support measures: Clean with [MEDICATION NAME] and lota every day or as needed.<br>-Resident #1 acquired in house deep tissue injury to the top of her 3rd left toe that measured 0.6 x 0.6 cm. identified on 4/04/17. Support measures: Clean with [MEDICATION NAME] and lota every day or as needed.<br>-Resident #1 had an in house acquired pressure ulcer (injury) identified on 2/28/17 to her coccyx (right and left buttock pressure injury merged across the coccyx on 3/21/17) that measured 5 x 5 cm. with necrotic tissue (eschar, black, brown or tan tissue. Support measures: Clean with dakins 0.25%, dry, apply aginate moistened with hydrogel and pack into wound. Apply [MEDICATION NAME] to peri-wound. Apply charcoal dressing and alleveyn dressing every day.<br>During an observation on 4/04/17 at 11:38 a.m. Resident #1 was lying in bed and 2 hospice aides had just finished giving Resident #1 a bed bath. The surveyor asked them if Resident #1 had any skin issues. An aide lifted up Resident #1's right heel and said she has this and she also has one area on her buttock but it had a dressing on it. The right heel had a large dark purple black area (approximately the size of a large egg). The hospice aide said Resident #1 did not have any type of dressing on the heel. The hospice aides did not make the facility staff aware of Resident #1's right heel (SDTI) or the hospice nurse. The surveyor requested the facility's treatment nurse assess the right heel on 4/04/17 at 4:40 p.m.<br>During an observation during wound care on 4/04/17 at 4:09 p.m. the treatment nurse got her supplies ready to do wound for Resident #1. The treatment nurse took off Resident #1's leg immobilizer and raised Resident #1's leg up to do a skin assessment of the leg. The treatment nurse changed the dressing to Resident #1's left knee and changed the dressing to the unstageable pressure injury on Resident #1's coccyx area. She said that was the only pressure injury resident #1 had at this time (indicating the wound to Resident #1's coccyx). While positioning Resident #1 in bed the treatment nurse had to put Resident #1's heel protectors back on. She raised the right lower leg and placed the heel protector on. The treatment nurse pointed out that Resident #1 had areas on her right 2nd and 3rd toe which she said they just cleansed the area but did not put dressing on them. The treatment nurse did not assess Resident #1's heels when she put the heel protectors back in position. The treatment nurse had finished her treatment and was walking out of Resident #1's room when the surveyor asked her to check Resident #1's right heel. The treatment nurse went to her medication cart and got out a measuring tape and re-entered Resident #1's room. The treatment nurse said she was unaware Resident #1 had anything to her right heel. She measured the area at 4 x 2.5 cm. She wrote the size on and appearance of the area on a scrap piece of paper and turned it into the Director of Nurses (DON) at 4:55 p.m. The treatment nurse said the said the DON would be the one to go in and stage the area.<br>During an interview on 4/05/17 at 8:51 a.m. the DON said she first learned about Resident #1's right heel injury the day before (4/04/17) when the treatment nurse informed her around 5:00 p.m. She said she was not sure when Resident #1 acquired the pressure injury. She said she had talked to the hospice nurse to see if anyone had reported it to her and she said the hospice aides did not report any new issues to her. The DON said the hospice nurse informed her that she asked the hospice aides if there was any thing she needed to know about Resident #1 and the aides told her no. She said the hospice nurse did not assess Resident #1's heels when she came in yesterday because Resident #1 was asleep and she didn't want to wake her. The DON said if there are any changes the charge nurse for that resident was informed. She said the charge nurse for Resident #1 was not informed of any new issues. She said she did not do a full body skin assessment of Resident #1 on 4/04/17 but would get the treatment nurse and do it now. The DON said she would have to get the hospice aides notes faxed to her.<br>During an interview on 4/06/17 at 9:48 a.m. hospice aides Q and R said they had just noticed Resident #1's right heel on Monday (4/04/17). They said they were supposed to report any resident changes to their hospice nurse. They said they did not report Resident #1's heel so they had to go to an in-service on reporting resident changes. The hospice aides said they had to report any thing different with the resident, like that resident's heel. They said they report changes immediately.<br>During an interview on 4/06/17 at 11:07 a.m. the treatment nurse said skin assessments were to be done weekly. She said she did medication pass on Monday's and then Tuesday's she had to go to wound care in Midland with one of the residents so she did not do treatments or skin assessments on those days. She said she did skin assessments on what ever day the aides were giving showers so she could be in the shower room while the residents were showered. She said she would look to see where the shower aides were giving the showers and that would be the hall she would do skin assessments on that day. She said she does not know if that was the way skin assessments are supposed to be done but that was how it had been done since she had been there. She said the charge nurses were to do wound care on their halls when she got pulled off treatments.