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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted onsite on 01/27/21. Additional information was obtained offsite on 01/28/21 - 02/10/21. Therefore the exit day was 02/10/21. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (K). The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/05/20 and was removed on 02/05/21. An extended survey was conducted. 1 of 14 complaint allegations was substantiated with deficency.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		3/8/21

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

Electronically Signed | 02/25/2021

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F 600	Continued From page 1 by: Based on physician interview, nurse practitioner interview, staff interview, and record review the facility neglected 1 of 2 sampled residents (Resident #6) reviewed for pressure ulcers when the facility failed to assess excoriation to the sacrum for eight days after it was identified, failed to obtain treatment orders for ten days after the skin impairment was identified, and failed to enter and initiate the treatment orders provided by the Wound Nurse Practitioner (NP) for eleven days in response to deterioration of the sacral wound. These delays in wound assessment, initiation of wound treatment, and implementation of changes to the treatment process resulted in Resident #6's sacral pressure getting larger, deeper, and developing a foul odor, with the resident eventually developing sepsis. After discharge from the nursing home, tunneling (channels that extended from the wound into and through tissue and/or muscle) was identified in the resident's sacral wound at the hospital, and Resident #6 passed away in hospice care with her death certificate documenting "sepsis due to pressure ulcer" as the immediate cause of death. Immediate Jeopardy began on 08/05/20 when the facility failed to complete a comprehensive assessment and treat Resident #6's sacral wound, and neglected to provide ongoing care and services necessary to prevent deterioration of the wound. The Immediate Jeopardy was removed on 02/05/21 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring	F 600	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? All residents have the potential to be affected. Unable to correct deficiency for the identified resident due to resident being discharged. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? New admissions and readmissions were reviewed by Senior Nurse Consultant for the past 30 days to ensure the skin observation was completed on the day of admission to identify any necessary skin interventions. Interventions would include, but not limited to if wounds were present, facility will ensure that orders were written, treatments were initiated, and appropriate notification upon identification to MD/NP. All wound care orders provided by attending physician in the past 30 days were audited by Senior Nurse Consultant for all current residents to	

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F 600	Continued From page 2 systems put into place are effective. Findings included: Review of a hospital Discharge Summary revealed Resident #6 was hospitalized from 07/31/20 until 08/05/20. The report did not document any problems with the resident's skin integrity at discharge other than a surgical incision to the resident's left hip post left-hemiarthroplasty (surgical procedure to repair fracture). However, Desitin Rapid Relief (zinc oxide), frequently used as a barrier to prevent skin irritation and excoriation, was documented as a medication to be discontinued. 08/03/20 lab work documented Resident #6's albumin (a protein which helps with skin repair) level was low at 3.0 milligrams per deciliter (mg/dL) with the normal range being 3.5 - 5.7 mg/dL. Resident # 6's medical record documented she was admitted to the facility on 08/05/20. Her documented diagnoses included left femur (hip) fracture, sacral pressure ulcer, and bilateral heel blisters/pressure ulcers. A 08/06/20 Braden Scale for Predicting Pressure Sore Risk documented Resident #6 was at high risk for pressure ulcers. The assessment identified the resident as having very limited sensory perception, having very moist skin, being chairfast, having very limited ability to change/control body position, having probable inadequate nutritional intake, and having a problem with friction and shearing. A 08/06/2020 12:53 PM Nursing Progress Note documented, "(Resident #6) refused breakfast and lunch today. Alternatives encouraged-	F 600	ensure that orders are being followed by verifying the care provided matches order. All licensed nursing staff were educated that upon admission, readmission, and any newly identified wounds on how to conduct an appropriate skin assessment and the appropriate interventions that they are responsible for. All licensed nursing staff will be educated on skin assessment schedule and schedules will be reviewed All licensed nursing staff were educated on abuse/neglect policy as it relates to patient care by Administrative Nurses and Senior Nurse Consultants. All Nursing assistants were educated on appropriate ADL care and the requirement to report any skin issues immediately to charge nurse by Administrative nurses and Senior Nurse Consultants. 100% skin audit was completed by Administrative Nurses and Senior Nurse Consultants. All Licensed Nursing Staff have been educated on Skin Assessment Policy to address and timely communicate any identified skin concerns. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Nurse Manager will be notified of new	

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refused....Refused to eat or drink this morning, multiple attempts made..."

On 08/06/20 "(Resident #6) has impaired skin integrity related to incontinence of (bowel and bladder) incontinence, impaired mobility, admitted with surgical wound to left hip" was identified as a problem in the resident's care plan. Approaches for the problem included, "Monitor for (signs and symptoms) of infection daily. Refer to wound care team as needed. Report any changes to provider. Treatments as ordered."

