STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045140	A. BUILDING _____ B. WING _____	01/10/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEARCY HEALTH AND REHAB, LLC	1205 SKYLINE DRIVE SEARCY, AR 72143

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # was substantiated (all or in part) with these findings. Based on observation, record review and interview, the facility failed to ensure a system was in place to assure thorough skin assessments and prompt identification of new areas of skin breakdown for residents at risk for the development of pressure sores to prevent delays in treatment and failed to ensure pressure relieving devices were used to prevent further skin breakdown for 1 (Resident #1) of 3 (Residents #1, #2 and #4) case mix residents who were at risk for the development of pressure sores. This failed practice resulted in a pattern of actual harm for Resident #1 who experienced deterioration of his right heel resulting in infection and hospitalization and had the potential to cause more than minimal harm for 20 residents who were at risk for skin breakdown according to a list provided by the Administrator on 1/22/14. The findings are: 1. A Wound Prevention and Treatment Policy provided by the Administrator on 1/8/14 documented, .Procedure- 1. Assess all residents.Assessments may include, but are not limited to: -Skin Assessment upon admission daily times three days, weekly thereafter and prior to discharge (exception is a 911 discharge).6. Develop and implement individualized preventive and/or treatment interventions. 2. Resident #1 had [DIAGNOSES REDACTED]. a. A Braden Risk Assessment Report dated 8/13/13 documented, .Friction (and) Shear: Potential Problem- Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down. . b. The October 2013 Physician order [REDACTED]. Check daily for s/s (signs and symptoms) of infection.9/26/13- Cleanse (unstageable) PU (pressure ulcer) to (right) lat (lateral) ankle (with) (wound) cleanser, apply [MEDICATION NAME] and wrap (with) Kling daily.10/28/13-.Cleanse PU to (left) heel (with) (wound) cl (cleanser), apply [MEDICATION NAME], cover (with) 4x4's and wrap (with) Kling daily. There were no orders documented for a pressure ulcer to the right heel. c. As of 1/9/14, there was no documentation of a weekly skin assessment/body audit completed by the Nurse in the clinical record for the months of September and October 2013 for this resident. On 1/9/14 at 4:20 p.m., the Director of Nursing (DON) was asked, Are body audits done weekly? The DON stated, Yes. When asked who does those, he stated, CNA's (Certified Nurse Aides) do them in the shower and the nurses check them off. When asked what does check off mean, he stated, If they give the nurse a body audit sheet that says clear, they don't go check it. If it identifies something, then the nurse goes and checks it. When asked does a professional do a body audit weekly, he stated, No. d. A Nurse's Note dated 10/29/13 at 10:35 a.m. documented, Late Entry for 10/28/13 at (4:15 p.m.). Order received to transfer resident to (Geropsych Hospital). Order noted and processed. Wife .aware of need for transfer for medication adjustment related to recent escalation of behaviors and physical violence toward staff . Resident willing and voluntarily leaving facility. There was no documentation of a skin assessment prior to discharge. On 1/10/14 at 11:20 a.m., the DON was asked, was a body audit done on discharge (10/28/13), and he stated, No. e. A (Hospital) Shift Assessment documented, .admitted : 10/28/13 at (8:58 p.m.). 1) A (Hospital) Nursing Notes dated 10/29/13 at (12:15 a.m.) documented, .Assessed feet of (patient). Both feet ever swollen. (Left) heel has a large decubitis and some portion of it draining yellow. Some portion has eschar. (Right) heel has eschar on it (approximately) 2 inches. (Right) great toe swollen, reddened with some purulent draining on top. 2) A (Hospital) Report of Consultation dated 10/29/13 documented, .Chief Complaint: Foot Ulcerations. History of Present Illness/Examination:.ulceration to the right lateral ankle.He has bilateral heel ulcerations that are necrotic with eschar formation that are secondary to pressure. The right heel ulceration measures approximately 3.0 x 4.0 x 0.1 cm (centimeters).He has a left heel pressure ulceration that measures approximately 5.5 x 5.0 x 0.1 cm. 3) A (Hospital) Laboratory Results documented, .Coll: (Collected) 10/29/13- 1340 (1:40 p.m.).Right Heel.Wound Culture- Final.Organism 1-[MEDICAL CONDITION] ([MEDICAL CONDITION]-Resistant Staphylococcus Aureus).Growth- Abundant.