STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING 00 B. WING	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00395451, IN00400251, IN00400314, and IN00400697. Complaint IN00395451 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00400251 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684 and F686. Complaint IN00400314 - Unsubstantiated due to lack of evidence. Complaint IN00400697 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684 and F686. Survey dates: February 13, 14, 15, 16, and 17, 2023 Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census Bed Type: SNF/NF: 92 SNF: 4 Total: 96 Census Payor Type: Medicare: 9 Medicaid: 58 Other: 29 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Majestic Care of Avon is respectfully requesting desk review rather than revisit on or after March 20, 2023 . Please feel free to contact me if you feel that additional information or documentation would assist you in that process. I can be reached at 317-745-2522. Thank you, Josiah Marx, ED	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Josiah Marx	Executive Director	03/17/2023

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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	Quality review completed on March 3, 2023.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to assess, document, and treat a non-pressure wound to the posterior head for 1 of 3 residents reviewed (Resident D). Findings include: During an interview on 2/14/23 at 3:08 p.m., Resident D's guardian indicated the resident had recently been discharged to the hospital on 1/22/23. While in the facility the resident had multiple falls, however she had no idea the resident had a wound on the back of her head. When she contacted the facility, they attempted to say she had been told about the head wound, but she absolutely had not. Staff told her the wound on back of her head was supposedly from a fall, was fluid filled, opened and started to drain, and was a stage 4 (deep wound reaching the muscles, ligaments, or bones). Resident D's record was reviewed on 2/14/23 at 10:49 a.m. Diagnoses on Resident D's profile included, but were not limited to, severe dementia with psychotic disturbance with delusions, major	F 0684	F 684 Quality of Care 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident has since discharged from facility · All care team members were immediately educated on 2/16/2023 by DNS 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? · All residents that have skin alterations (non-pressure or pressure) have the potential to be affected by this alleged deficient practice. · All care team members were educated by the DNS on 2/16/2023 on skin assessments, documentation, pressure	03/20/2023

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	depressive disorder, and type 2 diabetes mellitus. A Weekly Nursing Summary, dated 12/30/22 at 4:02 p.m., included a weekly skin assessment which indicated Resident D had no current skin issues. Skin Sweep Reports, dated November - February 2023, indicated the resident record lacked documentation regarding skin impairment to the posterior head. A physician's order for Resident D, dated 1/6/23, indicated Resident D was on a low air loss mattress (mattress designed to distribute resident's body weight over a broad surface area and help prevent skin breakdown). An interdisciplinary team (IDT) note, dated 1/3/23 at 11:05 a.m., included a review of a fall occurring on 12/31/22 when resident slid out of her wheelchair landing on her buttocks in the activity room. No injury was noted. Resident D struck her head on floor, and had a laceration to right eyebrow which was cleaned and steri-strips applied. A Nurse's Note, dated 1/4/23 at 1:58 p.m., indicated Resident D was found by staff laying on the floor next to her bed. Her skin was warm, dry, and intact. No skin alterations or discoloration were noted. An IDT Note, dated 1/5/23 at 12:06 p.m., included a review of a fall on 1/4/22. Resident D was found lying on top of contoured mat beside bed in supine position with legs outstretched and arms at side. No new injury was noted. Handwritten Skin Monitoring: CNA Shower		ulcer/non-pressure care, treatment, and notification. · The DNS, designees, and wound NP's conducted skin assessments on all residents. · Nurse managers and DNS reviewed medical records to ensure weekly skin assessments were completed and treatment recommendations/orders were in place. · A care plan audit was conducted by MDS to ensure that treatment recommendations/orders were on the care plan and that the care plan was being followed. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? · All nursing care team members will receive education upon hire, annually, and as needed on skin assessments, documentation, pressure ulcer/non-pressure care, treatment and notification . All current nursing care team members were educated on 2/16/2023 by DNS. · Training will be conducted upon hire and as needed by DNS or designee. · All facility policies and procedures related to skin care, wound care, and pressure injury prevention were reviewed and revised as needed. · For residents returning from the hospital, treatment	