In her 08/06/20 1:54 PM Late Entry Admission Note the admitting nurse (Nurse #1) documented Resident #6 was suffering from debility associated with a left hip fracture and status post-surgery whose recovery was hindered by congestive heart failure, atrial fibrillation, dementia, and a history of breast cancer. "Excoriations on sacrum with protective foam noted..."

In her 08/06/20 2:13 PM Admission Observation Nurse #1 documented Resident #6 had a sacral pressure ulcer which measured 0.1 x 0.1 centimeters (cm) with no depth and a pressure ulcer to the coccyx which also measured 0.1 x 0.1 cm with no depth.

In his nursing home History and Physical, completed on 08/06/20 at 2:30 PM, Physician #1 documented Resident #6 was discharged to the nursing home for medical management as well as continued rehabilitation. Associated signs and symptoms included "positive for pain, negative for skin breakdown, and positive for weakness." An incision to the left hip with staples and bruising to the left lower extremity was noted. "Extremity:

admissions/readmissions by Admissions Director and new admissions/readmissions will be reviewed in morning clinical meeting by nurse manager to identify if skin observation was completed and if applicable to ensure wound care orders and necessary interventions were initiated. Senior Nurse Consultant educated and reviewed 24-hour chart report process and responsibility with Nurse Managers.

Nurse Manager will review skin audits the following day to ensure proper identification, observation, notification, orders, orders initiated. Nurse Managers were educated related to this process.

IDT team will meet weekly w/ Wound NP to include, but not limited to by ensuring that wounds continue to be monitored for changes, treatments changed as needed, appropriate notifications and monitoring.

The treatment nurse will be responsible for functioning with her respective role and should any need occur outside the scope of functioning as a treatment nurse the treatment nurse will notify the Director of Health Services immediately and a plan of coverage will be established by the DHS.

How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.

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F 600	Continued From page 4 no ulceration" was also documented. Edema to the bilateral lower extremities ranging form 1+ non-pitting edema to a trace of pitting edema was noted. During a telephone interview with Nurse #1 on 01/28/21 at 1:50 PM she stated in her Admission Observation 0.1 x 0.1 cm was not an actual measurement, but a place holder to let the Treatment Nurse know that Resident #6 had some type of skin impairment on the sacrum and coccyx which needed to be assessed. She explained she was not allowed to measure or stage wounds, and the Treatment Nurse set the treatments which were appropriate for the wounds. Nurse #1 stated it looked like to her that the first layer of skin had been pulled off areas on Resident #6's sacrum and coccyx. She commented she thought when the Treatment Nurse assessed the wounds later in the day or the next morning she would discover stage I or stage II pressure ulcers. According to Nurse #1, the Treatment Nurse would decide upon the appropriate treatment at that time. A 08/07/20 9:36 AM Physician Assistant (PA) Note documented, "...Frail elderly with muscle wasting- concern for poor recovery/poor prognosis from...surgery." The PA documented she was working with the facility's Registered Dietitian (RD) to provide the resident with nutritional supplementation. A 08/09/20 12:59 PM Nursing Progress Note documented Resident #6 was refusing medications and spitting out her food, refusing to eat. In her 08/10/20 Weekly Skin Check Nurse #2	F 600	DHS will review weekly body audits in IDT team meeting to ensure proper identification, observation, notification, orders, orders initiated. Administrator will audit to ensure IDT team will meet weekly w/ Wound NP to include, but not limited to by ensuring that wounds continue to be monitored for changes, treatments changed as needed, appropriate notifications and monitoring. DHS will audit to ensure that the treatment nurse will be responsible for functioning with her respective role and should any need occur outside the scope of functioning as a treatment nurse the treatment nurse has notified the Director of Health Services immediately and a plan of coverage will be established by the DHS. Results will be presented by the Director of Health Services to the Quality Assurance Performance Improvement Committee meetings monthly for 90 days and then quarterly thereafter. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Date of Compliance: 3/8/21	

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documented Resident #6's skin was warm and dry with normal color and skin turgor. "No alterations in skin integrity."

During a telephone interview with Nurse #2 on 01/28/21 at 12:12 PM she stated the weekly skin checks were head to toe assessments, and during those assessments the nurse was only looking for skin integrity issues which had newly emerged since the previous weekly wound assessment or the admission assessment. She reported her documentation on the 08/10/20 Weekly Skin Check meant there were no new wounds, bruises, abrasions, or skin tears found on Resident #6 other than what was identified during previous assessments. Nurse #2 commented she could not remember if there were still skin impairment issues on the resident's sacrum or if the area was covered by some type of dressing. According to Nurse #2, it was not the nurse's responsibility to assess pre-existing wounds during Weekly Skin Checks.

