DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00382657, IN00385927, and IN00387551. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00382657 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00385927 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387551 - Substantiated. Federal and State deficiency is cited at F686. Survey dates: August 8, 9, 10, 11, 12, 13, 14, 15, and 16, 2022 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 8 Medicaid: 69 Other: 18 Total: 95 These deficiencies reflect State Findings cited in	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on August 8-16, 2022.** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	accordance with 410 IAC 16.2-3.1. Quality review completed on August 23, 2022.			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance			

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	directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on record review and interview, the facility failed to ensure a resident's code status was updated to reflect their choice to become a DNR (do not resuscitate) for 1 of 41 resident's whose advanced directives were reviewed. Findings include: The clinical record for Resident 18 was reviewed on 8/10/22 at 8:24 a.m. The diagnoses included, but were not limited to, chronic kidney disease, heart disease, diabetes mellitus type 2, and history of COVID-19. The care plan, dated 2/21/22, indicated the resident was on Hospice services. The physician's order, dated 10/8/21, indicated the resident was a full code, attempt cardiopulmonary resuscitation (CPR). The care conference note, dated 11/11/21 at 11:21 a.m., indicated the resident was a full code status and desired CPR. The nurse's note, dated 1/17/22 at 3:56 p.m., indicated the Nurse Practitioner gave an order to consult hospice services for evaluation and treatment. The resident's Physician Orders for Scope of	F 0578	- **F578- Request/Refuse/Discontinue Treatment; Formlte Adv. Dir.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 18 remains in the facility and was identified as being affected by the deficient practice. Resident 18's Advanced Directive was immediately verified with order and care plan updated to resident's preferred code status. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the deficient practice. A 100% audit of the current resident's code status has been completed. Any identified concerns were immediately	09/06/2022

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	Treatment (POST) form, dated 1/18/22, indicated the resident wished to have comfort measures only for medical interventions and wished to be a Do Not Resuscitate (DNR) The social services note, dated 2/9/22 at 12:19 p.m., indicated the resident was admitted to hospice services. The clinical record lacked documentation of the resident's code status being updated to reflect the resident's wishes to be a DNR. During an interview on 8/12/22 at 8:25 a.m., Resident 18 indicated she was on hospice services and she did not want CPR, "... I just want a natural death..." During an interview on 8/12/22 at 10:06 a.m., the Director of Nursing (DON) indicated code status should be updated as soon as the resident's code status changed. Resident 18 went into hospice services on January 18, 2022. Her code status should have been updated immediately. The facility had talked about the resident being hospice, but they had not done the audit. Her code status should have been checked. The General Code Status policy and procedure, last reviewed 6/24/21, provided on 8/12/22 at 11:00 a.m. by the Executive Director, included, but was not limited to, "... It is the intent of this facility to honor the wishes and rights of the resident/representative to make the determination of what, if any, resuscitative measures will be implemented in the event the resident's respirations and/or pulse cease either by natural or unnatural causes... The use of an electronic health record (EHR) provides for fast retrieval to identify and how to appropriately respond to		addressed **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Administrator/Director of Nursing/Designee completed education with the licensed nursing staff regarding “The General Code Status” policy related to ensuring the resident POST form and code status are current and verified and the order and care plan are updated to reflect the resident’s preference per the signed POST form. **Corrective actions to be monitored to ensure the Deficient practice will not recur:** The Director of Nursing/Social Service/Unit Manager/Designee will audit 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 1 residents weekly for 4 weeks to ensure the resident code status order and care plan match what is reflected in the signed Post form. This will continue for no less than 3 months or compliance is maintained. Any concerns observed during monitoring will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any	

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	respiratory and cardiac arrest based upon the resident/representative wishes... Procedures... General... c. Code Status is found in the electronic record and will be used by the nurse to validate Code Status before initiating CPR... New admissions and changes in code status will be placed on the 24 hour summary log for review and confirmation at the next daily clinical meeting... Document any changes made to the code status following... The nurse will enter the Code Status in EHR using the two-step validation process... Any changes to DNR status will be entered into the medical record using the 2 Step validation process..." 3.1-4(f)(5)		patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0686 SS=K Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §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.			
	Based on observation, record review, and interview, the facility failed to implement interventions to prevent the development and worsening of multiple facility acquired pressure	F 0686	**F686 Treatment/Services to Prevent/Heal Pressure Ulcer** **1. What corrective action(s)**	08/16/2022

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	ulcers resulting in three unstageable wounds, two Stage 3 pressure ulcers (PU) and a reopened Stage 2 PU. Two of the pressure ulcers worsened to a Stage 4; two of the pressure ulcers developed infections; and one Stage 4 PU worsened with osteomyelitis requiring IV antibiotics for 5 of 10 residents reviewed for Presure Ulcers. (Residents E, D, B, C, and F) The Immediate Jeopardy began on 1/13/22 when the facility failed to identify, prevent, and implement interventions to prevent and worsening of pressure ulcers. The Executive Director, Director of Nursing, and Clinical Director of Clinical Operations were notified of the Immediate Jeopardy on 8/12/22 at 3:30 p.m. The Immediate Jeopardy was removed on 8/16/22, but noncompliance remained at the lower scope and severity level of H. Findings include: 1. The clinical record for Resident E was reviewed on 8/9/22 at 11:08 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, COPD (chronic obstructive respiratory disease), heart failure, anoxic brain injury, severe protein calorie malnutrition, other specified dermatitis, altered mental status, chronic pain syndrome, contracture of unspecified joint, neuromuscular dysfunction of bladder, and tracheostomy status. The Annual MDS (Minimum Data Set) assessment, dated 6/3/22, indicated the resident was cognitively intact, did not exhibit any refusal of care behaviors, required extensive assistance of two staff with bed mobility and personal hygiene, was completely dependent with toileting, was always incontinent of stool, was at risk for developing pressure ulcers, had a stage 3		**will be accomplished for those residents found to have been affected by the deficient practice** During minimal observations made by the survey team, the facility was alleged to be deficient in the implementation of interventions to prevent the development and worsening of multiple facility acquired pressure ulcers resulting in three unstageable wounds, two Stage 3 pressure ulcers (PU) and a reopened Stage 2 PU. Two of the pressure ulcers developed infections, two of the pressure ulcers worsened to a Stage 4. One Stage 4 PU worsened with osteomyelitis requiring IV antibiotics. Documentation provided by the survey team alleges the following residents being identified as part of the deficient practice mentioned within the IJ template: Residents B, C, D, E, F were identified to be affected by the deficient practice related to a complaint survey, therefore, the facility is unable to provide the immediate actions taken for these residents. Resident B developed an unstageable pressure ulcer to the right heel that worsened to a Stage 4 and developed ostemomyelitis identified on 7/5/22. Resident C developed an identified Stage 3 pressure ulcer to the left buttocks on 3/25/22 and	

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	pressure ulcer which was present on admission, a stage 4 pressure ulcer which was not present on admission, had a pressure reducing device for her bed, but did not have a turning or repositioning program, and received pressure ulcer care. The resident had impairments in functional range of motion to the bilateral upper and lower extremities. The care plan, dated 6/7/21, indicated the resident was at risk for altered skin integrity due to disease process, immobility, incontinence, tracheostomy, and g-tube (feeding tube) status. The interventions included, but were not limited to, administer treatments as ordered, apply appropriate pressure reducing appliances to bed and wheelchair, apply barrier creams post incontinent episodes, apply protective garments as ordered, avoid pressure from drainage tubes, orthotics, braces, and footwear, complete skin at risk assessment upon admission, readmission, quarterly and as needed, complete weekly skin checks, ensure residents are turned and repositioned, evaluate existing wound daily for changes, notify resident or representative and medical provider of any decline in wound healing, nutritional consult on admission, quarterly, and as needed, podiatry consult as ordered, provide appropriate off-loading cushion to chair, provide appropriate off-loading mattress, provide diet as ordered, and PT/OT to evaluate and treat as needed for positioning and wound care. The wound analysis, dated 5/18/21, indicated the resident had an area of MASD (Moisture-Associated Skin Damage) to the sacrum, acquired in house. No measurements were documented. The wound had scant sanguineous drainage, was debrided, and a treatment of daily wound cleanser, zinc paste, and bordered foam was put into place. The wound had been active		a new reopened Stage 2 to the heel on 8/2/22. Resident D with mulitiple pressure ulcers developed newly identified unstageable pressure ulcers to the right elbow on 7/22/22 and Stage 2 to the posterior leg on 8/5/22. Resident E had a facility acquired Stage 3 pressure ulcer to the left ischium on 1/13/22 worsen to a Stage 4 on 4/5/22. Resident F had an identified unstageable pressure ulcer to the left heel and observations of the lack of interventions related to off loading and protective boots. The facility was surveyed on January 7, 2022 where the facility received the citation of F684 Quality of Care where the facility was identified to have a deficient practice in completion of wound care. As part of the auditing for the plan of correction a 30 day look back from 1/1/22 to 2/4/22 had been completed for opportunities of improvement related to documentation and completion of wound treatments and interventions. Identified concerns were immediately addressed. The audits for the plan of correction continued until 5/5/22 with any identified concerns immediately addressed as appropriate. These audits were reviewed in the 2/22/22 and 3/28/22 QA meetings. The facility self -identified deficient	