<br>Review of a written statement dated 4/12/17 by the DON documented she spoke to the Hospice Director on 4/04/17. She said she made rounds (to see the hospice residents) on 4/04/17 and said the hospice aides did not report any new skin issues for Resident #1 to her. The Hospice Director said she did not assess Resident #1's heels on 4/04/17 because the resident seemed comfortable. The DON said she interviewed the facility staff regarding Resident #1's deep tissue injury and the staff denied observing any new areas of skin breakdown during their shift. Some of the staff members verbalized that Resident #1 tended to remove her heel protectors at times. Staff reported putting Resident #1's heel protectors back on, however they said they did not look at her heels.<br>During an interview on 4/6/17 at 11:54 a.m. the Administrator was informed of the Immediate Jeopardy. She said she was not informed of Resident #1's unstageable pressure injury or that the surveyor had found it. The Administrator said the facility talked about skin issues every morning in stand-up meeting and she was not informed of Resident #1's new pressure injury. She said she received a copy of the facility's skin report and did not realize that 6 new pressure injuries had developed (close to 10% of the facility's census) in 2 months. She said that's too much.<br>During an interview on 4/6/17 at 1:58 p.m. the Treatment Nurse said she had been the treatment nurse off and on for several years. She said this time she had been the treatment nurse for over a year. She said she got pulled treatments to do other jobs because of staffing issues. She said her Corporate Office had said she was not to be pulled. She said last week she had to go to wound care Monday and Friday and then Wednesday she was pulled to work the floor which gave her 2 days to do treatments and skin assessments. She said this week (4/3/17 - 4/7/17) she was pulled to the floor on 4/3 to be the medication nurse and 4/04/17 she had to transport a resident to wound care. She said she had talked to the DON about sending one resident with just two aides to wound care. She said she physically counted the number of wounds in the building when she did the skin report and was very aware of the number of residents with pressure injuries. She said the numbers seem up there. She said the aides were usually very good about reporting changes to her. The Treatment Nurse said she tried to do skin assessments on one hall a day.<br>During an interview on 4/06/17 at 2:55 p.m. the Administrator said she was not informed of Resident #1's pressure injury until the next day. She said unstageable was the most explanation she got. The Administrator was informed that no full body assessment was completed until after 9 a.m. the day after the unstageable was discovered on Resident #1. The Administrator acknowledged the system had broken down. She said it appeared the problem started with the Hospice aides and not telling any of the staff. She said once the Treatment Nurse was notified she should have done a full assessment. The Administrator said the facility CNA's provided incontinent care and as needed bed baths. She said they provided care like repositioning and putting on the heel protectors that everyone kicks off. She said as they were repositioning Resident #1 she would think they would see the unstageable pressure injury. |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 9)<br>During an interview on 4/06/17 at 3:35 p.m. the Administrator said she did not know how the breakdown in the facility processes happened. She said the staff did a skin assessment the previous Thursday (3/30/17) and there was no areas on her heels. She said they did a culture on the wound on Resident #1's coccyx and got her on an antibiotic for that. The Administrator acknowledged the Treatment nurse was pulled to the floor and did have to do wound care appointments. She said maybe it would be a good idea to have a second set of eyes to check skin. The Administrator said they did discuss skin at each QA meeting and it was constant training, follow-up, follow-up, and follow-up. She said she monitored to make sure the skin process remained effective by talking about it every week in the quality of care meetings where they talked about skin and weights. She said they failed to recognize the pattern of increased pressure injuries to the feet. The Administrator said she thought the biggest failure is people did not see how their jobs were connected and could cause a ripple effect through the entire building. The Administrator said the facility had a lot of falls/ reportable incidents she thought they lost focus on the pressure injuries and focused more on the falls and the focus came off the pressure injuries.