STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. BUILDING _____ B. WING _____	08/02/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	PINE & BRISTOW DRUMRIGHT, OK 74030

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to notify the physician of worsening pressure ulcers. The resident was admitted to the facility on [DATE] with one stage II pressure ulcer on the right buttock that measured 2 cm x 3 cm. The resident subsequently developed additional pressure ulcers on the left buttock and the sacrum. The resident was sent to the hospital on [DATE], with increasing weakness, decreased oxygen saturation levels, and worsening pressure ulcers. Hospital records documented upon arrival to the hospital, the resident was found to be septic with an advanced stage III to IV sacral pressure ulcer with active drainage, necrotic tissue, bone exposure, and tunneling into the right and left gluteal muscles and pelvic area. The pressure ulcer required a 10 cm x 10 cm x 7 cm surgical debridement with [DEVICE] treatment. Biopsies of the debrided area revealed [MEDICAL CONDITION] of the soft tissue and osteo[DIAGNOSES REDACTED] in the sacral bone. The resident expired in the hospital on [DATE]. At 12:41 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 12:44 p.m., the administrator and director of nursing were notified of the IJ situation related to the facility's failure to notify the physician of worsening pressure ulcers. On [DATE] at 2:33 p.m., an acceptable plan of removal was provided. The plan of removal documented, .1. Physician Notification: In service will be conducted to all nurses regarding physician notification including, but not limited to ~ When and how soon the physician should be notified ~ Where physician notification should be documented ~ Why the physician is being notified ~ Notifying the DON and Admin of all changes in condition A change in notification form will be completed by the nurses for the DON and Admin to monitor daily in stand up. The weekend RN will monitor these forms on Saturday and Sunday if there are any, and then they will be addressed in stand up. This form will include date, time, resident's name, the stated change in condition, and the physician's response/new orders, physician/DON/Admin notified, and if it was documented in the chart . This plan of removal will be completed on [DATE] by midnight (12:00 am). The immediate jeopardy was removed on [DATE] at 11:15 p.m., when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm. Based on observation, interview, and record review, it was determined the facility failed to notify the physician of worsening pressure ulcers and the development of new pressure ulcers for two (#3 and #4) of four sampled residents who had pressure ulcers. Resident #3 was admitted to the facility on [DATE] with one stage II pressure ulcer. The resident was sent to the hospital on [DATE], and was found to be septic, with an advanced stage III to IV sacral pressure ulcer with active drainage, necrotic tissue, bone exposure, and tunneling into the right and left gluteal muscles and pelvic area. The pressure ulcer required a 10 cm x 10 cm x 7 cm surgical debridement with [DEVICE] treatment. Biopsies of the debrided area revealed [MEDICAL CONDITION] of the soft tissue and osteo[DIAGNOSES REDACTED] in the sacral bone. The resident expired in the hospital on [DATE]. Resident #4 developed a facility acquired unstageable pressure ulcer to the left buttock. The facility had knowledge of the pressure ulcer and did not notify the physician of the pressure ulcer for a minimum of three days. The facility identified 50 residents as residing in the facility and no residents with pressure ulcers. Findings: The facility's policy for notification of changes, dated ,[DATE], documented, .Except in a medical emergency or when a resident is incompetent, this facility will consult with the resident immediately and notify the resident's physician .when there is: .A significant change in the resident's physical, mental, or psychosocial status . The facility's policy and procedure for the prevention and treatment of [REDACTED].The facility will notify the physician upon the onset of the ulcer and obtain treatment orders . The facility will notify the physician if the ulcer appears to be deteriorating or if no improvement is noted in ,[DATE] weeks of the initial treatment orders . Orientation/training forms, dated [DATE], for RN #1 and LPNs #1, #2, #3, #4, and #5 documented, .Knows procedure for completion of wound care, collection of wound characteristic data and required documentation . The forms were signed by the director of nursing. 1. A hospital wound care team progress note for resident #3, dated [DATE], documented, .Pressure Ulcer Stage .II .Sacral .Length 3 cm Width 2 cm Depth 0.1 cm . Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Braden Scale form, used for predicting pressure sore risk and dated [DATE], documented the resident scored a 14. The form documented, .Total score of 12 or less represents HIGH RISK . An untitled facility form, dated [DATE], documented the resident had three open areas on the buttocks/sacral area. The form had the image of a body on it, and there were three circles drawn on the body image, with two on the right buttock and one on the sacral area. It was documented, .Open areas . There were no measurements or descriptions of the areas. A nurse's note, dated [DATE] at 1:35 p.m., documented, .(right) buttock c a 3 cm x 1.5 cm open area also gaulding to buttock . The note did not contain any other documentation related to pressure ulcers. A wound flow sheet, dated [DATE], documented the resident had a stage II pressure ulcer on the right buttock. It was documented the pressure ulcer measured 2 cm x 3 cm and was pink in color. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Admission physician orders, dated [DATE], documented the resident was to receive Prostat, a protein supplement, 30 ml daily and B-complex vitamins daily as a supplement. The orders documented to clean the right buttock daily with normal saline and apply Venelex ointment and cover with [MEDICATION NAME] border. It was also documented the resident could have a urinary catheter due to impaired skin integrity. An informed consent form for the use of an indwelling urinary catheter, dated [DATE], documented, .may have foley catheter d/t impaired skin integrity . The form was signed by the resident, the physician, and a member of the facility staff.

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

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) A physician's progress note, dated [DATE], documented, .(right) buttock 2 x 3 cm open area . A skilled nurse's note, dated [DATE] and untimed, documented, .Tx done on (right) buttock. 8 cm long x 0.25 cm wide open area noted to coccyx area. Call made .N.O. apply Venelex (and) cover c [MEDICATION NAME] .Staff reminded to reposition q 2 (hours) and encourage resident to get (up) . A physician's telephone order, dated [DATE], documented to use Venelex ointment for all open areas on the buttocks. A wound flow sheet, dated [DATE], documented the resident had a stage II pressure ulcer to the coccyx. It was documented the pressure ulcer measured 8 cm x 0.25 cm, was red, and had some bleeding. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. A skilled nurse's note, dated [DATE] at 7:00 p.m., documented, .Lying in bed c eyes open. c/o (left) hip pain. PRN pain medication given .Asked if resident would like to sit (up) in chair for a little while. Resident very hesitant afraid it will make her hurt more . A skilled nurse's note, dated [DATE] at 6:45 p.m., documented, .Buttocks are red c open areas . A physician's telephone order, dated [DATE], documented the resident was to receive Vitamin C, 500 mg daily and Zinc, 220 mg daily for wound healing. A wound flow sheet, dated [DATE], documented the resident had a stage II pressure ulcer on the left buttock. It was documented the ulcer measured 3 cm x 3 cm and that Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician was notified of the new open area to the left buttocks. Medication administration records, dated [DATE], documented the resident did not receive the ordered Prostat. It was documented, .not in . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. An admission assessment, dated [DATE], documented the resident was cognitively intact; required extensive assistance with bed mobility, transfers, and toileting. It was documented the resident had occasional pain that was very horrible and limited her activities. It was also documented the resident was at risk for pressure ulcers; had one stage II pressure ulcer; and had pressure relieving devices for her bed and chair. A wound flow sheet, dated [DATE], documented the right buttock pressure ulcer was a stage II ulcer that measured 1 cm x 1 cm. An additional measurement of 2 cm x 2 cm was documented. It was documented the ulcer was raw and pink, and Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. A physician's progress note, dated [DATE], documented, .Buttocks .wounds .open 3 x 4 cm area . A physician's telephone order, dated [DATE] documented, .Air mattress to bed Gel cushion to w/c . A skilled nurse's note, dated [DATE] at 9:30 a.m., documented, .n.o. for air mattress to bed and gel cushion to w/c . A skilled nurse's note, dated [DATE] at 6:00 p.m., documented, .Redness/open areas to pannus/buttocks . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. A skilled nurse's note, dated [DATE] at 4:00 a.m., documented, .Buttocks c redness, excoriation to anal area .c/o buttocks pain. given prn order of [MEDICATION NAME] . An undated physician's telephone order, signed by the physician on [DATE], documented to clean the open area to the left buttocks, apply Venelex, and cover daily. The order was listed on the physician telephone order sheet between an order written [REDACTED]. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. The resident's care plan, dated [DATE], documented a problem related to impaired skin integrity. The goal was the resident would have healing of skin over the next 90 days. Approaches were to perform dressing changes as ordered; gel cushion to the wheelchair; turn and reposition every two hours; avoid supine position; use care when applying lotions over bruises; and a low air loss mattress to the bed. A social services progress note, dated [DATE] at 6:48 a.m., documented, .Got a few words and a laugh out of her. However she did me (sic) her backside was bothering her . A skilled nurse's note, dated [DATE] and untimed, documented, .able to move side ways - c/o pain when moved differently .tx to buttocks areas red, raw .Has gel cushion in w/c .call to (physician name withheld) - orders to dc f/c (after) 24 (hour) bladder training . A physician's telephone order, dated [DATE], documented to discontinue the resident's urinary catheter after 24 hours of bladder training. A wound flow sheet, dated [DATE], documented the right buttock pressure ulcer was a stage II ulcer that measured 3 cm x 3 cm and was raw and red. It was also documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated [DATE], documented the left buttock pressure ulcer was a stage II ulcer that measured 5 cm x 3 cm, was red and raw, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician was notified of the worsening of the wounds. There was no wound flow sheet dated [DATE] for the coccyx pressure ulcer. A skilled nurse's note, dated [DATE] and untimed, documented, .@ 1615 (4:15 p.m.) cath was dc'd . A wound flow sheet, dated [DATE], documented the right buttock pressure ulcer was a stage II ulcer that measured 1.5 cm and 1 cm and 2 cm wide. It was documented the ulcer was triangular in shape, with red and raw edges. It was documented there was slight drainage and Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated [DATE], documented the left buttock pressure ulcer was a stage II ulcer that measured 3.5 cm x 3 cm, was pink with red edges, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated [DATE], documented the coccyx pressure ulcer was a stage II ulcer that measured 4 cm x 1 cm x 0.5 cm, was red with a dark center to the side, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician had been notified that all three wounds had drainage. A skilled nurse's note, dated [DATE] and untimed, documented, .Pt is confused at times, dressings on buttocks are clean (and) intact . There was no documentation to show the physician was notified of the resident's confusion. A skilled nurse's note, dated [DATE] at 4:45 a.m., documented, .Open wounds to buttocks et coccyx. Has been turned from side to side. Foley catheter dc'd [DATE]. Has started becoming incontinent . A urinalysis, dated [DATE], documented the resident's urine sample contained large amounts leukocyte esterase (normal - none), was positive for [MEDICATION NAME] (normal - negative), and 4+ bacteria (normal - none). It was documented the urine was sent for a culture and sensitivity test. A physician's telephone order, dated [DATE], documented the resident was to receive Cipro, an antibiotic, 500 mg twice daily for a urinary tract infection. A skilled nurse's note, dated [DATE] at 7:00 p.m., documented, .Buttocks/coccyx area red - irritated - open areas . A skilled nurse's note, dated [DATE] at 2:00 a.m., documented, .Buttocks, coccyx, peri-area all red/irritated A skilled nurse's note, dated [DATE] at 9:00 a.m., documented, .Sitting (up) in w/c eating breakfast. c/o some dizziness .c/o of buttocks pain. Wants to lay back down (after) breakfast . A skilled nurse's note, dated [DATE] at 6:30 p.m., documented, .does c/o buttocks pain . A skilled nurse's note, dated [DATE] at 4:00 a.m., documented, .continues to have reddened, irritated to peri area .Buttocks c several open areas tx provided. Coccyx decubitus draining serosanguinous fluid on drsg from tx provided. Resident is