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	since 4/27/21, and the clinical record indicated the wound later developed into two stage 3 pressure ulcers to the left ishium and coccyx on 1/13/22. The wound analysis, dated 1/13/22, indicated the resident had a stage 3 pressure ulcer to the coccyx, measuring 3.37 cm in length by 4.07 cm in width by 0.10 cm in depth which was worsening. It had 90% granulation and 10% epithelialization, the peri wound was fragile, there was scant serous drainage. Treatment included to cleanse with wound cleanser three times weekly and dress with medi-honey and bordered foam and ensure compliance with turning and repositioning. The wound analysis, dated 1/13/22, indicated the resident had a new unstageable pressure ulcer to the left ischium, measuring 2.63 cm on length, 2.28 cm in width by 0.1 cm in depth. The wound had 2.71 cm of red tissue, 0.32 cm of pink tissue, and 0.45 cm of black tissue. There was scant serosanguinous drainage. The wound was 100% slough or eschar (dead tissue). The treatment indicated to cleanse with normal saline, apply medihoney, and a bordered foam dressing three times weekly. The clinical record indicated this wound healed on 2/8/22. The wound note, dated 1/13/22 at 9:14 p.m., indicated the resident was seen for a comprehensive skin and wound evaluation for a left ischium ulcer and coccyx pressure ulcer. The resident had a stage 3 pressure ulcer to the left ischium which was new, and a stage 3 pressure ulcer to the coccyx, which was previously MASD. Recommendations included pressure reduction and discussion with staff at the time of the visit of recommendations to include heel protection and pressure reduction to bony prominences, recommendations to provide frequent incontinent		practice within the wound program and developed a QAPI plan to include monitoring of interventions put in place for the prevention of development or worsening of pressure ulcers. This was developed and put into place on 4/12/22 and ran through the QA meeting on 4/26/22 was recommended by the QA committee to extend the audits through 7/25/22 at which time the wound nurse continued through the current date and will provide auditing results and opportunities to the QA committee at the August QA meeting for further review and adjustment to the monitoring needs. Areas of concern were noted and ongoing monitoring in place throughout the following months of May, June, July and August. Any identified concerns throughout the auditing process were immediately addressed as appropriate. The CommuniCare company as the Midwest Division has identified wounds as a focus and has developed a wound initiative; to include the audit of the wound program with focus on pressure ulcers and appropriate interventions, preventions of development and/or worsening of pressure ulcers. The RDCO for Sellersburg completed wound education with the facility Director of Nursing Services for Sellersburg on 8/3/22 during a zoom meeting	

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	care. Due to the patient's comorbidities and risk factors for wound decompensation the patient required turning and repositioning every 1 hour and may consider avoiding sitting or lying directly flat at all times when possible. The care plan lacked documentation of any updates with interventions to turn and reposition the resident every hour. The wound analysis, dated 1/18/22, indicated the resident had a wound to the right ischium, which was first observed on 1/13/22. The wound was classified as an unstageable pressure ulcer. The wound measured 1.40 cm in length, 1.28 cm in width, and 0 cm in depth. The wound was 100% covered with slough or eschar. Treatment indicated to cleanse with normal saline and apply medihoney and a bordered foam dressing every 3 days. The wound analysis, dated 1/18/22, indicated the coccyx wound measured 7.43 cm in length, with a width of 9.69 cm and a depth of 0 cm. The wound was worsening, and had 70% granulation, 30% slough, moderate serosanguinous drainage with no odor, and the treatment was unchanged. Pressure reduction included mattress overlay, specialty bed, ensure compliance with turning protocol, and wedge/foam cushion for offloading. The wound note, dated 1/18/22 at 4:01 p.m., indicated the resident was seen for a comprehensive wound evaluation for left and right ischium ulcers and a pressure ulcer to her coccyx and her right back. The wounds were described as a stage 3 pressure ulcer to her left ischium and a stage 3 pressure ulcer to her coccyx with major overall worsening, which was previously MASD. She had a new area to the right		with the facilities she provides consultation and to which included appropriate interventions and the prevention of the development and/or worsening of pressure ulcers. Auditing of the pressure ulcers was initiated 7/27/22 and will be completed for current pressure ulcers on a weekly basis with follow up to be completed by the facility clinical team until compliance is met. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by the alleged deficient practice. The DON/UM/Wound Nurse/Designee will complete an audit of all residents braden scores and/or physician orders based on resident needs to ensure interventions are in place as appropriate and care planned. Any residents identified as refusing appropriate interventions will be care planned for those refusals. Identified concerns will be immediately addressed. The DON/UM/Wound Nurse/Designee will completed a skin assessment for all residents with the potential for skin breakdown (after notification of the IJ), to include all residents with a decrease in mobility related to the	

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	upper back which was classified as a deep tissue injury. The resident had experienced an oral intake decline and often refused meals. The resident was severely contracted in almost every joint. Staff indicated the resident refused to turn many times to relieve pressure. The physician discussed pressure reduction and turning precautions with staff at the time of the visit, including heel protection and pressure reduction to bony prominences. The resident had extensive wound decline, culture and lab results were pending with a potential for diagnosis of opportunistic infection. The resident may need IV medications based on labs or cultures. The resident required turning and repositioning every hour and may consider avoiding sitting or lying directly flat at all times when possible. The wound analysis, dated 1/18/22, indicated the resident had a new suspected DTI to the right back, measuring 12.56 cm in length, 6.08 cm in width, and 0 cm in depth. Treatment included skin prep twice daily. The clinical record indicated this wound was healed on 3/15/22. The lab report, dated 1/19/22, indicated the resident had a basic metabolic panel (BMP) and a complete blood count (CBC). The resident's white blood cell count was high at 13.0 k/cmm with a normal value range of 4.5 to 10.8K/cmm. The resident's absolute neuts were high at 9.90 K/uL with a normal value range of 1.50 to 7.60 K/uL. The resident's monocytes were high at 1.20 K/uL with a normal value range of 0.15 to 1/10 K/uL. The resident's EOS were high at 0.10 K/uL with a normal value range of 0.20 to 0.80 K/uL. The nurse's note, dated 1/19/22 at 2:47 p.m., indicated the NP reviewed the resident's lab results and ordered doxycycline monohydrate 100		need for interventions to prevent skin breakdown. The assessment will include validation that all interventions in place and being followed. Identified concerns will be immediately addressed. The facility has reviewed the last 6 months of QA meetings and the wound QAPI plan to identify the area(s) with opportunities for improvement through the process of completing a Root Cause Analysis (RCA). As a result of the RCA, the Regional Director of Clinical operations provided education to the direct care staff and Interdisciplinary team (IDT), increased wound nurse coverage for wound treatment, and monitoring tools initiated based on the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Regional Director of Clinical Operation (RDCO) will provide education related to the “Skin Care and Wound Management Overview” and “Pressure Ulcer Prevention (high, Moderate, low risk)” policies as it relates to ensuring weekly skin assessments are completed, appropriate interventions are in place to prevent the development and worsening of pressure ulcer	

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	mg every morning and at bedtime for a wound infection for 10 days. The wound note, dated 1/26/22 at 8:23 p.m., indicated the resident had multiple scattered pressure ulcers with observed deep tissue injuries. She had increased moisture at the wound site. Staff were encouraged to keep the site always covered and avoid contamination with feces. She required turning and repositioning every hour. The wound analysis, dated 2/22/22, indicated the wound measured 9.13 cm in L x 8.69 cm in width x 0.02 cm in D (depth), improving, 60% granulation, 40% slough. Treatment unchanged. The wound was debrided. The wound note, dated 2/22/22 at 6:29 p.m., indicated the surgical debridement was performed to the resident's ulcer. Devitalized epidermis, dermis and subcutaneous tissue (tissue that impedes healing and acts as an origin for wound infection) including but not limited to biofilm were removed to keep the wound in an active state of healing. Nursing staff were given detailed ulcer care instructions and asked to monitor for any signs of prolonged bleeding or debridement intolerance. The wound note, dated 3/15/22 at 2:30 p.m., indicated the resident's wounds were now joining together. The re-admission skin grid pressure assessment, dated 4/1/22, indicated the resident had a stage 3 pressure ulcer to the sacrum measuring 6.5 cm in L x 6 cm in W x 0 cm in D. The treatment order, dated 4/1/22, indicated to apply calazime-zinc oxide lotion to sacrum twice		and identifying pressure ulcers and risks based on the Braden assessment completed at the time of admission, quarterly or with a new identified area. The Regional Director of Clinical Operations (RDCO) will provide education related to the “Wound Care” policy will all licensed nursing staff to ensure the appropriate steps are followed while providing wound care and infection control practices are followed for those residents identified as having a skin alteration. The Regional Director of Clinical Operations will provide education to the licensed nurses of the facility related to the “Stage 1, Stage II, Stage III, Stage IV and sDTI” as it relates to staging and treatment of these identified areas for residents with newly identified areas of concern. The Healing Partners Nurse Practitioner will be the final determination of the actual wound staging for identified skin alterations. The Regional Director of Clinical Operations has provided education to direct care staff on the facilities “Kardex” process which identifies what interventions are ordered and required for prevention in wound development and worsening. The Wound nurse/designee oversight will be increased to 5 days per week to include observations of wound treatments	

