| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING _____ B. WING _____ | C 11/11/2021 |

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| ASPEN MEADOWS HEALTH AND REHABILITATION CENTER | 3155 AVE C BILLINGS, MT 59102 |

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| F 000 | INITIAL COMMENTS<br><br>A Complaint survey was completed by the Department of Health and Human Services, Office of Inspector General, Certification Bureau, on 11/11/21. Facility Reported Incidents were not investigated during the survey.<br><br>The facility census on entrance was 66.<br><br>DEFICIENCIES NOT CITED:<br>Refer to FORM CMS-2567; Event ID: 90CC11 for findings.<br><br>Deficient practices were NOT cited for the complaints with Intake numbers: MT00051247 and MT00051335.<br><br>DEFICIENCIES CITED:<br><br>Refer to FORM CMS-2567; Event ID: 97J11 for findings.<br><br>Deficient practices were cited for the complaints with Intake numbers: MT00051333, MT00051334, and MT00051364.<br><br>IMMEDIATE JEOPARDY<br><br>On 11/10/21 at 5:40 p.m., the facility Administrative and corporate personnel were notified that an Immediate Jeopardy existed in the area of F686 - The Prevention of Pressure Ulcers.<br><br>Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of K, and upon removal of immediacy, lowered to H. | F 000 | | |

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

Electronically Signed | 12/08/2021

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| F 000 | Continued From page 1<br>Details:<br><br>The facility failed to identify, accurately assess, implement interventions, notify the physician as required, or monitor and document the ongoing treatment and status of pressure ulcers for 3 (#s 1, 2, and 3) residents of the 8 residents sampled for pressure wounds.<br><br>- Resident #1 had a Stage II pressure ulcer, which worsened to Stage IV and Unstageable. Resident #1 was admitted to the hospital where the severity of the pressure ulcers were identified, had immediate surgery, later had more surgeries, and eventually passed away.<br><br>- For resident #2, the facility failed to document worsening of a red mushy heel wound. The facility documented it as a Stage II. An alternate wound was open and draining sanguineous fluid; a new area next to the first, approximately the size of a dime, was black in color and Unstageable.<br><br>- For resident #3, the facility failed to address a heel wound, and prevent additional pressure injuries. Resident #3 had 3 wounds, the original heel wound was Unstageable and necrotic, a second heel wound was not documented upon admission, which was a Stage II. A sacrum wound was documented the day after resident #3's admission as an excoriation, which is now a Stage II/III, open, and draining sanguineous fluid.<br><br>The facility did submit an acceptable plan to remove the immediacy on 11/11/21 at 3:21 p.m., which was verified by the surveyors prior to the end of the survey. | F 000 | | |

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| F 000 | Continued From page 2 | F 000 | | |

PLAN TO REMOVE IMMEDIACY

The facility submitted the following plan for the removal of immediacy:

"1. Resident #1 no longer resides in the center. Residents #2 and #3 will have skin evaluations (including measurements and stage of wound as appropriate), Braden scales, and physician orders requested and/or implemented for treatment and care plan for skin integrity completed by 11/11/2021. The Wound Care Nurse ensured that the current wound treatments in place were accurate per physician's orders on 11/11/21. The Nurse Practitioner visually assessed both residents, validated that assessments were correct, and that treatment orders are in place on 11/11/21.

2. Staff Development Coordinator has been identified as a full time RN who has the skill set necessary for wound care, and who will oversee the wound program for all facets of care related to wounds. Assistant Director of Nursing will be Staff Development Coordinator's back up should a need arise. Wound care nurse, is a BSN with 19 years of experience in acute care trauma and orthopedics which dealt extensively with wounds. She was a supervisor for 8 years in the acute care setting as well.

3. All residents will have skin evaluations completed by licensed nurses, physician orders for treatment requested, if needed, by 11/11/2021. On 11/11/21 the Wound Care Nurse confirmed that there are no new pressure ulcers in the center, and she verified the treatments were accurate for the two identified by the survey agency. Any residents identified with skin

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| F 000 | Continued From page 3 | F 000 | | |

impairments will have Braden scales and care plans for skin integrity completed by 11/12/2021. Responsible parties and physicians were notified of wound status and treatment on 11/10/21 and 11/11/21.

4. AGACNP-BC, MSN (Adult Gerontology Acute Care Nurse Practitioner-Board Certified, Masters of Science in Nursing), Vice President of Clinical Operations for Empres Healthcare educated Divisional Directors of Clinical Operations on Empres Skin Integrity Policy, Skin Integrity Definitions, Pressure Ulcer Stages Grid, Wound Care Protocols per CDC, CMS Regulations on 11/11/21. Director of Nursing Services was re-educated on 11/11/21 by DDCO on the procedure for submitting the Weekly Skin Report-Pressure Ulcers to the DDCO. On 11/10/2021, the Divisional Director of Clinical Operations provided education to Director of Nursing using: Empres Skin Integrity Policy, Skin Integrity Definitions, Pressure Ulcer Stages Grid, Wound Care Protocols per CDC, CMS Regulations. Director of Nursing educated the following RN's on 11/10/2021: MDS Coordinator, Staff Development Coordinator, and Assistant Director of Nursing. These staff will complete education with all licensed staff nurses using the aforementioned tools prior to their next scheduled shift. The aforementioned management nurses will provide education for CNAs regarding their role in skin care to include reporting skin deficits to a licensed nurse before their next scheduled shift using Medline Skin Care Guidelines. Center has supplied binder with skin care policy and procedures for both nursing stations which include all the aforementioned training documents. All residents records are electronic and all required forms are available to all nursing

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| F 000 | Continued From page 4 | F 000 | | |

staff. On 11/11/21, the Divisional Director of Clinical Operations re-educated the Director of Nursing, Assistant Director of Nursing, Staff. Development Coordinator, and MDS coordinator were re-educated on the Daily Clinical Meeting Policy."