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
incontinent (dribbles) of urine .c/o pain to buttocks .
There was no documentation to show the physician was notified of the drainage from the wound or the pain to the resident's buttocks.
A skilled nurse's note, dated [DATE] at 9:30 a.m., documented, .Tx done to buttocks .cont to c/o pain, states prn meds given earlier 'helped some' .
There was no documentation to show the physician had been notified of the resident's partially relieved pain.
A urine culture report, dated [DATE], documented the urine contained greater than 100,000 org/ml of [DIAGNOSES REDACTED] bacteria.
A skilled nurse's note, dated [DATE] at 2:30 a.m., documented, .dressing to coccyx (changed) due to it was soiled. Buttocks very red. [MEDICATION NAME] applied @ this time. c/o buttocks et lower back pain .
A skilled nurse's note, dated [DATE] at 10:00 a.m., documented, .tx to buttocks and coccyx area Tolerated well. Want to stay in bed .Call to (physician name withheld) re: resident (increased) weakness, (not) eating, unable to stand .wanted to go back to bed .
A skilled nurse's note, dated [DATE] at 2:00 p.m., documented, .orders to send to (hospital name withheld) .
A physician's telephone order, dated [DATE], documented to send the resident to the hospital.
A certificate of medical necessity for nursing home transport, documented, .What medical condition exists that makes transport by ambulance necessary? (Increased) weakness, (decreased) sats, (no) appetite = needs fed, decubs to coccyx .
A nursing home to hospital transfer form, dated [DATE], documented, .reason(s) for transfer (decreased) sats, (increased) weakness, (decreased) appetite, (increased) decubs . It was documented the resident had pressure ulcers on the buttocks and coccyx.
A discharge summary, dated [DATE], documented the resident was discharged due to decreased oxygen saturation levels, increased weakness, and decreased appetite. It was documented the resident's condition on discharge was poor.
An ambulance record, dated [DATE], documented the ambulance arrived at the facility at 2:52 p.m. It was documented transportation to the hospital began at 3:03 p.m., and the resident arrived at the hospital and was given over to hospital care at 4:02 p.m.
Hospital laboratory results, dated [DATE] at 4:40 p.m., documented the resident's white blood cell count was 18.91. Normal values were 4.00 to 10.50.
A computerized tomography scan result, dated [DATE] at 6:13 p.m., documented, .There is moderate subcutaneous induration overlying the coccyx, and there is a decubitus ulcer, with air tracking into both gluteal muscles, worse on the right side. Air also tracks into the deep pelvis along the right side of a rectal sling .Impression .New subcutaneous induration and bubbles of air are identified adjacent to the coccyx, tracking into the gluteal muscles, more evident on the right, and also into the pelvis along the right side of the anal sling. The changes are thought to be due to a decubitus ulcer with tracking of air into the adjacent soft tissues .
An emergency room nurse's note, dated [DATE] at 7:41 p.m., documented, .Pts perineal area very red and swollen. Pt has an approx 2 inch (5 cm) open pressure wound on her sacrum that appears to have tunneling. Pt also has green, lose (sic) stool .
A hospital history and physical note, dated [DATE] at 8:16 p.m., documented, .Chief complaint:[MEDICAL CONDITION] .was discharged last month from (hospital name withheld) after she was treated for [REDACTED]. The patient was discharged to nursing home. She reportedly was brought in from the nursing home today by the family who reports that she has failure to thrive. She has some generalized weakness and fever and she also being treated for [REDACTED]. She was seen in the emergency room and was found to have elevated white count and was started on antibiotics. She had a CAT scan of her abdomen and pelvis, which revealed a possible gases tissue, which is concerning her either necrotizing fascitis or deep decubitus ulcer .I examined the patient. At this point, the concern for necrotizing fascitis is less likely and this is probably from tunneled wound, which is advanced stage probably ,[DATE] decubitus ulcer. She also has some [DIAGNOSES REDACTED] and redness in the perineal area. She does have incontinence of both stool and for urine. She reports that she has been getting on and off physical therapy; however, she feels as if she is having generalized weakness. Her vitals revealed a temperature of 36.1 (degrees Celsius, 96.98 degrees Fahrenheit) and blood pressure of ,[DATE] .Assessment: 1.[MEDICAL CONDITION], present on admission, likely secondary to decubitus ulcer. 2. Advanced stage III-IV decubitus ulcer with tunneled wound and active drainage .
A pressure ulcer consultation note, dated [DATE] at 9:06 a.m., documented, .sacral ulcer present with necrotic tissue and bone exposed underlying and tunneling present, multiple areas of ulceration from friction and shear with full-thickness skin loss .Assessment: 1. Stage IV pressure ulcer to sacrum, questionable necrotizing fascitis per CT as of yesterday. 2.[MEDICAL CONDITION] .We will continue n.p.o .The patient may have surgery today .possible debridement .
Review of hospital CT scan results, emergency room nurses' notes, wound consultant report, and hospital physician history and physical notes revealed documentation of the resident's sacral pressure ulcer that was inconsistent with the last noted pressure ulcer documentation from the facility.
An operative note, dated [DATE] and untimed, documented, .Preoperative Diagnosis: [REDACTED]. Postoperative Diagnosis: [REDACTED]. Procedures: 1. Excisional debridement of skin, subcutaneous tissue and sacral bone with sharp excisional debridement measuring 10 cm width x 10 cm length x 7 cm depth. 2. Debridement of sacral bone with bone biopsy and bone excision for cultures .Findings: Extensive sacral decubitus, full thickness, down to sacral bone at the depth. The exposed bone was debrided with a rongeur and sent for biopsies and cultures .
A pathology report, with a collection date of [DATE] and a verified date of [DATE], documented, .A. Bone, sacral region, debridement - [MEDICAL CONDITION] and acute osteo[DIAGNOSES REDACTED] involving reactive and degenerating bone and soft
tissue. B. Soft tissue, sacral region, debridement - skin and soft tissue necrosis with associated [MEDICAL CONDITION] and abscess .
A discharge summary, dated [DATE], documented .Discharge Diagnoses: [REDACTED].Advanced stage III-IV decubitus ulcer that was tunneled with active drainage, questionable [DIAGNOSES REDACTED] per CT, status [REDACTED].MRI of the pelvis showed
positive developing osteo .patient .was recently discharged from (hospital name withheld) in April for [MEDICAL CONDITION] and urinary tract infection. The patient was discharged to a nursing home. Apparently , her family went to visit her at the nursing home and reported the patient continued to get weaker and have failure to thrive. She was found to have a fever and a urinary tract infection .There was concern that her [MEDICAL CONDITION] is also worsening and that she was developing a wound in the sacral region. Therefore, she was sent to the Emergency Department, found to have an elevated white blood count and immediately started on antibiotics. A CT of her abdomen and pelvis was obtained, which revealed possible [MEDICATION NAME] tissue, concern for [DIAGNOSES REDACTED] or deep decubitus ulcer. She was found to have a decubitus
tunneled wound in the sacral region, stage III-IV. Therefore, General Surgery was consulted and the patient is now status [REDACTED].(physician name withheld) with Infectious Disease was also consulted due to the extensiveness of this wound and the patient'[MEDICAL CONDITION] on admission. An MRI was obtained, which showed a concern for developing osteo[DIAGNOSES
REDACTED]. Therefore, the patient will need to be on IV antibiotics, [MEDICATION NAME] for the next 6 weeks. [MEDICATION
NAME] was started on [DATE] .The patient has chronic debility and weakness. She is bedridden. Therefore, she has required a Foley catheter as well as a rectal tube for healing of her sacral decubitus ulcer .The patient has done well with all these procedures and her mentation has improved over the course of her hospital stay .She is now currently stable and will be discharged .for further care and treatment of [REDACTED].
A hospital history and physical, dated [DATE] at 11:03 p.m., documented, .This is a patient that was recently discharged on [DATE] to (facility name withheld) for chronic care of large sacral decubitus with osteo[DIAGNOSES REDACTED], found to have [DIAGNOSES REDACTED], the patient was on meropenem. She was also known to have a history of [MEDICAL CONDITION], on
[MEDICATION NAME] and oral iron. They noted yesterday that the patient had a hemoglobin of 6.1. They transfused her and transferred her here for further evaluation of her [MEDICAL CONDITION]. This has been worked up thoroughly. There is no obvious source of her [MEDICAL CONDITION] with no obvious signs of bleed. the patient is an elderly woman with multiple ecchymosis. Her large sacral decubitus has areas of bleeding during debridement and this may possibly be a source of chronic [MEDICAL CONDITION]. She was initially admitted on [DATE] [MEDICAL CONDITION] secondary to the large sacral decubitus .She did present with a Foley catheter and a rectal tube .Past Medical History: [MEDICAL CONDITION] .recent [MEDICAL CONDITION] with UTI, sacral decubitus with osteo[DIAGNOSES REDACTED], positive for [DIAGNOSES REDACTED] .chronic
[MEDICAL CONDITIONS] .Review of systems: The patient is seen lying in bed complaining of pain from sacral decubitus. She notes it hurts to roll over .She does complain of continued chronic weakness .She has a very large sacral decubitus that is

