

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2022
NAME OF PROVIDER OR SUPPLIER Regal Heights Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6525 Lancaster Pike Hockessin, DE 19707	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>20835</p> <p>Based on record review and interview, it was determined that for one (R1) out of three (3) sampled residents for pressure ulcer (PU) review, the facility failed to review and revise the care plan for an identified resident care area. Findings include:</p> <p>Cross refer F686, Example #2.</p> <p>Review of R1's clinical record revealed the following:</p> <p>11/30/20- R1 was admitted to the facility.</p> <p>1/15/21 - R1 was readmitted to the facility from the hospital due to pneumonia from COVID-19 and had no PU's.</p> <p>1/21/21 - The Significant Change MDS Assessment documented that R1 was moderately impaired for decision making with a BIMS score of 9, required extensive assistance of two plus staff for bed mobility, one person physical assistance for transfers, total assistance for dressing and eating, required total dependence of two plus staff for toileting, was always incontinent of bowel and bladder, and had no PU.</p> <p>1/22/21 - R1's Braden Scale score was 12 indicating that R1 was at high risk for the development of PU's.</p> <p>2/2/21 - A Skin Evaluation documented a fluid filled intact blister on R1's left heel.</p> <p>2/2/21 - The facility's contracted Wound Care Consultant (E11) documented the presence of a stage II (2) PU to the left heel. Interventions in place to address the condition of R1's skin and immobility included an alternating low air loss mattress and to order heel boots which were to be worn at all times while in bed.</p> <p>2/2/21 - The care plan for the stage II wound to R1's left heel related to impaired mobility included interventions to administer treatments as ordered and monitor for effectiveness, and educate caregivers as to the causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulation/mobility, and good nutrition.</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was lack of evidence of revising the care plan to include the alternating low air loss mattress and heel boots which were to be worn at all times while in bed.</p> <p>3/10/22 2:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (Director of Clinical Services), and E5 (RN Risk Manager).</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20835</p> <p>Based on interview, review of the clinical record, review of the facility's policy and procedure, review of the facility's guideline, and review of professional clinical resources as indicated, it was determined that for two (R1 and R2) out of three sampled residents for pressure ulcer (PU) reviews, the facility failed to ensure that the residents received the necessary treatment and services, consistent with professional standards of practice, to prevent new pressure ulcers (PU's) from developing. R2 was admitted to the facility with no PU's and the facility failed to implement preventative measures resulting in R2 acquiring an avoidable unstageable PU of the sacrum on 2/6/21 and an avoidable deep tissue injury (DTI) PU to his left heel on 2/7/21. R1 was readmitted to the facility on [DATE] with no PU's and the facility failed to implement interventions to relieve pressure from R1's heels. R1 subsequently acquired an avoidable stage II (2) PU of the left heel on 2/2/21 that resolved on 3/2/21. Findings include:</p> <p>Review of the facility's policy and procedure (P & P) titled Prevention of Pressure Injuries [Ulcer], with a revision date of April 2020, stated, .The purpose of this procedure is to provide information regarding the identification of pressure injury risk factors and interventions for specific risk factors .Risk Assessment 1. Assess the resident on admission (within 8 hours) for existing pressure injury (ulcer) risk factors. Repeat the risk assessment weekly and upon any change in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factor .</p> <p>Review of the facility's Braden Scale Guideline, with a revision date of March 2018, stated that the facility would utilize this guideline to implement interventions for the prevention of PU's based on the score from the Braden Scale, a standardized PU screening tool:</p> <p>AT RISK (15-18): Repositioning, protect heels, manage moisture, friction and shear, pressure-reduction support surface to bed and chair, moisture barrier for incontinence.</p> <p>MODERATE RISK (13-14): All the above interventions [as noted for AT RISK] and lateral positioning devices and dietary consult if oral intake less than 50%.</p> <p>HIGH RISK (10-12): All the above interventions [as noted for AT RISK and MODERATE RISK] as well as small repositioning shifts between the scheduled turning and repositioning and a resident nap between lunch and dinner.