<br>During an interview on 4/10/17 at 3:57 p.m. the DON said she did not know how the IJ in pressure injuries happened. She said she had tried to keep up with it the best she could by going over daily orders and incident - accident reports. The DON said she was making sure measures were put in place with Resident #1 to prevent the pressure sore. The DON said she thought it was a communication issue with the Hospice Agency who did not report the breakdown to the facility Charge Nurse. She said to monitor to make sure the pressure injury process was effective was she talked to the Hospice Supervisor and they were now in-servicing the Hospice Team with the regular CNA's. The DON said the Hospice Aides now had a binder with skin report sheets just like the regular CNA's. She said she did not evaluate the facility's policies for effectiveness because she did not realize there was a problem. She thought the root cause of this IJ was a lack of communication. The DON acknowledged she had seen an overall increase in weight loss/ decrease in appetites in residents which contributed to the development of wounds. She said this was identified the last week of March and there had not been time to monitor that for effectiveness. The DON said they identified three new pressure injuries when they did skin assessments. She said the facility and Hospice CNA's had been in-serviced on proper repositioning. The DON acknowledged half the pressure injuries were to resident heels and half of those residents were not bed bound so she was still trying to figure out how they occurred. She said they facility had an IJ in pressure injuries last year but it was confined to one person - this year it was prevention and identification and she could not identify a pattern to why they were developing. She was asked if she checked the Braden Assessments for accuracy and she said how did I miss that? We were all just so exhausted when we did those.<br>During an interview on 4/7/17 the Regional Director said the facility did a clinical stand up meeting every day and did a really good job with it, but they were just not seeing trends in care.<br>Review of the Certified Nursing Assistant Job Description (undated) documented, in part:<br>Summary: Provide nursing care to the residents according to established policies and procedures and to ensure that the highest degree of quality of care is maintained at all times.<br>Safety and Sanitation: Report all incidents and accidents immediately.<br>Review of the facility's February 2014 Policy and Procedure on Pressure Ulcer Risk Assessment documented, in part:<br>Purpose: The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers.<br>Preparation: Review the resident's care plan to assess for any special needs of the resident.<br>Once a pressure ulcer develops, it can be extremely difficult to heal.<br>Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor.<br>Assessment:<br>Skin Assessment: Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated.<br>Review of the facility's February 2014 policy and procedure on Prevention of Pressure Ulcers documented, in part:<br>Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors.<br>General Guidelines: Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue.<br>Use pillows, wedges or other off-loading devices to keep bony prominence's such as knees or ankles from touching each other. Do not massage bony prominence's.<br>When in bed every attempt should be made to float heals (keep heels off the bed) by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician.<br>The facility's Plan of Removal Of Immediate Jeopardy was accepted on 4/04/17 and included the following:<br>Prevention of Pressure Sores<br>Nurses and CNA's re-educated on positioning, turning, preventative measures and reporting related to skin by DON.<br>Date of Completion 4/07/17. In-service on going.<br>Identification/interventions of Pressure Sores<br>The DON, ADON (assistant director of nurses), treatment nurse and LVN (licensed vocational nurse) charge nurse conducted 100% skin Evaluation and Intervention Form. Risk Evaluation and intervention form. The Braden Scale was updated for all residents in the facility. Preventative interventions were put into place for all newly identified residents. They physician was notified of any new skin problems that were identified and orders obtained for treatment (s). The resident and/or responsible party was also notified of any newly identified pressure sores and the new orders that were obtained from the physician.<br>Date of Completion: 4/06/17.<br>Staff education related pressure sores<br>The DON/designee in-serviced and education the Treatment Nurse on the prevention of pressure sores, ensuring proper turning and positioning of residents; identification and reporting any skin change noted during care. The treatment nurse was also in-serviced on proper documentation requirements related to a pressure sore and notification of the physician, resident,/responsible party and nurse DON/Designee when a resident has any change in condition.<br>Completed on 4/07/17<br>Additional in-service with nursing staff was proved by the DON and the ADON on 4/07/17 addressing the prevention of pressures sores.<br>Completed on 4/07/17<br>The Regional Nurse Consultant completed wound care competencies with the DON and Treatment Nurse which included return demonstrations.