Abbreviations:

| | |
|---|---|
| ADL | activities of daily living |
| ADON | assistant director of nursing |
| ARD | assessment reference date |
| CDC | Centers for Disease Control |
| CMS | Centers for Medicare and Medicaid |
| CM | centimeter |
| CNA | certified nursing assistant |
| DNS | director of nursing |
| DTI | deep tissue injury |
| EHR | electronic health record |
| FNP | family practice nurse |
| IN | inch |
| LN | licensed nurse |
| LT | left |
| LPN/LN | licensed practical nurse |
| MD | medical doctor |
| MDS | minimum data set |
| POC | plan of care |
| PRN | as needed |
| PT | physical therapy |
| OR | operating room |
| R | right |
| RCM | resident care manager |
| Res | resident |
| RN | registered nurse |
| SBAR | situation, background, assessment, recommendation |
| ST I | Stage One |
| ST II | Stage Two |
| S/SX | Signs/Symptoms |

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| F 000 | Continued From page 5<br>TAR treatment administration record<br>w/c wheelchair | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. | F 580 | | 12/24/21 |

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| F 580 | Continued From page 6<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to notify the physician, and the family, about a worsening pressure ulcer for 1 (#1) of 8 residents reviewed for pressure ulcers. Findings include:<br><br>Review of the facility document titled, "Admission-Readmission Nursing Evaluation - V7," dated 08/23/21, showed resident #1 had a coccygeal pressure ulcer, Stage II.<br><br>During an interview by phone on 11/10/21 at 1:07 p.m., the FNP said she did not feel she was aware of, or had been notified, by the patient, staff, or the hospital, regarding resident #1's coccygeal pressure ulcer. She would usually be notified by receiving a note, or staff would tell her.<br><br>During a phone call on 11/09/21 at 8:15 a.m., NF1 said the family was never notified by the facility regarding a pressure wound for resident #1. | F 580 | F580<br>1. Resident #1 no longer resides in the facility.<br>2. Director of Nursing or designee validated that other residents with a change of condition had family and provider notification on or before 12/17/21.<br>3. Director of Nursing or designee will re-educate licensed nurses on the requirements of notification of change in condition on or before 12/10/21.<br>4. Director of Nursing or designee will review 5 residents with a change in condition to validate family and provider were notified weekly for 4 weeks, then monthly for 2 months. Audits will be brought to QAPI on or before 12/17/21 to identify trends and sustainability.<br>5. 12/24/21 | |

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| F 580 | Continued From page 7<br>During an interview on 11/10/21 at 9:03 a.m., staff member B said, "We just totally missed the documentation of what was done with the ulcer, and we could not find documentation that the physician or the family had been notified [of resident #1's wound]."<br><br>Review of the facility policy titled, "Skin Integrity," last updated May 2019, showed, "...6. ... b. Notifies the Physician and, if needed, obtains a treatment order ... c. Notifies Responsible Party ..." | F 580 | | |
| F 600 SS=G | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility neglected to provide goods and services to prevent the worsening of a Stage II coccygeal pressure ulcer to a Stage IV pressure ulcer for 1 (#1) of 8 residents reviewed for pressure ulcers.This deficient practice and neglect lead to | F 600 | F600<br>1. Resident #1 no longer resides in the facility.<br>2. Director of Nursing or designee will validate that other residents with pressure ulcers have completed assessments, | 12/24/21 |

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| F 600 | Continued From page 8<br>the worsening of the Stage II pressure ulcer to a Stage IV, which required surgical interventions, and sacral ulcer was listed as contributing to the death of the resident. Finding include:<br><br>Review of resident #1's face sheet showed she was readmitted to the facility on 8/23/21.<br><br>Review of the facility document titled, "Admission-Readmission Nursing Evaluation - V7," dated 08/23/21, showed resident #1 had a coccygeal pressure ulcer, Stage II.<br><br>Review of the facility document titled, "eINTERACT Transfer Form V5," dated 9/9/21, showed resident #1 was discharged to the hospital with, "... Coccyx Stage 2 pressure injury ..."<br><br>Requests were made throughout the survey for documentation of resident #1's wound assessments, including size, measurements (length, width, depth), exudate, color, odor, physician and family notification of the wound, physician treatment orders for wound dressings and care, and an updated care plan that reflected the existence of the Stage II ulcer. No further documentation was provided for resident #1's coccygeal wound, with the exception of one dressing change, and a prior care plan that had not been updated.<br><br>Review of the facility document titled, "Weekly Skin Report," dated 8/25/21, showed, "3 open areas on Buttocks, cleansed and covered [with] DermaBlue and Optifoam gentle." This document was the only identified assessment and treatment after resident #1's admission on 8/23/21, provided by the facility. | F 600 | orders, and treatments completed on or before 12/17/21.<br>3. DDCO or designee will re-educate licensed nurses on abuse and neglect policy. Staffing was reviewed as a potential factor on or before 12/10/21. Agency staffing companies have been contacted to enhance nursing staff in the facility. Wound documentation education was completed at the time of the survey 11/11/21. A designated nurse has been established to follow pressure ulcers on a weekly basis.<br>4. Director of Nursing or designee will review 5 pressure ulcers to validate there are treatments, orders, and assessments completed weekly for 2 months, then monthly for 2 months. Audits will be brought to QAPI on or before 12/17/21 to identify trends and sustainability.<br>5. 12/24/21 | |

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| F 600 | Continued From page 9<br><br>Review of [hospital] clinical records, dated 9/9/21 through 10/17/21 showed resident #1 was admitted to the hospital with an, "Infected sacral pressure ulcer with tracking. This needs to be cleaned out and debrided in the operating room for control. This might require more than one surgical intervention for optimal management." "On admission a Stage IV coccygeal ulcer was reported ... extensive subcutaneous emphysema compromising the perirectal area ... taken to OR on 9/11 for incision and drainage where extensive necrotic tissue was reported compromising soft tissue, buttocks, and perirectal area. The patient was returned to the OR on multiple occasions ..." Resident #1 received procedures in the OR for the sacral ulcer on 9/11/21, 9/12/21, 9/13/21, and 9/14/21. She was diagnosed with elevated white blood cell counts and multiple infectious agents. Resident #1 passed away 9/17/21.<br><br>Review of Resident #1's death certificate, dated 10/17/21, listed sacral pressure wound as a contributing factor in her death.<br><br>During an interview on 11/10/21 at 9:03 a.m., staff member B said "I know it was taken care of, but we just totally missed the documentation of what was done with the ulcer. I will just have to swallow my pride on that. He said, "We just lost that tool of getting all her assessments and parts of the process completed, like notifying the doctor. She fell right into that crack. There is nothing documented. We have searched and searched." | F 600 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans | F 657 | | 12/24/21 |

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| F 657 | Continued From page 10<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to update a care plan for 3 (#s 1, 2, and 3) of 8 residents reviewed for pressure ulcers, to include new goals, treatments, and interventions for treating current pressure ulcers. Resident #1's care plan did not reflect a Stage II pressure ulcer, which worsened. Resident #2's care plan did not reflect updates for the right heel pressure ulcer, dressing, or treatments. Resident #3's care plan was not updated with current interventions for the coccyx and heel wounds. These deficient practice | F 657 | F657<br>1. Resident #1 no longer resides at the facility. Resident #2 care plan was updated to reflect right heel pressure ulcer, dressing, and treatments on 11/16/21. Resident #3 care plan was updated to reflect current interventions for wounds on 11/12/21.<br>2. Director of Nursing or designee will validate other care plans are current and reflect the current status of the resident on | |