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	daily for skin irritation. The wound analysis, dated 4/5/22, indicated the sacrum wound measured 6.48 cm in L, 7.33 cm in W, 0.02 cm in D. The wound was worsening and was now classified as a stage 4 with exposed bone. There was 60% granulation and 40% slough. The treatment for medihoney and a bordered foam was resumed on 4/5/22. The wound analysis, dated 4/5/22, indicated the resident had an unstageable pressure ulcer to the left upper sacrum which was previously grouped with the sacrum and had separated and made as it's own wound. The wound measured 2.62 cm in length, 1.57 cm in width, and 0 cm in depth. The wound was covered with 100% slough or eschar. The wound note, dated 4/5/22 at 9:40 p.m., indicated the resident had a comprehensive skin and wound evaluation for readmission to the facility. She had a stage 4 pressure ulcer to the sacrum which was previously a stage 3 and a stage 3 to the upper sacrum which was previously clustered with the sacrum. She had a right hip unstageable pressure ulcer. The physician recommended to keep the wound dry, to turn and reposition every 1 hour, and a nutrition consult. The nurse's note, dated 5/4/22 at 8:50 p.m., indicated the resident returned to the facility and was refusing all skin assessments, however had a wound to her sacrum. The wound analysis, dated 5/6/22, indicated the wound measured 4.27 cm in L x 5.58 cm in W x 0.01 cm in depth, improving, 90% granulation 10% slough, treatment unchanged. During an observation on 8/10/22 at 10:11 a.m.,		and interventions. Any identified concerns will be addressed immediately. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON/UM/Wound Nurse/Designee will audit and observe 5 residents daily for 5 days on varying days and shifts x 4 weeks, then 5 residents daily for 3 days on varying days and shifts x 4 weeks, then 3 residents one day a week x 4weeks on varying days and shifts to observe wound care completed with infection control practices followed, weekly skin assessments are completed with no new identified concerns and are accurate, ensure interventions are in place as appropriate based on the residents braden assessment and physician orders that are based on resident needs, and care planned interventions are reflected on the Kardex for all staff for the prevention of development and/or worsening of pressure ulcers and are observed to be in place and effective . Any identified concerns will be immediately addressed. The Regional Director of Clinical Operations will audit through record review and observation 5	

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	Resident E was resting abed. Her lower extremities were completely contracted and were positioned on a pillow, with her right foot and heel directly touching the pillow and were not offloaded. Her left heel was floating off the edge of the pillow. The resident did not have any pressure relief boots in place. The Respiratory Therapy Director removed the blanket and observed the resident, however, did not reposition the resident or place any pressure relief boots on her. During an observation on 8/10/22 at 11:47 a.m., LPN 7 and the Wound Nurse entered the resident's room to perform wound care. The blankets were removed and both of the resident's heels were observed to be lying directly on a pillow and were not properly offloaded. There were no pressure relief boots in place. A large portion of the resident's bottom was covered in scar tissue. The wound nurse indicated she believed the resident had a stage 3 pressure ulcer and the facility had a lot of pressure ulcers. Two open areas were observed to the coccyx which appeared to be fully granulating with less than 5% yellow tissue. The wound was cleansed, collagen with silver was applied to the wound bed with a foam border secondary dressing applied. The resident was repositioned with her heels again lying directly on the pillow and not floated. Staff indicated the care was completed and left the room. On 8/11/22, Resident E was observed to be lying turned to her right side in her bed. The resident's heels were resting directly on a pillow, with both heels touching and resting on the surface of the pillow. At 8:33 a.m., a nurse entered the room but did not reposition the resident. At 8:50 a.m., the Wounds Care nurse entered the room but did not reposition the resident. Staff did not reposition		residents weekly to ensure the known concerns were followed through with interventions and monitoring for 3 months. The facility Quality Assurance Committee will review the wound program related to acquired wounds or wounds with a decline during the monthly QA meeting to determine the effectiveness of the QAPI plan. If the facility identifies newly in house acquired wounds, or current wounds with a decline, the QA Committee will complete a Root Cause Analysis to determine the deficient process, amend the current QAPI plan, and initiate appropriate monitoring based on the RCA findings. This will continue for no less than 3 months and compliance is maintained The DON/Designee will report findings from the audits to the QA committee monthly. The QA committee will determine when compliance is achieved or if ongoing monitoring is required.	

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	the resident until 10:42 a.m., when CNA 5 and CNA 6 entered the room and turned her to the left side. They replaced the pillow under the resident's feet, resting her heels directly on the pillow without allowing them to float. The resident did not appear to be resistive to turning or repositioning and did not refuse to allow staff to turn her. During an interview on 8/11/22 at 10:33 a.m., CNA 5 and CNA 6 indicated they had not turned the resident since before breakfast, which would have been prior to 8:00 that morning. During an interview on 8/11/22 at 10:42 a.m., CNA 5 and CNA 6 indicated they tried to turn the residents every 2 hours but, " ... we may be a little off ..." They were not aware of the resident requiring any more frequent turning schedules. They were unaware of the resident every wearing heel protector boots, and they had never seen any in her room. During an interview, on 8/12/22 at 8:42 a.m., the Wound NP indicated when she took over care for the resident, she had a lot of sacral and hip wounds. She at one point had an upper back wound, and now was dealing with a stage 4 wound to her sacrum. She was very contracted and underweight. If she were to put pressure on the pillows, there would be a concern for developing a pressure wound. If the resident had boots, she had not seen them on her. She recommended they off load and float the resident's heels, and she would have recommended heel protectors in the past. 2. The clinical record for Resident D was reviewed on 8/9/22 at 1:13 p.m. The diagnoses included but were not limited to, chronic respiratory failure,			

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	type 2 diabetes mellitus, anemia, neuromuscular dysfunction of bladder, peripheral vascular disease, overactive bladder, kidney failure, and chronic pain. The admission skin assessment, dated 5/4/22, indicated the resident had a stage 4 pressure ulcer to the coccyx which measured 10 cm in length, by 7 cm in width, by 0.5 cm in depth. The resident's sensory perception was completely limited, his skin was constantly moist, he was bedfast, he was completely immobile, his nutrition was very poor, and he had an identified problem with friction and shear. His Braden scale scoring was 6, which was classified as a very high risk for developing pressure ulcers. The care plan, dated 5/5/22, Indicated the resident had impaired skin integrity, including pressure ulcers to his coccyx, a stage 3 to his sacrum, a stage 2 pressure ulcer to his left heel, related to immobility. An intervention to elevate the resident's legs as he would allow was initiated on 8/3/22. The care plan indicated to ensure the resident was turned and repositioned but did not specify a schedule or instructions to turn every hour. The wound analysis, dated 5/6/22, indicated the resident had an unstageable pressure ulcer to the sacrum, which was present on admission, which measured 8.39 cm in L x 4.99 cm in W x 0 cm in depth. The treatment indicated to cleanse with normal saline, and dress with medi-honey and bordered foam every 3 days and as needed for soilage. The wound note, dated 5/11/22 at 4:05 p.m., indicated the resident had multiple wounds including an unstageable pressure ulcer to the			

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sacrum, an unstageable pressure ulcer to the left heel and a deep tissue injury to the right heel. Recommendations included, but were not limited to, heel protection and pressure reduction to bony prominences, turning every 1 hours due to the patient's comorbidities and risk factors for wound decompensation and new wound development, avoid sitting or lying flat at all times when possible. A nutrition consult was recommended to optimize wound healing.

The Wound Analysis, dated 6/3/22, indicated the resident's wound was worsening. The measurements were 7.63 cm in L x 9.1 cm in W x 0 cm in D. The resident's treatment was unchanged.

The Admission MDS assessment, dated 6/8/22, indicated the resident was severely cognitively impaired, was totally dependent on staff for bed mobility, toileting, and personal hygiene, did not exhibit any behaviors of rejection of care, was at risk for developing pressure ulcers. The resident had a pressure reducing device for the chair and bed and pressure ulcer care but did not indicate a turning and repositioning program.

The wound analysis, dated 6/14/22, indicated the wound was reclassified as a stage 3 pressure ulcer.

The wound analysis, dated 7/12/22, indicated the wound measured 6.88 cm in L x 8.51 cm in W x 2.5 cm in D, stable. The measurements were post debridement, treatment unchanged.

The wound analysis, dated 7/22/22, indicated the resident developed a new unstageable pressure ulcer to the right elbow, measuring 1.38 cm in length by 1.02 cm in W by 0 cm in D. It was a suspected DTI. Treatment indicated to apply skin

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prep and leave open to air three times daily. Preventative measures included offloading the elbow on a pillow.

The wound analysis, dated 8/5/22, indicated the resident developed a new stage 2 pressure ulcer to the right posterior leg measuring 6.45 cm in L x 4.2 cm in W x 0 cm in depth which was described as having intact epithelium which was serous filled (a blister). Treatment indicated to apply skin prep and leave open to air twice daily.