<br>on 4/07/17<br>Monitoring of Pressure Sores<br>The DON will check all known pressure sores at least once a week to evaluate the effectiveness of the treatment, to ensure that the treatment nurse is providing the treatments as ordered by the physician, and to evaluate the pressure reducing devices that are in place. The DON will or Designee will also complete random skin assessments on the least 3 individuals per week. Regional Nurse will review the DON Random Skin Audits at least once a month in the facility. Findings will be evaluated during the Weekly Quality of Care meeting and monthly during QA (quality assurance) & A for a minimum of 3 months and thereafter until the satisfaction of the QA & A committee is achieved.<br>Started 4/06/17<br>In-serviced on 4/07/17 and distribution of the booklets on 4/07/17<br>The Certified Nursing Assistants (CNA) were in-serviced by the DON and the ADON on 4/07/17 about the continuous Pressure Ulcer Prevention booklets which provide the CNA's with a tool to document any noted skin change for a resident that they identify during routine daily resident care (see attached copy of the form and guidelines). The form is a triplicate copy with one distributed to the DON, one to the charge nurse and the other is kept by the CNA. the CNA's were all given a set of the forms and guidelines which are included on 4/07/17.<br>Initiated 4/07/17 |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 10)<br>Date of Completion 4/07/17<br>CNA's will complete a Daily CNA Shift Report Sheet. This will be completed on every shift and used as shift-to-shift communication tool between aides. Communication will include any observed changes in resident condition. CNA's are to notify the charge nurse as well. The sheets will be reviewed during the daily clinical meetings.<br>Started 4/17/17<br>Shower aides were in-serviced by the ADON on completing skin observations and implementation of skin sheets for every resident showered whether skin issues are identified or not. Shower aides will bring and report on shower log, skin sheets and any other concerns at daily stand-up. This will ensure residents are not over looked for skin issues during showers.<br>Monthly and ongoing<br>Nursing Management will review all residents with changes of condition including pressure sores during the Daily Clinical Meeting.<br>On-Going Skin Management System<br>Resident will have a skin check and a Braden Scale completed on admission/readmission by the charge nurse who is completing the admission. Any identified pressure sore or there skin problem will be reported to the physician to obtain treatment orders and notify the resident/responsible part. The charge nurse will document all findings on the admission paperwork and the 24 hour report. Al new resident admissions/readmissions will be reviewed in the daily Clinical Meeting. The DON/designee will check the newly admitted /readmitted resident's skin within 24 hours of admission or on Monday following a weekend admission to ensure all skin problems are identified and addressed.<br>On-going<br>Starting 4/07/07<br>All resident that are admitted /readmitted will have a Braden scale completed by the charge nurse or treatment nurse on admission and then for 3 consecutive weeks for a total of 4 weeks to establish a baseline. The DON/Designee will verify completion at the Daily clinical meeting.<br>In addition to the Braden scale, the Treatment Nurse will complete the Skin Risk Evaluation and Interventions form for all residents who have a Braden scale of 18 or less and/or the resident has a wound (refer to attached skin risk evaluation and intervention form attached). The resident plan of care related to an identified wound and/for a resident that is high risk for breakdown will be initiated with the interventions portion of the form.<br>Initial Skin Risk Evaluation and Interventions form will be completed on the current resident with a Braden assessment of 18 or less and/or a resident with a wound by 4/07/17 then on-going.<br>The treatment nurse will conduct weekly head to toe skin assessments on every resident in the facility. The treatment nurse will report any newly identified skin problem to the DON and the DON will ensure proper documentation, notifications and interventions are in place. The physician will be contacted for treatment orders and resident/responsible party will also be notified. The treatment nurse will initiate the treatment, note the skin problems and new order on the 24 hour report and document all the above in the nurses' progress notes. The ordered treatment will be noted on the current treatment documentation form. The Nurse Management team will check that all the above are completed in the daily Clinical meeting.<br>On-going<br>The treatment nurse will be responsible for providing the treatments for all residents as ordered by the physician in the event the treatment nurse is off, the charge nurse for each hall will be responsible for providing the physician ordered treatments to the residents on the assigned hall.<br>On-going<br>The Nurse Management Team will meet every week to complete the Weekly Quality of Care Review. The Nurse Management team will<br>review all residents identified with new pressure sores in the last week to ensure that all appropriate treatments and pressure prevention measures are in place and completed as ordered. The Management Team at this time will also review the weekly skin assessment sheets to ensure all residents skins are assessed on a weekly basis.