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| F 657 | Continued From page 11<br>contributed to lack of care and worsening of existing pressure ulcers. Findings include:<br><br>1. Review of resident #1's facesheet showed she was readmitted to the facility on 8/23/21.<br><br>Review of resident #1's initial nursing assessment, dated 8/23/21, showed resident #1 had a Stage II coccyx ulcer.<br><br>Review of resident #1's care plan, last updated, 7/23/21, showed the care plan had not been updated to include the newly identified Stage II coccyx ulcer after readmission to the facility on 8/23/21.<br><br>During an interview and review of resident #1's care plan, on 11/09/21 at 2:09 p.m., staff member D said that she had not added resident #1's pressure ulcer to the MDS. Staff member D said the care plan would be developed based on what was added to the MDS. She said the ulcer had been missed, and "I missed that." She said that another nurse [the nurse conducting the skin assessment] should have put the wound on the care plan, but this didn't happen. She said, at the end of August (2021) we had three to four nurses leave, and I have been on the floor working. She said it was the facility policy that every time staff updated the MDS they were supposed to go through and make sure everything put in the MDS was on the care plan.<br><br>Written requests were given to the facility on 11/9/21 at 2:30 p.m., asking for a copy of the care plan policy. The policy was not provided by the end of the survey.<br><br>2. Review of resident #2's care plan provided on | F 657 | or before 12/24/21.<br>3. Director of Nursing or designee will re-educate IDT and licensed nurses on care plan timing and revision including change of condition and wounds on or before 12/10/21.<br>4. Director of Nursing or designee will review 5 care plans to validate care plan has been revised timely weekly for 2 months, then monthly for 2 months. Audits will be brought to QAPI on or before 12/17/21 to identify trends and sustainability.<br>5. 12/24/21 | |

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| F 657 | Continued From page 12 | F 657 | | |

11/9/21 at 2:27 p.m., showed a revision date of 8/12/21. Under the problem area it showed "actual impairment to skin integrity of the right heel." The intervention portion included heelpad over dressing, float heels when in bed, identify/document causative factors and eliminate/resolve where possible, monitor/document location, size, and treatment of skin injury, report abnormalities failure to heal, s/sx of infection, maceration ect. to MD. The goal showed the resident will maintain or develop clean and intact skin by the review date.

Review of the Nursing progress note for resident #2 dated 7/21/21 showed, Skin/Wound Note, "went in to look at residents right heel, it is not open but looks like a black and blue deep tissue. I cleansed the area and put a heel cup on and wrapped in kerlix." The note was signed by staff member E. Review of resident #2s facility Skin and Wound Evaluation dated 8/6/21, showed, ST 1 pressure, acquired in house, wound bed eschar, no exudate, attached edge, dark reddish brown.

The care plan for resident #2, provided by the facility, had not been updated/revised with the current plan of care for the right heel to include the current dressing and wound treatment management.

During an interview on 11/9/21 at 5:25 p.m., staff member A stated the resident care plans were updated per the RAI (Resident Assessment Instrument) manual, and the Federal Regulations.

3. Review of resident #3's face sheet showed he was admitted to the facility on 9/29/21.

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| F 657 | Continued From page 13<br>Review of the care plan for resident #3, provided on 11/9/21 at 2:27 p.m., showed a revision date of 10/8/21. Under the problem area it showed actual impairment to skin integrity. The intervention portion included a pressure relieving mattress, keep skin clean and dry, monitor/document location, size, and treatment of skin injury, report abnormalities failure to heal, s/sx of infection, maceration ect. to MD. The goal showed the resident will have no complications through the review date. Assistance with off loading boots was not added until 11/10/21.<br><br>The care plan provided by the facility for resident #3 did not show updates/revisions for the current interventions for wounds to his coccyx and bilateral heel wounds.<br><br>During an interview on 11/10/21 at 11:35 a.m., staff member D stated resident #3 was admitted to the facility with abrasions only to his coccyx. | F 657 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure dependent residents received showers or baths as per their care planned frequency, for 2 (#s 2 and 11) of 15 sampled residents. Findings include:<br><br>1. Record review of the facility EHR (electronic health record) documentation for showers, | F 677 | F677- ADL Care Provided for Dependent Residents<br><br>1) Resident #2 received a shower on 11/16/2021. Resident #11 received a shower on 11/15/2021.<br>2) Director of nursing or designee will review dependent residents bathing | 12/24/21 |

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| F 677 | Continued From page 14<br>provided on 11/9/21, for resident #2, showed the resident did not have a shower/bath documented for the following days:<br><br>7/14/21 through 8/5/21, 23 days; and,<br>8/13/21 through 8/25/21, 13 days.<br><br>The documentation did not show that the resident had refused her shower/bath during the above time frames.<br><br>Review of resident #2's plan of care, with a revision date of 7/26/21, showed she required assistance with bathing, and preferred one to two showers/baths a week.<br><br>During an interview on 11/10/21 at 8:45 a.m., resident #2 was unable to answer questions regarding her lack of showers.<br><br>2. Record review of the facility EHR documentation for showers, provided on 11/9/21, for resident #11, showed the resident needed supervision with showers and did not have a shower/bath documented for the following days:<br><br>7/29/21 through 8/11/21, 14 days;<br>8/13/21 through 8/24/21, 12 days; and,<br>9/11/21 through 9/22/21, 12 days.<br><br>The documentation did not show that the resident had refused his shower/bath during the above time frames.<br><br>Review of resident #11's plan of care, with a revision date of 4/29/21, showed he required assistance with bathing, and preferred one to three showers/baths a week. | F 677 | preferences and update task list per resident choice. Other dependent residents within center will be reviewed to validate bathing schedule is being followed on or before 12/10/2021.<br>3) Director of nursing or designee will reeducate licensed nurses and certified nursing assistance on ADL care provided for Dependent Residents on or before 12/10/2021.<br>4) Director of Nursing or designee will review showers weekly for one month, then twice a month for two months therefore to validate accuracy. Observation finding will be brought to QAPI on or before 12/17/2021, then monthly thereafter to identify trends and sustainability.<br>5) Date corrective action to be completed: 12/24/2021. | |

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| F 677 | Continued From page 15<br>During an interview on 11/10/21 at 7:20 a.m., resident #11 stated it made him feel terrible when he was unable to get his showers. He stated he would like to have one every day. Resident #11 stated he was supposed to receive a shower three times a week. He stated staff do not say anything to him when he did not get his shower/bath as scheduled.<br><br>3. During an interview on 11/10/21 at 7:30 a.m., staff member K, stated that she "gets pulled form showers to the floor one or two times a week." | F 677 | | |
| F 686 SS=K | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>On 11/10/21 at 5:40 p.m., the facility administrative and corporate personnel were notified that an Immediate Jeopardy existed in the area of F686 - The Prevention of Pressure Ulcers.<br><br>Severity and Scope identified for the Immediate | F 686 | F686<br>1. Resident #1 no longer residents at the facility. Residents #2 and #3 will have skin evaluations (including measurements and stage of wound as appropriate), Braden scales, and physician orders requested and/or implemented for | 12/24/21 |

