STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035114	A. Building B. Wing	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor	1045 Sandretto Drive Prescott, AZ 86305

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on clinical record review, staff interviews, and policy and procedure, the facility failed to ensure that care and services related to pressure ulcer was provided for 1 of 3 sampled residents (#1). The deficient practice could result in developing and/or worsening of the pressure ulcer. Findings include: Resident #1 was admitted on [DATE] with diagnoses that included cerebrovascular disease, congestive heart failure, severe protein-calorie malnutrition, and type II diabetes. A skin/wound observation dated February 23, 2023 included the skin was intact. A Braden Scale Risk assessment dated [DATE] revealed the resident's sensory perception was slightly limited, the skin was often moist and the resident's activity level was bedfast with very limited mobility. The assessment also included that nutrition was very poor; and, the resident was at high risk for developing pressure ulcers. The clinical record revealed the resident was admitted to hospice care on February 23, 2023. An MDS (Minimum Data Set) assessment dated [DATE] included the resident had no unhealed pressure injuries. Another Braden Scale Risk assessment dated [DATE] revealed sensory perception was slightly limited, the skin was often moist, the activity level was bedfast with very limited mobility, nutrition was very poor; and, the resident was at high risk for developing pressure ulcers. A nursing progress note dated [DATE] included that the nurse requested from hospice documentation on assessments, measurements, wound orders for the resident's wound to the coccyx. Per the documentation, the nurse was informed that hospice does not measure wounds as they do not treat wounds, they just do care/orders to help protect the wounds . A physician order dated [DATE] included to cleanse the unstageable wound to the sacrum with normal saline and cover with foam dressing daily and as needed if soiled. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The progress note dated [DATE] included that the nurse did the wound care on the coccyx area which had a lot of sloughing noted. Per the documentation, hospice came in about 10 minutes after and assessed the wound to the coccyx and heels. It also included that hospice said that there was no change to the wound just that the wound bed was basically debriding itself. Per the documentation, hospice will be coming daily to do wound care and to change dressing as needed when soiled. Despite documentation that the resident had an unstageable pressure ulcer to the coccyx/sacral area, there was no evidence found in the clinical record that the wound was assessed to include measurement, description of the wound bed, wound edges, presence of exudate, odor, tunneling or undermining and surrounding area From [DATE] through 15, 2023. A Weekly Skin Report dated [DATE] through [DATE] included an unstageable coccyx/sacral wound that measured 9 cm (centimeters) by 7 cm by 2.8 cm.; had 2 cm undermining at 11 o'clock, 3.5 cm at 12 o'clock, and 4 cm at 2 o'clock. Per the documentation, the wound had an onset date of February 22, 2023. The report did not include documentation on the appearance of the wound bed, surrounding skin, and drainage/exudate. A care plan initiated on [DATE] revealed the resident was high risk for pressure ulcers and had a stage 4 pressure injury to the sacrum. The goals were that the resident would have optimum skin management and that the pressure injury would improve. Interventions included to provide pressure reducing surfaces on bed and chair, provide pillows or other supportive/protective devices to assist with positioning, repositioning every two hours, pressure reducing device, and two-person assist to avoid friction/sheering. Review of the TAR (treatment administration record) for [DATE] revealed a treatment order for the unstageable wound to the sacrum was transcribed. Further review of the TAR revealed that the treatment was not documented as administered on [DATE],12, 17, 18 and 21, 2023. There was no documentation on the clinical record of reason why treatment was not completed on dates not marked in the TAR; and that, the physician was notified. Continued review of the clinical record revealed that the resident #1 expired on [DATE] at approximately 3:30 pm. During an interview conducted with a Certified Nursing Assistant (CNA/staff #13) on [DATE] at approximately 10:00 a.m., the CNA stated that residents on hospice are turned every two hours if they have bed sores; and that, anytime she assists a resident on hospice she looks them over. Staff #13 stated that hospice staff does the showers or bed baths and wound care; and, hospice will tell the facility staff if there were any skin issues and what care hospice had provided. Regarding resident #1, The CNA stated that the resident had a sore on the coccyx on admission that kept getting larger and it was smelly. Staff #13 stated they assisted the hospice nurse with wound care twice; and that, the last time she assisted with wound care was one week before the resident expired. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on [DATE] at approximately 10:15 a.m. with another CNA (staff #22) who stated that resident #1 arrived with a gnarly sore and needed to be repositioned every two hours. Staff #22 stated the wound would constantly leak requiring a full bed linen change regularly. Staff #22 stated the wound did not grow in size because the skin was dying and nothing can be done for a dying skin. Staff #22 stated the odor got better for a while but there were days when the wound would drain and leak. During an interview conducted with the Director of Nursing (DON/staff #31) on [DATE] at approximately 10:20 a.m., the DON stated that hospice residents are provided care in collaboration with the facility. The DON stated that the residents on hospice were still the facility's resident; and that, the facility should make sure skin care was provided and assessed. The DON stated that hospice would provide wound care supplies for the staff who should be assessing and documenting care. The DON stated that wounds should be care planned, should have provider orders for care and assessments documented. The DON further stated that wound care provided should be documented in the clinical record. An interview was conducted on [DATE] at approximately 10:30 am with a Registered Nurse/Wound Nurse (RN/staff #40) who stated that even if a resident was on hospice, it is their responsibility to provide wound care. Staff #40 stated that hospice will order treatments and if there are changes to treatment they will let the facility know. Staff #40 stated that any assessments that hospice does should be given to the facility including measurements. Regarding resident #1, the RN stated that they were not notified on admission that the resident had a wound on the coccyx area; and that, hospice had something documented on [DATE] or 6, 2023 about the resident's wound. Staff #40 stated they attempted to reach out to hospice on the [DATE] for the assessment or information about the coccyx wound. Further, staff #40 stated that the first time she assessed the coccyx wound was on [DATE]; however, she did not get measurements. Staff #40 said that this was because she was told by hospice that they (hospice) do not measure or treat pressure wounds on hospice residents, only protect them. Staff #40 stated that the first documented measurements by the facility was on [DATE] (one day before the resident passed); and that, the staff was providing wound care with saline cleanser and a foam dressing. Staff #40 stated they saw additional wound care supplies in the room from hospice; but, the facility did not have orders for it so they did not use it. Staff #40 stated they just had orders to protect it and that the idea was that hospice was managing (the resident's) skin and we were waiting on instructions. A facility Wound and Skin Care Protocols and Procedures (revised ,d+[DATE]) included that the purpose was to promote a systematic approach and monitoring process for the care of residents with existing wounds and for those who are at risk for skin breakdown. This included that the Director of Nursing will be responsible for reviewing weekly wound report and monitoring progress/decline of any wound and assuring compliance with current standards of wound care practices. The protocol included that a complete wound assessment and documentation will be done weekly on all pressure ulcers untiled healed. The criteria include site/location, stage, size, appearance of wound bed, undermining/tunneling, surrounding skin, and drainage.