During an observation on 8/10/22 at 11:13 a.m., the wound nurse and LPN 7 provided wound care for Resident D. The wound to the resident's coccyx appeared to be a large open wound with approximately 30% of the wound bed covered with yellow stringy tissue. The wound to the resident's right elbow was scabbed over and indicated as healed by the wound nurse. The wound to the resident's left heel was a superficial pink, healing wound with scant serosanguineous drainage. The wound to the right posterior leg was observed to be healing, with no drainage, there was a dry area of reddish discoloration. A new wound to the resident's right ankle bone was observed at this time which the Wound Nurse estimated was approximately 2 cm in length by 1 cm in width, with 25% of the wound presenting as a red open area, and 75% of the wound with a moist, darkened black-purple area. There was a scant amount of serosanguinous drainage as described by the Wound Nurse to the edge of the wound. The wound nurse indicated the resident often got blisters on his lower extremities.

The Skin Grid Pressure note, dated 8/10/22 at 1:00 p.m., indicated the resident had a new area to the right outer ankle, which was classified as a stage one. The measurements of the wound were 2 cm in

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length by 1 cm in width, by 0.2 cm in depth.

The IDT follow up note, dated 8/10/22 at 1:23 p.m., indicated the resident had developed a new stage 1 pressure ulcer to his right outer ankle, the root cause was pressure to the right outer ankle. The intervention put into place was heel lift boots, dietary consult on 8/10/22, and prostat twice daily.

Observations of Resident D were conducted on 8/11/22. At 8:20 a.m., the resident was observed to be lying on his right side, with a purple wedge pillow under his right elbow, heel protector boots in place, and a pillow under his left side. At 8:56 a.m., the nurse entered the room and provided medications to the resident. She exited the room at 9:05 a.m., but did not reposition the resident during the time she was in the room. At 9:05 a.m., the Wound Nurse entered the room and administered the resident's tube feeding and replaced his water flush bag but did not turn or reposition the resident. She exited the room at 9:20 a.m. Staff did not enter the resident's room again until 10:20 a.m., when CNA 5 and CNA 6 entered the room to provide care and reposition the resident. They both indicated the last time they repositioned the resident was before 8:00 that same morning. The area to the resident's right ankle was observed to be about nickel sized, with a dark, black hardened tissue covering the wound bed. The surrounding skin was reddened. The wound appeared larger than the day before. The CNA's removed the pillows from the resident's left side, and moved it to his right side, and removed the wedge from the resident's right side and moved it to his left side. The resident was not turned and remained positioned on his right side. The CNAs did not attempt to reposition the resident onto his back or his right side. The resident did not make any independent movement

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or attempts to reject or resist care.

During an interview on 8/11/22 at 9:20 a.m., CNA 5 and CNA 6 both indicated they tried to turn the resident every 2 hours, from his right side to his back, or his left side, however the resident preferred his right side and usually ended up going back there so they moved the pillows and wedges to the opposite side of whatever side they were on. They were not aware of the resident needing to be turned any more frequently than every 2 hours.

During an interview on 8/11/22 at 11:24 a.m., the DON indicated usually a stage 1 pressure ulcer was not open. It was a non-blanchable reddened or discolored area. If it were open, it would be a stage 2, 3, or 4. If the wound was moist and dark, it sounded like it would be a DTI. She was informed of the resident developing a new pressure wound on 8/10/22 by the Wound Nurse, who informed her it a stage 1 pressure ulcer and it wasn't opened. She had described it to her as discolored and it was a stage 1. With the resident's comorbidities, things could happen very quickly for him. His skin assessment was due either 8/10/22 or 8/11/22. It had been several days since he'd had a true skin assessment. The Wound Nurse told her it looked like a scab, but she wasn't sure if it was scab. She told the wound nurse if it was opened it was a stage 2, 3, or 4. The Wound NP may change the staging.

During an interview on 8/12/22 at 8:40 a.m., the Wound NP indicated she saw the resident on 8/12/22 for a new wound to his ankle. She was not able to stage it and classified it as an unstageable pressure ulcer. The perimeter of the wound had opened. The facility told her they thought it was a DTI, but because the skin had broken open and

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she could not see the wound bed it was unstageable. The resident had admitted with a wound to his sacrum. He had developed a lot of DTIs since admission to the facility. He was very overweight, and very hard to move in bed. It was hard to get him in a decent position. He liked to cross his legs and ankles so she could see how he got the ankle wound. Staff should be turning him every 2 hours, but if they could do more that would be great. Their system automatically recommended turning every 1 hour, but that was not very feasible. She recommended they turn at least every 2 hours. It was hard for her to say the wounds to either Resident D or Resident E were unavoidable. They were both at a very high risk for developing new wounds. She would have to see both residents daily to know if they were unavoidable.

The Wound Analysis, dated 8/12/22, indicated the resident was seen by the Wound NP. He had a new unstageable pressure ulcer to the right lateral ankle. The wound measured 1.68 cm in length, by 1.58 cm in width, by 0.01 cm in depth. There was 1.14 squared cm of black tissue to the wound bed and scant serous drainage. The recommended treatment was to cleanse with normal saline, apply medihoney, and a bordered foam daily. The pressure reduction interventions included to float the resident's heels and apply soft offloading boots.

3.The clinical record for Resident B was reviewed on 8/10/22 at 1:32 p.m. The diagnoses included, but were not limited to, cerebral infarction, history of traumatic brain injury, paraplegia, polyneuropathy, neuromuscular dysfunction of the bladder, blindness in one eye and low vision in the other eye, localized edema, repeated falls, osteoarthritis, muscle weakness, and dysphagia.

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The Quarterly MDS assessment, dated 10/23/21, indicated the resident had impairments to the bilateral lower extremities.

The annual MDS assessment, dated 7/29/22, indicated the resident was cognitively intact, did not exhibit any refusal of care behaviors, required extensive assistance of two staff with bed mobility and personal hygiene, was completely dependent with toileting, was always incontinent of stool, was at risk for developing pressure ulcers, had a stage 4 pressure ulcer which was not present on admission, had a pressure reducing boot for his right heel, but did not have a turning or repositioning program, and received pressure ulcer care. The resident had impairments to the bilateral lower extremities.

The care plan, dated 11/24/21 and revised on 6/22/22, indicated the resident had the potential and actual impairment to skin integrity related to impaired mobility with paraplegia. The right heel pressure ulcer was unstageable on 11/23/21 and resolved on 5/18/22. On 6/22/22 the pressure wound reopened at a stage 4. The bottom of the right foot deep tissue injury on 12/14/21 and resolved on 1/4/22. The interventions included, but were not limited to, educate the resident, family and caregivers of causative factors and measures to prevent skin injury, elevate legs and float heels as resident will allow, encourage good nutrition and hydration in order to promote healthier skin, encourage resident to turn and reposition every 1 to 2 hours as resident will allow, followed by wound consult, and identify and document potential causative factors and eliminate or resolve where possible, keep the skin clean and dry. Staff were to monitor and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms

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	of infection, maceration etc. to the physician, use pressure relieving and reducing cushion to protect the skin while the resident was up in the chair. Treatments as ordered. The wound analysis, dated 11/23/21, indicated the resident had a suspected deep tissue injury the right heel. The measurements included length 4.45 cm (centimeters), width 4.35 cm, and depth 0. The pressure wound was acquired in house. The periwound was macerated (when the skin was in contact with moisture for too long). Treatment included betadine dressing with a secondary kling or kerlix dressing. The dressing was to be changed 2 times a day and elevate the resident legs to level of his heart or above for 30 minutes one time a day. Pressure reduction and offloading, elevate legs regularly using a wedge or foam for offloading. The wound analysis, dated 1/25/22, indicated the resident's right heel was a stage 4 with exposed tendons. The measurements included length 4.58 cm, width 4.62 cm, and depth 1.00 cm. The wound had a heavy amount of serosanguinous drainage and had a malodorous odor. The peri wound was erythema. Treatments included cleanse the wound with normal saline, Dakin's moist to dry dressing, and cover with a border dressing. The wound analysis, dated 3/01/22, indicated the right heel wound was a stage 4. The measurements included length 3.84 cm, width 4.07 cm, and depth 0. The wound had 60 % (percent) granulation tissue and 40% slough or eschar. There was a moderate amount of serosanguinous drainage with no odor. The peri wound had erythema. The treatments included cleanse the wound with normal saline and apply a collagen dressing 1 time per day and cover with a boarder			

dressing.

The wound analysis, dated 2/8/22, indicated the resident's right heel was a stage 4 and the wound bed had exposed tendons. Measurements included length 4.84 cm, width 5.88 cm, and depth 0.30 cm. The wound has 90% granulation tissue and 10% slough or eschar. There was a moderate amount of serosanguinous drainage with no odor. The
Peri wound had erythema. Treatments included cleanse the wound with normal saline, apply a Santyl dressing and cover with a bordered dressing 1 time a day.

The wound analysis, dated 3/8/22, indicated the resident's right heel wound measurements included length 3.98 cm, width 4.26 cm, and depth 0.01 cm. The wound had 80% granulation tissue and 20% slough or eschar. Moderate amount of serous drainage with no odor. The peri wound had erythema. Treatments included a collagen dressing and covered with a secondary bordered gauze 1 time per day.