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) covered with a wet-to-dry dressing noted. There are some areas of bleeding .The sacral decubitus is nonodorous at the moment . A death summary, dated [DATE], documented, .Discharge Diagnoses: [REDACTED]. [MEDICAL CONDITION] from osteo[DIAGNOSES REDACTED] .Hospital Course: .was admitted with severe [MEDICAL CONDITION] and worsening sacral decubitus ulcer with osteo[DIAGNOSES REDACTED]. She had a prolonged hospitalization with involvement of multiple consultants. The patient underwent EDG and colonoscopy during this admission. She was started on broad-spectrum antibiotics for her osteo[DIAGNOSES REDACTED]. She, however, continued to develop progressively worsening [MEDICAL CONDITION] due to uremia [MEDICAL CONDITION]. She became hypotensive and had to be transferred to ICU; given her multiple comorbidities, after discussion with the family; In accordance with patient's wishes physicians placed the patient on comfort measures and she passed away this morning . The resident's death certificate, with a certification date of [DATE], documented, .Cause of Death . Part I .Immediate Cause (Final disease or condition resulting in death .[MEDICAL CONDITION] . Sequentially list condition, if any, leading to the cause listed on line a. b. End Stage [MEDICAL CONDITION] . Enter the UNDERLYING CAUSE (disease Or injury that initiated the events resulting in death) LAST. c. Sacral Decubitus Ulcers with [DIAGNOSES REDACTED] . Part II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I Acute on chronic systolic and diastolic [MEDICAL CONDITION] exacerbation, severe malnutrition, [MEDICAL CONDITION], and [MEDICAL CONDITION] from osteo[DIAGNOSES REDACTED] . On [DATE] at 1:00 p.m., LPN #1 was asked if she remembered resident #3. She stated yes. She was asked why the resident was sent out to the hospital. She stated her pressure ulcer had opened up over the weekend. She was asked if she had notified the physician. She stated yes. She stated the doctor had ordered her to send the resident to the hospital. LPN #1 was asked if she could see the resident's sacral bone when the ulcer opened up. She stated, No. She stated the ulcer had progressed from a superficial ulcer to a stage II. LPN #1 was asked if the DON had looked at the resident's ulcers. She stated, No. She stated the DON did not look at ulcers. On [DATE] at 3:29 p.m., RN #1 was asked if she remembered resident #3. She stated yes. She was asked if the resident had pressure ulcers. She reviewed clinical records and stated yes. She stated the resident had right arm [MEDICAL CONDITION] and sores on her buttocks. She stated the resident was noncompliant. She stated staff would try to turn her but she would go right back to her back. RN #1 was asked where the resident's pressure ulcers were. She stated there was one on the coccyx. She stated it looked like the buttock fold had split open. She was asked what stage the ulcer was. She stated it was a stage II or III. She stated it kept trying to split open. RN #1 stated the ulcer was not that bad until her urinary catheter was taken out. She stated staff could not keep her dry. RN #1 stated the ulcer started gaping pretty good as soon as the urinary catheter was removed. RN #1 was asked if she notified the physician when the ulcer began to worsen. She stated, No, I didn't. I work the ,[DATE] shift. RN #1 was asked if the resident had pain with her ulcers. She stated the resident would say her bottom hurt, and then it was her legs. She stated she had petechiae on her legs, and there was some swelling. RN #1 was asked if there had been a concern with the resident being left on the bed pan an excessive amount of time. She stated, Yes. She stated the resident had asked to be put on the bed pan, and when she was rolled over, the bed pan was already there. She was asked how long the resident had been left on the bed pan. She stated she did not know. She was asked at what time it was identified the resident was on the bed pan. She stated it was maybe 4ish (4:00 a.m.). RN #1 was asked what day this occurred on and who the aide was assigned to the resident. She stated she did not remember. RN #1 was asked what she did when the resident was found on the bed pan. She stated she counseled the aide. She was asked if she reported the incident to the DON. She stated, No. On [DATE] at 4:29 p.m., RN #1 was asked if the resident had requested the bed pan to urinate or to have a bowel movement. She stated she did not know. RN #1 stated when she had counseled the aide, the aide had told her the resident had not been on the bed pan very long. RN #1 stated the event occurred during the time the resident was getting confused. On [DATE] at 8:51 a.m., CNA #1 was asked if she had cared for the resident. She stated, Yes. She was asked if the resident had pressure ulcers. She stated yes. She stated there was one on the right buttock and one in the coccyx area. She stated the gluteal fold was cracked. CNA #1 stated, It seemed to me when the catheter came out, it seemed like it aggravated the situation. She stated the resident wanted the catheter out and had asked for it to be removed for about a week and a half. She stated the resident had been emphatic about it. She stated, I don't know if it hurt her or was just annoying. CNA #1 was asked if she saw the pressure ulcers. She stated she helped the nurse when treatments were completed, and it appeared the ulcers would get better and (TRUNCATED)
F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to have an effective system for the care of a resident with pressure ulcers. The facility failed to implement medical and nutritional interventions to promote the healing of pressure ulcers and aid in the prevention of new pressure ulcers; conduct accurate and thorough pressure ulcer assessments; notify the physician of worsening pressure ulcers; and ensure nursing staff had the necessary skills sets to care for residents with pressure ulcers. The resident was admitted to the facility on [DATE] with one stage II pressure ulcer on the right buttock that measured 2 cm x 3 cm. The resident subsequently developed additional pressure ulcers on the left buttock and the sacrum. The resident was sent to the hospital on [DATE], with increasing weakness, decreased oxygen saturation levels, and worsening pressure ulcers. Hospital records documented upon arrival to the hospital, the resident was found to be septic, with an advanced stage III to IV sacral pressure ulcer with active drainage, necrotic tissue, bone exposure, and tunneling into the right and left gluteal muscles and pelvic area. The pressure ulcer required a 10 cm x 10 cm x 7 cm surgical debridement with [DEVICE] treatment. Biopsies of the debrided area revealed [MEDICAL CONDITION] of the soft tissue and osteo[DIAGNOSES REDACTED] in the sacral bone. The resident expired in the hospital on [DATE]. At 12:41 p.m., the Oklahoma State Department of Health verified the existence of the IJ situation. At 12:44 p.m., the administrator and director of nursing were notified of the IJ situation related to the facility's failures in caring for a resident with pressure ulcers. On [DATE] at 2:33 p.m., an acceptable plan of removal was provided. The plan of removal documented, .2. Pressure Ulcers: CNAs will be inserviced on residents with pressure sores, placing them on bed pans, and that timeliness is a factor. They will be educated on how quickly skin breakdown can occur. CMAs will be in serviced on notifying the nurse when something on the MAR indicated [REDACTED]. In service will be conducted to all nurses regarding pressure ulcers including, but not limited to ~ Measuring wounds and proper wound description documentation ~ Who is responsible for ordering items such as Pro Stat ~ Interventions and timely implementation (same day) ~ Notifying the physician if an order can not be obtained and implemented the same day so alternate interventions may be implemented A head to toe skin assessment will be performed on all residents. A change in notification form will be completed by the nurses for the DON and Admin to monitor daily in stand up. The weekend RN will monitor these forms on Saturday and Sunday if there are any, and then they will be addressed in stand up. This form will include date, time, resident's name, the stated change in condition, and the physician's response/new orders, physician/DON/Admin notified, and if it was documented in the chart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375466	A. BUILDING _____ B. WING _____	08/02/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	PINE & BRISTOW DRUMRIGHT, OK 74030

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 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) The DON /RN will observe random wound care each week to ensure nurses are properly treating and documenting all wounds and then document in the residents chart. This plan of removal will be completed on [DATE] by midnight (12:00 am). The immediate jeopardy was removed on [DATE] at 11:15 p.m., when all components of the plan of removal were carried out. The deficient practice remained at a pattern of actual harm. Based on observation, interview, and record review, it was determined the facility failed to: ~ perform initial and ongoing thorough skin and pressure ulcer assessments; ~ notify the physician of new pressure ulcers or the worsening of existing pressure ulcers; ~ implement medical and nutritional interventions to aid in the healing of pressure ulcers; ~ obtain physician orders [REDACTED]. ~ ensure staff was competent in their skills sets for the delivery of pressure ulcer treatments and management for two (#3 and #4) of four sampled residents who had pressure ulcers. The facility identified no residents as having pressure ulcers. Resident #3 was admitted to the facility on [DATE] with one stage II pressure ulcer. The resident was sent to the hospital on [DATE], and was found to be septic, with an advanced stage III to IV sacral pressure ulcer with active drainage, necrotic tissue, bone exposure, and tunneling into the right and left gluteal muscles and pelvic area. The pressure ulcer required a 10 cm x 10 cm x 7 cm surgical debridement with [DEVICE] treatment. Biopsies of the debrided area revealed [MEDICAL CONDITION] of the soft tissue and osteo[DIAGNOSES REDACTED] in the sacral bone. The resident expired in the hospital on [DATE]. Resident #4 developed a facility acquired unstageable pressure ulcer to the left buttock. The facility had knowledge of the pressure ulcer and did not notify the physician of the pressure ulcer for a minimum of three days. Findings: The facility's policy and procedure for the prevention and treatment of [REDACTED].Upon admission, the facility will evaluate each resident for factors that may put the resident at risk for the development of pressure ulcers. The facility will utilize a tool that identifies risk factors including sensory perception, moisture, activity level, mobility, nutrition, friction and shear .The risk factor tool will be completed upon admission and then may be completed additionally at intervals during the first four weeks post admission .Additional factors that may place a resident at risk for the development or to not heal pressure ulcers include: ~ Impaired/decreased mobility and decreased functional ability ~ Co-morbid conditions, such as [MEDICAL CONDITIONS] disease or diabetes mellitus . ~ Resident refusal of some aspect of care and treatment . ~ Exposure of skin to urinary and/or fecal incontinence . Should a resident have an existing pressure ulcer or develop a pressure ulcer post admission, the facility will implement procedures to evaluate the ulcer regularly, implement treatment measures to promote healing and prevent and/or treat infection and to manage any pain experienced by the resident . The facility will evaluate the ulcer at least weekly, utilizing a flow sheet that notes the location of the ulcer, the stage, presence of eschar, size, color, odor, drainage, tunneling/sinus tract/undermining if present, the notation of a culture if signs of infection are present, treatment including dressing, antibiotic, debridement and pain management. The facility will notify the physician upon the onset of the ulcer and obtain treatment orders . The facility will notify the physician if the ulcer appears to be deteriorating or if no improvement is noted in ,[DATE] weeks of the initial treatment orders . In order for a pressure ulcer to heal, the wound bed must be clean, moist, free of infection and with adequate blood supply. Interventions should be directed toward achieving this end. Additionally, removing/preventing pressure to the ulcer area and adequate nutrition and hydration will promote healing. Pain is often associated with the presence of a pressure area. Evaluate the resident for the presence of pain . Orientation/training forms, dated [DATE], for RN #1 and LPNs #1, #2, #3, #4, and #5 documented, .Knows procedure for completion of wound care, collection of wound characteristic data and required documentation . The forms were signed by the director of nursing. 1. A hospital wound care team progress note for resident #3, dated [DATE], documented, .Pressure Ulcer Stage .II .Sacral .Length 3 cm Width 2 cm Depth 0.1 cm . Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Braden Scale form, used for predicting pressure sore risk and dated [DATE], documented the resident scored a 14. The form documented, .Total score of 12 or less represents HIGH RISK . An untitled facility form, dated [DATE], documented the resident had three open areas on the buttocks/sacral area. The form had the image of a body on it, and there were three circles drawn on the body image, with two on the right buttock and one on the sacral area. It was documented, .Open areas . There were no measurements or descriptions of the areas. A nurse's note, dated [DATE] at 1:35 p.m., documented, .(right) buttock c a 3 cm x 1.5 cm open area also gaulding to buttock . The note did not contain any other documentation related to pressure ulcers. A wound flow sheet, dated [DATE], documented the resident had a stage II pressure ulcer on the right buttock. It was documented the pressure ulcer measured 2 cm x 3 cm and was pink in color. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Admission physician orders, dated [DATE], documented the resident was to receive Prostat, a protein supplement, 30 ml daily and B-complex vitamins daily as a supplement. The orders documented to clean the right buttock daily with normal saline and apply Venelex ointment and cover with [MEDICATION NAME] border. It was also documented the resident could have a urinary catheter due to impaired skin integrity. An informed consent form for the use of an indwelling urinary catheter, dated [DATE], documented, .may have foley catheter d/t impaired skin integrity . The form was signed by the resident, the physician, and a member of the facility staff. A skilled nurse's note, dated [DATE] at 6:00 p.m., documented, .Butt paste to open area on buttocks . A physician's telephone order, dated [DATE] at 10:00 p.m., documented, .DC Vitamin B complex caps . A physician's progress note, dated [DATE], documented, .(right) buttock 2 x 3 cm open area . Medication administration records, dated [DATE] through [DATE], documented the resident did not receive the ordered Prostat. It was documented not in for each day. Treatment records, dated [DATE] through [DATE], documented treatments were completed to the right buttock pressure ulcer as ordered by the physician. A skilled nurse's note, dated [DATE] and untimed, documented, .Tx done on (right) buttock. 8 cm long x 0.25 cm wide open area noted to coccyx area. Call made .N.O. apply Venelex (and) cover c [MEDICATION NAME] .Staff reminded to reposition q 2 (hours) and encourage resident to get (up) . A physician's telephone order, dated [DATE], documented to use Venelex ointment for all open areas on the buttocks. A wound flow sheet, dated [DATE], documented the resident had a stage II pressure ulcer to the coccyx. It was documented the pressure ulcer measured 8 cm x 0.25 cm, was red, and had some bleeding. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. A skilled nurse's note, dated [DATE] at 7:00 p.m., documented, .Lying in bed c eyes open. c/o (left) hip pain. PRN pain medication given .Asked if resident would like to sit (up) in chair for a little while. Resident very hesitant afraid it will make her hurt more . A skilled nurse's note, dated [DATE] at 6:45 p.m., documented, .Buttocks are red c open areas . A physician's telephone order, dated [DATE], documented the resident was to receive Vitamin C, 500 mg daily and Zinc, 220 mg daily for wound healing. A wound flow sheet, dated [DATE], documented the resident had a stage II pressure ulcer on the left buttock. It was documented the ulcer measured 3 cm x 3 cm and that Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician was notified of the new open area to the left buttocks. Medication administration records, dated [DATE], documented the resident did not receive the ordered Prostat. It was documented, .not in .