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	Review sheets, provided on 2/16/23, indicated, a. On 1/18/23, Resident D had redness/rash on the back of the head and bottom, scabbed area on the back of the head, open area on the back of the head and bottom, and discharge from the back of the head. b. On 1/20/23, Resident D had redness/rash on the back of the head. The resident record lacked documentation of a skin care plan regarding skin impairment to the posterior head. Nurse Practitioner (NP) 10 notes, dated 1/11/23 at 3:07 p.m., indicated Resident D was seen for a routine visit in a wheelchair in the activity room. Resident D had a reported fall on 1/4/23 with a large posterior head hematoma (seen under the skin as purplish bruises) and abrasion. Noted healing facial bruising at various stages. Wound rounds completed and reconciled with wound nurse today. Wound NP 9 notes, dated 1/11/23 at 3:08 p.m., indicated Resident D was being seen for a comprehensive skin and wound evaluation. The notes lacked documentation regarding skin impairment to the posterior head. An IDT notes, dated 1/19/23 at 3:30 p.m., indicated Resident D was found on the floor beside her bed. Resident D had discoloration to right cheek area, a 2.4 centimeters (cm) by (x) 1.1 cm laceration to right distal area under her eye, and a 1.4 cm x 0.5 cm laceration to right eyebrow. The notes lacked documentation regarding skin impairment to the posterior head. An IDT Risk Review notes, dated 1/20/23 at 1:25 p.m., indicated weekly follow up of weight loss		recommendations/orders and wound care appointments will be transcribed and overseen by unit managers and reviewed Monday-Friday during clinical meeting. Wound NP will assess all new resident admissions. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? · QAPI tool will be completed by DNS or designee weekly x 4 weeks, bi-monthly x 2, and monthly x 4 months. · If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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	and wound. Care plan updated/reviewed. Lacked documentation regarding skin impairment to the posterior head. An eInteract Transfer Form, dated 1/22/23 at 2:35 p.m., indicated Resident D was transferred to the hospital due to shortness of breath. Section related to skin/wound care for pressure ulcers or other skin wounds, or bruises was left blank with no documentation of wounds. A Nurse's Notes, dated 1/22/23 at 8:35 p.m., indicated Resident D was admitted to a local hospital for infiltrates (pneumonia) and urinary tract infection (UTI). A Nurse's Notes by Registered Nurse (RN) 7, created 1/25/23 at 2:22 p.m., and back dated to 1/19/23 at 2:21 p.m., indicated Resident D had a raised area on back of her head with moderate amount of serous drainage noted. Resident was assessed by MD and no new orders were given. Area was not open, and dressing was in place. The resident's record lacked additional documentation of a wound to the back of Resident D's head being identified, reported to the physician, having treatment orders, or being monitored in the progress notes, skin sweep reports, or care plans dated November 2022 through February 2023. An additional NP 10 note, provided and dated 2/16/23, indicated Resident D was seen for a federally mandated visit on 1/11/23 by this provider. "Please refer to note on 1/11/23" of general decline, malnutrition with weight loss, recurrent falls, and noted skin failure. Nursing reported concern of developing area of concern to posterior head on 1/16/23 and 1/18/23. The			

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	resident was seen "as a courtesy" on 1/16/23 and 1/18/23. Reassured nursing area to the back of the head 'appeared stable," and "appearance seemed worse than actually was due to area of injury" due to there not being anywhere for the fluid to rapidly reabsorb or dissipate. The NP asked the medical director to assess area on 1/20/23. The Medical Director felt area was seroma (accumulation of clear fluid under the skin, typically near the site of a surgical incision), fluid collection, and would resolve spontaneously. A significant change in condition Minimum Data Set (MDS) assessment completed on 1/18/23, assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 5 which indicated significant cognitive impairment. The resident was an extensive assistance of 2 or more (+) persons physical assist for bed mobility, transfers, toilet use and personal hygiene. The resident was always incontinent of bladder and bowel. She had had 2 or more falls since the last assessment without major injury. Resident was at risk of developing pressure ulcers/injuries and had one or more unstageable pressure ulcers. A hospital report, dated 1/23/23, indicated Resident D was transported to the hospital via emergency medical services (EMS) and presented in acute respiratory distress. The resident was bagged in route and on 50 liters (L) oxygen for oxygen saturations levels in the 70's. The resident was found to have pressure related unstageable wounds to her sacral, occiput area (posterior or back of head), left lateral foot, and a laceration over her right eye. The resident was started on intravenous (IV) Ampicillin and azithromycin (both used to treat bacterial infections) for pneumonia and Gentamycin (used to treat bacterial infections of the blood) for a urinary tract			

