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 03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE VALLEY	123 MAIN STREET ANYWHERE, USD 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=H	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, manufacturer's review, and policy review, the provider failed to ensure four of five sampled residents (21, 41, 47, and 53) who required staff assistance with care had not developed facility acquired pressure injuries. Findings include: 1. Review of resident 41's medical record revealed: *She had been admitted on 8/1/17. *She had short and long term memory problems. *Her decision making ability was severely impaired. *Her diagnoses included dementia with behavioral disturbance, altered mental status, major depressive disorder, anxiety disorder, repeated falls, a history of a dislocation to her right humerus, muscle weakness, a history of fracture to her left humerus, and a history of a deep venous thrombosis to her left leg. *She was dependent on the staff to: -Anticipate her care needs. -Initiate and implement interventions to ensure her health and safety. *She developed facility acquired pressure injuries to both her heels on 2/19/18. -She also had skin concerns to both her great toes. Observation on 03/13/18 at 08:17 a.m. of resident		All current and future residents are potentially affected by the deficiency regarding Treatment/services for prevent/heal pressure ulcers. Resident 21 Care plan was reviewed and revised for current status and interventions in place for pressure ulcer prevention/care/documentation. Resident 41 Care plan was reviewed for current status and interventions in place for pressure ulcer prevention/care/documentation. Information updated on caregiver crib sheet for follow through. Resident 47 Care plan was reviewed for current status and interventions in place for pressure ulcer prevention/care/documentation. Resident 53 Care plan was reviewed and revised for current status and interventions in place for pressure ulcer prevention/ care/documentation. Facility is researching available resources for education of wound care prevention and treatment, algorithms for treatment options of skin concerns/ changes, DON/or designee will readdress orders for skin treatment options and present to the Medical Director for review and approval. Education to licensed nursing to be completed by **4/25** related to skin care, pressure ulcer prevention, interventions, follow up care plan items, orders for skin care, documentation on initial notification of injury, follow up documentation related to any skin concerns. DON educated nursing staff of assessment format changes to include extension of documentation of skin concerns. Review of Braden scores weekly with wound committee, any resident at risk interventions put into place to include but not limited to two hour repositioning (hourly if needed), nutritional supplementation, cushion to either bed or chair. Education to all staff regarding meaning of Braden scores, proper assessment, skin care, expectations of process with any skin concern, interventions to be initiated, interventions are available in-house to use for pressure ulcer interventions, Education of the process for proper usage of pressure reducing devices review of care plan for interventions, order noting, verification, **24** hour check process. Initiation of one skin assessment document to decrease risk of error. Education to be completed prior to **4125.** MOS Nurse/designee will audit 3-5 residents at least weekly for risk for skin breakdown/pressure ulcer, interventions to be initiated or already initiated and appropriate. Audit tools will be utilized and presented	

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F 686	Continued From page 1 41 revealed: *She was laying in bed on her right side with her face covered with blankets. *She had one foam heel boot sitting on top of the covers. -It was not on her foot. Interview and record review on 03/13/18 at 10:09 a.m. with licensed practical nurse (LPN) D regarding resident 41 revealed he: *Was her charge nurse that day. *Was a traveling nurse and had been working there since 2/1/18. *Stated she had pressure injuries and treatments of: -Daily left heel and right heel pressure injury monitoring by the nurse. -A blister area to her right great toe. -Optifoam dressing to her left heel suspected deep tissue injury to be changed every three days as needed. -Optifoam dressing to her right heel suspected deep tissue injury to be changed every three days and as needed. *Stated he was already done with her treatments for the day. *Stated her Optifoam dressing changes were due to be changed on 3/14/18. -The surveyor requested to observe that dressing changed and he agreed stating he would be working again. Observation and interview on 03/13/18 at 11:06 a.m. with certified nursing assistant (CNA) supervisor I during resident 41's personal care revealed: *The resident was out at activities in her wheelchair. *The CNA wheeled her into her room and	F 686	to the QAPI team monthly but no less than quarterly for at least six months for review and decision of changes or continuation. Education of the process for proper usage of pressure reducing devices. MDS Nurse or designee will complete 3-5 resident care plan audits related to skin care at least weekly and present findings to the IDT on a weekly basis. The audits will be presented to the QAPI team monthly for 6 months with the committee determining continuation of audits or recommendations for changes. MDS Nurse or designee will complete 3-5 audits of residents with skin changes at least weekly focusing but not limited to observation of resident care, positioning, interventions completed as ordered. These audits will be reviewed weekly and brought to the QAPI committee monthly and no less than quarterly for the next 6 months. The QAPI committee after review will determine if the desired outcome has been achieved or if further action in audits is necessary. DON/designee to audit 3-5 resident medical records at least weekly for appropriate and complete documentation, assessments completed as per policy, physician orders follow through. Audit results will be reviewed and discussed on a weekly basis at stand up and will be reported monthly but no less than quarterly to the QAPI committee by the individuals responsible for audits for the next 6 months. The QAPI committee after review will determine if the desired outcome has been achieved or if further action in audits is necessary.	

