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	345301	A. BUILDING _____ B. WING _____	C 09/24/2019

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F 000	INITIAL COMMENTS A complaint survey was conducted on 9/24/19 (Event JX5K11). The complaint survey involved one allegation, which was substantiated.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview the facility failed to place a functional air mattress on a resident's bed and failed to notify the resident's Physician of an elevated white blood cell count during the time period the resident was experiencing both a change and odor of his pressure sore for one (Resident # 1) of three sampled residents with pressure sores. The findings included: Record review revealed Resident # 1 was admitted to the facility on 8/9/19 following a hospitalization for a stroke. Additionally, the resident had diagnoses of dementia, coronary atherosclerosis, chronic kidney disease, diabetes,	F 686	White Oak Manor Burlington provides residents with pressure ulcers the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident #1 no longer resides at White Oak Manor Burlington as of 9/1/2019. An initial audit was started on 9/27/2019 of residents utilizing specialty mattresses to assure the resident is on the appropriate mattress\device and that the	10/22/19

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

Electronically Signed | 10/08/2019

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F 686	Continued From page 1 atrial fibrillation, hypertension, rhabdomyolysis, and debility. A pressure ulcer report was completed on 8/9/19 for Resident # 1. The report specified the resident had an unstageable pressure ulcer to the sacrum which was 0.5 cm (centimeters) X .5 cm. According to the report there was no necrotic tissue or drainage, and the treatment plan was "observation only." The area did not require any dressing changes. The resident's care plan, dated 8/9/19, identified the resident was at risk for skin integrity problems due to decreased mobility and incontinence. One of the interventions was to provide pressure reducing surfaces on the bed and chair. On 8/13/19 a physician's order was written for a palliative care consult. A pressure ulcer report was completed on 8/14/19. The report specified the resident continued to have the 0.5 cm X 0.5 cm unstageable skin area to the sacrum. There was no necrosis or drainage. The treatment plan was to continue observation of the area. On 8/21/19 Resident # 1's care plan was updated to note he had an unstageable pressure sore. Although not all inclusive, some of the care plan interventions were to refer the resident to the wound treatment nurse for evaluation and treatment, assess the wound for healing weekly, and provide a pressure reducing surface on the bed and chair. On 8/22/19 at 10:18 AM the Treatment Nurse documented the following. She had been made	F 686	mattress\device is functioning correctly. This will be completed by the Wound Care Nurse and finished by 10/4/2019. An initial audit of lab orders\results for residents with pressure ulcers was started on 9/27/2019 by the Wound Care Nurse to assure lab results\values were within normal limits and there was no indication of infection. This was completed by 10/4/2019. Nurses received education on proper functioning of specialty mattress\devices and if noted to not be functioning properly are to report this to the Wound Care Nurse or Director of Nursing. Additionally, the nurses received education on timely notification to the attending physician/extender of any abnormal lab values. This education was provided by the Wound Care Nurse, Staff Development Coordinator or the Director of Nursing. The education will be completed prior to 10/22/2019. Newly hired nurses receive this education during their job specific orientation by the Staff Development Coordinator or Wound Care Nurse. An extra specialty mattress with a pump will be kept at the facility to assure availability for resident use when it is needed. The extra specialty mattress was ordered and available for use as of 9/13/2019. The Wound Nurse will notify the Director of Nursing and the Administrator if the	

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F 686	Continued From page 2 aware Resident # 1 had skin breakdown. Upon assessment she found the resident to have a 2.5 cm X 2.3 cm X undetermined depth pressure sore. The wound bed was 90 % yellow slough (unhealthy tissue) and 10 % pink epithelial tissue (healthy tissue). There was moderate sero-sanguineous drainage, and the pressure sore would be treated with calcium alginate silver (an absorbent dressing that promotes healing) and covered with a foam dressing. The dressing would be done daily and as needed. Interview with the Treatment Nurse on 9/4/19 at 2:15 PM revealed 8/22/19 was the first time she assessed the resident. She recalled a staff member had summoned her to look at Resident # 1's skin. On the date of 8/22/19, there was some healthy pink skin in the wound bed, and therefore a treatment per the facility's protocol was begun. On 8/22/19 a physician's order was obtained for the daily calcium alginate silver dressing with a foam covering. Review of the August 2019 Treatment Administration Record revealed the 8/22/19 treatment order was initiated and carried out beginning 8/22/19. This order remained active until 8/26/19. On 8/23/19 at 9:27 AM the Registered Dietician documented, "CNA (certified nurse aide) reported that (resident) refused to be weighed yesterday." On Resident # 1's admission MDS (Minimum Data Set) assessment, dated 8/23/19, the resident was assessed to be moderately cognitively impaired and required extensive assistance with his hygiene, toileting needs, and	F 686	extra specialty mattress\device will be put to use. Medical Supply will immediately order another mattress\device to ensure an extra is available in the facility. If another resident needs a specialty mattress prior to the arrival of the ordered mattress, the facility will reach out to contracted vendors, sister facilities and \or a local vendor to obtain or rent a specialty mattress until the ordered one arrives. A weekly audit by the Wound Care Nurse or Safety Nurse, starting the week of 10/7/19 will be completed to monitor pressure relieving mattresses\devices to assure they are in place and functioning correctly. The audit will be completed weekly for 4 weeks, then monthly audits will be done for 2 months and randomly thereafter to ensure ongoing compliance to F686. The Director of Nursing, the Staff Development Coordinator or the Nursing Supervisor will audit the lab results weekly for four weeks, monthly for two months and then periodically thereafter to monitor for physician\extender notification for abnormal lab results and that it is reflected in the documentation along with any change in orders. This was started the week of 10/7/2019. The Director of Nursing and\or the Nursing Supervisor, using the lab manifest, will monitor the daily labs to ensure the lab specimen was obtained and documented as completed, this was started on 9/30/2019. The evening	