Resident #6's 08/10/20 admission minimum data set (MDS) documented she had short and long term memory impairment, her decision making skills were severely impaired, she exhibited no behaviors including resistance to care, she required extensive assistance from the staff with bed mobility/eating, she was dependent on staff for transfers/dressing/toileting/hygiene/bathing, she was always incontinent of bowel and bladder, she was 66 inches tall and weighed 100 pounds, she had no skin ulcers, she had a surgical wound, and she had pressure-reducing devices for her bed.

Review of wound documentation revealed Resident #6's sacral/coccyx wound was

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assessed by the facility's Treatment Nurse and Wound Care Nurse Practitioner (NP) on 08/13/20.

In her 08/13/20 Wound Management Detail Report the Treatment Nurse documented Resident #6 had an unstageable pressure ulcer to her sacrum which measured 2.5 x 1.5 x 0.2 cm with a moderate amount of seropurulent (malodorous) drainage which was yellow or tan, cloudy, and thick. The Treatment Nurse documented the wound bed was comprised of slough, but there was no undermining or tunneling. She also noted, "LAL (low air loss mattress) ordered and placed on bed."

During a telephone interview with the facility's Treatment Nurse on 01/28/21 at 12 noon she stated she had a communication book in which a nurse had documented on 08/06/20 that Resident #6 had a wound to her sacrum which needed to be assessed. However, she reported she could not read the nurse's initials. She commented that the way the system was set up was the admitting nurse should have notified the hall nurse that the resident had a wound, and the hall nurse would have done a preliminary assessment, and a treatment would have been put in place and entered into the electronic medical record system until she (the Treatment Nurse) could have measured, staged, and assessed the wound, and decided if the treatment could remain the same or needed to be changed. According to the Treatment Nurse, it was important for her to assess wounds quickly, usually the day the wound was identified or the day after at the latest, because sometimes what might look like an excoriation to a nurse who did not have wound care training might actually be discolored tissue

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with more serious things going on underneath. The Treatment Nurse stated she was delayed in assessing Resident #6's sacral wound because she was pulled to work a hall medication cart for a week. She reported she had no wound care back-up when she was pulled to administer medications.

In her 08/13/20 Evaluation and Management Report the Wound NP documented, "...She was admitted with an unstageable pressure ulcer to the sacrum. There is black-yellow colored necrotic tissue present in the wound bed. There is a musky odor to the wound exudate. The wound will be cleaned with Dakin's 0.5% moistened gauze. The wound will be treated with Santyl ointment...."

Review of Resident #6's August 2020 Treatment Administration Record (TAR) documented the first time the resident received a wound treatment to her sacrum via physician order was on 08/15/20 to "Cleanse sacrum with Dakin's 0.5% solution, apply Santyl ointment nickel thickness to wound bed, cover with dry dressing, change daily and prn (as needed)."

During a telephone interview with the facility's Treatment Nurse on 01/28/21 at 2:02 PM she stated if Resident #6 had a true excoriation to her sacrum/coccyx on admission barrier cream could have been utilized, and a physician order was not necessary. However, she reported if the resident had a stage II pressure ulcer on admission the admission nurse or hall nurse should have entered the standing order into the electronic medical record system: wound cleanser followed by application of a hydrocolloid dressing secured with Tegaderm film to be changed every 3 days

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and prn (as needed). She commented she could not explain why the treatment recommended by the Wound NP on 08/13/20 was not implemented until 08/15/20. After reviewing Resident #6's August 2020 TAR she stated it appeared there was some confusion about getting the correct order into the electronic medical record system. She stated facility staff entered physician orders into the electronic medical system.

In her 08/17/20 Weekly Skin Check Nurse #2 documented Resident #6's skin was warm and dry with normal color and skin turgor. She noted the resident now had blisters on her bilateral heels.

A 08/20/20 10:52 AM PA Note documented Resident #6 was seen for ongoing poor intake of food and liquids. The resident refused to drink a supplemental shake for the PA, refusing to open her mouth. The resident reported she was not hungry. The PA documented she spoke with a family member who stated she had no problem consulting hospice since the resident continued to refuse to eat.