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	infection. Hospital wound documentation, dated 1/23/23, included: a. A posterior occiput full thickness skin loss unstageable pressure ulcer with small tunnel. Measurements: approximately 3.2 cm x 1.8 cm x 1 cm with tunnel 1.5 cm. Description was 100% black eschar. During an interview and review of the resident record on 2/14/23 at 2:47 p.m., RN 7 indicated, Resident D had discharged to the hospital on 1/22/23. RN 7 indicated she had documented a late entry note, with an effective date of 1/19/22, but created on 1/26/23 several days after the resident had discharged to the hospital, that indicated the resident had a soft raised spot on back of her head from an unidentified fall that was beginning to open, she had put a dressing on the wound and notified the MD. An aide had notified her of the area on the back of the head, but she had not documented any of this information at that time. There were no skin sheets, no MD documentation, no MD orders, and the wound team did not see or document the head wound as open. An IDT note on 1/20/23 did not mention a head wound, and there was no care plan related to a head wound. She could not explain how staff were supposed to know to monitor the head wound or how to treat it with no documentation while the resident was in the facility. During an interview on 2/15/23 at 10:13 a.m., the Hospital Wound and Ostomy Nurse indicated Resident D had admitted to the hospital on 1/22/23 with extensive advanced wounds on her sacrum, back of the head (occiput), left and right ischium (cheeks of buttocks), and lower extremity. The head wound was "definitely" from pressure,			

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	covered in slough, a full thickness ulcer, and caused by chronic pressure on the back of the head and/or not being moved, and usually not having the head on a pillow. The resident's wounds could have contributed to the sepsis diagnosis. During an interview on 2/15/23 at 11:04 a.m., the facility Wound NP 9 indicated when residents were newly admitted a full skin assessment was completed to look for wounds. If an existing resident developed a wound that resident was added to the list of residents to see during weekly visits. As residents were seen skin pictures were taken, a Tissue Analysis (TA) documented with an electronic list generated, and the resident was seen for follow up the next week. The TA reports were available in the resident electronic medical record (EMR) where measurements were automatically documented from the pictures using a green dot for size comparison. Upon review of her records, she had seen Resident D for an unstageable pressure ulcer on the sacrum twice on 1/11/23 and again the next week on 1/18/23. Staff had not reported any further wounds for her to see. During an interview and review of the resident record, on 2/15/23 at 2:01 p.m., the Director of Nursing Services (DNS) indicated Resident D had been diagnosed with COVID-19 on December 11, 2022 and after that her health declined. The resident had a history of falls to include on 12/31/22 with a laceration to the right eyebrow, and again on 1/4/23 with no skin injury noted. The DNS indicated the resident record lacked documentation of a head wound until NP 10 had documented on 1/11/23 during a visit. Discrepancies in wound documentation between NP 10 and wound NP 9 on 1/11/23 was most likely			

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	because NP 10 was in the facility multiple times that week and was asked to see the resident's head and wound NP 9 was not told. The DNS indicated NP 10 had diagnosed the area on the back of Resident D's head as a seroma and had asked the MD to also look at it. Per the MD there was no treatment for a seroma nor need for one as it would heal on its own. Documentation was lacking that the MD had been made aware of the head wound or that NP 10 or the MD had followed up the wound. The head wound had not been care planned, and there was no wound documentation on the hospital transfer form. On 1/24/22 Resident D's guardian e-mailed the DNS regarding hospital discharge plans, and this was the first they were aware of a pressure ulcer on the back of the head. During a phone interview with the DNS and ADON in attendance on 2/15/23 at 3:08 p.m., NP 10 indicated the nurses had reported to her multiple times Resident D had a soft area on the back of her head, and she saw it several times due to the size of the area. She diagnosed the area as a seroma although she did not document the diagnosis. Per her request, the MD also observed the resident, and he said the area on her head was fluid filled and nothing to do as it would reabsorb by itself. NP 10 indicated neither she nor the MD had documented on the resident's head wound after her note 1/11/23 where she documented a hematoma from a fall on 1/4/23. The area on the back of Resident D's head could have been an abrasion that further developed. NP 10 acknowledged lack of documentation in the resident record. On 2/15/23 at 3:46 p.m., the DNS provided a Skin Management policy, dated October 2019, and indicated the policy was the one currently being used by the facility. The policy indicated it was			