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| F 686 | Continued From page 16<br>Jeopardy was identified to be at the level of K, and upon removal of immediacy, lowered to H.<br><br>Based on observation, interview, and record review, the facility failed to identify, assess, monitor, and treat a Stage two ulcer that progressed to a Stage four ulcer for 1 (#1) resident; failed to prevent a pressure ulcer to the right heel for 1 (#2); and failed to prevent new and worseing pressure ulcers for 1 (#3) of 8 residents reviewed for pressure ulcers. This deficient practice lead to a worsening ulcer and need for surgical intervention in a local hospital, and was a contributing factor listed on resident #1's death certificate; and contributed to the worsening and increase in the number of pressure ulcers for #2 and #3. Findings include:<br><br>1. Review of Resident #1's face sheet showed she was readmitted to the facility on 8/23/21.<br><br>Review of the facility document titled, "Admission-Readmission Nursing Evaluation - V7," dated 08/23/21, showed resident #1 had a coccygeal pressure ulcer, Stage II.<br><br>Review of facility documents titled, "Progress Notes," between the dates of 8/23/21 and 9/8/21, showed the following documentation regarding the condition of resident #1's skin as related to the Stage II coccygeal ulcer:<br><br>8/23/21 - Coccyx Stage 2 pressure injury ...<br>8/24/21 - Coccyx Stage 2 pressure injury, ...<br>8/25/21 - Coccyx Stage 2 pressure injury, ...<br>8/26/21 - resident does not have other non-surgical skin conditions<br>8/27/21 - Coccyx Stage 2 pressure injury, ...<br>8/28/21 - Coccyx Stage 2 pressure injury, ... | F 686 | treatment and care plan for skin integrity completed by 11/11/21. Wound care nurse ensured that the current wound treatments in place were accurate per physician orders on 11/11/21. Nurse Practitioner visually assessed resident #2 and #3, validated that assessments were correct, and that treatment orders are in place on 11/11/21.<br>2. Staff Development Coordinator (RN) has been identified as a full time RN who has the skillset necessary for wound care, and who will oversee the wound program for all facets of care related to wounds. Assistant Director of Nursing (RN) will be Staff Development Coordinators back up should a need arise. All residents will have a skin evaluation completed by licensed nurses, physician orders for treatment requested, if needed, by 11/11/21. On 11/11/21, Staff Development RN confirmed that there are no new pressure ulcers in the center, treatments were accurate for the two identified by the survey agency. Any residents identified with a skin impairments will have Braden scales and care plans for skin integrity completed by 11/12/21. Responsible parties and physicians were notified of wound status and treatment on 11/10/21 and 11/11/21.<br>3. Vice President of EmpRes Healthcare Clinical Operations, AGACNP-BC, MSN (Adult Gerontology Acute Care Nurse Practitioner- Board Certified, Masters of Science in Nursing), educated Divisional Director of Clinical Operations on EmpRes skin Integrity Policy, Skin Integrity Definitions, Pressure Ulcer | |

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| F 686 | Continued From page 17<br>8/29/21 - Coccyx Stage 2 pressure injury, ...<br>8/30/21 - Coccyx Stage 2 pressure injury, ...<br>8/31/21 - resident does not have other non-surgical skin conditions<br>9/1/21 - resident does not have other non-surgical skin conditions<br>9/2/21 - Coccyx Stage 2 pressure injury, ...<br>9/3/21 - Coccyx Stage 2 pressure injury, ...<br>9/4/21 - Coccyx Stage 2 pressure injury, ...<br>9/5/21 - resident does not have other non-surgical skin conditions<br>9/6/21 - resident does not have other non-surgical skin conditions<br>9/8/21 - Coccyx Stage 2 pressure injury, ...<br><br>Review of the facility document titled, "eINTERACT Transfer Form V5," dated 9/9/21, showed resident #1 was discharged to the hospital with, "Coccyx Stage 2 pressure injury ..."<br><br>Review of the Family Nurse Practitioner note, dated 08/30/21, showed, "No concerns with skin."<br><br>Review of the facility document titled, "PT Evaluation and Plan of Treatment, for the certification period 8/24/21 - 9/22/21, showed resident #1 required the following assistance for Functional Mobility:<br><br>- Bed Mobility; roll left and right = dependent<br>- Sit to lying = dependent<br>- Lying to sitting on side of bed = dependent<br>- Self care raw score = 0 (lowest score)<br>- Assessment Summary, "...Upon PT evaluation she has significant impairments to strength of all exremities..." [sic].<br><br>Review of four pictures, provided by NF1 in a report to the Certification Bureau, of resident #1's | F 686 | Stages Grid, Wound Care Protocols per CDC, CMS Regulations. Divisional Director of Operations provided education to Director of Nursing on EmpRes skin Integrity Policy, Skin Integrity Definitions, Pressure Ulcer Stages Grid, Wound Care Protocols per CDC, CMS Regulations on 11/10/21. Director of Nursing educated the MDS Coordinator, Staff Development Coordinator, and Assistant Director of Nursing on 11/10/21 regarding EmpRes skin Integrity Policy, Skin Integrity Definitions, Pressure Ulcer Stages Grid, Wound Care Protocols per CDC, CMS Regulations. These staff will complete education with all the licensed staff nurses using the aforementioned tools prior to their next scheduled shift. The aforementioned management nurses will provide education for CNA□s regarding their role in skin care to include reporting skin deficits to a licensed nurse before their next scheduled shift using Medline Skin Care Guidelines. Center has supplied binder with skin care policy and procedures for both nursing stations which include all the aforementioned training documents. All residents records are electronic and all required forms are available to all nursing staff. On 11/11/21, the Divisional Director of Clinical Operations re-educated the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and MDS Coordinator were re-educated on the Daily Clinical Meeting Policy.<br>4. Director of Nursing or designee will review 5 residents with pressure ulcers to ensure pressure ulcer have orders, | |