<br>On-going<br>The DON or Designee will repeat all afore mentioned in-services monthly for a minimum of 3 months and thereafter until the satisfaction of the QA & A committee is achieved.<br>The Administrator was notified that the IJ was removed prior to exit on 4/07/16. The facility remained out of compliance at a scope of security level of Actual Harm that is not immediate jeopardy at a Pattern that was not IJ because the facility had not had time to implement and monitor their plan for effectiveness.<br>DEFINITIONS (taken from State Operations Manual guidance on Pressure Ulcers revised 5/01/16):<br>Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction & shear are not primary causes of pressure ulcers, friction & shear are important contributing factors to the development of pressure ulcers.<br>Assessment - An admission evaluation helps identify the resident at risk of developing a pressure ulcer, & the resident with existing pressure ulcer(s) or areas of skin that are at risk for breakdown. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified & have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care approaches.<br>While pressure ulcers on the sacrum remain the most common location, pressure ulcers on the heel are occurring more frequently, are difficult to assess & heal, & require early identification of skin compromise over the heel.<br>(From the Minimum Data Set (MDS) assessment dated [DATE])<br>Unstageable - Deep Tissue: Suspected Deep tissue injury in evolution.<br>Review of the form CMS 672 Resident Census and Conditions of Residents completed by RN E on 4/11/17 documented there were 13 residents with pressure ulcers in the building. |
| F 0518<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Train all employees on what to do in an emergency, and carry out announced staff drills.**<br><br>Based on observation, interview and record review the facility failed to ensure that 2 of 3 staff members interviewed (Certified Nurse Aide (CNA) P and Registered Nurse (RN) E) were trained in emergency procedures.<br>CNA P did not know what to do in case of a fire, did not know how to use a fire extinguisher, did not know the order of evacuation, did not know what to do in case of a bomb threat, and did not know what to do in case of a missing resident.<br>RN E did not know what to do in case of a fire, did not know the location of the fire alarm pull stations, did not know how to use a fire extinguisher, and did not know what to do in case of a bomb threat.<br>This failure had the potential to affect all 76 residents in the building in the event of a fire, a tornado, or a bomb threat.<br>The findings included:<br>During an interview on 4/12/17 at 1:10 p.m. CNA P said if the fire alarm went off she would go to the panel at the front nurse's station and look for the location of the fire. She said she would close all the doors to the rooms as she went. When asked how to use the fire extinguisher, CNA P said she did not know. CNA P went to the fire extinguisher and pulled it from its locker and was able to pantomime sweeping the hose but did not know to pull the pin or to squeeze the trigger of the fire extinguisher. CNA P said the order of evacuation was wheelchair bound, ambulatory residents, and then bed bound residents. CNA P confirmed she answered the phone. She said if someone said there was a bomb in the building she would call the police and fire department. She said if she discovered a missing resident she would tell her Charge Nurse and Director of Nurses. She said she did not remember when the last in-service on disaster preparedness was.<br>During an interview on 4/12/17 at 2:15 p.m. RN E said in case of a fire she would come out, and start directing staff to hallways to make sure there was someone on every hall and they would look at the fire panel. RN E said there was a fire pull station on every hall, but did not know if it was the front or the back of the hallway. RN E said the only part of working the fire extinguisher she remembered was pulling the pin. She acknowledged she answered the phone. She said if someone said a bomb was in the building she would let administration know and call the fire department.<br>During an interview on 4/12/17 at 2:30 p.m. the Administrator said in case the fire alarm went off she expected her staff to get the residents safe, someone to check the panel, get the extinguisher and and try to extinguish the fire while the other staff kept the residents safe. The Administrator said the fire pull stations were by the fire doors and by the exit doors. |

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|---|---|---|---|