In her 08/21/20 Wound Management Detail Report the Treatment Nurse documented Resident #6 had an unstageable pressure ulcer to her sacrum which measured 3.5 x 2.5 x 0.4 cm with a moderate amount of seropurulent (malodorous) drainage which was yellow or tan, cloudy, and thick. The Treatment Nurse documented the wound bed was comprised of slough/eschar. She also documented wound odor was present, and described this wound odor as "foul."

During a telephone interview with the facility's

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Treatment Nurse on 01/29/20 at 9:10 AM she stated she recollected the wound bed of Resident #6's sacral pressure remaining about 20 - 25% eschar and 75 - 80% slough during her entire nursing home stay. She reported the resident's wound did not receive physical debridement while in the facility.

In her 08/21/20 Evaluation and Management Report the Wound NP documented, "...The wound to the sacrum has increased in volume, and the base of the wound continues to be obscured by necrotic tissue. The wound exudate is malodorous. The treatment for the sacral wound will be changed to Dakin's 0.5% moistened gauze. There is moderate erythema to the peri-wound with accompanying warmth...." The NP also documented in her report that Resident #6's white blood count (WBC) was within normal limits per 08/18/20 lab results.

During a telephone interview with the Wound NP on 01/28/21 at 11:40 AM she stated there was a difference between malodorous drainage on an old dressing which was being removed and a wound itself being malodorous after it was cleaned with normal saline or wound cleanser. She reported the latter scenario was more serious, and appeared to be what was captured in the Treatment Nurse's 08/21/20 Wound Management Detail Report. She commented she realized a change in treatment needed to be made, but decided to change the wound treatment on 08/21/20 rather than start an antibiotic then since Resident #6 was not running a temperature and had a recent white blood cell count which was within normal limits. According to the Wound NP, on 08/21/20 she recommended discontinuing use of the Santyl and applying

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Dakin's-soaked gauze to the wound bed daily instead. She commented that Resident #6 was elderly, frail, and not eating, and under those circumstances a wound could decline significantly in as little as twelve hours. She stated under those circumstances in was important to respond quickly to declining wounds.

Review of Resident #6's August 2020 TAR revealed the resident continued to receive Santyl in her sacral wound bed through 08/30/20.

During a telephone interview with the facility's Treatment Nurse on 01/28/21 at 2:02 PM she stated she could not explain why the change from Santyl to Dakin's-saturated gauze which was recommended by the Wound NP on 08/21/20 was not placed in Resident #6's electronic medical record and implemented until 08/31/20.

In her 08/24/20 Weekly Skin Assessment Nurse #2 documented Resident #6's skin was warm and dry with normal color and skin turgor. "Existing skin issues still present."

In his 08/25/20 5:07 PM Progress Note Nurse #3 documented Resident #6 was alert and oriented x 1, she had a poor appetite, and her sacral wound "had foul smell and black tissue. Notified the Wound Treatment Nurse. Changed wound dressing as directed...."

During a telephone interview with the facility's Treatment Nurse on 01/28/21 at 2:02 PM she stated Nurse #3 no longer worked in the facility. She reviewed her communication notebook and found no entry by Nurse #3 in regard to Resident #6's wounds, but she reported this nurse often relayed information to her verbally in passing.

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She commented she may have told Nurse #3 that Resident #6 had an upcoming wound assessment due soon, and she would look more closely at the sacral wound then.

In her 08/28/20 Wound Management Detail Report the Treatment Nurse documented Resident #6 had an unstageable pressure ulcer to her sacrum which measured 5 x 3.5 x 1 cm with a moderate amount of seropurulent (malodorous) drainage which was yellow or tan, cloudy, and thick. The Treatment Nurse documented the wound bed was comprised of slough/eschar.

In her 08/28/20 Evaluation and Management Report the NP documented, "...The wound to the sacrum has increased in size. There is malodorous wound exudate, and there is erythema with accompanying warmth to the peri-wound. (Resident #6) will be started on a course of oral doxycycline (antibiotic) for cellulitis. Topical treatment for the wound will be changed to Dakin's 0.5% BID (twice daily)...."

Review of Resident #6's August 2020 TAR revealed the first time her sacral wound bed was treated with Dakin's-soaked gauze at all was on 08/31/20.

During a telephone interview with the facility's Treatment Nurse on 01/28/21 at 2:02 PM she stated she could not explain why the treatment recommended by the wound NP on 08/28/20 was not entered into the facility's electronic medical record and implemented until 08/31/20.