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| F 686 | Continued From page 18<br>wounds present on admission to the hospital on 9/9/21, showed resident #1 had three open wounds on the coccygeal area and either buttock cheek. These pictures showed full thickness wounds, with one wound appearing necrotic and Unstageable. Surrounding the wounds were areas of excoriation. No wound diagnosis, or measurements, or written descriptions of the wounds were provided with the pictures.<br><br>Review of resident #1's skin and ADL care plans, showed they were last updated on 07/23/21, which was prior to the 8/23/21 admission, and showed resident #1 required extensive assist with ambulation/mobility, dressing, grooming, used a pressure reducing mattress, and a w/c cushion. She required extensive assist with toileting, transfers, and was incontinent. Under potential/actual impairment to skin integrity, also last updated 07/23/21, it showed the staff were to monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, s/sx of infection, maceration, etc. to MD. The Stage II coccyxgeal ulcer was not added to resident #1's care plan when it was identified on the 08/23/21 admission assessment.<br><br>Review of Resident #1's most recent MDS, with an ARD of 8/23/21, was an entry tracking record and did not assess possible pressure ulcers. A 14-Day Admission MDS had not been completed.<br><br>Review of resident #1's Braden Scale For Predicting Pressure Sore Risk, dated 08/23/21, showed resident #1 scored a 14 and was at moderate risk for pressure sores.<br><br>Requests were made throughout the survey on 11/9/21 at 6:40 p.m., 11/10/21 at 11:30 a.m. and | F 686 | completed treatments, weekly skin evaluations, weekly measurements documented, Braden scale, accurate staging, and updated care plan weekly for 2 months, bi-weekly for 2 months, monthly for 2 months. Audits will be brought to QAPI on or before 12/17/21 to identify trends and sustainability.<br>5. 12/24/21 | |

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4:45 p.m., and 11/10/21 at 4:45 p.m., for documentation of wound assessments, including size, measurements (length, width, depth), exudate, color, odor, physician and family notification of the wound, and orders for wound dressings and care. No further documentation was provided for resident #1's coccxygeal wound, with the exception of one dressing change.

Review of the facility document titled, "Weekly Skin Report," dated 8/25/21, for resident #1, showed, "3 open areas on Buttocks, cleansed and covered [with] DermaBlue and Optifoam gentle." This document was the only identified assessment and treatment after resident #1's admission on 8/23/21, provided by the facility.

During an interview and record review, on 11/09/21 at 11:30 a.m., staff member E said she did not remember resident #1. She said if the admission nurse identified an ulcer on a resident when they were admitted for services, they would send her a note, or she may be notified of the wound orally. Staff member E said it would be up to the nurse [the nurse conducting the skin assessment] to notify the physician of the wound. Staff member E searched in the EHR and said there was no information regarding the Stage II ulcer listed under the skin and wound catagory. She said the (physician) would write the orders for how to treat a wound. Staff member E said she did not know if there were standing orders for treating wounds before orders were received from the physician. She said on most admissions she would have worked with an admissions nurse who was no longer with the facility. The nurse would have written a note in the SBAR [electronic] system to notify the physician of a wound, and then the physician would look at the

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wound and provide orders to treat the wound. Staff member E said normally orders to treat a wound would show up on the TAR.

During an interivew by phone, on 11/10/21 at 1:07 p.m., the FNP said she did not feel she was aware of, or had been notified, by the staff, patient, or hospital, regarding resident #1's coccygeal pressure ulcer. She would usually be notified by receiving a note, or staff would tell her. She did not assess the wound. The FNP said she was the only provider for the facility and if she was aware of a wound she would look at the wound, but she did not feel it was an expectation for her to conduct a full skin assessment with each visit. She said she tried to get the nurses to write an SBAR note to cover notification.

During an interview and review of resident #1's care plan, on 11/09/21 at 2:09 p.m., staff member D said that she had not added resident #1's pressure ulcer to the MDS. She said the care plan would be developed based on what was added to the MDS. She said the ulcer had been missed, and "I missed that." She said that another nurse should have put the wound on the care plan, but this didn't happen. Staff member D said, at the end of August (2021) "We had three to four nurses leave and I have been on the floor, and it was the facility policy that every time staff updated the MDS they were supposed to go through and make sure everything put in the MDS was on the care plan."

During a phone call on 11/09/21 at 8:15 a.m., NF1 said she felt the facility was understaffed when her mom was a resident there. She said the family was never notified by the facility regarding a pressure wound for resident #1. She said the

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wound required surgeries to address the wound and the surgeries were too much for her mother. She said the [hospital] said it [the wound] was the worst they had every seen. NF1 said her mother had four surgeries when she got to the hospital. She said the facility called and said her mother was going to the hospital for low oxygen levels. NF1 said after the surgeries, her mother never left the hospital. NF1 said her mother didn't have any treatment for the ulcers that she was aware of at the facility, and there was no record of care for the ulcers. "It was like someone saw it and it got brushed under the rug." NF1 said resident #1 was not mobile and had her arm in a sling due to just having had a pacemaker placed. NF1 felt all the surgeries had broken resident #1's spirit and that resident #1 had spent three days crying in the hospital when this happened.

During an interview on 11/10/21 at 9:03 a.m., staff member B said the facility process was that the ulcer would be picked up in clinical [meeting] and pushed off to the RCM. He said resident #1's ulcer was discovered about the time the RCM left at the end of August. Staff member B said, "I know it was taken care of, but we just totally missed the documentation of what was done with the ulcer. I will just have to swallow my pride on that." He said, "We just lost that tool of getting all her assessments and parts of the process completed, like notify in the doctor. She fell right into that crack.There is nothing documented. We have searched and searched. We have a new team rehired." He said the expectation was for the wound nurse to be measuring the wounds at least weekly, and to document. "At this point I need to find an IPAD that may have more information about wounds but I don't know if there is more information. If orders are not on

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point-click-care, then its not there. It is my subjective opionion that the documentation has fallen through the crack. I would expect the nurse to have a dressing change order before doing one."

Review of [hospital] clinical records, dated 9/9/21 through 10/17/21 showed resident #1 had an, "Infected sacral pressure ulcer with tracking. This needs to be cleaned out and debrided in the operating room for control. This might require more than one surgical intervention for optimal management." "On admission a Stage IV coccygeal ulcer was reported ... extensive subcutaneous emphysema compromising the perirectal area ... taken to OR on 9/11 for incision and drainage where extensive nectrotic tissue was reported compromising soft tissue, buttocks, and perirectal area. The patient was returned to the OR on multiple occasions ..." Resident #1 received procedures in the OR for the sacral ulcer on 9/11/21, 9/12/21, 9/13/21, and 9/14/21. She was diagnosed with elevated white blood cell counts and multiple infectious agents. Resident #1 passed away 9/17/21.

Review of resident #1's death certificate, dated 10/17/21, listed a sacral pressure wound as a contributing factor in her death.

Review of the facility policy, "Skin Integrity," last revised May 2019, showed, "...

5. Ongoing evaluation continues weekly with the LN completing a full body skin audit. Completion of the skin audit is documented on the Treatment Administration Record (TAR) with their initials, and either a "-" or "+". a. The "-" indicates no skin impairment present. b. The "+" indicates skin

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impairment present.