The wound analysis, dated 5/24/22, indicated the residents right heel had heeled.

The wound analysis, dated 6/24/22, indicated the right heel pressure wound reopened at a stage 4. Measurements included length 3.25 cm, width 4.35 cm, and depth 0.30 cm. The wound had 20% granulation tissue and 80% slough or eschar. Moderate amount of serosanguinous drainage with no odor. The peri wound was intact. Treatments included cleanse the wound with normal saline and apply a hydrogel dressing covered with a bordered gauze dressing.

The NP progress note, dated 7/5/22, indicated she

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recommend continuation of elevation of legs while in bed as well as floating bilateral heels. Wound culture was ordered by medical nurse practitioner and still awaiting results. The X-ray obtained showed osteomyelitis, but medical provider was awaiting culture for specified antibiotic orders. The labs were reviewed, and the white blood cell count is within normal limits. Additional Recommendations included, the resident had a pressure injury, pressure reduction and turning precautions discussed with staff at time of visit, including heel protection and pressure reduction to bony prominences. The resident was at a moderate to severe risk of significant complications, morbidity and/or mortality due to comorbidities and wound. The culture and lab results are pending with a potential for diagnosis of opportunistic infection. The patient may potentially need IV medications based on pending labs or cultures.

The NP progress note, dated 7/13/22, indicated a follow up to the resident's right heel pressure wound osteomyelitis. The right heel x-ray showed possible osteomyelitis on 7/1/22 and the wound culture results. The resident was started on IV (Intravenous) antibiotics for 10 days and a prevalon boot to the right foot. The resident's right heel wound had reopened with drainage and swelling. The resident was paraplegic and could not feel his bilateral lower extremities.

During an observation on 8/11/22 at 1:00 p.m., the wound care nurse donned gloves and removed the resident's prevalon boot and old dressing. She cleaned the wound with NS (Normal Saline). She removed her gloves and donned a clean pair of gloves and applied the collagen with silver nitrate dressing. A boarded foam dressing was applied over the collagen dressing. The wound had a

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	scabbed area approximately three and a half inch long. The wound had a sma ll dark area in the middle of the scab. No drainage or foul odor.During an interview on 8/10/22 at 1:32 p.m., Resident B indicated he was paralyzed from the chest down. The only time staff would turn him was when he got a bath. He tried to turn himself by holding onto the handrail and pushing back but was unable to turn himself. During an interview on 8/11/22 at 1:15 p.m., the wound care nurse indicated at one point the resident had osteomyelitis from his wound. He was on antibiotic and healing well. The interventions indicated staff were to turn and reposition the resident every 2 hours and apply a boot to the right heel. During an interview on 8/12/22 at 9:00 a.m., NP 5 indicated the resident did have a stage 4 pressure to his right heel. He did get osteomyelitis in his wound, but she could not answer the question as to why. He responded well to the antibiotics. His treatments were almost completed. He stayed up in his wheelchair all day and refused to lay down. He had been educated and indicated he understood. He did wear a boot for protection, and he was compliant with wearing the boot. The interventions included a collagen dressing to rebuild the wound base and covered with a boarder dressing, aggressive treatments, float heels,			

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	nutrition, and turning and repositioning at least every 2 hours. He had decreased mobility and edema. The care plan, dated 8/14/22, indicated the resident had a behavior problem refusal to turn and reposition every 2 hours, refusing to float heel when in bed and refusing to wear heel lift boots. The interventions included, but were not limited to, approach and speak in calm manor, educate, encourage, and communicate with the resident or representative regarding all risk related to refusals of skin breakdown and risk for infection related to skin breakdown, encourage the resident to express feelings, encourage to maintain as much independence and control and decision making as possible, honor residents preferred choices, and notify the medical provider of refusals. The clinical record lacked a care plan for any resident refusal of care prior to the care plan dated 8/14/22.4. The clinical record for resident C was reviewed on 8/9/22, at 9:15 a.m. The diagnoses include, but were not limited to quadriplegia at C5-C7, COPD (Chronic Obstructive Pulmonary Diaease), Neuromuscular dysfunction of the bladder, thrombocytopenia, mononeuropathy, lack of coordination, atrial fibrillation, and dorsopathy. The Quarterly MDS assessment, dated 8/6/21, indicated the			

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	resident had impairments bilaterally to the upper and lower extremities.The annual MDS assessment, dated 5/3/22, indicated the resident was cognitively intact, did not exhibit any refusal of care behaviors, required extensive assistance of two staff with bed mobility and personal hygiene, was completely dependent with toileting and transfers, was always incontinent of stool, was at risk for developing pressure ulcers, had a stage 3 pressure ulcer which was not present on admission. The resident did not have a turning or repositioning program, a nutritional or hydration program to prevent or manage skin problems and received pressure ulcer care. The care plan, dated 10/6/20, indicated the resident was at risk for altered skin integrity due to actual skin impairment related to skin/tissue breakdown related to a pressure ulcer history , immobility, incontinence, protein malnutrition, quadriplegia, very limited sensory perception, chair fast, very limited mobility, poor nutrition, friction, and tubing. The resident aquired the following pressure ulcers: on 3/25/22 left buttocks, unstageable update stage 3; on 5/17/22 left upper buttocks pressure ulcer, stage3; on 8/2/22 right heel (reopened), stage 2. The interventions included, but were not limited to, pressure redistribution mattress/overlay to bed, low air mattress and Roho w/c			

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	cushion, assess skin weekly and as needed, check function and inflation of air mattress every shift for prevention, complete pressure ulcer risk assessment on admission, quarterly and with change in condition, consult vascular physician, wound physician to evaluate and treat as needed, ensure compliance with turning protocal, fLoat heels as the resident will allow, keep the head of the bed as low as possible and draw sheet to bed to reduce friction, monitor and treat pain, monitor open areas for signs and symptoms of infection and report changes to physician, monitor placement of tubing during turning and repositioning to ensure tubing is not causing pressure on skin, provide the resident education regarding pressure ulcers and the need for frequent offloading on admission and as needed. The resident will understand the implications of placing pressure to open surgical wound, and will understand the risks of non-compliance with total bed rest, Registered Dietain to evaluate for nutritional needs, and treatments per physician orders. When he was out of bed, change position by offloading, shifting weight or return to bed for rest. The wound analysis, dated 3/25/22, indicated the resident had a wound to his left buttocks measuring 1.42 cm in length, width 3.73 cm and depth 0.50 cm. The wound status was new and aquired in			

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	house. The periwound was intact with and the wound had 100% slough/eschar. Wound care included cleaning the wound daily with normal saline, Medihoney, a secure boarder gauze,and pressure reducing and offloading. Ensure compliance with turning protocol, a wedge or foam cushion for offloading.The wound analysis, dated 3/29/22, indicated the resident had a stage 3 pressure wound to his left buttocks measuring length 1.72 cm, width 3.52 cm, and depth 0.40 cm. The periwound was intact. The wound had 80% granulation tissue and 20% slough/eschar. The pressure wound had a moderate amount of serosanguinous drainage and no odor. The wound analysis, dated 5/10/22, indicated the resident's stage 3 left buttock wound measurements included length 1.55 cm, width 3.11 cm and depth was 0.30 cm. There was 90% granulation with 10% slough/eschar. There was a moderate amount of serosanguinous drainage with no odor.Treatments were changed to cleanse the wound with normal saline, a collagen dressing with a dry gauze over the collagen and secure with a secondary dressing boarder gauze. The wound analysis, dated on 5/31/22, indicated the resident stage 3 left buttoch wound measuraments included, length 1.73 cm, width 1.87 cm, and depth 0.10 cm. There was 100% granulation. There was a moderate amount			

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	of serosanguinous drainage with no odor.The peri wound was intact.The wound nurse NP debrided the wound for skin substitutes (Puraply,treating chronic wounds) application. The skin substitute was placed and orders to not change the non-adherent dressing, only change the foam boarder dressing every 3 days and as needed for soilage. Other puraply treatment every 7 days, nonadherent dressing and steri strips. Cover with a secondary boarder foam. The wound analysis, dated 8/2/22, indicated the resident developed a pressure wound to the right heel on 7/12/22. The wound measured length 2.07 cm, width 1.65 cm and depth 0. The wound reopened and was aquired in house. The pressure wound was a stage 2 with no drainage and the peri wound was intact. The treatment included betadine and change the dressing 2 times a day. The Wound Care NP note, dated 8/8/22, indicated the resident's wound and periwound will be kept free of excessive moisture, offloading measures to be taken to include, but not limited to turning and repositioning every 2 hours, and a nutritional consultation and basic skin care recommended. The wound plan of care was to float bilateral heels, continue current management. The NP was recommending an air mattress for pressure reduction, skin prep to the wound site every shift. Pressure			