A 08/28/20 physician's order initiated doxycycline hyclate (an antibiotic) 100 mg BID x 10 days for

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wound infection. Review of Resident #6's August 2020 and September 2020 Medication Administration Records (MAR's) revealed the order was immediately implemented and administered as ordered until the resident's 09/03/20 discharge from the facility.

08/31/20 lab results documented Resident #6's albumin level was within normal range at 3.5 mg/dL with the normal range being 3.5 - 5.2 mg/dL.

Review of Resident #6's August 2020 MAR revealed Nurse #4 documented she completed a skin check for Resident #6 on 08/31/20, but did not complete a corresponding Weekly Skin Check document.

A 09/01/20 10/17 AM PA Note documented, "... (Resident #6) seen for discharge plans. She is scheduled to discharge to (assisted living) with hospice on 09/03/20...."

During a telephone interview with Nurse #4 on 01/28/21 at 1:31 PM she stated she not only completed a skin check on Resident #6 on 08/31/20, but she changed the resident's dressings on the morning of 09/03/20 before the resident was transferred out of the nursing home back to the assisted living facility where she had resided prior to a fall and subsequent hip fracture. She reported she could recall the sacral wound was large, full of necrotic tissue, and produced a large amount of drainage. However, she commented she did not remember the sacral wound having foul odor. According to Nurse #4, Resident #6 was only alert and oriented x 1 on her best of days, was dependent on the staff for all of her activities of daily living, was totally

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incontinent of bowel and bladder, was bedbound for most of her stay, and would purse her lips and clench her mouth frequently when food and medications were offered.

A 01/29/21 8:31 AM telephone interview was conducted with Physician #1 who cared for Resident #6 during her nursing home stay. He stated the Wound Care NP and facility's Treatment Nurse worked together to assess wounds and make recommendations. He reported he was available for consult if they needed him. He commented he expected the facility to implement the Wound Care NP's recommendations and immediately enter her orders into the facility's electronic medical record system. He stated foul wound odor and increasing size of the wound would cause him to "raise an eyebrow." He explained interventions needed to be put in place quickly when caring for residents who were frail and not eating and drinking well. According to the physician, wounds in such individuals could deteriorate in as little as 24 hours. He stated wound-related sepsis needed to be avoided, and signs of such included fever, tachycardia, elevated lactic acid, and elevated white blood cell count. He stated wounds not being treated with antibiotics which were malodorous, were deep and large in size, were presenting with increased necrotic tissue in the wound bed, and which developed tunneling were at an increased risk of becoming septic.

During a telephone interview with the facility's Administrator on 01/29/21 at 11:13 AM he stated the Treatment Nurse was expected to assess new wounds within a couple of days of being identified. He also reported orders provided by the Wound NP were supposed to be entered into

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the electronic medical record and implemented immediately without delay.

Review of 09/03/20 hospital Emergency Department (ED) notes revealed the receiving assisted living facility immediately sent Resident #6 out to the emergency room (ER) when her wounds were assessed on admission there. The assisted living facility was concerned about the necrotic pressure ulcer which presented with a strong, foul odor. "She (Resident #6) has this large stage IV decubitus ulcer to the sacrum with foul-smelling purulent drainage with necrotic tissue. She also has some mild skin breakdown to bilateral heels...At this point will place an IV and give her fluids and prophylactic antibiotics for this open wound to her sacrum. Will obtain labs to look for any signs of sepsis...." The ED notes also documented "...95 year old female with past medical history of ...failure to thrive ...Her vital signs here are stable except for her elevated heart rate at 146. Her physical exam findings were positive for her tachycardia where she is going in and out of (atrial fibrillation) ....(Family member) states that she is chronically in and out of (atrial fibrillation) ...(Family member) states that we can do whatever we feel is necessary but feels that (the resident) is giving up and is wanting to die ....Spoke to (assisted living facility) ...states that when she left to go the (nursing home) after breaking her hip she did have this small little sore on her bottom, but it was nowhere near the size of what it is now ...Patient labs are nonactionable with a normal white count and lactic acid. She does not appear to be severely dehydrated either ...."

Review of lab results from 09/03/20 ED lab draws revealed Resident #6's WBC and lactic acid were

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within normal limits, the blood culture was negative for growth after 6 days of incubation, and the wound culture gram stain documented, "Few WBC's, moderate gram-positive cocci in singles and pairs, few gram-positive rods, and few gram-negative rods." The ER noted the resident was being admitted to the hospital for wound care and tachyarrhythmia of her heart.

A 09/04/20 hospital wound consult documented Resident #6 had a stage IV sacral pressure ulcer which presented with a "necrotic, painful, palpable bone" appearance. The wound measured 5.5 x 4 x 2 cm with 3.5 cm of undermining. The wound presented with a moderate amount of purulent drainage.