6. For skin impairment identified with admission (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the LN completes the following:
a. Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation.
b. Notifies the Physician and, if needed, obtains a Treatment Order and documents on the Treatment Administration Record (TAR) after order is implemented.
c. Notifies Responsible Party/Family Member of skin condition and treatment plan.
d. Evaluates environment, mobility equipment, functional and cognitive ability, medications, and labs to identify interventions to promote healing/resolution or skin impairment.
e. Implements interventions and documents on the resident's care plan and Care Directive.

7. If skin impairment is noted after admission (in addition to the above steps," the LN:
a. Initiates Alert Charting.
b. Completes (and documents) notifications to the physician and Resident representative.
c. Completes Braden Scale and evaluates current interventions for necessary revision.
d. Implements new interventions as needed. Documents on the resident's care plan and Care Directive.
e. Notifies Food and Nutrition Services Manager (FANS) and/or Registered Dietitian of new Pressure Score, worsening wound condition for nutritional needs evaluation.
f. Notifies Director of Nursing Services (DNS) of

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Skin Impairments that indicate a potential significant change in condition (Stage I or greater Pressure Ulcer, surgical wound dehiscence, hematoma, or bruise on an area of the body not usually vulnerable to trauma (e.g. head, breasts, inner thighs).
g. The DNA and/or designee complete a comprehensive review of the resident's medical record to evaluate if the Pressure Ulcer was avoidable or unavoidable. This evaluation is documented in the Nurse's notes.

8. Non-Healing Wounds/Pressure Ulcers/Burns are reviewed at the Nutrition Hydration Skin Committee meeting.

9. Wounds are evaluated weekly by Center clinicians. Arterial, Pressure, Stasis, and Venous Ulcers, significant surgical wounds, and burns are evaluated, measured, and findings documented in the medical record. This evaluation includes pain associated with the wound during wound care. If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Representative are notified. If a new treatment order is obtained the LN:
a. Re-evaluates POC and resident's condition (e.g. off-loading pressure from skin impairment area, nutritional intake, blood sugars, and lab values).

10. Significant abrasions and bruises are evaluated weekly by the LN (excoriations, rashes, skin tears, etc.) and documented in the medical record.

11. Evaluate resident's compliance with POC. When the resident chooses to not have specified

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treatments or interventions implemented, the Center discusses the following with the resident and documents in the medical record:

a. The POC.
b. Risk factors and why the treatment is important to healing.
c. If able, the resident is provided instruction regarding shifting his/her weight while seated in chair/wheelchair.
d. Education and guidance is provided to residents/representative for those with pressure ulcers affecting the sacrum or coccyx, emphasizing that time spent sitting should be limited to 3 times daily for periods of 60 minutes or less.
e. Education and guidance is provided to resident/representative for those with pressure ulcers affecting the ischium, emphasizing that sitting in a fully erect posture while in bed or chair, should be avoided.
f. Discussed with resident's responsible party if resident does not make sound choices.
g. Notifies the Medical Doctor (MD) of choice.
h. Update the comprehensive care plan to include resident' choice to decline treatments.

12. If allowed, the LN removes devices/braces/splints/dressings (and associated wrappings) 2 times per week and as needed (PRN). Risks and benefits of non-removal are discussed with the resident and MD. One of these times will be scheduled and completed with the weekly head to toe skin check. The LN examines the skin under the device and document findings on the TAR with their initials and either a "-" or "+"..
a. "-" indicates no skin impairment. (If no impairment noted, the nurse reapplies the

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device."
b. "+" indicates skin impairment. (Proceed back to Step #7.)

2. During an observation on 11/10/21, resident #2's wound on the right heel was open and draining sanguineous fluid; there was a new area observed next to the open area, that was approximately the size of a dime, black in color, and unstageable.

Review of resident #2's Nursing Progress Notes, in the EHR, showed the following:

7/21/21 - Approx. 0300h, "CNA reported to this nurse upon assisting Res to bathroom, she observed swelling/sponginess on her right heel, color of skin a dark gray, approx. 3 in. diameter..."
7/21/21 - Skin/Wound Note, "Went in to look at right heel, it is not open but looks like a black and blue deep tissue..."
7/22/21 - Note "yesterday the Wound Nurse saw and assessed wound, labelled it a DTI versus stage 1 heel injury..."
7/23/21 - Skin/Wound Note, "Res has a DTI on back of right foot/heel, with a blood blister type intact roof.... Placed silver alginate over wound and covered with Tegaderm and kerlix..."
7/26/21 - Orders "... apply pressure relieving boot to right heel at all times..."
8/5/21 - "Wound on heel continues to heal..."
8/10/21 - "Wound on heel continues to heal..."
8/11/21 - "Orders ... eval and treat one time a day ..."
8/13/21 - Skin/Wound Note, "residents right heel is still painful to her. heel has eschar so cleansed wound with wound wash and applied honey and covered with optifoam and kerlix..."
8/18/21 - Skin/Wound Note, "residents right heel

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is still painful to her. heel has eschar so cleansed wound with wound wash and applied honey and covered with optifoam and kerlix..."
8/19/21 - "Wound on right heel continues to heal... Dressing is clean, dry and intact..."
8/20/21 - "wound to right heel was cleaned, thera honey applied and covered with foam dressing..."
8/21/21 - "Dressing to right heal wound changed... was cleaned and thera honey applied with opti foam dressing..."
8/24/21 - "Wound to right heel continues to heal...Dressing is clean, dry and intact..."
8/28/21 - "Re-dressed right heal with therahoney, heel cup, and kerlix..."
9/3/21 - " Orders, Cleanse R heel, apply collagen (honey if debridement needed), cover with heel cup then kerlix one time a day every Mon, Wed, Fri done by wound nurse."
9/12/21 - "Wound on residents right heel continues to heal..."
9/21/21 - "Wound on residents heel continues to heal..."
10/22/21 - "Orders, Apply pressure relieving boot to right heel at all times..."
11/8/21 - Skin/Wound Note, "... Heel cleansed with wound wash collagen applied then border gauze as the heel cup and kerlix might be easier to remove."
11/9/21 - "Orders, Apply pressure relieving boot at all times..." [sic].

Review of resident #2's care plan, provided on 11/9/21 at 2:27 p.m., showed a revision date of 8/12/21, under the problem area it showed "actual impairment to skin integrity of the right heel." The intervention portion included "heelpad over dressing, float heels when in bed, identify/document causative factors and eliminate/resolve where possible,

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monitor/document location, size, and treatment of skin injury. Report abnormalities failure to heal, s/sx of infection, maceration ect. to MD." The goal showed "resident will maintain or develop clean and intact skin by review date."

The care plan for resident #2, provided by the facility, had not been updated/revised with the current plan of care for the right heel to include the current dressing and wound treatment management.