| | 675722 | A. BUILDING _____ B. WING _____ | 04/14/2017 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| FORT STOCKTON LIVING & REHABILITATION | 501 N SYCAMORE FORT STOCKTON, TX 79735 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0518<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 11)<br>The Administrator said to use the fire extinguisher you pulled the pin, pointed at the fire, engaged the pressure handle and swept at the fire. The Administrator said the order of evacuation was ambulatory, wheelchair bound, and then bed bound. The Administrator said in the case of a missing resident, she expected the staff to alert the immediate staff and seach the building and the immediate outside areas then assign staff to work outward - if no resident after 15 minutes to notify the police department, the administration, and the resident's family. She said in case of a bomb threat she expected her staff to keep the caller on the line for as long as possible and listen for background noises and have someone else notify her and call 911. The Administrator said she did not remember when the last in-service on disaster preparedness was.<br>Review of the in-service binder 4/2017 - 4/2016 showed the last in-service on the disaster plan was 5/08/16.<br>Review of the facility's Disaster Plan documented, in part:<br>Bomb Threat<br>While bomb threats or warnings may be received by main or message, the most popular method is by telephone. An accurate analysis of the telephone threat can provide the police with many valuable clues. The caller could reveal a personal characteristic such as sex, ethnic background, mental background, and many unwittingly provide a clue to their location by background noises. They often intentionally or unintentionally provide accurate information on the type of bomb and its exact location.<br>The natural reaction of an untrained person receiving any threat is panic. A properly trained individual, however, will remain calm and take advantage to the situation to insure the incident will be safely handled. You should have another person listening in on all bomb threat calls.<br>Fire Procedure<br>If any employee or resident is involved in a fire (or on Fire), the employee discovering it shall go to the immediate aid of that person. While going to the aide of the victim, the discoverer will call aloud Doctor Red.<br>Any person hearing (Doctor Red) will activate the interior alarm and notify the Nursing Station at the Core.<br>d. Report the exact location of the fire to the Core Nursing station. Give location and your name.<br>The Core Nursing station Charge Nurse, designee, or administrative person in charge will call 911 to verify the alarm and give the specific location of a fire. He/she will also announce Doctor Red and the location over the PA system,.<br>a. All employees will report to their duty stations.<br>b. Close all doors and windows to prevent a draft.<br>c. Do not use telephone except for emergency messages.<br>d. Reassure residents in your work area.<br>e. Stand by for instructions from you department head.<br>If the fire occurs in another location of the facility, the employees will:<br>a. listen for the code and location;<br>b Reassure the residents in their areas.<br>c. Close all doors and windows<br>d. Do not use telephones for other than emergency messages.<br>e. Stand by for instructions from your department head.<br>Fire Procedures<br>A. Check zone on red box at nurse's station.<br>1. If zones 1 - 8 are lit, check diagram of building for location.<br>2. If zone B indicates a sprinkler head has gone off somewhere in the building, the entire building must be searched for location.<br>3. If zone 7 indicates that the fire extinguisher over the kitchen vent-a-hood has gone off, check with the kitchen.<br>B Charge Nurse will check zone and location. The first 2 aides to report to the station will be assigned to stay at the station and notify all other employees of the affected zone and location.<br>C. The Charge Nurses, all other aides, housekeepers, Department Heads, and Diet aides report to the fire zone.<br>D. All dietary employees report to affected area; only cooks remain in kitchen and turn off gas and electrical appliances.<br>E. If smoke is in evidence:<br>1. The person in charge will designate someone to call the fire department & 911.<br>2. Close doors in affected zone until the source is located.<br>3. Remove any residents in immediate danger<br>4. Close all doors in zone.<br>5. If possible, attempt to fight the fire with extinguishers.<br>6. If fire is too large to control, evacuate residents to another zone under the direction of the person in charge.<br>III Evacuation of Zone<br>A. Done only under direction of the person in charge<br>B Order of evacuation:<br>1. Ambulatory Residents - line up holding hands while one aide leads.<br>2. Non-ambulatory Alert resident - use wheelchairs or use a blanket to pull resident on the floor.<br>3. Non-ambulatory Confused residents - move by the safest means possible.<br>Review of the form CMS 672 Resident Census and Conditions of Residents documented there were 76 residents in the facility. |