</p> <p>Review of the facility's P & P titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, with a revision date of April 2018, stated, Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for development of pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissues; b. Pain assessment .</p> <p>According to the National Pressure Ulcer Advisory Panel (April 2019), the stages of pressure injuries/ulcers (categorization system used to describe the severity of PUs):</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated.</p> <p>Unstageable - Tissue loss in which the actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage is more severe than slough in the wound bed).</p> <p>Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue.</p> <p>1. Review of R2's clinical records revealed the following:</p> <p>8/12/20 - R2 was admitted to the facility with no PU's and weighed 193 pounds (#).</p> <p>8/12/20 - The Admission Nursing Assessment documented that R2's skin was intact and had no PU's.</p> <p>8/12/20 - R2 was assessed as not being at risk for the development of a PU with a Braden Scale score of 19.</p> <p>8/13/20 (Initial date and revised on 2/24/21) - A care plan for risk for further skin breakdown related to decreased mobility, fragile skin, and incontinence included the following interventions:</p> <ul style="list-style-type: none"> - apply lotion to skin to prevent dryness everyday with AM and PM care. - monitor alterations in nutrition and notify Medical Doctor and Dietician. - Roho pressure relief cushion to wheelchair (initiated 2/21/21). - pressure relief cushion to wheelchair (initiated 8/13/20). - turn and reposition, check skin and monitor pressure points every two hours and report changes to nurse. - weekly skin assessments by a nurse. <p>8/18/20 - The Admission MDS Assessment documented that R2 was moderately impaired for decisionmaking with a BIMS of 12, required extensive assistance of two plus staff for bed mobility and transfers, required extensive assistance of one person for toileting, was frequently incontinent of urine, always incontinent of bowel, and had no PU's.</p> <p>11/12/20 - The Quarterly MDS Assessment documented R2 was cognitively intact for daily decisionmaking with a BIMS of 13, required extensive assistance of one person for bed mobility, transfers, and toileting. required supervision of one person assistance for eating, was frequently incontinent of urine, occasionally incontinent of bowel, and had no PU's.</p> <p>11/30/20 - The Braden Scale score was 18, indicating that R2 was at risk for the development of PU's.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Although R2 was assessed to be at risk for the development of a PU, there was lack of evidence that the facility identified and implemented interventions to protect the heels, manage moisture, friction and shear, and to apply moisture barrier for incontinence per the facility's Braden Scale guidelines.</p> <p>2/1/21 through 2/6/21- CNA documentation stated that the following interventions were completed:</p> <ul style="list-style-type: none"> - turned and repositioned and skin assessed every 2 hours. - incontinence care every 2 hours and PRN. <p>2/6/21 2:33 PM - The Braden Scale score was 12 indicating that R2 was at high risk for PU development.</p> <p>2/6/21 4:19 PM - A Nurse Progress Note documented that at 2:15 PM, a CNA found and reported a wound to R2's coccyx (tailbone) area. R2 was assessed with a dark purple discolored area measuring 4 cm x 6 cm with a small superficial opening measuring 2 cm (length-L) x 2 cm (width-W) and the NP was notified. New orders were given to cleanse the area with NSS, apply Zinc Guard around the edges and apply Santyl to the open area and cover with a clean dry dressing. E6 (LPN, WCN) and R1's responsible party (RP2) were notified.</p> <p>Despite the fact that R2 was assessed at high risk for the development of a PU, there was lack of evidence that the facility identified and implemented additional measures to include protection of the heels, manage moisture, friction and shear, apply moisture barrier for incontinence, and consult for lateral positioning devices per the facility's Braden Scale guidelines.</p> <p>2/7/21 - CNA documentation stated that the following interventions were completed:</p> <ul style="list-style-type: none"> - turned and repositioned and skin assessed every 2 hours. - incontinence care every 2 hours and PRN. <p>2/7/21 12:33 PM - A Skin Only Evaluation documented the following:</p> <p>.Skin Issue: Deep Tissue Injury. Skin Issue Location: left heel Length: 2 cm Width: 2 cm Wound Bed: Necrotic. Wound Exudate: None. Peri Wound Condition: Fragile. Dressing Saturation: None. No wound odor. No tunneling. No undermining. Tissue: Firm. Tissue: Warm .