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	PINE & BRISTOW DRUMRIGHT, OK 74030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. An admission assessment, dated [DATE], documented the resident was cognitively intact; required extensive assistance with bed mobility, transfers, and toileting. It was documented the resident had occasional pain that was very horrible and limited her activities. It was also documented the resident was at risk for pressure ulcers; had one stage II pressure ulcer; and had pressure relieving devices for her bed and chair. A wound flow sheet, dated [DATE], documented the right buttock pressure ulcer was a stage II ulcer that measured 1 cm x 1 cm. An additional measurement of 2 cm x 2 cm was documented. It was documented the ulcer was raw and pink, and Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. A facility invoice, dated [DATE], documented one case of Prostat was ordered on [DATE]. A packing slip documented the ship date was [DATE]. Medication administration records, dated [DATE], documented the resident did not receive the ordered Prostat. It was documented, .not in . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. A physician's progress note, dated [DATE], documented, .Buttocks .wounds .open 3 x 4 cm area . A physician's telephone order, dated [DATE] documented, .Air mattress to bed Gel cushion to w/c . A skilled nurse's note, dated [DATE] at 9:30 a.m., documented, .n.o. for air mattress to bed and gel cushion to w/c . A skilled nurse's note, dated [DATE] at 6:00 p.m., documented, .Redness/open areas to pannus/buttocks . A durable medical equipment invoice, dated [DATE], documented an air mattress and pump were ordered. It was documented the requested ship date was [DATE]. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. Medication administration records, dated [DATE] and [DATE], documented the resident did not receive the ordered Prostat. It was documented not in for each day. A skilled nurse's note, dated [DATE] at 1:00 a.m., documented, .redness/irritation to .buttock areas c txs in progress . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. A skilled nurse's note, dated [DATE] at 4:00 a.m., documented, .Buttocks c redness, excoriation to anal area .c/o buttocks pain. given prn order of [MEDICATION NAME] . An undated physician's telephone order, signed by the physician on [DATE], documented to clean the open area to the left buttocks, apply Venelex, and cover daily. The order was listed on the physician telephone order sheet between an order written [REDACTED]. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] and untimed, documented, .Buttocks c excoriation et reddened skin care given et txs in progress . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. The resident's care plan, dated [DATE], documented a problem related to impaired skin integrity. The goal was the resident would have healing of skin over the next 90 days. Approaches were to perform dressing changes as ordered; gel cushion to the wheelchair; turn and reposition every two hours; avoid supine position; use care when applying lotions over bruises; and a low air loss mattress to the bed. A social services progress note, dated [DATE] at 6:48 a.m., documented, .Got a few words and a laugh out of her. However she did me (sic) her backside was bothering her . A skilled nurse's note, dated [DATE] and untimed, documented, .able to move side ways - c/o pain when moved differently .tx to buttocks areas red, raw .Has gel cushion in w/c .call to (physician name withheld) - orders to dc f/c (after) 24 (hour) bladder training . A physician's telephone order, dated [DATE], documented to discontinue the resident's urinary catheter after 24 hours of bladder training. A wound flow sheet, dated [DATE], documented the right buttock pressure ulcer was a stage II ulcer that measured 3 cm x 3 cm and was raw and red. It was also documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated [DATE], documented the left buttock pressure ulcer was a stage II ulcer that measured 5 cm x 3 cm, was red and raw, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician was notified of the worsening of the wounds. There was no wound flow sheet dated [DATE] for the coccyx pressure ulcer. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] and untimed, documented, .(left) buttock red raw and peeling, (right) buttock (dressing) dry .coccyx red c (dressing) . A skilled nurse's note, dated [DATE] and untimed, documented, .@ 1615 (4:15 p.m.) cath was dc'd . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] at 5:00 a.m., documented, .Pt has dressings x 3 on buttock x 3 CDI . A wound flow sheet, dated [DATE], documented the right buttock pressure ulcer was a stage II ulcer that measured 1.5 cm and 1 cm and 2 cm wide. It was documented the ulcer was triangular in shape, with red and raw edges. It was documented there was slight drainage and Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated [DATE], documented the left buttock pressure ulcer was a stage II ulcer that measured 3.5 cm x 3 cm, was pink with red edges, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated [DATE], documented the coccyx pressure ulcer was a stage II ulcer that measured 4 cm x 1 cm x 0.5 cm, was red with a dark center to the side, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician had been notified that all three wounds had drainage. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] and untimed, documented, .Pt is confused at times, dressings on buttocks are clean (and) intact . There was no documentation to show the physician was notified of the resident's confusion. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] at 4:45 a.m., documented, .Open wounds to buttocks et coccyx. Has been turned from side to side. Foley catheter dc'd [DATE]. Has started becoming incontinent . A urinalysis, dated [DATE], documented the resident's urine sample contained large amounts leukocyte esterase (normal - none), was positive for [MEDICATION NAME] (normal - negative), and 4+ bacteria (normal - none). It was documented the urine was sent for a culture and sensitivity test. A physician's telephone order, dated [DATE], documented the resident was to receive Cipro, an antibiotic, 500 mg twice daily for a urinary tract infection. A skilled nurse's note, dated [DATE] at 7:00 p.m., documented, .Buttocks/coccyx area red - irritated - open areas .

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	375466	A. BUILDING _____ B. WING _____	08/02/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	PINE & BRISTOW DRUMRIGHT, OK 74030