A 09/08/20 hospital Discharge Summary documented Resident #6's discharge diagnoses included (in order listed on report): tachyarrhythmia, congestive heart failure, chronic atrial fibrillation, hypertension, pacemaker, sick sinus syndrome, hip fracture, malignant neoplasm of upper-outer quadrant of left breast, hypothyroidism, and sacral decubitus ulcer Stage IV. "Family does not want to continue antibiotic treatment....Case manager notified regarding hospice and comfort care. Plan is to discharge patient to hospice house...."

A 09/18/20 death certificate documented "sepsis due to pressure ulcer" as the immediate cause of Resident #6's death.

On 02/03/21 at 9:20 AM the Administrator was notified of the Immediate Jeopardy by phone.

The facility's credible allegation of Immediate Jeopardy removal for F-600 Neglect included the

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following:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the non-compliance.

All residents have the potential to be affected. Unable to correct deficiency for the identified resident due to resident being discharged. It was identified that a comprehensive nurse assessment was not completed upon admission and no treatment order was obtained following identification. Orders were not initiated correctly upon being provided by Wound NP.

New admissions and readmissions will be reviewed by Senior Nurse Consultant for the past 30 days by 2/4 to ensure the skin observation was completed on the day of admission to identify any necessary skin interventions. Interventions would include, but not limited to if wounds were present, facility will ensure that orders were written, treatments were initiated, and appropriate notification upon identification to MD/NP.

All wound care orders provided by attending physician in the past 30 days will be audited by Senior Nurse Consultant by 2/4 for all current residents to ensure that all orders are being followed by verifying care provided matches order.

2.) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

All licensed nursing staff will be educated that upon admission, readmission, and any newly

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identified wounds on how to conduct an appropriate skin assessment and the appropriate interventions that they are responsible for. Nurses will be educated on these appropriate interventions such as observation, writing orders, initiating orders for the wound care to be provided, and appropriate notification upon identification to MD/NP and notification of IDT team. Immediate education was conducted by Administrative Nurses and Senior Clinical Consultants on 2/3/2021 and ongoing- to be completed by 2/5.

All licensed nursing staff will be educated on skin assessment schedule and schedules will be reviewed.

All licensed nursing staff will be educated on abuse/neglect policy as it relates to patient care by Administrative Nurses and Senior Nurse Consultants on 2/3 and ongoing- to be completed by 2/5.

All Nursing assistants will be educated on appropriate ADL care and the requirement to report any skin issues immediately to charge nurse by 2/5 via Administrative nurses and Senior Nurse Consultants.

100% skin audit has been completed on 2/3 by Administrative Nurses and Senior Nurse Consultants. All Licensed Nursing Staff have been educated on Skin Assessment Policy to address and timely communicate any identified skin concerns. IDT team was notified on 2/4 to meet weekly to review Wounds and interventions beginning 2/5.

Nurse Manager will be notified of new

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admissions/readmissions by Admissions Director and new admissions/readmissions will be reviewed in morning clinical meeting by nurse manager to identify if skin observation was completed and if applicable to ensure wound care orders and necessary interventions were initiated by 2/4. Senior Nurse Consultant will educate and review 24-hour chart report process and responsibility with Nurse Managers by 2/4/21.

Nurse Manager will review skin audits the following day to ensure proper identification, observation, notification, orders, orders initiated. Nurse Managers educated on 2/4 related to this process.

IDT team will meet weekly w/ Wound NP to include, but not limited to by ensuring that wounds continue to be monitored for changes, treatments changed as needed, appropriate notifications and monitoring.

The Treatment Nurse will be responsible for functioning with her respective role and should any need occur outside the scope of functioning as a Treatment Nurse the Treatment Nurse will notify the Director of Health Services immediately and a plan of coverage will be established by the DHS. DHS and Treatment nurse were educated on 2/4.

PruittHealth Raleigh alleges the removal of Immediate Jeopardy on 02/05/21.