</p> <p>Based on the above characteristics of the left heel PU, it would be consistent with an unstageable PU due to the presence of necrotic tissue in the wound bed.</p> <p>2/7/21 3:20 PM - A Nurse's Progress Note documented during routine care at 2 PM, a CNA found and reported a bruise to R2's left heel. R2 was assessed with a small dime sized dark purple discoloration/ bruise measuring 2 cm (L) x 2 cm (W) on his left heel. The area was cleansed with NSS and skin prep was applied and the heel was elevated. Notifications were made to E6 (LPN, WCN), E9 (NP) and E10 (MD).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2/7/21 - A NP Progress Note documented that R2 was diagnosed with a urinary tract infection and ordered antibiotics for six days.</p> <p>2/8/21 - A Health Status Note by E6 (LPN, WCN) documented her wound assessment of the left heel with dry eschar measuring 1.0 cm x 1.0 cm, an unstageable ulceration. The coccyx and bilateral buttocks had necrotic tissue with a split base of the wound that was 100% slough with a necrotic black area to the inner buttocks extending to the left buttock with a non-blanchable area to the left buttock. Santyl was ordered for the buttocks and the skin prep for the left heel. New interventions were to elevate R2's heels up on pillows and a low air loss mattress to the bed frame.</p> <p>2/9/21 - The facility's contracted Wound Care Consultant (E11) documented R2 was seen for an evaluation and management for wounds to the sacrum and left heel. The sacrum measured 9.0 cm (L) x 9.2 cm (W) x 0.2 cm (D) with 60% slough. R2 had no evidence of pain upon the wound being palpated. The left heel measured 1.4 cm (L) x 1.2 cm (W) purple/maroon intact skin. Plan: Unstageable pressure ulcer/injury of the left heel due to deep tissue injury .cleanse affected area with NSS .Apply skin prep daily and PRN . Unstageable pressure ulcer/injury of the sacrum secondary to slough .</p> <p>2/9/21 - A Registered Dietician Evaluation by E8 (RD) documented, Resident showing loss of 11.4 # in 6 days and highly likely related to overall decline in condition (noted to have decline in continence of b & b and requires extensive assistance with eating), noted with reduction in po intake past week .</p> <p>Although R2 had a decline in overall condition and the facility was monitoring R2's nutritional status, the facility failed to reevaluate R2's clinical condition and failed to implement interventions for the prevention of PU's. These failures resulted in R2 acquiring an avoidable PU of the sacrum on 2/6/21 and an avoidable DTI of the left heel on 2/7/21. On 2/8/21, the facility identified that both of the PUs were unstageable.</p> <p>3/9/22 1:35 PM - An interview with E6 (LPN, WCN) confirmed that the facility was utilizing the Braden Scale guideline when R2 acquired a new unstageable PU of the sacrum (coccyx) and a DTI of his left heel, however, E6 reiterated that the final interventions were determined by the Interdisciplinary Team.</p> <p>Cross refer F656.</p> <p>2. Review of R1's clinical record revealed the following:</p> <p>11/30/20 - R1 was admitted to the facility with no pressure ulcers (PU's) and weighed 193 pounds (#).</p> <p>11/30/20 - The Admission Nursing Assessment documented that R1's skin was intact.</p> <p>11/30/20 - R1's Admission Braden Score was 18 indicating that she was at risk for the development of a PU.</p> <p>12/8/20 - The Admission MDS Assessment documented that R1 was moderately impaired for decisionmaking, with a BIMS score of 9, required extensive assistance of two plus staff for bed mobility, transfers, toileting, was always incontinent of bowel and bladder, and had no PU's.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>12/9/20 (last revised on 12/24/20) - A care plan for the potential for impaired skin integrity related to decreased mobility and incontinence included the goal that the skin would remain intact. Interventions included to provide prompt perineal care following incontinence episodes and to provide turning and repositioning every 2 hours, including checking the skin.</p> <p>12/16/20 3:32 PM - A Nurse Progress Note documented that R1 was positive for COVID-19.</p> <p>12/1/20 - 12/30/20 - CNA documentation stated R1 was turned and repositioned every 2 hours, including skin checks.</p> <p>There was lack of evidence that additional interventions to prevent PU's were implemented to include protecting the heels, manage moisture, friction and sheer, and to apply moisture barrier for incontinence per the facility's guideline.</p> <p>12/24/20 12:48 PM - A care plan review note documented that R1's skin was intact and that the interventions implemented were effective.