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] at 2:00 a.m., documented, .Buttocks, coccyx, peri-area all red/irritated A skilled nurse's note, dated [DATE] at 9:00 a.m., documented, .Sitting (up) in w/c eating breakfast. c/o some dizziness .c/o of buttocks pain. Wants to lay back down (after) breakfast . A skilled nurse's note, dated [DATE] at 6:30 p.m., documented, .does c/o buttocks pain . Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] at 4:00 a.m., documented, .continues to have reddened, irritated to peri area .Buttocks c several open areas tx provided. Coccyx decubitus draining serosanguinous fluid on drsg from tx provided. Resident is incontinent (dribbles) of urine .c/o pain to buttocks . There was no documentation to show the physician was notified of the drainage from the wound or the pain to the resident's buttocks. A skilled nurse's note, dated [DATE] at 9:30 a.m., documented, .Tx done to buttocks .cont to c/o pain, states prn meds given earlier 'helped some' . There was no documentation to show the physician had been notified of the resident's partially relieved pain. A urine culture report, dated [DATE], documented the urine contained greater than 100,000 org/ml of [DIAGNOSES REDACTED] bacteria. Treatment sheets, dated [DATE], documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated [DATE] at 2:30 a.m., documented, .dressing to coccyx (changed) due to it was soiled. Buttocks very red. [MEDICATION NAME] applied @ this time. c/o buttocks et lower back pain . A skilled nurse's note, dated [DATE] at 10:00 a.m., documented, .tx to buttocks and coccyx area Tolerated well. Want to stay in bed .Call to (physician name withheld) re: resident (increased) weakness, (not) eating, unable to stand .wanted to go back to bed . A skilled nurse's note, dated [DATE] at 2:00 p.m., documented, .orders to send to (hospital name withheld) . A physician's telephone order, dated [DATE], documented to send the resident to the hospital. A certificate of medical necessity for nursing home transport, documented, .What medical condition exists that makes transport by ambulance necessary? (Increased) weakness, (decreased) sats, (no) appetite = needs fed, decubs to coccyx . A nursing home to hospital transfer form, dated [DATE], documented, .reason(s) for transfer (decreased) sats, (increased) weakness, (decreased) appetite, (increased) decubs . It was documented the resident had pressure ulcers on the buttocks and coccyx. A discharge summary, dated [DATE], documented the resident was discharged due to decreased oxygen saturation levels, increased weakness, and decreased appetite. It was documented the resident's condition on discharge was poor. Review of facility clinical records revealed no documentation the resident's pressure ulcers had been thoroughly assessed per current standards of practice. There was no documentation to show: ~ why the facility did not have the physician ordered Prostat supplement; ~ if the air mattress was placed on the resident's bed; ~ the facility attempted to educate the resident on the importance of the urinary catheter due to her impaired skin integrity; or ~ why the resident did not receive a treatment to the left buttock pressure ulcer for five days after it was first identified. An ambulance record, dated [DATE], documented the ambulance arrived at the facility at 2:52 p.m. It was documented transportation to the hospital began at 3:03 p.m., and the resident arrived at the hospital and was given over to hospital care at 4:02 p.m. Hospital laboratory results, dated [DATE] at 4:40 p.m., documented the resident's white blood cell count was 18.91. Normal values were 4.00 to 10.50. A computerized tomography scan result, dated [DATE] at 6:13 p.m., documented, .There is moderate subcutaneous induration overlying the coccyx, and there is a decubitus ulcer, with air tracking into both gluteal muscles, worse on the right side. Air also tracks into the deep pelvis along the right side of a rectal sling .Impression .New subcutaneous induration and bubbles of air are identified adjacent to the coccyx, tracking into the gluteal muscles, more evident on the right, and also into the pelvis along the right side of the anal sling. The changes are thought to be due to a decubitus ulcer with tracking of air into the adjacent soft tissues . An emergency room nurse's note, dated [DATE] at 7:41 p.m., documented, .Pts perineal area very red and swollen. Pt has an approx 2 inch (5 cm) open pressure wound on her sacrum that appears to have tunneling. Pt also has green, lose (sic) stool . A hospital history and physical note, dated [DATE] at 8:16 p.m., documented, .Chief complaint:[MEDICAL CONDITION] .was discharged last month from (hospital name withheld) after she was treated for [REDACTED]. The patient was discharged to nursing home. She reportedly was brought in from the nursing home today by the family who reports that she has failure to thrive. She has some generalized weakness and fever and she also being treated for [REDACTED]. She was seen in the emergency room and was found to have elevated white count and was started on antibiotics. She had a CAT scan of her abdomen and pelvis, which revealed a possible gases tissue, which is concerning her either necrotizing fascitis or deep decubitus ulcer .I examined the patient. At this point, the concern for necrotizing fascitis is less likely and this is probably from tunneled wound, which is advanced stage probably ,[DATE] decubitus ulcer. She also has some [DIAGNOSES REDACTED] and redness in the perineal area. She does have incontinence of both stool and for urine. She reports that she has been getting on and off physical therapy; however, she feels as if she is having generalized weakness. Her vitals revealed a temperature of 36.1 (degrees Celsius, 96.98 degrees Fahrenheit) and blood pressure of ,[DATE] .Assessment: 1.[MEDICAL CONDITION], present on admission, likely secondary to decubitus ulcer. 2. Advanced stage III-IV decubitus ulcer with tunneled wound and active drainage . A pressure ulcer consultation note, dated [DATE] at 9:06 a.m., documented, .sacral ulcer present with necrotic tissue and bone exposed underlying and tunneling present, multiple areas of ulceration from friction and shear with full-thickness skin loss .Assessment: 1. Stage IV pressure ulcer to sacrum, questionable necrotizing fascitis per CT as of yesterday. 2.[MEDICAL CONDITION] .We will continue n.p.o .The patient may have surgery today .possible debridement . Review of hospital CT scan results, emergency room nurses' notes, wound consultant report, and hospital physician history and physical notes revealed documentation of the resident's sacral pressure ulcer that was inconsistent with the last noted pressure ulcer documentation from the facility. An operative note, dated [DATE] and untimed, documented, .Preoperative Diagnosis: [REDACTED]. Postoperative Diagnosis: [REDACTED]. Procedures: 1. Excisional debridement of skin, subcutaneous tissue and sacral bone with sharp excisional debridement measuring 10 cm width x 10 cm length x 7 cm depth. 2. Debridement of sacral bone with bone biopsy and bone excision for cultures .Findings: Extensive sacral decubitus, full thickness, down to sacral bone at the depth. The exposed bone was debrided with a rongeur and sent for biopsies and cultures . A pathology report, with a collection date of [DATE] and a verified date of [DATE], documented, .A. Bone, sacral region, debridement - [MEDICAL CONDITION] and acute osteo[DIAGNOSES REDACTED] involving reactive and degenerating bone and soft tissue. B. Soft tissue, sacral region, debridement - skin and soft tissue necrosis with associated [MEDICAL CONDITION] and abscess . A discharge summary, dated [DATE], documented .Discharge Diagnoses: [REDACTED].Advanced stage III-IV decubitus ulcer that was tunneled with active drainage, questionable [DIAGNOSES REDACTED] per CT, status [REDACTED].MRI of the pelvis showed positive developing osteo .patient .was recently discharged from (hospital name withheld) in April for [MEDICAL CONDITION] and urinary tract infection. The patient was discharged to a nursing home. Apparently , her family went to visit her at the nursing home and reported the patient continued to get weaker and have failure to thrive. She was found to have a fever and a urinary tract infection .There was concern that her [MEDICAL CONDITION] is also worsening and that she was developing a wound in the sacral region. Therefore, she was sent to the Emergency Department, found to have an elevated white blood count and immediately started on antibiotics. A CT of her abdomen and pelvis was obtained, which revealed possible [MEDICATION NAME] tissue, concern for [DIAGNOSES REDACTED] or deep decubitus ulcer. She was found to have a decubitus

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	375466	A. BUILDING _____ B. WING _____	08/02/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	PINE & BRISTOW DRUMRIGHT, OK 74030

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) tunneled wound in the sacral region, stage III-IV. Therefore, General Surgery was consulted and the patient is now status [REDACTED].(physician name withheld) with Infectious Disease was also consulted due to the extensiveness of this wound and the patient'[MEDICAL CONDITION] on admission. An MRI was obtained, which showed a concern for developing osteo[DIAGNOSES REDACTED]. Therefore, the patient will need to be on IV antibiotics, [MEDICATION NAME] for the next 6 weeks. [MEDICATION NAME] was started on [DATE] .The patient has chronic debility and weakness. She is bedridden. Therefore, she has required a Foley catheter as well as a rectal tube for healing of her sacral decubitus ulcer .The patient has done well with all these procedures and her mentation has improved over the course of her hospital stay .She is now currently stable and will be discharged .for further care and treatment of [REDACTED].
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure one (#1) of three sampled residents whose medications were reviewed did not receive an antipsychotic medication without adequate indication for use of the medication. The facility identified 17 residents as receiving antipsychotic medications. Findings: A Food and Drug Administration alert, dated 04/11/05, documented, .FDA has determined that patients with dementia-related [MEDICAL CONDITION] treated with atypical (second generation) antipsychotic medications are at an increased risk of death compared to placebo. Based on currently available data, FDA has requested that the package insert for [MEDICATION NAME] be revised to include a black box warning describing this risk and noting that this drug is not approved for this indication . The facility's policy and procedure for drug therapy and the use of unnecessary drugs, dated 07/1992, documented, .This facility will attempt to have each resident free from unnecessary drugs, as specified by the doctor. Antipsychotic drugs will not be used and given unless such antipsychotic drug therapy is necessary to treat a specific condition as [DIAGNOSES REDACTED]. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A hospital behavioral care note, with a fax date of 07/25/17, documented, .The treatment team found that how one approached (resident #1) made a big difference in his compliance (calm, active listening, making eye contact, even tone, volume, speed of speech, using simple commands, giving him time to respond). Approach him with a smile and he usually responds well to a calm, warm voice. When he becomes upset, redirect him to a more pleasant topic. Do not argue with him and state what is expected and needs to be done. The treatment team feels that Benzodiazepines are counter-productive and contraindicated in the elderly. Dementia is defined as a chronic or persistent [MEDICAL CONDITION] disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes and impaired reasoning. It is difficult for those with dementia to make new memories or learn new things . admission orders [REDACTED] ~ [MEDICATION NAME], 10 mg at bed time for [MEDICAL CONDITION]; and ~ [MEDICATION NAME], 5 mg every day for [MEDICAL CONDITION]. The resident did not have physician orders [REDACTED]. A skilled nurse's note, dated 07/25/17 at 4:00 p.m., documented, .Has periods of confusion/forgetfulness . A skilled nurse's note, dated 07/26/17 at 9:30 p.m., documented, .Has been @ NS talking on phone. Pleasant man .Walking halls with walker and doing well . A skilled nurse's note, dated 07/27/17 at 11:30 a.m., documented, .Confusion noted this a.m. Re-orientation c place et why he is here . A skilled nurse's note, dated 07/27/17 at 8:30 p.m., documented, .Resident roaming hallways and is very confused @ this time. Try to re-orient has very short memory. Called (family member) POA .talked c him, will be in here @ (8:00 a.m.). Resident doesn't understand why he can't go home .Put a big chair in him room because he doesn't (unknown) . A skilled nurse's note, dated 07/27/17 at 9:40 p.m., documented, .Put chair in resident's room. Having a place to sit has helped confusion . A skilled nurse's note, dated 07/28/17 at 1:00 a.m., documented, .(up) et OOB sporadically through the N(NAME). Incont of bladder @ N(NAME) .Resd repeats same questions, 'Where's my wallet', and 'I need to get home', and 'Where's (POA)?' Food offered but refused, PO flds offered took sm amt. Assisted back into bed several times this N(NAME) . A skilled nurse's note, dated 07/28/17 at 9:00 a.m., documented, .Confusion noted. Does not know why he's here. Can't find his room. Re-orientation by staff . A skilled nurse's note, dated 07/28/17 and untimed, documented, .Called (physician name withheld) to get something for anxiety not sure what yet . A physician's telephone order, dated 07/28/17, documented, .[MEDICATION NAME] 5 mg tab (one) PO HS ([MEDICATION NAME]) antipsychotic . A skilled nurse's note, dated 07/28/17 at 5:00 p.m., documented, .Confused and looking for his family. Doesn't want to be here and is requesting to go home, 'Please' . Medication administration records, dated 07/28/17, documented the resident received 5 mg [MEDICATION NAME] at bedtime. A skilled nurse's note, dated 07/29/17 at 2:00 a.m., documented, .Resd barricaded himself in his rm, blocking his door c a chair and locking his BR door. This staff knocked on door et resd let us in. Incont of bladder, clothes (changed) et linens (changed) on bed . A skilled nurse's note, dated 07/29/17 and untimed, documented, .Pleasant et cooperative .Out c family, (POA), today for a few hrs. Back to facility. Happy et 'ready to rest.' . Medication administration records, dated 07/29/17, documented the resident received 5 mg [MEDICATION NAME] at bedtime. A skilled nurse's note, dated 07/30/17 at 10:00 a.m., documented, .In chair in room. alert c some confusion . Medication administration records, dated 07/30/17, documented the resident received 5 mg [MEDICATION NAME] at bedtime. A skilled nurse's note, dated 07/31/17 at 12:35 a.m., documented, .Resident (up) in chair in room. He has packed all his stuff et stated 'I am ready to go home.' Explained to resident where he was. He asked 'When did I get here?' Explained that family brought him 5 days ago. he told this nurse that he didn't know where he was. He thought maybe he had broken into someone's house et was just sitting there. He ask (sic) repeatedly where he was et if his family knew he was here. Resident is in pleasant mood, however is very anxious et confused. Resident said he was going to lay down for a while et wait on family to get here. Assisted resident to bed. He refused to remove cloths (sic) et put on night cloths (sic). He said he would take off his shoes et that his cloths (sic) are fine . Medication administration records, dated 07/31/17, documented the resident received 5 mg [MEDICATION NAME] at bedtime. A skilled nurse's note, dated 08/01/17 at 5:15 a.m., documented, .Rested well this shift. Remains confused regarding place et time . Review of the clinical record revealed no documentation to show why the resident was placed on an antipsychotic medication. It was documented the resident was easily directed with verbal communication and had no behaviors that put himself or other residents at risk. On 07/31/17 at 1:00 p.m., the resident was observed walking in the facility. No behaviors were noted. On 08/01/17 at 3:14 p.m., CNA #2 was asked if the resident had any behaviors. She stated, No. She was asked how long the resident had been at the facility. She stated he had been there about a week. She was asked if the resident had any trouble adjusting to the facility. She stated, Not that I know of. CNA #2 was asked what type of training she had received in caring for residents with dementia. She stated she kept a close watch on them, kept their room in order, and used mats and alarms if they were a fall risk. On 08/01/17 at 3:15 p.m., CNA #4 was asked if the resident had any behaviors. She stated, No. She stated the resident would get agitated some times, but he would calm down easily if staff spoke with him. She stated it was a new place for the resident and he needed time to get adjusted. On 08/01/17 at 3:16 p.m., CMA #2 was asked if the resident had any behaviors. She stated, Not that I know of. She was asked if the resident had been started on a new medication since coming to the facility. She stated, Yes, I believe [MEDICATION NAME]. She was asked why the resident was started on [MEDICATION NAME]. She stated she did not know.