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F 686	Continued From page 3 bathing needs. The resident was coded as being frequently incontinent of both bowel and bladder, and as having one unstageable pressure sore. On 8/23/19 the social worker entered a notation within the record noting Resident # 1 rejected care. On 8/23/19 Resident # 1's care plan was updated to reflect he had a history of rejecting care. The care plan directed staff not to challenge the content of the resident's behavior and report the onset or increase in behaviors to his physician. The care plan was also updated to reflect he needed increased nutrients to heal his pressure sore. The care plan directed that the resident would be served whole milk every morning, served large portions for breakfast and lunch, and provided vitamin and mineral supplementation. On 8/26/19 the resident's treatment orders for the pressure sore were changed to the following. The area was to be cleansed with Dakin's solution (a solution made from diluted bleach and which helps kill viruses and bacteria). The wound was to also be treated with Santyl (an ointment used to help remove dead tissue from a wound bed). The area was also to be filled with calcium alginate and covered with a foam dressing. The dressing was to be done on a daily and as needed basis. Review of the August 2019 Treatment Administration Record revealed the new treatment order was initiated and carried out beginning 8/27/19. This order remained active through the resident's discharge. On 8/27/19 the Treatment Nurse documented the following. She had noticed a decline in Resident #	F 686	supervisor will be provided with the lab manifest daily to ensure adequate follow up, i.e.: physician\extender notification of abnormal lab values, this was started 9/30/2019. The evening supervisor will sign the manifest, meaning all was complete and notification has occurred, and return to the Director of Nursing daily to assure ongoing compliance. This will continue on an ongoing basis. This was initiated on 9/30/2019. The Director of Nursing is responsible for ongoing compliance to F686. Any concerns will be discussed in daily meetings.	

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1's pressure sore on the date of 8/26/19. The pressure sore had a foul odor on 8/26/19, and the wound bed was completely necrotic. The measurements were documented as 2.5 cm X 2.3 cm X 1. 3 cm. The wound nurse also documented she spoke with the physician and responsible party, and she had ordered an air mattress for the resident.

On 8/27/19 Resident # 1 had a CBC (Complete Blood Count) completed. The results showed the resident's WBC (White Blood Cell) count was elevated. The result was 11. 1 (normal 4.1 to 10.9). (An elevated white blood cell count can sometimes indicate an infection).

On 8/27/19 a physician's order was written to repeat the CBC on Thursday, 8/29/19.

On 8/28/19 a note was made in the record that physical therapy would be doing diathermy ultrasound to the resident's wound. (Ultrasound is used to stimulate circulation to wounds in order to facilitate healing).

Interview with the Treatment Nurse on 9/4/19 at 2:15 PM and again on 9/4/19 at 3:20 PM revealed the following information. She recalled looking at Resident # 1's pressure sore on the Friday of 8/23/19. She next returned to work on Monday, 8/26/19, and observed a noticeable decline in the wound bed. Monday (8/26/19) was the first time she noticed a foul odor, and the wound bed had changed in three days from having some pink healthy tissue to being totally necrotic. She had spoken to the physician and the family. The resident liked to be out of bed a lot. Per the treatment nurse, the resident had a pressure relieving wheelchair cushion, but she felt he

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needed to lie down more often and she had spoken to the family and obtained a different mattress for him on 8/26/19. Per the facility's protocol the resident was to have a mattress which circulated air beneath the resident by using a pump while he was in bed. She placed an air flow mattress on Resident # 1's bed on 8/26/19, but on the day she placed it on his bed, the pump broke and did not circulate the air. There was not another replacement pump in the facility. She therefore had to order one, but it never came before the resident was later discharged on 9/1/19. Therefore, the treatment nurse stated the resident would have still needed to have been turned because the air mattress he was on did not have a working pump to circulate the air and relieve pressure beneath him. She was aware of the wound odor but stated she had never observed purulent drainage from the wound bed, and she had gotten an order to use Dakin's to cleanse the wound because of the odor. The Treatment Nurse thought the odor might have been coming from the necrotic tissue. The Treatment Nurse was not aware the resident had an elevated white blood cell count prior to his discharge.