</p> <p>12/30/20 8:58 AM - A Nurse Progress Note documented a change in condition including altered mental status and a physician's order was received to send R1 to the emergency room (ER) for an evaluation. R1 was transferred to the ER and was subsequently hospitalized .</p> <p>1/15/21 - R1 was readmitted to the facility from the hospital due to pneumonia from COVID-19, had no PU's and weighed 177.3 #.</p> <p>1/15/21 - R1's Braden Scale Score was 13 indicating that R1 was at moderate risk for the development of PU's.</p> <p>1/21/21 - The Significant Change MDS Assessment documented that R1 was moderately impaired for decisionmaking with a BIMS score of 9, required extensive assistance of two plus staff for bed mobility, one person physical assistance for transfers, total assistance for dressing and eating, total dependence of two plus staff for toileting, was always incontinent of bowel and bladder, and had no PU's.</p> <p>1/22/21 - R1's Braden Scale score was 12 indicating that R1 was at high risk for the development of PU's.</p> <p>Despite R1 being high risk for the development of a PU, there was lack of evidence that the facility identified and implemented additional interventions to include protection of the heels, manage moisture, friction and sheer, apply moisture barrier for incontinence, and consult for lateral positioning device(s) per the facility's Braden Scale guidelines.</p> <p>1/15/21 through 1/31/21 - CNA documentation stated that R1 was turned and repositioned every 2 hours and skin was checked.</p> <p>1/21/21 - A Registered Dietician Evaluation revealed that R1's current weight was acceptable and the weight loss was due to the recent hospitalization and COVID pneumonia. The plan was to continue weekly weights and closely monitor weight trend.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2/2/21 - A Skin Evaluation documented a fluid filled intact blister on R1's left heel.</p> <p>2/1/21 through 2/2/21-CNA documentation stated that R1 was turned and repositioned and skin was checked every 2 hours.</p> <p>2/2/21 - The facility's contracted Wound Care Consultant (E11) documented the presence of a stage II PU to left heel, an intact blister measuring 5.7 cm (L) x 6.0 cm (W). The plan was to cleanse with NSS and to apply skin prep daily and PRN, continue repositioning in accordance to assessed need, offload pressure to the affected area and monitor nutritional intake via gastrostomy tube feeding. Interventions in place to address the condition of R1's skin and immobility included an alternating low air loss mattress and to order heel boots, which were to be worn at all times while in bed.</p> <p>2/2/21 - The care plan for actual wounds to the left heel stage II (2) related to immobility was developed and implemented. Interventions included to administer treatments as ordered and monitor for effectiveness and educate caregivers as to the causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulation/mobility, and good nutrition.</p> <p>2/2/21 beginning on the evening shift - 2/28/21 - CNA documentation revealed heel booties were on at all times except during hygiene, in addition to turning and positioning and skin checks every 2 hours.</p> <p>3/2/21 - The facility's contracted Wound Care Consultant (E11) documented R1's left heel PU was resolved.</p> <p>3/8/22 2:30 PM - An interview with E6 (LPN), the facility's designated Wound Care Nurse (WCN) was asked by the Surveyor if the interventions to prevent PU were revised following R1's readmission to the facility on [DATE] prior to the new stage II PU on the left heel. E6 stated she was unable to determine if there were any changes in interventions for the prevention of PU's and confirmed there was no intervention to offload R1's heels. During this interview, it was unclear what the facility's system was to ensure that appropriate preventative interventions were implemented for the prevention of a new PU.</p> <p>3/9/22 1:35 PM - The Surveyor was provided the above guideline titled Braden Scale Guideline by E6 (LPN, WCN) who stated this was the guideline which were in place when R1 acquired a new left heel stage II (2) PU. E6 stated that this was the guideline to be utilized, but E6 emphasized that the final interventions were determined by the Interdisciplinary Team.</p> <p>3/9/22 2 PM - An interview with E7 (LPN, MDSAC) revealed that the MDSACs did not determine the interventions for PU prevention and it was her understanding that it was the responsibility of the Unit Manager.</p> <p>The facility failed to ensure interventions were implemented to prevent new PU development, resulting in R1 acquiring a stage II PU on the left heel on 2/2/21.</p> <p>3/10/22 2:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (Director of Clinical Services), and E5 (RN Risk Manager).</p>		