Review of resident #2's Quarterly MDS, with an ARD 9/13/21, showed the following documentation in section M for Skin Conditions:

M0100 A. "Resident has a Stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device - check mark"
M0150 "Risk for Pressure Ulcers 1- yes"
M0210 "Unhealed Pressure Ulcer(s) 1- yes"
M0300 "Current Number of Unhealed Pressure Ulcers at Each Stage-
A. Number of Stage 1 pressure ulcer - 1"

Review of resident #2's Braden Scale assessments for 7/22/21 and 9/10/21, showed a score of 18, which meant at risk for skin impairment.

Review of the facility forms, titled Weekly Skin Report, were provided for 7/19/21, 8/6/21, 8/13/21, and 8/18/21. None of the forms reflected the stage of the wound to the right heel for resident #2. Forms dated 8/6/21 and 8/13/21 noted resident #2's wound was caused in the facility. No further Weekly Skin Reports after 8/18/21 were provided regarding the wound to resident #2's right heel.

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Review of the Skin and Wound Evaluations for resident #2 provided included the following:

8/6/21 - "... ST 1 pressure, right heel, acquired in house, with eschar to wound bed, progress is deteriorating, measures 5.1cm (centimeters) x 2.7cm x 2.4cm, no exudate, attached edge, dark reddish brown..."

8/13/21- "... ST 1 pressure, right heel, acquired in house, progress stable, measured at 3.6cm x 2.4cm x 2.2cm..."

There were no other measurements provided during the survey for resident #2's right heel wound.

Review of the facility Nutrition Hydration Skin Committee Review Forms provided for 9/9/21 and 10/11/21 showed in section 8a, "Pressure Ulcer stage comments, ST 11..." for resident #2's right heel wound.

During an interview on 11/9/21 at 3:50 p.m., staff member C stated the facility has a clinical meeting and Stand-Up meeting every morning that he attends when working. He stated during the clinical meeting the team goes through every chart for documentation from the previous day. Staff member C stated there would not be an instance where documentation was missed for an open wound or anything. Staff member C stated if documentation was missed, the staff member would be notified that day to document a late entry. Resident #2 did not have daily documentation in the medical record for the wound to her right heel.

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The facility failed to consistently assess and document the worsening of a pressure ulcer injury to the right heel of resident #2. The facility documentation of the wound showed it as ST I (Stage 1) and other documentation as ST 11 (Stage II) during the same time frames.

3. Resident #3 was admitted to the facility on 9/29/21. The facility failed to heal a heel wound and prevent additional pressure injuries for resident #3. Hospital discharge records showed one heel wound. Currently resident #3 has three wounds: the original heel wound is Unstageable necrotic, a second heel wound, was documented as purple upon admission, and is a Stage II, the sacrum wound, was documented the day after admission as an excoriation on the buttock on both sides, is Stage II/III, on both sides and is open and draining sanguineous fluid. Documented on the Admission MDS, were three pressure areas, the resident currently has four pressure areas.

Resident #3's wounds were observed on 11/10/21 at 11:35 a.m., with staff member D. Resident #3 was lying flat on his back upon entry to the room. The resident's left buttock had an open area approximately the size of a quarter. The right buttock had a ST 11 wound. The right heel had a darkened black/purple area approximately 0.5 cm which was open to air. The residents's left heel had a large dark area purple/brownish, dry eschar. The resident's left heel was Unstageable. The left buttock was a ST 11, the right buttock had a ST 11, and the right heel had a scab, which was Unstageable.

Review of resident #3's Nursing Progress Notes, provided by facility, for the pressure ulcer wounds

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showed the following:

9/29/21 - "... Lt heel is black, Rt heel is purple (heel protectors in place, Buttock excoriated & broken down on both sides, optifoam in place..."
10/2/21 -"... sore buttocks, DTI to both heels, they are off loaded..."
10/3/21 - "... DTI to left and right heel. pressure sore to bottom..."
10/6/21 - "... Left heel black, Right heel purple and heel protectors in place. Buttock is excoriated broken down on both side of the buttock..."
10/7/21 - "... pressure ulcer to buttocks, barrier cream and optifoam applied DTI to both heels. they are offloaded..."
10/8/21 - "... Left heel is black, Right heel purple and heel protectors in place. Buttock is excoriated broken down on both sides of the buttock..."
10/9/21 - "... pressure ulcer to buttock..."
10/21/21 - "... Left heel is unstageable, right heel is purple and heel protectors are in place, Buttocks are excoriated broken down on both sides of the buttocks. Moderate amount of drainage..."
11/10/21 - "... Lt buttock has area approx. quarter skin that is pink with healing loose skin. Rt buttock has healing ST 2 wound with irregular edges ... Rt heel has healing DTI...Theres is small dark area approx. 0.5cm of dark purple area at 12 o'clock area. Wound is OTA ... Lt heel shows DTI area ... dark area purple/brownish dry eschar. Wound is unstageable..." [sic].

Review of the Skin/Wound Notes provided for resident #3 showed:

10/4/21 - Skin/Wound Note "... fridat October 1st. the pressure ulcer on his left heel looked like a DTI it is black. lotioned well and put on foam

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| F 686 | Continued From page 32<br>boots to off load..."[sic]<br><br>Review of resident #3's care plan, provided on 11/9/21 at 2:27 p.m., showed a revision date of 10/8/21. Under the problem area the plan showed "actual impairment to skin integrity." The intervention portion included "pressure relieving mattress, keep skin clean and dry, monitor/document location, size, and treatment of skin injury. Report abnormalities failure to heal, s/sx of infection, maceration ect. to MD." The goal showed "resident will have no complications through the review date."<br><br>The care plan provided by the facility for resident #3 did not show updates/revisions for the current interventions for wounds to his coccyx and bilateral heel wounds.<br><br>Review resident #3's Admission MDS, with an ARD of 10/5/21, section M for skin conditions, showed the resident was at risk for pressure ulcers, had one unhealed pressure ulcer, one ST 1 and 11 pressure ulcer, one St 11 pressure ulcer was present on admission, and one Unstageable pressure ulcer, and one Unstageable pressure ulcer present on admission.<br><br>Review of resident #3's Braden Scale Assessments, dated 11/10/21, showed a score of 13, moderate risk, and on an 11/11/21 assessment, it showed a score of 12, high risk.<br><br>Review of resident #3's Weekly Skin Evaluation, dated 11/10/21, showed the following documentation:<br><br>"Left buttock - open area approx quarter size with skin that is pink with healing loose skin... | F 686 | | |