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	reduction and turning precautions were discussed with the staff at time of her visit and recommended heel protection and pressure reduction to bony prominences. The staff was educated on all aspects of care. The wound analysis, dated 8/9/22, indicated the resident's right heel wound measurments included length 1.87 cm, width 2.11 cm and depth 0. The periwound was intact with no drainage and no change in treatment.During an interview on 8/9/22 at 9:15 a.m., Resident C indicated he felt the pressure ulcer on his bottom was due to his brief being pulled up too tight and bunched up under him. During an interview on 8/12/22 at 8:44 a.m., the NP indicated the resident had a wound to his left buttock. His treatment included skin sub with collegan. He had this done weekly. The wound had to be debrided before applying the skin sub and covered with a dressing. The peri wound was intact and skin prep was applied to the peri wound. The wound had greatly improved and his skin sub will be done next week. The treatment included 10 treatments. She would expect interventions to include turn and reposition every 2 hours. The resident gets up early and stays up until bedtime. He had been educated and understands the instructions. He did need assistance with his turning. He ate well and his nutrition was not a problem. 5. The			

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	clinical record for Resident F was reviewed on 8/10/22 at 8:46 a.m. The diagnoses included, but were not limited to, quadriplegia, polyneuropathy, schizoaffective disorder, pressure ulcer of the sacral region at stage 4, weakness, acute embolism, and thrombosis of the deep veins of the right upper extremity. The Quarterly MDS assessment, dated 1/18/22, indicated the resident was cognitively intact. The resident required the assistance of two staff for transfers and bed mobility. She needed substantial or maximal assistance for toileting, upper and lower body dressing, and was dependent for showering and applying footwear.The care plan, dated 4/27/21 and last revised on 8/3/22, indicated the resident had impaired skin integrity, or at risk for altered skin integrity related to a history of wounds, quadriplegia and ongoing refusal to lay down for offloading and or wound care, for the stage 3 left heel pressure ulcer, for the stage 4 sacral pressure ulcer, and for the stage 2 right heel pressure ulcer, which was resolved. The interventions included, but were not limited to, administer medications as ordered, monitor for side effects and effectiveness, dated 5/5/22. Administer treatments as ordered by the medical provider, dated 4/27/21. Apply appropriate pressure reducing appliances to bed and to			

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	wheelchair, dated 4/27/21. Complete skin at risk assessment upon admission or readmission, quarterly, and as needed, dated 4/27/21. Complete Weekly Skin checks dated 4/27/21. Educate the resident on the need for turning and repositioning and limiting the amount of time up in the chair, dated 3/29/22. Elevate legs and float heels as the resident would allow 8/3/22. Encourage the resident to lay down twice per shift to offload pressure from buttocks and wound care in an effort to heal her chronic pressure ulcers, dated 1/11/22. Ensure residents were turned and repositioned, dated 4/20/22. Evaluate the existing wound daily, for changes (redness, edema, drainage, pain, foul odor, dated 4/27/21. Limit the time up in a wheelchair to one hour a day, dated 2/8/22. Monitor meal intake dated 4/27/21. Notify the resident or resident representative, medical provider of any decline in wound healing, dated 3/22/22. Nutritional consult on admission, quarterly, and as needed, dated 4/27/21. Pad seat belt to power chair to prevent skin impairment 11/29/21. Provide appropriate off-loading cushion to the chair, dated 6/9/22. Provide an appropriate off-loading mattress, dated 6/9/22. Provide heel protectors per orders, dated 6/9/22. Resident referred out to wound care clinic MD consult, dated 4/6/22. Wound care consult and follow up,			

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	dated 1/11/22.The care plan, dated 1/18/21 and last revised 1/21/21, indicated the pressure ulcer documented as a stage 4 to the sacrum and an unstageable to the left ischium which resolved on 1/21/21. The interventions indicated to administer vitamins and supplements per the MD order 1/18/21. Educate the resident or representative about proper skin care to prevent skin breakdown 1/18/21. Educate the resident or representative on the importance of keeping skin clean and moisturized 1/18/21. Encourage the resident to frequently shift weight 1/18/21. Encourage the use of lifting devices while in bed 1/18/21. Keep the skin clean and well lubricated 1/18/21. Low air loss mattress 1/18/21. Monitor nutritional status 1/18/21. Monitor ulcer for signs of progression or declination 1/18/21. Provide skin care per facility guidelines and as needed 1/18/21. Provide wound care per treatment order 1/18/21.The care plan, dated 1/18/21, indicated the resident was at risk for impaired skin integrity. The interventions indicated to educate the resident or representative about proper skin care to prevent skin breakdown 1/18/21. Educate the resident or representative about the causes of pressure ulcers 1/18/21. Encourage the resident to frequently shift weight 1/18/21. Encourage the use of lifting devices while in bed 1/18/21. Keep skin			

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	clean and well lubricated 1/18/21. Monitor for moisture, apply barrier product as needed 1/18/21. Monitor nutritional status 1/18/21. Position resident to reduce causes of friction or shear 1/18/21. Provide skin care per facility guidelines and as needed 1/18/21. Utilize pillows or foam wedges to avoid direct contact with bony prominences 1/18/21. Utilize pressure relieving devices on appropriate surfaces 1/18/21. The intervention added on 8/14/22 indicated to educate the resident on all risks related to refusals to turn and reposition every 2 hours or wear heel lift boots.The nurse's note, dated 1/1/22 at 2:59 p.m., indicated the resident had a new pressure area on the right heel was discovered. The area was red to purple in color and had an intact blister. Mepilex was applied and resident indicated she had no pain from the new area. A Skin Grid was completed, and the resident was advised to float her heels. The resident was currently up in her wheelchair and had been educated that she would have to elevate her legs more since she now had an area on the heel.On 1/13/22, the wound center indicated the resident's facility acquired pressure ulcer to the right heel was identified on 1/1/22. The wound measured 1.16 cm long by 2.97 cm wide. Offloading of the heels was ordered by elevating the legs regularly and to apply a povidone iodine solution.On			

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	2/15/22, the wound center indicated the resident's pressure ulcer to the right heel was a stage 2 and measured 0.71 cm long by 1.35 cm wide. The was scant sanguineous drainage. The wound was to be cleaned daily with normal saline and a secondary dressing of a bordered gauze was ordered. The order indicated to elevate the legs one time daily for 30 minutes.The stage 2 pressure ulcer to the right heel was healed on 3/22/22.The wound center visit on 4/13/22, indicated the pressure ulcer to the left heel, which was acquired on 4/1/22 at the facility was assessed. The wound measured 8.5 cm long by 8 cm wide by 0.1 cm deep and was a non-blanchable, deep tissue pressure injury with moderate serosanguineous exudate. There was 1 to 25 percent slough with 51 to 75 percent granulation.The physician's order, dated 6/2/22, indicated the resident was to be placed on a pressure reducing/relieving mattress every shift.The physician's order, dated 6/2/22, indicated to obtain a wound MD consult as needed. The resident's stage 3 wound to the left heel measured 1.4 cm long by 1.19 cm wide on 6/21/22. The legs were to be offloaded three times daily for 30 minutes. The order was for a calcium alginate with a bordered foam dressing.The physician's order, dated 7/13/22, indicated to apply a pressure reducing cushion to the			

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SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

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	chair as needed. The physician's order, dated 7/13/22, indicated to apply diluted sodium hydrochlorite (1/2 strength) external wound cleaning solution 0.25 percent to the sacrum, topically, every shift for the wound. The staff were to cleanse the wound with normal saline, pat dry, pack with the diluted sodium hydrochlorite moistened gauze, twice a day and as needed and apply to the sacrum topically every 2 hours as needed for the wound. The physician's order, dated 7/15/22, indicated to perform a daily wound assessment of the sacrum. Document abnormalities in the progress notes of drainage and pain. Document the level of pain at the wound site, every shift. The physician's order, dated 7/15/22, indicated to perform a daily wound assessment of the left heel. Document abnormalities in progress notes of drainage, tissue present, odor, and pain. Document the level of pain at the wound site, every shift.The physician's order, dated 7/15/22, indicated staff were to apply a povidone iodine external solution 5 percent. Apply to the left heel wound topically every morning and at bedtime for skin irritations.The physician's order, dated 8/3/22, indicated to elevate the legs regularly and float the heels, as the resident would allow, every shift.The wound center note, dated 8/9/22, indicated the pressure ulcer to the left heel measured 0.72 cm long by 0.59			

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	cm wide. The order was for a povidone iodine solution. The clinical record lacked documentation the resident had refused to turn and reposition, float heels, or wear boots.During an interview on 8/10/22 at 1:49 p.m., Resident F indicated the staff did not ever turn her. They did not even offer. When she told them to lift her heels, they did it, but they would not do it if she did not ask them to. She had laid all day in a soiled brief and had a catheter. Her catheter had not been changed out since she got it placed again, for over a week. She had a pressure ulcer on her spine, butt, and one black spot on her foot. They did wound care daily, but she thought the care was ordered twice daily. During an interview on 8/12/22 at 8:56 a.m., the Wound NP indicated the system recommends every hour turns, but the protocol at the facility was for every 2 hours. The interventions were to turn, skin prep to unopened area, good nutrition, mattress with floating system, anything that would prevent the heels from touching. She was already here with the sacral she had developed wounds to the heels and abdomen. She would not keep the boots on, and they were discontinued. She was not a complete quadriplegic but was classified as one. The resident indicated to her, that the staff were not floating her heels. She was minimal on self-turning. She tried to help.			