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	the policy of the facility to assess each resident to determine the risk of potential skin integrity impairment. Residents will have a skin assessment completed upon admission and no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment. " ...Prevention: 1. All resident beds will have a pressure reducing mattress. 2. A head to toe assessment will be completed by a licensed nurse upon admission/readmission and no less weekly ...7. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas ...Procedure For Alterations in Skin Integrity: 1. Alterations in skin integrity will be reported to the physician/NP and responsible party/family. 2. Treatment orders will be obtained. 3. All alterations in skin integrity will be documented in the medical record ...(b) All newly identified areas after admission will be documented on the weekly pressure/non-pressure evaluation ...5. Skin care interventions will be added to the caregiver Kardex. 6. IDT review of new alterations in skin will be completed weekly. 7. A plan of care will be initiated to include resident specific risk factors with appropriate intervention ...." This Federal tag relates to Complaints IN00400251 and IN00400697. 3.1-40(a)(1) 3.1-40(a)(2) 3.1-40(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§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 interview, and record review, the facility failed to prevent, assess, and accurately document pressure ulcers for 1of 3 residents reviewed (Resident D). Findings include: During an interview on 2/14/23 at 3:08 p.m., Resident D's guardian indicated the resident had recently been discharged to the hospital on 1/22/23. While in the facility the resident had multiple falls and she had recently been informed of a pressure wound to her bottom which staff told her was healing. However, she had no idea how bad the wound was on her bottom, or that she had additional wounds on her right and left buttocks. Resident D's record was reviewed on 2/14/23 at 10:49 a.m. Diagnoses on Resident D's profile included, but were not limited to, severe dementia with psychotic disturbance with delusions, major depressive disorder, and type 2 diabetes mellitus. A Weekly Nursing Summary, dated 12/30/22 at 4:02 p.m., included Resident D's weekly skin	F 0686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident has since discharged from facility. 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? · All residents that have skin alterations (non-pressure or pressure) have the potential to be affected by this alleged deficient practice. · All care team members were immediately educated on 2/16/2023 by DNS · The DNS, designees, and wound NP's conducted skin assessments on all residents. · Nurse managers and DNS reviewed medical records to	03/20/2023

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	assessment which indicated she had no current skin issues. As of 1/5/23 there were 3 new pressure ulcers identified. 1. The first pressure ulcer was documented to be on the sacrum. A Pressure Ulcer-Weekly Observation report, dated 1/5/23 at 1:47 p.m., indicated a stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer with possible visible slough and/or eschar) on the sacrum measuring 1.2 centimeters (cm) by (x) 1.0 cm x 0.2 cm. First observation of ulcer currently an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) with slough (a mass of dead tissue separating from an ulcer) tissue present described as yellow, tan, white, and stringy. Necrotic (dead cells) tissue present described as brown, black, leather, scab-like. The wound had 40% slough and 60% eschar, scant amount serous draining, and no odor. Resident had had loose stools frequently and was on scheduled antidiarrheal medications. The resident had a decline in mobility and was not bearing weight upon transfers most days. The resident was to be placed on a low air loss mattress. Skin Sweep Reports, dated November - February 2023, indicated, unstageable pressure ulcer on sacrum, in-house acquired, a. On 1/11/23 a new wound measured 3.66 cm x 1.72 cm x 0 cm b. On 1/18/23 the wound measured 2.2 cm x 1.38 cm x 0.1 cm and was stable. Tissue Analysis Reports indicated, an		ensure weekly skin assessments were completed and treatment recommendations/orders were in place. · A care plan audit was conducted by MDS to ensure that treatment recommendations/orders were on the care plan and that the care plan was being followed. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? · All nursing care team members will receive education upon hire, annually, and as needed on skin assessments, documentation, pressure ulcer/non-pressure care, treatment and notification . All current nursing care team members were educated on 2/16/2023 by DNS. · Training will be conducted upon hire and as needed by DNS or designee. · All facility policies and procedures related to skin care, wound care, and pressure injury prevention were reviewed and revised as needed. · For residents returning from the hospital, treatment recommendations/orders and wound care appointments will be transcribed and overseen by unit managers and reviewed Monday-Friday during clinical meeting. Wound NP will assess all new resident admissions.	