(Right) Great Toe.Wound Culture- Final.Organism 1-[MEDICAL CONDITION]- Abundant.Left Heel.Wound Culture- Final.Organism 1-[MEDICAL CONDITION]- Abundant. f. A Skilled Documentation Note dated 12/18/13 documented, .Summary .Resident readmitted to facility today. Arrived via facility van accompanied by one staff member. Resident continues to have open areas to right lateral malleus and left lateral leg, as well as right great toe. Pressure ulcer noted to both right and left heels. Treatment on admit. Will not remove . g. A handwritten note dated 12/19/13 on the Care Plan signature page (unsigned) documented, Readm (readmitted) to facility 12/18 excoriated area on coccyx, healing US (unstagable) PU (Pressure Ulcer) to L (left) lat (lateral) heel, healing PU to R (right) lat ankle, Tx (Treatment per MD (Medical Doctor) orders. Also healed US PU to R heel (with) soft tissue present. h. A Body Audit dated 12/19/13 and signed by Certified Nurse Assistant documented, Right and Left heels calluses, Right lateral ankle sore. i. A Wound Assessment Report dated 12/23/13 and signed by Licensed Practical Nurse (LPN) #2 documented, Notes: Area was a healed US pu from recent hospital stay but on readmit area was very thin and fragile, now has superficial open wound with serous drainage, no odor, tx (treatment) initiated with [MEDICATION NAME] Extra Ag and [MEDICATION NAME] dsg (dressing) q (every) m,w, f & prn (Monday, Wednesday, and Friday and as needed) res (resident) encouraged to keep feet elevated on pillows when in bed, but res not always compliant, res also prefers to sit up in w/c (wheelchair) majority of day. j. The Quarterly Minimum Data Set with an assessment reference date of 12/25/13 documented the resident scored 7 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, had impairment to a lower extremity on one side, was at risk for developing pressure ulcers and had pressure ulcers. k. The Care Plan updated 12/26/13 documented, Problem Onset: 5/28/13- I am at risk for skin breakdown r/t (related to) lack of mobility.I currently have US (unstageable) PU (pressure ulcer) to right lateral ankle.Approaches.Body Audit weekly and PRN (as needed) by nurse. Document any new or worsening of skin condition and report promptly. The Care Plan did not address any other skin concerns prior to the October discharge. l. A Wound Assessment Report dated 12/23/13 and signed LPN #2 documented, Notes: Area same with current tx of [MEDICATION NAME] extra ag and kling dsg daily, less drainage noted, res non-amb (ambulatory) at this time, prefers to stay up in w/c most of day, allowing feet and legs to dangle, cont (continue) to have [MEDICAL CONDITION] to BLE (bilateral extremities), encouraged to elevate when in bed, res not always compliant, . m. On 1/8/14 at 11:16 a.m., the resident was up in a wheelchair, propelling himself in the hallway with socks on his feet bilaterally. There was no pressure relieving device in place on his feet. At 1:25 p.m., the resident was in a wheelchair with wound dressings and socks in place on both feet. Both feet resting on pedals of wheel chair. There was no pressure relieving device to the feet. n. On 1/9/14 at 8:53 a.m., 12:45 p.m., and 1:55 p.m., the resident was in a wheel chair and had on his feet non-skid socks over the wound dressings on both feet. There was no pressure relieving device in place on his feet. o. On 1/9/14 at 1:55 p.m., LPN #2 provided wound care. Observation of the residents wounds to heels and ankles were as follows: Left heel with eschar in center with granulation tissue covering the outer area of wound bed measuring approximately 2.5 centimeter (cm) x 2cm; Right heel with small area of eschar covering wound bed to upper area of heel measuring approximately 2 cm x 2 cm; and right great toe, open abrasion measuring approximately .5 cm, with red tissue, and

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

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) right ankle has open area tissue pink measuring approximately 1 cm x 1 cm. p. On 1/9/14 at 4:20 p.m., the DON was asked why an intervention was not implemented for this resident's feet and the DON stated, He's not going to leave a boot on. q. On 1/9/14 at 4:50 p.m., Licensed Practical Nurse (LPN) #1 applied bilateral Prevalon boots to the resident ' s lower extremities. r. On 1/10/14 at 8:45 a.m., the resident was up in a wheelchair propelling himself in the hallway with the blue Prevalon boots in place to both lower extremities. At 12:05 p.m., the resident was in a wheel chair. The blue Prevalon boots remained in place to the lower extremity of both feet.