On 02/10/21 at 1:45 PM, the facility's credible allegation for Immediate Jeopardy removal was validated by the following:
*review of facility-wide audits including head-to-toe skin checks on 98 residents, skin

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F 600	Continued From page 19 observations completed for admits/re-admits on the day of admission/re-admission (for the past 30 days), implementation of wound care orders for 34 residents (for the past 30 days). *review of outlines/handouts/agendas/sign-in sheets for in-servicing regarding the facility wound policy/procedure, ADL care and reporting of new or worsening skin integrity issues, charting process and meetings related to interdisciplinary detection and treatment input on wounds, and neglect. *interviews with nurses who worked from 7:00 AM until 7:00 PM, nurses who worked from 7:00 PM until 7:00 AM, nursing assistants (NAs) who worked first shift, NAs who worked second shift, NAs who worked third shift, the nurse manager for week days, and the nurse manager for weekends about the key points that were emphasized during their in-servicing. *review of daily body check audits *review of minutes from the 02/04/21 Weekly Patients at Risk Meeting Wounds meeting which was attended by the Dietary Manager, Nurse Navigator, Registered Dietitian, Therapy Manager, Treatment Nurse, Wound NP, Social Workers, MDS Coordinator, and Director of Nursing. *review of minutes from the 02/05/21 QAPI meeting which focused on review of the citation at F600. *interview with Treatment Nurse about being pulled to complete other tasks without back-up to complete wound assessment tasks. The credible allegation of Immediate Jeopardy removal on 02/05/21 was confirmed on 02/10/21.	F 600		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		3/15/21

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F 688	Continued From page 20 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility failed to provide palm guards and restorative services for 1 of 1 sampled residents (Resident #3) reviewed for contracture management. Findings included: Record review revealed Resident #3 was admitted to the facility on 02/06/20 and was most recently readmitted to the facility on 09/30/20 following a hospital stay. The resident's documented diagnoses included contractures of the wrists and hands, subarachnoid hemorrhage with aphasia and dysphagia, and COVID-19. Resident #3's 02/07/20 Occupational Therapy (OT) Plan of Care documented, "The patient demonstrates PROM (passive range of motion) of BUE (bilateral upper extremities) from 0 - 10	F 688	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? All residents w/ recommended PROM and/or splint restorative programs have the potential to be affected. Unable to correct deficiency for the identified resident due to resident being discharged. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Audits conducted of residents discharged form therapy services within past 30 days	

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F 688	Continued From page 21 degrees...with severe spasticity and moderate discomfort noted with minimal ROM (range of motion). Resident #3's 02/13/20 admission minimum data set (MDS) documented the resident had short and long term memory impairment, her decision making skills were severely impaired, she was dependent on the staff for all of her activities of daily living (ADL's), and she had impairment in her range of motion on both sides of her upper and lower extremities. On 02/18/20 "At risk for impaired skin integrity due to incontinence, immobility, nutritional status and contractures to both wrists and hands, contractures to bilateral lower feet" was identified as a problem in Resident #3's care plan. A 04/09/20 OT Daily Treatment Note documented, "...PROM/stretch to BUE's to minimize negative effects of spasticity, prevent further loss of ROM, hand hygiene performed with B (bilateral) palm guards placed.. Current level of function was documented as, "The patient demonstratres PROM of BUE from 0 - 20 degrees." A 04/09/20 OT Discharge Summary documented Resident #3 was on OT caseload from 02/07/20 until 04/09/20 for right and left hand contractures and abnormal posture. It was noted on 04/09/20 "The patient demonstrates donning/doffing of BUE palmar guards with assistance level of total assistance. Long term goals: nursing staff/RNP (restorative nursing program) will be able to provide patient with contracture management program with PROM and splinting to prevent further loss of ROM. Goal not met. Explanation:	F 688	to determine if a PROM and/or splint therapy program was recommended. ADHS or designee will be responsible for overseeing the Restorative program. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Therapy Outcomes Coordinator educated the Therapy staff on the Restorative Program process and how to alert nursing upon recommendation. Administrative Nurses educated the Nursing staff on the Restorative Program process and how to implement restorative program once deemed appropriate. DHS and Senior Nurse Consultants educated the Nursing staff on the necessary components to the Restorative Program. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. Assistant Director of Health Services or Designee will audit PROM and/or splint restorative program orders weekly x3 weeks and monthly thereafter to ensure that the programs are functioning appropriately per the Restorative Program Guidelines. Results will be presented by the Director of Health Services to the Quality Assurance Performance Improvement	