Interview with Nurse Aide (NA) # 1 on 9/24/19 at 3:10 PM revealed Resident # 1 was combative most of the time and refused help with incontinent care, turning and positioning. The NA also stated the resident would tear off his brief and dig into his wound.

Record review revealed Resident # 1's CBC was redrawn on Friday (8/30/19) rather than Thursday (8/29/19) secondary to the resident's refusal on 8/29/19. The lab result, dated 8/30/19, showed Resident # 1's White Blood Count had increased

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to 14.3. According to the lab record, the result was faxed to the facility on 8/30/19 at 3:39 PM. There was no documentation the physician was called and consulted when the lab returned to the facility. There were no nursing progress notes on 8/30/19 or 8/31/19.

On 9/1/19 at 10:02 AM Nurse # 2 documented the resident complained of pain to the sacrum during his treatment. The resident's vital signs were as follows: blood pressure 76/47; pulse 111; respirations 22; and temperature 99.8. Nurse # 2 noted she notified the physician of the recent white blood count and vital signs. An order was obtained to send the resident out to the emergency room.

Review of Resident # 1's hospital admission records, emergency records, and hospital progress notes for the hospitalization beginning 9/1/19 revealed Resident # 1 was admitted with sepsis due to an infected pressure sore to the sacrum. The emergency department physician noted the pressure sore had foul, purulent drainage. A surgical consult was obtained and Resident # 1 underwent surgical cleansing and debridement of the wound on 9/3/19. Antibiotics were started. After debridement, the resident's bone was exposed in the sacral area due to the amount of skin injury which had occurred.

The Second Shift Supervisor was interviewed on 9/24/19 at 3:10 PM. The Supervisor stated if she had seen Resident # 1's white blood count had been elevated to 14. 3 on 8/30/19, she would have called the physician. She did not recall why she had not seen the labs on the evening of 8/30/19 but stated that was the first day she was supervisor following her orientation and she may

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have gotten busy. She did not recall anything in supervisor's report about Resident # 1's pressure sore being worse or odorous.

Interview with the Treatment Nurse on 9/4/19 at 3:20 PM revealed per her assessment of the declining wound, Resident # 1 had needed the constant air flow mattress. She did not know why the pump had never been delivered to the facility to replace the broken one on the resident's bed. The treatment nurse stated corporate had helped handle the replacement request. The treatment nurse stated the facility usually kept spare air mattresses and pumps on hand, but there had been no replacement in the facility when Resident # 1's was broken.

The DON was interviewed on 9/24/19 at 2:40 PM. The DON stated he knew the resident had not been eating well and refused care which had contributed to the pressure sore worsening. He also stated the Treatment Nurse oversaw when pressure relieving mattresses needed to be implemented, and therefore the treatment nurse had handled that. Regarding the failure to report the elevated white blood count, the DON stated the supervisor on second shift should have reviewed the labs on the evening of 8/30/19 and called the physician when Resident # 1's white blood cell count was 14.3. The DON stated a new nurse had just started in the supervisory position on 8/30/19, and this may have led to the elevated WBC result not being called to the physician.

Resident # 1's facility medical physician was interviewed on 9/24/19 at 1:30 PM and 9/24/19 at 3:25 PM. The physician reported the following information. She was aware the resident's wound

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had a foul odor and the Dakin's solution was intended to help with that. She was also aware the resident had a border line elevated WBC on 8/27/19, and it was her intent to monitor this by ordering that the lab be repeated on Thursday 8/29/19. The Physician stated she would have ordered antibiotics for Resident # 1 on Friday, 8/30/19, if the staff had called her when the WBC returned further elevated, but they had not done so. The Physician also stated it was her opinion that if she had started the antibiotics on 8/30/19 it would not have changed the outcome for Resident # 1 in anyway. According to the Physician, the resident had shown a history of elevated white blood counts near the beginning of August 2019, and it was possible some of the skin injury had occurred below the skin surface before the wound opened. The resident had multiple medical diagnoses which contributed to the development and lack of healing of the wound. Also, his refusal of care had contributed to the development and lack of healing. The Physician stated she had personally witnessed the resident refuse care. According to the physician the decline in the resident's pressure sore was unavoidable regardless of services rendered.