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	She could have pillow supports. She went to wound care due to the heel wound not getting better for a couple of weeks. The wound was surgically debrided, and the wound center would not touch it now because another surgeon surgically debrided it. Her left heel was stable and improving. It was a stage 3 at the wound center. It has remained closed. She had ordered the povidone iodine and to keep the wound open to air. The heels should be lifted. Her legs were on a pillow at times. She had a lot of factors to develop the ulcers. She spent 12 to 14 hours a day in her chair, her weight status, and UTIs not that long ago. During an observation on 8/12/22 at 10:37 a.m., the resident's heels were lying directly on top of a pillow. The resident's heels were not offloaded. The right heel appeared healed. The left heel had a dark pink appearance with peeling dry edges on the entire heel and healing. There was one light black scabbed area on the anterior heel, measuring 1 cm long by 0.3 cm wide.During an interview on 8/12/22 at 10:50 a.m., LPN 4 indicated the resident was compliant with treatments, turning and repositioning, or for a pillow being placed under her back, when she was in her bed. The nurse's note, dated 8/14/22 at 7:17 a.m., indicated the resident refused to be turn every two hours. The resident also refused heel boots.The clinical record lacked			

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	any resident refusal of care prior to the nursing note dated 8/14/22.The policy for Skin Care and Wound Management, last reviewed 5/30/19, was provided by the Regional Director of Clinical Operations on 8/15/22 at 9:46 a.m. The policy included, but was not limited to, " ... Skin care and wound management program included, but is not limited to ...Application of treatment protocols based on clinical 'best practice' standards for promoting wound healing ... Identification of residents/ patients at risk for development of pressure ulcers. Implementation of prevention strategies to decrease the potential for developing pressure ulcers ... Procedure: Prevention ... 7. Modify and document goals and interventions as indicated ... Treatment ... 7. Evaluate effectiveness of interventions during the clinical meeting. 8. Modify goals and interventions as indicated ..."The Immediate Jeopardy that began on 1/13/22 was removed on 8/16/22 when the facility's RDCO educated staff on implementing interventions to prevent pressure ulcers, completed a skin sweep of all residents in the facility, and audited all resident charts for inclusion of appropriate pressure ulcer prevention interventions and accurate Braden scale assessments. The Immediate Jeopardy was removed on 8/16/22, but the noncompliance remained at the lower scope			

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	and severity of pattern, no actual harm with potential for more than minimal harm that was not Immediate Jeopardy, because the wound nurse/designee oversight will be increased to 5 days per week and not all staff had been educated by the RDCO on skin and wound management, pressure ulcer prevention, skin and Braden assessments, ensuring appropriate interventions are in place, and appropriate steps for wound care. This Federal tag relates to Complaint IN003875513.1-40(a)(1)3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and			

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	(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure appropriate catheter care for residents with a history of UTIs (Urinary Tract Infections) for 2 of 3 resident's reviewed for UTIs. (Residents E and 92) Findings include: 1. During an observation on 8/11/22 at 10:42 a.m., CNA (Certified Nurse Aide) 5 and CNA 6 entered the room to provide catheter care for Resident E. A moderate amount of dark brown stool was observed on the resident's rectum. CNA 6 indicated the resident had a bowel movement and used a disposable wipe to clean the residents rectum. Dark brown stool was observed on the catheter tubing. The CNA used 6 swipes of the same wipe from the catheter insertion site, down over the rectum, in repeating motions. She grabbed a clean wipe, and again cleansed with 4 swipes of the same side of the wipe. She folded the wipe and then used 9 swipes with the same side of the wipe. She then grabbed a clean wipe and cleansed with 6 swipes of the same wipe down the length of the tubing, stool was observed on the wipe during the passes down the tubing. The care was completed and both CNAs exited the room.	F 0690	**F 690 Bowel/Bladder Incontinence, Catheter, UTI** **Corrective action for the residents found to have been affected by the deficient practice:** Resident E was identified as being affected by the deficient practice. Resident 92 continues to reside at the facility and was identified as being affected by the deficient practice. CNA 5, CNA 6 and CNA 11 were immediately educated regarding appropriate catheter care by the Director of Nursing. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents having catheters and a history of UTIs (Urinary Tract Infections) have the potential to be affected by the deficient practice. An audit of the last 30 days for residents having catheters and history of UTIs (Urinary Tract Infections) has been completed to	09/06/2022

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	The clinical record for Resident E was reviewed on 8/10/22 at 11:00 a.m. The diagnoses included, but were not limited to, altered mental status, anoxic brain injury, and neuromuscular dysfunction of bladder. The Annual MDS (Minimum Data Set) assessment, dated 6/3/22, indicated the resident required extensive assistance of 2 or more staff with personal hygiene, was totally dependent on 2 or more staff for toileting, was always incontinent of bowel, and had an indwelling urinary catheter. The care plan, dated 8/3/20, indicated the resident had a history of ESBL (extended spectrum beta-lactamase) Urinary Tract Infection. The interventions included, but were not limited to, monitor, document, and report to physician as needed signs and symptoms of a UTI. The care plan, dated 10/6/20, indicated the resident had a indwelling catheter due to neurogenic bladder. The goal, dated 6/3/21, was for the resident to show no signs or symptoms of urinary tract infections. Interventions included, but were not limited to, resident has an 18 Fr (French) catheter, position catheter bag and tubing below the left of the bladder and provide privacy bag (6/3/21), observe for and report to MD (Medical Doctor) any signs or symptoms of a UTI including pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating pattern (11/11/20), provide catheter care every shift and as needed, notify MD if urine is of abnormal color, consistency, or odor (11/11/20).		ensure appropriate catheter care has been completed as ordered by the physician. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee held an in-service for nursing staff to provide education and expectations as it relates to the “Catheter Care” policy and providing appropriate catheter care for residents with a history of UTIs (Urinary Tract Infections). Education included a completion of a catheter care competency. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON/Unit Manager/Designee will observe catheter care of residents who have a catheter and a history of Urinary Tract Infections (UTI) as follows: 3 residents a week x 4 weeks, then 2 residents a week x 4 weeks, then 1 resident a week for 4 weeks to ensure appropriate catheter care is provided. This will occur for no less than 3 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that	

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	The physician's order, dated 7/7/22, indicated the resident had a 20 Fr indwelling urinary catheter related to neurogenic bladder. The physician's order, dated 7/7/22, indicated staff were to provide catheter care for the resident by cleansing with soap and water every shift. The nurse's note, dated 7/5/22 at 4:55 a.m., indicated the resident was admitted to the hospital with a diagnoses of sepsis and urinary tract infection. During an interview on 8/16/22 at 8:39 a.m., CNA 5 indicated the resident had a catheter and they did catheter care when they went in to change her. She was not aware if the resident had a history of any UTIs. When performing catheter care, one would most definitely not want to wipe forward toward the catheter. They would want to make sure the catheter was good and clean and free of any stool. She cleaned all around the resident's perineal area to make sure they were clean. 2. During an observation on 8/12/22 at 9:26 a.m., of catheter care for Resident 92, CNA 11 obtained a basin, washcloths and a towel. The washcloths were placed into the basin of warm water. She applied no rinse soap onto the washcloth as she folded the corners down for each application of the no rinse soap. She pulled the washcloth down the tubing, 1 inch from the labia down the tubing 3 inches, without holding the tubing. The resident moaned as she pulled. A washcloth was obtained and the CNA swiped the labia 2 times with the same area of the washcloth. She folded the washcloth and swiped 3 times with the same area to clean the creases to each side of the labia. She folded the washcloth and swiped down the labia 3 times with the same area of the washcloth. She obtained a clean wet washcloth, applied no rinse		are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	soap and swiped down the labia 2 times with the same area of the washcloth. She folded the washcloth and cleaned the creases to each side of the labia. She obtained a dry towel and with 2 swipes, she dried the labial area. She used another area of the towel and with 2 pats with the same area of the towel, dried the labia again. The rectal area was not cleaned. She replaced the same brief, indicating the brief was dry. The bed was lowered and the lower half of the catheter was folded onto the floor. The catheter bag was a quarter full of yellow urine. The clinical record for Resident 92 was reviewed on 8/12/22 at 9:49 a.m. The diagnoses included, but were not limited to, epilepsy, type 2 diabetes mellitus, stage 4 chronic kidney disease, acute cystitis, need for assistance with personal care, bipolar disorder, anemia with chronic kidney disease, acidosis, and dementia. The Quarterly MDS assessment, dated 7/29/22, indicated the resident was moderately cognitively impaired. The resident required extensive assistance of 2 staff for toileting. The care plan, dated 7/5/22 and last reviewed on 8/9/22, indicated the resident had a UTI (urinary tract infection). The interventions (dated 7/5/22) indicated to administer antibiotics and antimicrobials per the medical provider's orders, to observe for side effects and effectiveness, to report abnormal findings to the medical provider, resident, and the resident representative, to educate the resident and the resident representative regarding proper perineal care, to encourage the resident to completely empty her bladder when toileting, and to observe for signs and symptoms of urinary infections, to report abnormal findings to the medical provider,			

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	resident and the resident representative, to observe for signs and symptoms of infection, to obtain and monitor labwork and diagnostic studies as ordered, and to report abnormal findings to the medical provider, resident and the resident representative. The care plan, dated 5/3/22, indicated the resident was incontinent of urine. The interventions dated, 5/3/22 indicated to apply a barrier cream as needed, to change the disposable briefs as needed, check the resident for incontinence, wash, rinse and dry the perineum, change clothing as needed after incontinent episodes, observe for signs and symptoms of a UTI, and observe and report to the medical provider if a UTI was identified. The nurse's note, dated 6/21/22 at 4:14 p.m., indicated the NP ordered a urine collection for a urinalysis with culture and sensitivity. The urinalysis report, dated 6/22/22, indicated the urine was turbid amber colored with 2 plus protein, 3 plus leukocytes 6 to 20 per HPF red blood cells, and greater than 50 white blood cells. The culture indicated greater than 10,000 to 50,000 escherichia coli and greater than 100,000 enterococcus faecium. The nurse's note, dated 6/27/22 at 2:51 p.m., indicated the NP ordered Macrobid 100 mg to be administered by g (gastrostomy)-tube the Macrobid 100 mg twice daily for 7 days. The physician's order, dated 8/8/22, indicated to administer one Cefuroxime axetil 500 mg tablet by g-tube every morning and at bedtime for the UTI for 7 days.			