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) On 08/01/17 at 3:26 p.m., LPN #6 was asked if the resident had any behaviors or acted inappropriately. She stated, He hasn't with me. She stated the resident could get confused and ask the same question repeatedly. She stated he was very concerned about the location of his wallet and checkbook. LPN #6 was asked if the resident had any behaviors that affected his well being. She stated, No. She stated he could get agitated somewhat. She stated he had slid his chair in front of his door one night and locked his bathroom door. She stated she had found out another resident had entered his room without permission, and it had agitated him. LPN #6 was asked if the resident had let her into the room. She stated, Yes. She stated she knocked on the door and asked if she could come in, and he opened the door. She stated the resident told her he was scared someone was going to come in on him. LPN #6 asked what she did. She stated she reassured the resident that he was alright and that his POA had his wallet and checkbook. She stated the resident calmed down without incident. LPN #6 was asked why the resident was started on [MEDICATION NAME]. She stated, They called and asked the doctor for something. She was asked who they were. She stated the POA and the ADON had called the doctor and requested a medication for anxiety. LPN #6 was asked what drug classification [MEDICATION NAME] belonged to. She stated it was an antipsychotic. She was asked if there were any type warnings associated with the use of antipsychotics in residents with dementia. She stated yes. She stated there was a black box warning that documented there was an increased risk of death. LPN #6 was asked if the family was provided any education related to the use of antipsychotics in residents with dementia. She stated staff was instructed to not contact the family if the resident had behaviors. She stated they were instructed to treat the resident like any other resident and try to handle the behaviors on the resident level. LPN #6 was asked if the resident had exhibited any behaviors that put himself or any other resident at risk. She stated, No. She was asked if the resident had any behaviors that could not be addressed by talking with him. She stated, No. On 08/01/17 at 3:45 p.m., LPN #5 was asked if the resident had any behaviors that put himself or any other resident at risk. She stated the resident was complacent. On 08/01/17 at 3:55 p.m., the POA was asked if she had requested a medication for the resident for agitation. She stated she had taken the resident to the doctor after his discharge from the hospital, but she had not requested any medication at that time. She stated after the resident had been at the facility, she had requested something for anxiety because the resident seemed to get anxious. She stated the resident was always inquiring as to the location of his checkbook and wallet. She was asked if she knew [MEDICATION NAME] was an antipsychotic medication. She stated, No. She stated she had thought that maybe he needed something to take the edge off and help him calm down. On 08/01/17 at 4:24 p.m., the ADON was asked if she had called the physician and requested a medication for behaviors for resident #1. She stated she had called the doctor and talked to the nurse. She stated she informed the nurse the family wanted something for anxiety. She stated she had been informed the physician was busy, and the nurse would have him call something in. The ADON was asked why she requested a medication for the resident. She stated the family had wanted her to call the doctor because the resident was agitated. She was asked what signs of agitation the resident was exhibiting. She stated he was talking about where he was at; he wanted to walk home; he went up and down the halls; and complained he did not want to be at the facility. She stated he complained that someone had stole his wallet. The ADON was asked where the resident's wallet was. She stated the POA had it and his checkbook. The ADON was asked if the resident had exhibited any behaviors that could have been detrimental to himself, other residents, or staff. She stated, No. The ADON was asked what training had been provided to the nursing staff on the care of individuals with dementia and those with behaviors. She stated she did not know. The ADON was asked if she was aware the physician had ordered [MEDICATION NAME] for the resident. She stated, Not til the next day. She was asked what she did when she found out. She stated she let the POA and DON know. She stated, I didn't do anything. The ADON was asked if she knew the medication had a black box warning regarding the use of the medication with residents with dementia. She stated, Yes. She stated she did not find out about the black box warning until this day, 08/01/17. The ADON was asked if she had informed the POA about potential side effects of the medication. She stated, No. On 08/01/17 at 4:25 p.m., the resident was observed in the front lobby talking with a family member and another resident. No behaviors were noted. On 08/02/17 at 11:00 a.m., the DON was asked why the resident was placed on [MEDICATION NAME]. She stated the resident had been having some behaviors. She stated he had been trying to go home and cursing. She stated he had locked the bedroom door on one occasion and would not let staff in. She was asked if the resident had let staff in the room when they had knocked and asked to enter. She stated yes. The DON was asked why staff had been instructed not to call family for assistance if the resident was having behaviors. She stated she did not know they had been. The DON was asked what nonpharmalogical interventions had been attempted for the resident before requesting medications for behaviors. She stated reorientation and redirection. She stated the resident was provided coffee, which he loved. She stated most of the time these interventions were successful. The DON stated she did not know about the black box warning until the previous day. The DON was asked if the resident was a danger to himself, other residents, or staff. She stated no. The DON stated the facility had contacted the resident's primary care physician on 08/01/17, and the physician had refused to discontinue the medication. The DON was asked how she involved the facility's medical director in the situation. She stated she had not. She stated she did not know she could do that.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure staff providing care and services to two (#3 and #4) of 4 sampled residents had the competencies and skill sets necessary to provide pressure ulcer care. The facility identified 50 residents as residing at the facility. Findings: The facility's policy and procedure for the prevention and treatment of [REDACTED].Upon admission, the facility will evaluate each resident for factors that may put the resident at risk for the development of pressure ulcers. The facility will utilize a tool that identifies risk factors including sensory perception, moisture, activity level, mobility, nutrition, friction and shear .The risk factor tool will be completed upon admission and then may be completed additionally at intervals during the first four weeks post admission .Additional factors that may place a resident at risk for the development or to not heal pressure ulcers include: ~ Impaired/decreased mobility and decreased functional ability ~ Co-morbid conditions, such as [MEDICAL CONDITIONS] disease or diabetes mellitus . ~ Resident refusal of some aspect of care and treatment . ~ Exposure of skin to urinary and/or fecal incontinence . Should a resident have an existing pressure ulcer or develop a pressure ulcer post admission, the facility will implement procedures to evaluate the ulcer regularly, implement treatment measures to promote healing and prevent and/or treat infection and to manage any pain experienced by the resident . The facility will evaluate the ulcer at least weekly, utilizing a flow sheet that notes the location of the ulcer, the stage, presence of eschar, size, color, odor, drainage, tunneling/sinus tract/undermining if present, the notation of a culture if signs of infection are present, treatment including dressing, antibiotic, debridement and pain management. The facility will notify the physician upon the onset of the ulcer and obtain treatment orders . The facility will notify the physician if the ulcer appears to be deteriorating or if no improvement is noted in 2-4 weeks of the initial treatment orders . In order for a pressure ulcer to heal, the wound bed must be clean, moist, free of infection and with adequate blood supply.