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	unstageable pressure wound on sacrum, a. On 1/11/23 at 8:52 a.m. measurements 3.66 cm x 1.72 cm x 0. b. On 1/18/23 at 9:10 a.m. measurements 2.2 cm x 1.8 cm x 0. A physician's order for Resident D, dated 1/5/23 indicated Santyl Ointment (a debriding agent) 250 UNIT/GM (units/gram) apply to sacrum topically every day shift for wound care. Cleanse wound with normal saline, pat dry and apply Santyl on moistened gauze, apply to wound bed and cover with foam dressing daily and as needed (prn) for soilage/dislodgement. 2. The second pressure ulcer was documented to be on the right buttock. A Pressure Ulcer-Weekly Observation report, dated 1/5/23 at 2:05 p.m., indicated stage 3 (full-thickness loss of skin in which adipose [fat] is visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present) pressure ulcer on right buttock measuring 0.8 centimeters (cm) x 0.7 cm x 0.1 cm. The first observation of ulcer was described as a stage 3 with 100 % granulation tissue present (beefy red), scant serous drainage and no odor. Pressure ulcer notes, dated 1/5/23 at 2:05 p.m., indicated first observation of an acquired stage 3 (through all layers of skin into the fat tissue) pressure ulcer on right buttock. Measurements 0.8 cm x 0.7 cm x 0.1 cm. with scant amount serous (thin watery fluid) drainage. The record lacked additional measurements of the wound after 1/5/23. 3. The third pressure ulcer was documented on the right buttock as well. A Pressure		4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? · QAPI tool will be completed by DNS or designee weekly x 4 weeks, bi-monthly x 2, and monthly x 4 months. · If 100% compliance is not obtained an action plan will be developed. This information will be presented monthly to the QAPI committee.	

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	Ulcer-Weekly Observation report, dated 1/5/23 at 2:07 p.m., indicated a stage 3 pressure ulcer on right buttock measuring 0.8 cm x 0.6 cm x 0.1 cm. The first observation of ulcer described the wound as a stage 3 with 100 % granulation tissue present, small amount serous drainage and no odor. A pressure ulcer notes, dated 1/5/23 at 2:07 p.m., indicated first observation of acquired stage 3 on right buttock. Measurements 0.8 cm x 0.6 cm x 0.1 cm. with small amount serous drainage. A physician's order for Resident D dated 1/15/23 indicated Triad Hydrophilic wound paste dressing (absorbs low to moderate amounts of fluid and creates a moist healing environment that assists with autolytic debridement). Apply to left and right buttock topically every shift for wounds. A physician's order for Resident D, dated 1/6/23, indicated low air loss mattress (mattress designed to distribute resident's body weight over a broad surface area and help prevent skin breakdown). A MAR (medication administration record), dated January 2023, indicated Triad paste was documented as applied every shift 1/5/23 through 1/27/23. The resident was in the hospital 1/22/23 through 1/27/23. Handwritten Skin Monitoring: CNA Shower Review sheets provided on 2/16/23, indicated, a. On 1/6/23, Resident D had redness/rash to the buttocks. b. On 1/10/23, Resident D had an open area on the buttocks. c. On 1/18/23, Resident D had redness/rash to the bottom and an open area on bottom. d. On 1/20/23, Resident D had an open area to			

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	buttocks. A skin care plan for Resident D, dated 1/5/23, indicated the resident had impaired skin integrity pressure ulcers on the sacrum and left and right buttocks. The goal was for tissue injury to heal and be free from complications. Interventions included assess and document skin condition, notify MD of signs of infection (redness, drainage, pain, fever). Assess for pain and treat as indicated. Assist with bed mobility to turn and reposition routinely. Assist with toileting. Check for incontinence and provide incontinence care as needed. Notify nurse of any redness or irritation. Notify MD of worsening or not improvement in wound. Pressure reduction/redistributing cushion in chair and on bed. Supplements as ordered. Wound treatment as ordered. Wound location: sacrum, right buttock, left buttock. Update to care plan on 1/9/23 indicated low air loss mattress. Nurse Practitioner (NP) 10 notes, dated 1/11/23 at 3:07 p.m., Resident D was seen for a routine visit in a wheelchair in the activity room. Nursing reported new wounds to sacrum with one (1) unstageable and two (2) stage 3 ulcers. Directed to see skin and wound assessment for more information. Wound rounds were completed and reconciled with the wound nurse. Wound NP 9 notes, dated 1/11/23 at 3:08 p.m., indicated Resident D was being seen for a comprehensive skin and wound evaluation for a sacrum unstageable pressure injury. The resident recently was ill with COVID-19 and had a decline in overall status. She developed an unstageable pressure ulcer to sacrum. Directed to see tissue analysis (TA) reports for details. An IDT Risk Review notes, dated 1/20/23 at 1:25			