| F 0526<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to have an effective communication process between the facility and the hospice provider to communicate a significant change in condition. This failure effected Resident #1.<br>Resident #1 developed an unstageable pressure injury to her heel (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages: Persistent non-blanchable deep red, maroon or purple discoloration). The hospice aides were aware of the pressure injury on 4/04/17 and did not communicate it to any staff in the facility.<br>This failure cause a delay in appropriate treatment, possible pain, and risk of further breakdown for Resident #1 or any of the 3 remaining residents on Hospice Services at the time of the survey.<br>The findings included.<br>RESIDENT #1<br>Review of Resident #1's face sheet dated 1/31/17 documented she was [AGE] years of age admitted on [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #1's MDS assessment dated [DATE] documented in part:<br>-She scored 3 of 15 on the mental status exam (indicating severe cognitive impairment).<br>-She showed no signs of [MEDICAL CONDITION].<br>-She rejected care.<br>-She was dependent on staff for all Activities of Daily Living (AD's).<br>-She was incontinent of bowel and bladder.<br>-She was checked for at risk for pressure injuries.<br>Review of Resident #1's Care Plan updated 2/19/17 documented:<br>-Resident #1 had actual functional loss in transfers/bed mobility, used wheelchair and needed assistance with locomotion. Identified approaches included attempt to alleviate barriers to self performance of ADL's (activities of daily living), provide assistance with ADL's necessary to complete task.<br>-Resident #1 had self care deficit and required total assistance with showers, hygiene, and dressing. Identified approaches were Resident #1 required total dependence assistance with hygiene and showering.<br>-Resident #1 required a splint to her left leg (due to fracture). Identified approaches included to inspect skin to left leg, observe and report any red or broken areas.<br>-Resident #1 was expected to have skin breakdown or/and pressure ulcers related to end stage. Identified approaches included to utilize heel protectors; position with pillows to elevate pressure points, turn and reposition every 2 hours or as needed, skin assessment and inspection every shift with close attention to heels.<br>During an observation on 4/04/17 at 11:38 a.m. Resident #1 was lying in bed and 2 hospice aides had just finished giving |

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| F 0526<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 12)<br>Resident #1 a bed bath. The surveyor asked them if Resident #1 had any skin issues. An aide lifted up Resident #1's right heel and said she has this and she also has one area on her buttock but it had a dressing on it. The right heel had a large dark purple black area (approximately the size of a large egg). The hospice aide said Resident #1 did not have any type of dressing on the heel. The hospice aides did not make the facility staff aware of Resident #1's right heel (SDTI) or the hospice nurse. The surveyor requested the facility's treatment nurse assess the right heel on 4/04/17 at 4:40 p.m.<br>During an observation during wound care on 4/04/17 at 4:09 p.m. the treatment nurse got her supplies ready to do wound for Resident #1. The treatment nurse took off Resident #1's leg immobilizer and raised Resident #1's leg up to do a skin assessment of the leg. The treatment nurse changed the dressing to Resident #1's left knee and changed the dressing to the unstageable pressure injury on Resident #1's coccyx area. She said that was the only pressure injury resident #1 had at this time (indicating the wound to Resident #1's coccyx). While positioning Resident #1 in bed the treatment nurse had to put Resident #1's heel protectors back on. She raised the right lower leg and placed the heel protector on. The treatment nurse pointed out that Resident #1 had areas on her right 2nd and 3rd toe which she said they just cleansed the area but did not put dressing on them. The treatment nurse did not assess Resident #1's heels when she put the heel protectors back in position. The treatment nurse had finished her treatment and was walking out of Resident #1's room when the surveyor asked her to check Resident #1's right heel. The treatment nurse went to her medication cart and got out a measuring tape and re-entered Resident #1's room. The treatment nurse said she was unaware Resident #1 had anything to her right heel. She measured the area at 4 x 2.5 cm. She wrote the size on and appearance of the area on a scrap piece of paper and turned it into the Director of Nurses (DON) at 4:55 p.m. The treatment nurse said the said the DON would be the one to go in and stage the area.<br>During an interview on 4/05/17 at 8:51 a.m. the DON said she first learned about Resident #1's right heel injury the day before (4/04/17) when the treatment nurse informed her around 5:00 p.m. She said she was not sure when Resident #1 acquired the pressure injury. She said she had talked to the hospice nurse to see if anyone had reported it to her and she said the hospice aides did not report any new issues to her. The DON said the hospice nurse informed her that she asked the hospice aides if there was any thing she needed to know about Resident #1 and the aides told her no. She said the hospice nurse did not assess Resident #1's heels when she came in yesterday because Resident #1 was asleep and she didn't want to wake her. The DON said if there are any changes the charge nurse for that resident was informed. She said the charge nurse for Resident #1 was not informed of any new issues. She said she did not do a full body skin assessment of Resident #1 on 4/04/17 but would get the treatment nurse and do it now. The DON said she would have to get the hospice aides notes faxed to her.