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) Interventions should be directed toward achieving this end. Additionally, removing/preventing pressure to the ulcer area and adequate nutrition and hydration will promote healing. Pain is often associated with the presence of a pressure area. Evaluate the resident for the presence of pain . Orientation/training forms, dated 09/16/16, for employees RN #1 and LPNs #1, #2, #3, #4, and #5 documented, .Knows procedure for completion of wound care, collection of wound characteristic data and required documentation . The forms were signed by the director of nursing. 1. A hospital wound care team progress note for resident #3, dated 04/27/17, documented, .Pressure Ulcer Stage .II .Sacral .Length 3 cm Width 2 cm Depth 0.1 cm . Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Braden Scale form, used for predicting pressure sore risk and dated 05/02/17, documented the resident scored a 14. The form documented, .Total score of 12 or less represents HIGH RISK . An untitled facility form, dated 05/02/17, documented the resident had three open areas on the buttocks/sacral area. The form had the image of a body on it, and there were three circles drawn on the body image, with two on the right buttock and one on the sacral area. It was documented, .Open areas . There were no measurements or descriptions of the areas. A nurse's note, dated 05/02/17 at 1:35 p.m., documented, .(right) buttock c a 3 cm x 1.5 cm open area also gaulding to buttock . The note did not contain any other documentation related to pressure ulcers. A wound flow sheet, dated 05/02/17, documented the resident had a stage II pressure ulcer on the right buttock. It was documented the pressure ulcer measured 2 cm x 3 cm and was pink in color. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Admission physician orders, dated 05/02/17, documented the resident was to receive Prostat, a protein supplement, 30 ml daily and B-complex vitamins daily as a supplement. The orders documented to clean the right buttock daily with normal saline and apply Venelex ointment and cover with [MEDICATION NAME] border. It was also documented the resident could have a urinary catheter due to impaired skin integrity. An informed consent form for the use of an indwelling urinary catheter, dated 05/02/17, documented, .may have foley catheter d/t impaired skin integrity . The form was signed by the resident, the physician, and a member of the facility staff. A skilled nurse's note, dated 05/02/17 at 6:00 p.m., documented, .Butt paste to open area on buttocks . A physician's telephone order, dated 05/02/17 at 10:00 p.m., documented, .DC Vitamin B complex caps . A physician's progress note, dated 05/03/17, documented, .(right) buttock 2 x 3 cm open area . Medication administration records, dated 05/03/17 through 05/07/17, documented the resident did not receive the ordered Prostat. It was documented not in for each day. Treatment records, dated 05/03/17 through 05/07/17, documented treatments were completed to the right buttock pressure ulcer as ordered by the physician. A skilled nurse's note, dated 05/07/17 and untimed, documented, .Tx done on (right) buttock. 8 cm long x 0.25 cm wide open area noted to coccyx area. Call made .N.O. apply Venelex (and) cover c [MEDICATION NAME] .Staff reminded to reposition q 2 (hours) and encourage resident to get (up) . A physician's telephone order, dated 05/07/17, documented to use Venelex ointment for all open areas on the buttocks. A wound flow sheet, dated 05/07/17, documented the resident had a stage II pressure ulcer to the coccyx. It was documented the pressure ulcer measured 8 cm x 0.25 cm, was red, and had some bleeding. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. A skilled nurse's note, dated 05/07/17 at 7:00 p.m., documented, .Lying in bed c eyes open. c/o (left) hip pain. PRN pain medication given .Asked if resident would like to sit (up) in chair for a little while. Resident very hesitant afraid it will make her hurt more . A skilled nurse's note, dated 05/08/17 at 6:45 p.m., documented, .Buttocks are red c open areas . A physician's telephone order, dated 05/08/17, documented the resident was to receive Vitamin C, 500 mg daily and Zinc, 220 mg daily for wound healing. A wound flow sheet, dated 05/08/17, documented the resident had a stage II pressure ulcer on the left buttock. It was documented the ulcer measured 3 cm x 3 cm and that Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician was notified of the new open area to the left buttocks. Medication administration records, dated 05/08/17, documented the resident did not receive the ordered Prostat. It was documented, .not in . Treatment sheets, dated 05/08/17, documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. An admission assessment, dated 05/09/17, documented the resident was cognitively intact; required extensive assistance with bed mobility, transfers, and toileting. It was documented the resident had occasional pain that was very horrible and limited her activities. It was also documented the resident was at risk for pressure ulcers; had one stage II pressure ulcer; and had pressure relieving devices for her bed and chair. A wound flow sheet, dated 05/09/17, documented the right buttock pressure ulcer was a stage II ulcer that measured 1 cm x 1 cm. An additional measurement of 2 cm x 2 cm was documented. It was documented the ulcer was raw and pink, and Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. A facility invoice, dated 05/09/17, documented one case of Prostat was ordered on [DATE]. A packing slip documented the ship date was 05/10/17. Medication administration records, dated 05/09/17, documented the resident did not receive the ordered Prostat. It was documented, .not in . Treatment sheets, dated 05/09/17, documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. A physician's progress note, dated 05/10/17, documented, .Buttocks .wounds .open 3 x 4 cm area . A physician's telephone order, dated 05/10/17 documented, .Air mattress to bed Gel cushion to w/c . A skilled nurse's note, dated 05/10/17 at 9:30 a.m., documented, .n.o. for air mattress to bed and gel cushion to w/c . A skilled nurse's note, dated 05/10/17 at 6:00 p.m., documented, .Redness/open areas to pannus/buttocks . A durable medical equipment invoice, dated 05/10/17, documented an air mattress and pump were ordered. It was documented the requested ship date was 05/10/17. Treatment sheets, dated 05/10/17, documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. Medication administration records, dated 05/10/17 and 05/11/17, documented the resident did not receive the ordered Prostat. It was documented not in for each day. A skilled nurse's note, dated 05/11/17 at 1:00 a.m., documented, .redness/irritation to .buttock areas c txs in progress . Treatment sheets, dated 05/11/17, documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. A skilled nurse's note, dated 05/12/17 at 4:00 a.m., documented, .Buttocks c redness, excoriation to anal area .c/o buttocks pain. given prn order of [MEDICATION NAME] . An undated physician's telephone order, signed by the physician on 05/12/17, documented to clean the open area to the left buttocks, apply Venelex, and cover daily. The order was listed on the physician telephone order sheet between an order written [REDACTED]. Treatment sheets, dated 05/12/17, documented the resident received the physician ordered dressing changes to the right buttock and coccyx pressure ulcers. There was no documentation the resident received a treatment to the left buttock pressure ulcer. Treatment sheets, dated 05/13/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) A skilled nurse's note, dated 05/14/17 and untimed, documented, .Buttocks c excoriation et reddened skin care given et txs in progress . Treatment sheets, dated 05/14/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. The resident's care plan, dated 05/15/17, documented a problem related to impaired skin integrity. The goal was the resident would have healing of skin over the next 90 days. Approaches were to perform dressing changes as ordered; gel cushion to the wheelchair; turn and reposition every two hours; avoid supine position; use care when applying lotions over bruises; and a low air loss mattress to the bed. A social services progress note, dated 05/15/17 at 6:48 a.m., documented, .Got a few words and a laugh out of her. However she did me (sic) her backside was bothering her . A skilled nurse's note, dated 05/15/17 and untimed, documented, .able to move side ways - c/o pain when moved differently .tx to buttocks areas red, raw .Has gel cushion in w/c .call to (physician name withheld) - orders to dc f/c (after) 24 (hour) bladder training . A physician's telephone order, dated 05/15/17, documented to discontinue the resident's urinary catheter after 24 hours of bladder training. A wound flow sheet, dated 05/15/17, documented the right buttock pressure ulcer was a stage II ulcer that measured 3 cm x 3 cm and was raw and red. It was also documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated 05/15/17, documented the left buttock pressure ulcer was a stage II ulcer that measured 5 cm x 3 cm, was red and raw, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician was notified of the worsening of the wounds. There was no wound flow sheet dated 05/15/17 for the coccyx pressure ulcer. Treatment sheets, dated 05/15/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/16/17 and untimed, documented, .(left) buttock red raw and peeling, (right) buttock (dressing) dry .coccyx red c (dressing) . A skilled nurse's note, dated 05/16/17 and untimed, documented, .@ 1615 (4:15 p.m.) cath was dc'd . Treatment sheets, dated 05/16/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/17/17 at 5:00 a.m., documented, .Pt has dressings x 3 on buttock x 3 CDI . A wound flow sheet, dated 05/17/17, documented the right buttock pressure ulcer was a stage II ulcer that measured 1.5 cm and 1 cm and 2 cm wide. It was documented the ulcer was triangular in shape, with red and raw edges. It was documented there was slight drainage and Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated 05/17/17, documented the left buttock pressure ulcer was a stage II ulcer that measured 3.5 cm x 3 cm, was pink with red edges, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. Another wound flow sheet, dated 05/17/17, documented the coccyx pressure ulcer was a stage II ulcer that measured 4 cm x 1 cm x 0.5 cm, was red with a dark center to the side, and had slight drainage. It was documented Venelex ointment and a [MEDICATION NAME] dressing were used for daily dressing changes. There was no documentation to show the physician had been notified that all three wounds had drainage. Treatment sheets, dated 05/17/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/18/17 and untimed, documented, .Pt is confused at times, dressings on buttocks are clean (and) intact . There was no documentation to show the physician was notified of the resident's confusion. Treatment sheets, dated 05/18/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/19/17 at 4:45 a.m., documented, .Open wounds to buttocks et coccyx. Has been turned from side to side. Foley catheter dc'd 5/16/17. Has started becoming incontinent . A urinalysis, dated 05/19/17, documented the resident's urine sample contained large amounts leukocyte esterase (normal - none), was positive for [MEDICATION NAME] (normal - negative), and 4+ bacteria (normal - none). It was documented the urine was sent for a culture and sensitivity test. A physician's telephone order, dated 05/19/17, documented the resident was to receive Cipro, an antibiotic, 500 mg twice daily for a urinary tract infection. A skilled nurse's note, dated 05/19/17 at 7:00 p.m., documented, .Buttocks/coccyx area red - irritated - open areas . Treatment sheets, dated 05/19/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/20/17 at 2:00 a.m., documented, .Buttocks, coccyx, peri-area all red/irritated A skilled nurse's note, dated 05/20/17 at 9:00 a.m., documented, .Sitting (up) in w/c eating breakfast. c/o some dizziness .c/o of buttocks pain. Wants to lay back down (after) breakfast . A skilled nurse's note, dated 05/20/17 at 6:30 p.m., documented, .does c/o buttocks pain . Treatment sheets, dated 05/20/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/21/17 at 4:00 a.m., documented, .continues to have reddened, irritated to peri area .Buttocks c several open areas tx provided. Coccyx decubitus draining serosanguinous fluid on drsg from tx provided. Resident is incontinent (dribbles) of urine .c/o pain to buttocks . There was no documentation to show the physician was notified of the drainage from the wound or the pain to the resident's buttocks. A skilled nurse's note, dated 05/21/17 at 9:30 a.m., documented, .Tx done to buttocks .cont to c/o pain, states prn meds given earlier 'helped some' . There was no documentation to show the physician had been notified of the resident's partially relieved pain. A urine culture report, dated 05/21/17, documented the urine contained greater than 100,000 org/ml of [DIAGNOSES REDACTED] bacteria. Treatment sheets, dated 05/21/17, documented the resident received the physician ordered dressing changes to the right buttock, coccyx, and left buttock pressure ulcers. A skilled nurse's note, dated 05/22/17 at 2:30 a.m., documented, .dressing to coccyx (changed) due to it was soiled. Buttocks very red. [MEDICATION NAME] applied @ this time. c/o buttocks et lower back pain . A skilled nurse's note, dated 05/22/17 at 10:00 a.m., documented, .tx to buttocks and coccyx area Tolerated well. Want to stay in bed .Call to (physician name withheld) re: resident (increased) weakness, (not) eating, unable to stand .wanted to go back to bed . A skilled nurse's note, dated 05/22/17 at 2:00 p.m., documented, .orders to send to (hospital name withheld) . A physician's telephone order, dated 05/22/17, documented to send the resident to the hospital. A certificate of medical necessity for nursing home transport, documented, .What medical condition exists that makes transport by ambulance necessary? (Increased) weakness, (decreased) sats, (no) appetite = needs fed, decubs to coccyx . A nursing home to hospital transfer form, dated 05/22/17, documented, .reason(s) for transfer (decreased) sats, (increased) weakness, (decreased) appetite, (increased) decubs . It was documented the resident had pressure ulcers on the buttocks and coccyx. A discharge summary, dated 05/22/17, documented the resident was discharged due to decreased oxygen saturation levels, increased weakness, and decreased appetite. It was documented the resident's condition on discharge was poor. Review of facility clinical records revealed no documentation the resident's pressure ulcers had been thoroughly assessed per current standards of practice. There was no documentation to show: ~ why the facility did not have the physician ordered Prostat supplement;

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	375466	A. BUILDING _____ B. WING _____	**08/02/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	**PINE & BRISTOW DRUMRIGHT, OK 74030**

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 0353

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 11)
~ if the air mattress was placed on the resident's bed;
~ the facility attempted to educate the resident on the importance of the urinary catheter due to her impaired skin integrity; or
~ why the resident did not receive a treatment to the left buttock pressure ulcer for five days after it was first identified.

An ambulance record, dated 05/22/17, documented the ambulance arrived at the facility at 2:52 p.m. It was documented transportation to the hospital began at 3:03 p.m., and the resident arrived at the hospital and was given over to hospital care at 4:02 p.m.

Hospital laboratory results, dated 05/22/17 at 4:40 p.m., documented the resident's white blood cell count was 18.91. Normal values were 4.00 to 10.50.

