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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **0000** | A. BUILDING ______ B. WING ______ | C **08/01/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **STONEVALLEY** | **315 MAIN STREET** **ANYWHERE, US 00000** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 686 SS=D | §483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 82 residents, with 3 residents selected for sample. Each sampled resident had current facility acquired or recently healed pressure ulcers. Based on observation, interview and record review, the facility failed to provide one of three residents with the necessary treatment and services (timely/thorough assessment of a facility acquired pressure ulcer after it developed) to promote healing and prevent new ulcers from developing for Resident<br><br>(R)1.<br><br>Findings included: | F 686 | | |

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

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



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| F 686 | Continued From page 1 | F 686 | | |

- Resident (R)1's clinical record included a 06/25/19 "Admission Minimum Data Set" (MDS) which identified the resident with moderate cognitive impairment (Brief Interview for Mental Status score of 12), the need for extensive assistance of one staff for bed mobility and transfers and an inability to walk. According to the assessment, the resident had one unhealed/unstageable pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) that was not present on admission on 6/18/19.

The 07/03/19 "Care Plan" noted the presence of a pressure ulcer on R1's heel and directed staff to float the resident's heels off the bed and use pillows to assist with positioning.

The 06/18/19 "Braden Skin Assessment" (a standardized tool used to assess a resident's risk of skin breakdown) identified the resident as "mild risk" for skin breakdown.

Review of the "Progress Note" dated 06/18/19 at 01:53 PM described R1's admission to the facility and refusal of a skin assessment.

Review of the "Progress Note" dated 06/18/19 at 09:58 PM described R1's continuing refusal of a skin assessment.

Review of "Wound Assessment Notes" dated 06/19/19 identified R1 with no skin conditions.

A "Weekly Skin Condition Report" dated 06/23/19 identified the resident with an open area to the left



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| F 686 | Continued From page 2 | F 686 | | |

heel. According to the report, initial treatment orders included "Skin prep [liquid film-forming dressing that forms a protective film to help reduce friction] to heel and elevate while in bed." Review of the clinical record revealed no evidence of a physician's order for skin prep to the newly developed pressure ulcer on the left heel. The clinical record also lacked evidence the facility notified the resident's physician of the facility acquired pressure ulcer.

A "Wound Measurement Sheet" dated 06/28/19 described a 4.7 centimeter (cm) by 7.6 cm "new wound" on the left heel, which was considered a "deep tissue injury" (purple of maroon areas of intact skin of blood-filled blisters caused by damage to the underlying soft tissues from prolonged pressure).

"Wound Assessment Notes" dated 07/01/19 included, "Late entry from 6/27/19 - charted in wrong chart. Wound rounds completed. Patient has unstageable DTI [deep tissue injury] to L [left heel]. Wound measures 4.7 cm by 7.6 cm. Wound edges has hard callus [sic] with eschar [dead tissue] in center of wound and is not open...Waiting on call back from doctor office at this time."

The clinical record lacked evidence of thorough, timely assessments of the newly developed pressure ulcer on R1's left heel by facility staff in the 4 day time period from 06/23/19 to 06/27/19.

During an observation on 7/31/19 at 03:45 PM, R1 sat outside on his motorized scooter. The resident was alert and oriented and able to communicate his needs. The resident wore a splint like device on the left lower leg. The



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| F 686 | Continued From page 3<br>resident refused to allow observation of the pressure ulcer on his left heel.<br><br>On 08/01/19 at 09:00 AM, R1 again refused to allow observation of the pressure ulcer on his left heel.<br><br>During an interview on 08/01/19 at 12:00 PM, Administrative Nurse D confirmed documentation on 06/19/19 identified R1 with no skin breakdown but Nurse D reported she questioned that assessment. Nurse D reported she serves as the "wound nurse" for the facility. According to Administrative Nurse D, a Licensed Nurse found the left heel pressure ulcer on 06/23/19 and called the on-call Physician and left a message. The nurse wrote the order for skin prep but never used it. Staff started offloading the resident's heels immediately. Nurse D reported the information about the new pressure ulcer did not get communicated to her immediately and therefore there was a delay in her assessment/measurement of the wound.<br><br>The 01/20/19 "Wound Care Protocol" lacked guidance related to expectations/timeliness of thorough nursing wound assessments following development of a facility acquired pressure ulcer.<br><br>The facility failed to provide R1 with the necessary treatment and services (timely/thorough assessment of a facility acquired pressure ulcer after it developed) to promote healing and prevent new ulcers from developing. | F 686 | | |



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