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F 688	Continued From page 22 RNP has not been implemented at this time." On 10/01/20 approaches were developed for the 02/18/20 care plan problem of skin integrity. They included, "Assess both hands daily for skin breakdown due to contractures. Wash hands with soap and water every shift. Palm protectors to both hands as ordered." Resident #3's 01/06/21 quarterly MDS documented the resident had short and long term memory impairment, her decision making skills were severely impaired, she was dependent on the staff for all of her ADL's, and she had impairment in her range of motion on both sides of her upper and lower extremities. During an interview with the facility's Therapy Manager on 01/27/21 at 12:24 PM she stated the facility had hoped to manage Resident #3's bilateral hand/wrist contractures using hand splints and elbow extension splints, but during the 02/07/20 evaluation and assessment it was determined the resident's hand/wrist contractures were "already fixed". The Therapy Manager explained that the window of opportunity had passed for the facility to be able to improve the contracted nature of the resident's hands. She reported the best the facility could do was supply something less rigid than splints to minimally limit further decline in range of motion and mostly aid with moisture control and promote easier and less painful hand hygiene. She commented Resident #3 should still be wearing bilateral palm guards to help protect the skin integrity of her hands. According to the Therapy Manager, she thought the restorative program was without a coordinator and was temporarily disbanded in March and April 2020 due to the COVID	F 688	Committee meetings monthly for 90 days and then quarterly thereafter. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Date of Compliance: 3/15/21	

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pandemic. However, she stated therapy should have educated the direct care staff assigned to Resident #3 about the application and wearing of the bilateral palm guards and reminded them about passive range of motion for the resident's upper extremities. The Therapy Manager reported Resident #3's hand/wrist contractures had not worsened during the resident's nursing home stay.

During an observation of Resident #3 on 01/27/21 at 1:52 PM the resident was in bed with bilateral palm guards in place. The resident's bilateral hands/wrists were extremely contracted, but there was no skin breakdown in her palms, and there was no odor coming from her hands. At this time the Therapy Manager re-stated the resident's hand contractures remained "fixed" with the degree of contracture remaining basically the same during her nursing home stay.

During an interview with Nursing Assistant (NA) #5 on 01/27/21 at 1:57 PM she stated she had not seen the palm guards which had been applied to Resident #3's hands before. She explained about an hour ago someone from therapy brought them and placed them on the resident. The NA commented she had cared for the resident since 01/12/21 when the resident was moved to her hall on the COVID unit. She reported Resident #3 did not come to her hall with palm guards, there were no palm guards in the resident's current room, and no one told her she was supposed to be applying palm guards.

During a follow-up interview with the Therapy Manager on 01/27/21 at 3:12 PM she stated today a therapist could not find any palm guards in Resident #3's current room so some were

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pulled from therapy stock and applied to the resident's hands. She reported, after reviewing Resident #'3 therapy and electronic medical records, she realized a physician order was never obtained for Resident #3's palm guards, and a restorative care plan was never developed for Resident #3 which would have triggered the provision of restorative services. The Therapy Manager commented NA #1, #2, and #3, who cared for Resident #3 before she was moved to the COVID unit, would have a better idea about the use of any palm guards between April 2020 and December 2020.

During a telephone interview with NA #1 on 01/28/21 at 12:36 PM she stated Resident #3's hands were so contracted that keeping them clean was a challenge. She reported for awhile a therapist applied palm guards to the resident's hands, and they were helpful in making the resident's hands more pliable and less moist. She commented once therapy finished their services she did not see the palm guards again. According to NA #1, Resident #3's hand contractures had been about the same the whole time she cared for the resident.

During a telephone interview with NA #2 on 01/28/21 at 12:58 PM he stated it was very difficult to keep Resident #3's hands clean when he provided care to her. He reported the resident's hands stayed moist a lot, and it was difficult getting a wash cloth between her clenched fingers. According to NA #2, he had never seen any palm guards on the resident's hands or in her room.

During a telephone interview with NA #3 on 01/28/21 at 1:10 PM she stated she had to use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	C 02/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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wipes to keep Resident #3's hands clean. She reported the resident's hands had to be cleaned frequently to keep the odor down. However, she commented she had not observed skin breakdown in the resident's palms. According to NA #3, she had never seen any palm guards on the resident's hands or in her room. The NA reported Resident #3's hand contractures had been about the same the whole time she cared for the resident.

During a telephone interview with Physician #1 on 01/29/21 at 8:31 AM he stated for residents with "fixed contractures" palm guards were flexible enough to protect the hands from skin breakdown, and they helped with moisture and odor control. He reported if therapy found the palm guards beneficial then they should have made sure the restorative and/or direct care staff knew when and how to apply them so their benefit could be sustained.

During a telephone interview with the Administrator on 01/29/21 at 11:13 AM he stated he was not aware that the whole restorative program was placed "on hold" during March and April 2020. Instead, he reported he thought the program focused on those residents who were at low COVID risk and individualized their programs. The Administrator commented the restorative program was important because it allowed the progress that was made in therapy to be continued or even enhanced.