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	p.m., indicated weekly follow up of weight loss and wound. Resident had a stable unstageable pressure area to sacrum and lost 2 pounds (lb.) this week. Resident had interventions and supplements in place and the plan was to continue current treatments. Care plan updated/reviewed. An eInteract Transfer Form, dated 1/22/23 at 2:35 p.m., indicated Resident D was transferred to the hospital due to shortness of breath. Section related to skin/wound care for pressure ulcers or other skin wounds, or bruises was left blank with no documentation of wounds. A Nurse's Notes, dated 1/22/23 at 8:35 p.m., indicated Resident D was admitted to a local hospital for infiltrates (pneumonia) and urinary tract infection (UTI). The resident's record lacked documentation of a left buttock pressure ulcer had been assessed and description documented. The record lacked additional documentation with measurements or descriptions of a second right buttock pressure ulcer. A significant change in condition Minimum Data Set (MDS) assessment completed on 1/18/23, assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 5 which indicated significant cognitive impairment. The resident was an extensive assistance of 2 or more (+) persons physical assist for bed mobility, transfers, toilet use and personal hygiene. The resident was always incontinent of bladder and bowel. She had had 2 or more falls since the last assessment without major injury. Resident was at risk of developing pressure ulcers/injuries and had one or more unstageable pressure ulcers.			

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A hospital report, dated 1/22/23, indicated Resident D's diagnoses included, but were not limited to, acute hypoxemia (low levels of oxygen in the blood) respiratory failure, anemia, decubitus ulcer of sacral region, and unstageable on the POA (posterior occipital or back of head), fever, tachycardia or high heart rate and leukocytosis or high white blood count), severe malnutrition, and a urinary tract infection.

During an interview and review of the resident record on 2/14/23 at 2:47 p.m., RN 7 indicated, Resident D had discharged to the hospital on 1/22/23 with an unstageable pressure wound to the sacrum. The resident had been experiencing chronic diarrhea which had made it hard to keep her clean and dry. She had documented pressure reports dated 1/5/23 to indicate a new unstageable pressure wound to the sacrum and stage 3 pressure wounds on the right and left buttocks.

During an interview on 2/15/23 at 11:04 a.m., the facility Wound NP 9 indicated when residents were newly admitted a full skin assessment was completed to look for wounds. If an existing resident developed a wound that resident was added to the list of residents to see during weekly visits. As residents were seen skin pictures were taken, a Tissue Analysis (TA) documented with an electronic list generated, and the resident was seen for follow up the next week. The TA reports were available in the resident electronic medical record (EMR) where measurements were automatically documented from the pictures using a green dot for size comparison. Upon review of her records, she had seen Resident D for an unstageable pressure ulcer on the sacrum twice on 1/11/23 and again the next week on 1/18/23. Staff had not reported any further wounds for her

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	to see. During an interview on 2/15/23 at 2:24 p.m., the Assistant Director of Nursing (ADON) indicated there was no further documentation in the resident record regarding the left and right buttock stage 3 pressure wounds after 1/5/23, when the wound NP assessed Resident D on 1/11/23 the wounds had already resolved. Residents were assessed by the nursing team and a contracted wound NP upon admission, and again during monthly skin sweeps. Residents with wounds were physically assessed by the nursing team and the contracted wound NP weekly. Nurses completed weekly skin assessments, and any resident identified with a new skin issue were reported to the unit manager (UM). The UM would then assess the skin issue and bring information to the DNS and ADON who would also assess the new wound and notify the wound NP for orders. On 2/15/23 at 3:46 p.m., the DNS provided a Skin Management policy, dated October 2019, and indicated the policy was the one currently being used by the facility. The policy indicated it was the policy of the facility to assess each resident to determine the risk of potential skin integrity impairment. Residents will have a skin assessment completed upon admission and no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment. " ...Prevention: 1. All resident beds will have a pressure reducing mattress. 2. A head to toe assessment will be completed by a licensed nurse upon admission/readmission and no less weekly ...7. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises,			

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	open areas ...Procedure For Alterations in Skin Integrity: 1. Alterations in skin integrity will be reported to the physician/NP and responsible party/family. 2. Treatment orders will be obtained. 3. All alterations in skin integrity will be documented in the medical record ...(b) All newly identified areas after admission will be documented on the weekly pressure/non-pressure evaluation ...5. Skin care interventions will be added to the caregiver Kardex. 6. IDT review of new alterations in skin will be completed weekly. 7. A plan of care will be initiated to include resident specific risk factors with appropriate intervention ...." This Federal tag relates to Complaints IN00400251 and IN00400697. 3.1-40(a)(1) 3.1-40(a)(2) 3.1-40(a)(3)			