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F 686	Continued From page 2 assisted her to the bathroom. *The resident was wearing small slippers and compression stockings to both legs. *The surveyor questioned if the resident had any skin concerns and the CNA stated: -When the resident had come back from the hospital she was in bed and a lot more sleepy than she had been before. -She thought the resident had some pressure areas on her buttocks and a spot on the back of her head. -The resident also had a history of scratching her shins. -She did not mention any pressure areas to her heels. *The CNA offered to remove the resident's compression stockings and slippers to view the resident's legs and feet. *Her skin had: -Some scratch marks on her shins. -Dark brown/black scab-like areas to the backs of both her heels. -A darkened spot on the tip of her left great toe. -A callus-like area on the tip of her right great toe. *The surveyor questioned if the nurses had done treatments to those heel and toe areas. -CNA stated she was not sure but there was nothing on them when she had gotten her up that morning for breakfast or the day before when she had given her a bath. *The CNA questioned if the resident should be wearing her compression stockings when she had those areas on her feet. -The surveyor questioned her back and asked how she would find out that information. -The CNA stated she would refer to her CNA cheat sheet. *Review of that undated CNA cheat sheet revealed:	F 686		

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F 686	Continued From page 3 -No mention of skin concerns for her. -She should have been wearing a compression stocking to her left leg only. -There was no mention of heel boots or when to wear them. *The CNA stated she thought the resident only needed to wear the heel boots when she was in bed. During the above interview and observation at 03/13/18 11:13 a.m. LPN D arrived to the resident's room: *The surveyor: -Requested he come in to look at the resident's feet and legs. -Asked him about the Optifoam dressings he said had been in place that morning. *He stated he had done her treatments around 5:00 a.m. and he thought the dressings were there. -He stated she should have the foam dressings on her heels and the foam boots on at all times. *He then left the room saying he would be right back. Continued observation and interview on 03/13/18 at 11:17 a.m. in resident 41's room revealed: *Registered nurse (RN) E and LPN D arrived back to the room. *RN E stated she oversaw the pressure injuries in the building and did the weekly measurements on them. -She stated the resident's heel pressure injuries started as purple spongy areas about three weeks prior. -She thought they were looking better. *When the surveyor questioned what was in place for pressure injury prevention RN E stated they:	F 686		

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F 686	Continued From page 4 -Put an air mattress on her bed. -Started the foam boots at all times. -Initiated the Optifoam dressing changes. -Notified the dietary department. *She confirmed all those interventions had been implemented after the pressure injuries had developed. -Prior to that she had a regular pressure relieving mattress and repositioning every two hours like all residents. *She applied new Optifoam dressings to both heels. *When asked to stage or identify those areas currently she: -Said they were scab-like areas now. -Would not answer what stage they were currently. --She stated she would have to look them up but they started as deep tissue injuries. *RN E thought the resident should have been wearing heel boots at all times. -That was listed on the nurse treatment administration record (TAR) for them to check placement. *CNA I was still in the room and stated she thought the boots were just when the resident was in bed. *When asked about the resident's compression stockings she stated the resident probably should not have been wearing them but she was not sure. -CNA I confirmed the CNA cheat sheet said for the resident to wear the left leg stocking only. *All three staff confirmed there was a lack of communication and collaboration for the resident's intervention between what the nurses' expectations were and what the CNA expectations had been. *The CNA cheat sheet was again reviewed with	F 686		

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F 686	Continued From page 5 the nurses and CNA and they confirmed there was no mention of the resident's pressure injuries or foam boots.	F 686		