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	The physician's order, dated 8/4/22, indicated to change the indwelling catheter and drainage bag as needed unless specified by a physician order for specified medical reasons as needed. The physician's order, dated 8/4/22, indicated to secure the indwelling catheter tubing using an anchoring device to prevent movement and urethral traction. The physician's order, dated 8/4/22, indicated to place the indwelling urinary (foley) catheter in a privacy bag and catheter leg strap on at all times. The physician's order, dated 8/4/22, indicated indwelling urinary (foley) catheter: measure and record output every shift. The physician's order, dated 8/4/22, indicated to cleanse the indwelling urinary (foley) catheter with soap and water every shift. The urinalysis results, dated 8/5/22, indicated the urine was cloudy with 2 plus protein and 3 plus leukocytes. There were 21 to 50 per high power field in the white blood cell count and a moderate amount of bacteria. There was greater than 100,000 colony forming units per milliliter escherichia coli. During an interview on 8/12/22 at 9:39 a.m., CNA 11 indicated for perineal catheter care she would get ready by gathering supplies of a peri spray, a basin of water, and folding the corners of the washcloth. She should clean the catheter tubing first, then clean the perineal area. She would clean the catheter tubing where the catheter goes in, folding the washcloth with each swipe. By folding the washcloth she wasn't contaminating the area.			

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	During an interview on 8/15/22 at 2:42 p.m., the DON indicated for perineal catheter care, she would clean the resident's labia, from front to back with a new or clean area of the washcloth or wipe. Obviously if the resident was soiled and stool was on the catheter tubing, they would want to clean the tubing. The staff do this to prevent the spread of bacteria. The CNAs were trained to perform catheter care per the procedure. They should wash down the catheter tubing from the urethra down the tubing 3 inches. The rectal area should be cleaned during perineal catheter care, cleaning from the labia or scrotum back. The catheter bag should not touch the floor. The Catheter Care policy, last reviewed on 4/20/17, was provided by the DON on 8/15/22 at 9:30 a.m. The policy included, but was not limited to, "... II. Female or Male Resident with Catheter a. Perform Pericare first following organizational policy for Peri-Care for Male or Female resident as appropriate... f. Securely grasp the catheter tubing nearest the meatal opening to prevent movement or accidental dislodgement. g. Clean around catheter just above entrance to meatus. i. Wipe the catheter from meatus downward approximately 6 inches... V. Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder..." 3.1-41(a)(2)			
F 0867 SS=D Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:			

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	(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; Based on record review and interview, the facility failed to identify an unresolved deficiency involving pressure ulcers. This deficiency had the potential to affect 95 current residents residing in the facility. Findings include: During this recertification survey, from 8/8/22 to 8/16/22, one deficiency was a repeated citation from the last annual survey; F686. The current facility QAPI (Quality Assurance Performance Improvement) Plan with a most recent revision date of May 30, 2019, was provided by the Administrator on 8/8/22. The policy indicated, "...QAPI is data-driven. QAPI is a proactive approach to improving quality of life, care and services. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement, address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions..." The facility's Quality Assurance Committee did not identify, develop, and implement appropriate measures to correct identified issues or prevent the deficiency as follows: Pressure Ulcers: Based on record review and interview, the facility failed to ensure preventive measures were implemented to prevent the development and worsening of pressure wounds for 5 of 10	F 0867	**F 867 QAPI/QAA Improvement Activities** **Corrective action for the residents found to have been affected by the deficient practice:** Based on record review and interview, the facility allegedly failed to identify an unresolved deficiency involving pressure ulcers. The facility immediately initiated a plan of action for wounds as identified through the alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice. The facility reviewed the last 6 months QAPI meetings to identify any missed areas of opportunity for improvement in the QAPI process. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Regional Director of Clinical Operation (RDCO) will provide education related to the “Skin Care and Wound Management	09/06/2022

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	155659	A. BUILDING 00 B. WING	08/16/2022

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	residents reviewed for pressure ulcers. (Resident B, C, D, E and F) Cross Reference F686 During an interview on 8/16/22 at 10:09 a.m., the DON (Director of Nursing) she indicated they had submitted the POC (Plan of Correction). We had started the education and made the decision for the RDCO (Regional Director of Clinical Operations) to do the education and she was doing the education. She did start that immediately. She will be working on that until that's completed. The E.D. (Executive Director) and DON were educating and it wasn't valid, the RDCO had to redo it all. From what she was told the education had to be from the corporate level. She had to educate all of the direct care staff including CNA's (certified nursing aides) LPN's (Licensed Practical Nurses) RN's on wounds, turning and repositioning and staging. There are still staff that need to be educated. They don't have a lot of direct care staff. But they would have to educate agency as they come in before the start of their shift. During the POC when she used an agency nurse she would come in on the weekend. She would educate them on what she needed from them. She had done a house wide audit of the Braden Skin assessments and made sure they were done correctly. She made sure the questions were answered appropriately. On the resident's wounds she printed off her sheet and she went through and looked at what the NP (Nurse Practitioner) was advising and recommending and looked through the care plans, they went in teams and went from room to room on each hall and looked at interventions on each resident and compared the information to the care plan to make sure the interventions were in place. If they refused we care planned them for the refusals.		Overview" and "Pressure Ulcer Prevention (high, Moderate, low risk)" policies as it relates to ensuring weekly skin assessments are completed, appropriate interventions are in place to prevent the development and worsening of pressure ulcer and identifying pressure ulcers and risks based on the Braden assessment completed at the time of admission, quarterly or with a new identified area. The Regional Director of Clinical Operations (RDCO) will provide education related to the "Wound Care" policy will all licensed nursing staff to ensure the appropriate steps are followed while providing wound care and infection control practices are followed for those residents identified as having a skin alteration. The Regional Director of Clinical Operations will provide education to the licensed nurses of the facility related to the "Stage 1, Stage II, Stage III, Stage IV and sDTI" as it relates to staging and treatment of these identified areas for residents with newly identified areas of concern. The Healing Partners Nurse Practitioner will be the final determination of the actual wound staging for identified skin alterations. The Regional Director of Clinical Operations has provided education to direct care staff on the facilities	

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	They completed staff interviews and audits. She was including education on how to properly offload heels. They ordered more pillows and more heel lift boots. They got a different type of heel lift boot ordered. If a resident does not want the big lift boots they would try those. They had done full room to room where they split and looked for interventions. She didn't feel like they failed on their skin sweep. They did a lot of education over the weekend. She reviewed the pressure ulcers and staging and they did a management huddle and they know they're supposed to be checking rooms. They were developing an audit. 3.1-52(b)(2)		"Kardex" process which identifies what interventions are ordered and required for prevention in wound development and worsening. The Wound nurse/designee oversight will be increased to 5 days per week to include observations of wound treatments and interventions. Any identified concerns will be addressed immediately. The Regional Director of Operations/ Regional Director of Clinical Operations/Designee held an in-service for members of the QAPI committee to provide education and expectations regarding the "Quality Assurance Performance Improvement" policy to include the process to identify, develop, and implement appropriate measures to correct identified issues. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Regional Director of Clinical Operations will audit through record review and observation 5 residents weekly to ensure the known concerns were followed through with interventions and monitoring for 3 months and compliance is maintained. The Regional Director of Clinical Operations/Designee will attend the QA meeting and report	

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			findings from the audits to the QA committee monthly. The QA committee along with the Regional Director of Clinical Operations will determine when compliance is achieved or if ongoing monitoring is required by review of the wound program to identify if improvement is made with a decrease of newly acquired in house pressure areas or current pressure areas with a decline for 3 months and compliance is met. If compliance is not met, the Regional Director of Clinical Operations and QA committee will recommend that ongoing monitoring is required. Further, the QA Committee will complete a Root Cause Analysis to determine the deficient process, amend the current QAPI plan, and initiate appropriate monitoring based on the RCA findings. This will continue for no less than 3 months and compliance is maintained	