<br>During an interview on 4/06/17 at 9:48 a.m. hospice aides Q and R said they had just noticed Resident #1's right heel on Monday (4/04/17). They said they were supposed to report any resident changes to their hospice nurse. They said they did not report Resident #1's heel so they had to go to an in-service on reporting resident changes. The hospice aides said they had to report any thing different with the resident, like that resident's heel. They said they report changes immediately.<br>During an interview on 4/06/17 at 11:07 a.m. the treatment nurse said skin assessments were to be done weekly. She said she did medication pass on Monday's and then Tuesday's she had to go to wound care in Midland with one of the residents so she did not do treatments or skin assessments on those days. She said she did skin assessments on what ever day the aides were giving showers so she could be in the shower room while the residents were showered. She said she would look to see where the shower aides were giving the showers and that would be the hall she would do skin assessments on that day. She said she does not know if that was the way skin assessments are supposed to be done but that was how it had been done since she had been there. She said the charge nurses were to do wound care on their halls when she got pulled off treatments.<br>Review of a written statement dated 4/12/17 by the DON documented she spoke to the Hospice Director on 4/04/17. She said she made rounds (to see the hospice residents) on 4/04/17 and said the hospice aides did not report any new skin issues for Resident #1 to her. The Hospice Director said she did not assess Resident #1's heels on 4/04/17 because the resident seemed comfortable. The DON said she interviewed the facility staff regarding Resident #1's deep tissue injury and the staff denied observing any new areas of skin breakdown during their shift. Some of the staff members verbalized that Resident #1 tended to remove her heel protectors at times. Staff reported putting Resident #1's heel protectors back on, however they said they did not look at her heels.<br>During an interview on 4/10/17 at 3:57 p.m. the DON said she did not know how the Immediate Jeopardy in pressure injuries happened. The DON said she was making sure measures were put in place with Resident #1 to prevent the pressure sore. The DON said she thought it was a communication issue with the Hospice Agency who did not report the breakdown to the facility Charge Nurse. She said to monitor to make sure the pressure injury process was effective was she talked to the Hospice Supervisor and they were now in-servicing the Hospice Team with the regular CNA's. The DON said the Hospice Aides now had a binder with skin report sheets just like the regular CNA's.<br>DEFINITIONS (taken from State Operations Manual guidance on Pressure Ulcers revised on 5/01/15)<br>Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). Although friction & shear are not primary causes of pressure ulcers, friction & shear are important contributing factors to the development of pressure ulcers.<br>Assessment - An admission evaluation helps identify the resident at risk of developing a pressure ulcer, & the resident with existing pressure ulcer(s) or areas of skin that are at risk for breakdown. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified & have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care approaches.<br>While pressure ulcers on the sacrum remain the most common location, pressure ulcers on the heel are occurring more frequently, are difficult to assess & heal, & require early identification of skin compromise over the heel.<br>Review of the facility's 5/07/16 Contract with the Hospice Agency documented, in part:<br>1. Responsibilities of Hospice:<br>1.03 Information/ Documentation provided to Facility on admission and on-going:<br>- Copies of clinical notes after each visit.<br>1.04 Coordination/ Continuity of Care<br>- Maintain communication with facility staff, patient/ family and physician with appropriate documentation.<br>- Designate a member of each IDT (Interdisciplinary Team) that is responsible for a patient who is a resident of the Facility. The designated member is responsible for:<br>< Communicating with Facility representatives and other providers to ensure quality of care for the patient/ family.<br>- Maintain professional management responsibly/ coordination of facility services and ensure services are furnished in a safe, timely, and effective manner, according to the Plan of Care. Responsible for the patient/ family assessments to include medical, nursing, psychosocial, and spiritual.<br>2. Responsibilities of the the Facility:<br>2.04 Notify Hospice if:<br>- Significant change in patient's physical, mental, social, or emotional status occur;<br>- Clinical complications appear that suggest need to alter the plan of care;<br>- Need for changes in level of care due to patient's condition.<br>Review of the form CMS 672 Resident Census and Conditions of Residents completed by RN E documented there were 4 residents receiving Hospice Services at the time of the visit. |