A computerized tomography scan result, dated 05/22/17 at 6:13 p.m., documented, .There is moderate subcutaneous induration overlying the coccyx, and there is a decubitus ulcer, with air tracking into both gluteal muscles, worse on the right side. Air also tracks into the deep pelvis along the right side of a rectal sling .Impression .New subcutaneous induration and bubbles of air are identified adjacent to the coccyx, tracking into the gluteal muscles, more evident on the right, and also into the pelvis along the right side of the anal sling. The changes are thought to be due to a decubitus ulcer with tracking of air into the adjacent soft tissues .

An emergency room nurse's note, dated 05/22/17 at 7:41 p.m., documented, .Pts perineal area very red and swollen. Pt has an approx 2 inch (5 cm) open pressure wound on her sacrum that appears to have tunneling. Pt also has green, lose (sic) stool .

A hospital history and physical note, dated 05/22/17 at 8:16 p.m., documented, .Chief complaint:[MEDICAL CONDITION] .was discharged last month from (hospital name withheld) after she was treated for [REDACTED]. The patient was discharged to nursing home. She reportedly was brought in from the nursing home today by the family who reports that she has failure to thrive. She has some generalized weakness and fever and she also being treated for [REDACTED]. She was seen in the emergency room and was found to have elevated white count and was started on antibiotics. She had a CAT scan of her abdomen and pelvis, which revealed a possible gases tissue, which is concerning her either necrotizing fascitis or deep decubitus ulcer .I examined the patient. At this point, the concern for necrotizing fascitis is less likely and this is probably from tunneled wound, which is advanced stage probably 3-4 decubitus ulcer. She also has some [DIAGNOSES REDACTED] and redness in the perineal area. She does have incontinence of both stool and for urine. She reports that she has been getting on and off physical therapy; however, she feels as if she is having generalized weakness. Her vitals revealed a temperature of 36.1 (degrees Celsius, 96.98 degrees Fahrenheit) and blood pressure of 106/46 .Assessment: 1.[MEDICAL CONDITION], present on admission, likely secondary to decubitus ulcer. 2. Advanced stage III-IV decubitus ulcer with tunneled wound and active drainage .

A pressure ulcer consultation note, dated 05/23/17 at 9:06 a.m., documented, .sacral ulcer present with necrotic tissue and bone exposed underlying and tunneling present, multiple areas of ulceration from friction and shear with full-thickness skin loss .Assessment: 1. Stage IV pressure ulcer to sacrum, questionable necrotizing fascitis per CT as of yesterday. 2.[MEDICAL CONDITION] .We will continue n.p.o .The patient may have surgery today .possible debridement .

Review of hospital CT scan results, emergency room nurses' notes, wound consultant report, and hospital physician history and physical notes revealed documentation of the resident's sacral pressure ulcer that was inconsistent with the last noted pressure ulcer documentation from the facility.

An operative note, dated 05/24/17 and untimed, documented, .Preoperative Diagnosis: [REDACTED]. Postoperative Diagnosis: [REDACTED]. Procedures: 1. Excisional debridement of skin, subcutaneous tissue and sacral bone with sharp excisional debridement measuring 10 cm width x 10 cm length x 7 cm depth. 2. Debridement of sacral bone with bone biopsy and bone excision for cultures .Findings: Extensive sacral decubitus, full thickness, down to sacral bone at the depth. The exposed bone was debrided with a rongeur and sent for biopsies and cultures .

A pathology report, with a collection date of 05/24/17 and a verified date of 05/30/17, documented, .A. Bone, sacral region, debridement - [MEDICAL CONDITION] and acute osteo[DIAGNOSES REDACTED] involving reactive and degenerating bone and soft tissue. B. Soft tissue, sacral region, debridement - skin and soft tissue necrosis with associated [MEDICAL CONDITION] and abscess .

A discharge summary, dated 06/05/17, documented .Discharge Diagnoses: [REDACTED].Advanced stage III-IV decubitus ulcer that was tunneled with active drainage, questionable [DIAGNOSES REDACTED] per CT, status [REDACTED].MRI of the pelvis showed positive developing osteo .patient .was recently discharged from (hospital name withheld) in April for [MEDICAL CONDITION] and urinary tract infection. The patient was discharged to a nursing home. Apparently , her family went to visit her at the nursing home and reported the patient continued to get weaker and have failure to thrive. She was found to have a fever and a urinary tract infection .There was concern that her [MEDICAL CONDITION] is also worsening and that she was developing a wound in the sacral region. Therefore, she was sent to the Emergency Department, found to have an elevated white blood count and immediately started on antibiotics. A CT of her abdomen and pelvis was obtained, which revealed possible [MEDICATION NAME] tissue, concern for [DIAGNOSES REDACTED] or deep decubitus ulcer. She was found to have a decubitus tunneled wound in the sacral region, stage III-IV. Therefore, General Surgery was consulted and the patient is now status [REDACTED].(physician name withheld) with Infectious Disease was also consulted due to the extensiveness of this wound and the patient'[MEDICAL CONDITION] on admission. An MRI was obtained, which showed a concern for developing osteo[DIAGNOSES REDACTED]. Therefore, the patient will need to be on IV antibiotics, [MEDICATION NAME] for the next 6 weeks. [MEDICATION NAME] was started on 05/28/2017 .The patient has chronic debility and weakness. She is bedridden. Therefore, she has required a Foley catheter as well as a rectal tube for healing of her sacral decubitus ulcer .The patient has done well with all these procedures and her mentation has improved over the course of her hospital stay .She is now currently stable and will be discharged .for further care and treatment of [REDACTED].

A hospital history and physical, dated 06/06/17 at 11:03 p.m., documented, .This is a patient that was recently discharged on [DATE] to (facility name withheld) for chronic care of large sacral decubitus with osteo[DIAGNOSES REDACTED], found to have [DIAGNOSES REDACTED], the patient was on meropenem. She was also known to have a history of [MEDICAL CONDITION], on [MEDICATION NAME] and oral iron. They noted yesterday that the patient had a hemoglobin of 6.1. They transfused her and transferred her here for further evaluation of her [MEDICAL CONDITION]. This has been worked up thoroughly. There is no obvious source of her [MEDICAL CONDITION] with no obvious signs of bleed. the patient is an elderly woman with multiple ecchymosis. Her large sacral decubitus has areas of bleeding during debridement and this may possibly be a source of chronic [MEDICAL CONDITION]. She was initially admitted on [DATE] [MEDICAL CONDITION] secondary to the large sacral decubitus .She did present with a Foley catheter and a rectal tube .Past Medical History: [MEDICAL CONDITION] .recent [MEDICAL CONDITION] with UTI, sacral decubitus with osteo[DIAGNOSES REDACTED], positive for [DIAGNOSES REDACTED] .chronic [MEDICAL CONDITIONS] .Review of systems: The patient is seen lying in bed complaining of pain from sacral decubitus. She notes it hurts to roll over .She does complain of continued chronic weakness .She has a very large sacral decubitus that is covered with a wet-to-dry dressing noted. There are some areas of bleeding .The sacral decubitus is nonodorous at the moment .

A death summary, dated 06/26/17, documented, .Discharge Diagnoses: [REDACTED]. [MEDICAL CONDITION] from osteo[DIAGNOSES REDACTED] .Hospital Course: .was admitted with severe [MEDICAL CONDITION] and worsening sacral decubitus ulcer with osteo[DIAGNOSES REDACTED]. She had a prolonged hospitalization with involvement of multiple consultants. The patient underwent EDG and colonoscopy during this admission. She was started on broad-spectrum antibiotics for her osteo[DIAGNOSES REDACTED]. She, however, continued to develop progressively worsening [MEDICAL CONDITION] due to uremia [MEDICAL CONDITION]. She became hypotensive and had to be transferred to ICU; given her multiple comorbidities, after discussion with the family; In accordance with patient's wishes physicians placed the patient on comfort measures and she passed away this morning .

The resident's death certificate, with a certification date of 06/30/17, documented, .Cause of Death .

Part I .Immediate Cause (Final disease or condition resulting in death .[MEDICAL CONDITION] .

Sequentially list condition, if any, leading to the cause listed on line a. b. End Stage [MEDICAL CONDITION] .

Enter the UNDERLYING CAUSE (disease Or injury that initiated the events resulting in death) LAST. c. Sacral Decubitus Ulcers with [DIAGNOSES REDACTED] .

Part II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DRUMRIGHT NURSING HOME	PINE & BRISTOW DRUMRIGHT, OK 74030

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 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) Acute on chronic systolic and diastolic [MEDICAL CONDITION] exacerbation, severe malnutrition, [MEDICAL CONDITION], and [MEDICAL CONDITION] from osteo[DIAGNOSES REDACTED] . On 07/31/17 at 1:00 p.m., LPN #1 was asked if she remembered resident #3. She stated yes. She was asked why the resident was sent out to the hospital. She stated her pressure ulcer had opened up over the weekend. She was asked if she had notified the physician. She stated yes. She stated the doctor had ordered her to send the resident to the hospital. LPN #1 was asked if she could see the resident's sacral bone when the ulcer opened up. She stated, No. She stated the ulcer had progressed from a superficial ulcer to a stage II. LPN #1 was asked if the DON had looked at the resident's ulcers. She stated, No. She stated the DON did not look at ulcers. On 07/31/17 at 3:29 p.m., RN #1 was asked if she remembered resident #3. She stated yes. She was asked if the resident had pressure ulcers. She reviewed clinical records and stated yes. She stated the resident had right arm [MEDICAL CONDITION] and sores on her buttocks. She stated the resident was noncompliant. She stated staff would try to turn her but she would go right back to her back. RN #1 was asked where the resident's pressure ulcers were. She stated there was one on the coccyx. She stated it looked like the buttock fold had split open. She was asked what stage the ulcer was. She stated it was a stage II or III. She stated it kept trying to split open. RN #1 stated the ulcer was not that bad until her urinary catheter was taken out. She stated staff could not keep her dry. RN #1 stated the ulcer started gaping pretty good as soon as the urinary catheter was removed. RN #1 was asked if she notified the physician when the ulcer began to worsen. She stated, No, I didn't. I work the 11-7 shift. RN #1 was ask(TRUNCATED)
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to have an effective quality assessment and assurance program in place to identify problems and develop and implement plans of action to correct quality deficiencies, which would in turn ensure the nursing staff provided nursing and related services to enable residents to achieve and maintain their highest practicable well-being. This had the potential to affect 50 of 50 residents who resided in the facility. Findings: 1. The facility failed to provide care and services to aid in the prevention and treatment of [REDACTED]. Refer to F314. On 08/02/17 at 4:05 p.m., the administrator was asked if, prior to the survey, the facility had identified any concerns related to pressure ulcers. She stated, Not recent ones. She was asked if the facility had identified any concerns with pressure ulcers after the incidents involving resident #3. She stated, I don't believe so. 2. The facility failed to notify the physician of worsening pressure ulcers and/or the development of new pressure ulcers for two (#3 and #4) sampled residents who were reviewed for pressure ulcers. Refer to F157. On 08/02/17 at 4:10 p.m., the administrator was asked if, prior to the survey, the facility had identified any concerns related to physician notification. She stated, No.