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| F 686 | Continued From page 33<br>pressure ulcer... pressure ulcer ST 11...", "Right buttock - healing ST 11 with irregular shapes ... length 6, width 5, depth 0.2, irregular shaped, 0.2 -0.3 at top of wound...," "Left heel - DTI area dark purple/brownish dry eschar. Wound is unstageable & OTA ..., length 5.6, width 5.9, depth 0, shape is round, over heel & extending to back of heel ...", ... "Right heel - healing DTI with some loose healing sin & pink wound bed ... length 2.5, width 2.5, depth 0, shape round quarter size ... pressure ulcer..."<br><br>Review of resident #3's Nutrition Hydration Skin Committee documentation, dated 10/11/21 and 10/28/21, showed,"... Sacral Stage 11, heels bilat are unopened DTI, black eschar under skin..."<br><br>During an interview on 11/9/21 at 4:25 p.m, staff member P stated she does a skin assessment upon admission. She stated if there is a skin problem she will note it in the medical record, and notify the nurses, then leave a note for the wound nurse, staff member E.<br><br>During an interview on 11/10/21 at 11:35 a.m., staff member D stated resident #3 was admitted to the facility with abrasions to his coccyx. After staff member D changed the dressings to resident #3s wounds, on 11/10/21 at 11:35 a.m., she stated, resident #3 has a ST 1, ST 11, one deep tissue injury, and one Unstageable pressure ulcer. | F 686 | | |
| F 725 SS=G | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to | F 725 | | 12/24/21 |

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| F 725 | Continued From page 34<br>provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to maintain enough staffing to effectively manage the care needs of the residents which lead to a lack of up-to-date care planning, failure to notify physician/family of a resident change of status, neglect of resident care needs, worsening pressure ulcers, failure to identify pressure ulcers, failure to provide treatment for pressure ulcers, for 1 (#1); and shower concerns for 4 (11, 12, 13, and 15); untimely call light response times for 4 (12, 13, 14, and 15); and for Grievance resolution related to care for 1 (#6) of 15 sampled residents. | F 725 | F725<br>1. Strategies to increase nursing staff include adding agency nursing staff and implementing incentive programs to assist with increasing staffing per shift as well as encourage less call offs of scheduled shifts. Nurse management team will also be part of the staffing as needed.<br>2. Administration team will reach out to travel agencies to identify opportunities to recruit agency staff while continuing to recruit and retain nursing staff.<br>3. The Extra Mile incentive program was | |

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| F 725 | Continued From page 35<br>Findings include: Findings include:<br><br>During a phone call from NF1 on 11/09/21 at 8:15 a.m., NF1 felt the facility was understaffed when her mom [resident #1] was there. She said, "They were hard to get a-hold of on the phone. At that time, you could call in and arrange for a time to visit, but you couldn't get a-hold of them to make that arrangement. Sometimes five days would go by when you couldn't get a-hold of anyone. I don't know what was going on there, I really don't. She [resident #1] passed away on the 17th. The wound care [at the hospital] and the amount of damage was just too much for her. [Local hospital] said it was the worst they had every seen. We were never notified [by the facility] or contacted this was going on. My brother and sister were notified about other things, but not the ulcer. We didn't find out about it until she was at the [local hospital]. She had four surgeries when she got to the hospital. I had been compulsively calling them for days. They called and said she [resident #1] had low oxygen levels and was going to the hospital. Her oxygen level was normal at the hospital, but her blood counts were up. She had four surgeries after that and she never left the hospital. She didn't have any treatment that I know of at the facility. There was documentation of the cleaning of the incision of the pacemaker site. It was like someone saw it [stage II coccyx ulcer] and it got brushed under the rug.<br><br>During an interview on 11/09/21 at 2:09 p.m., staff member D said, "At the end of August (2021) we had three or four nurses leave and I have been on the floor [working.]<br><br>During an interview on 11/10/21 at 9:03 a.m., staff | F 725 | implemented on 11/16/21 which is open to staff members. Each staff member that works 4 extra shifts over the two pay periods without calling off any scheduled work shift, will receive a $1000 bonus. Contracts with nurse travel agencies have been approved and currently getting agency nurses into the facility. Staff from other facilities under EmpRes Healthcare Management are covering shifts as needed. Currently in the progress of hiring a scheduler to assist with managing nursing needs. Director of Nursing or designee re-educated staff regarding sufficient staffing on or before 12/10/21. Director of Nursing, clinical team, and Executive Director will review staffing schedules 3 times per week.<br>4. Director of Nursing will audit staffing schedules to validate sufficient staffing 3 times per week for 2 months, then weekly for 2 months, then monthly for 2 months. Audits will be brought to QAPI on or before 12/17/21 to identify trends and sustainability.<br>5. 12/24/21 | |

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| F 725 | Continued From page 36 | F 725 | | |

member B said, regarding resident #1's Stage II coccyx ulcer, "The process was that it would be picked up in clinical and pushed off to the RCM. That was about the time my RCM left at the end of August. I know it was taken care of, but we just totally missed the documentation of what was done with the ulcer. I would just have to swallow my pride on that. We just lost that tool of getting all her assessments and parts of the process completed, like notify in the doctor. She fell right into that crack. There is nothing documented. We have searched and searched. We have a new team rehired. Between [staff member D] and I we did clinical's, we ended up doing a lot of floor work. We had three of our team members step down. Within the last week of August all three of Managers quit, and I lost a night nurse to surgery, so now it's [staff member D] and I and [staff member E] picking up the shifts. We lost another nurse to COVID on nights. We've had a few nurses from agency that we have hired and then they will call back and say they got another job. We had to fire a nurse for drug diversion a couple of weeks ago. About half the time, still, some of the team has had to work on the floor to cover the shifts. We always have at least the minimum CNAs. We have some people that will come in part time. Our activities director left and we are down an Activities director now."
During an interview on 11/9/21 at 9:50 a.m., resident #12 and resident #13 each stated showers did not happen as scheduled or less than once a week due to staffing issues; often the shower aide is "working the floor" instead of giving showers.

During an interview on 11/9/21 at 10:00 a.m., resident #15 stated showers happened less than scheduled due to staffing issues.

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| F 725 | Continued From page 37<br><br>During an interview on 11/9/21 at 9:50 a.m., resident #12 and resident #13 each stated call lights were not answered very quickly.<br><br>During an interview on 11/9/21 at 9:55 a.m., resident #14 stated call lights were not answered very quickly.<br><br>During an interview on 11/9/21 at 10:00 a.m., resident #15 stated call lights were not answered quickly.<br><br>Resident Council Notes showed complaints relating to not enough resident showers in two out of three months of meetings.<br><br>The Grievance Log and grievances showed resident #6 filed a grievance stating she had not received a shower in 12 days. Four residents each stated showers did not happen as scheduled or less than once a week due to staffing issues; often the shower aide is "working the floor" instead of giving showers.<br><br>A review of the resident shower records were unreliable as dates and information was inconsistent and missing.<br><br>A review of the staffing schedules showed management staff working as nurses or CNAs. During an interview on 11/9/21 at 9:35 a.m., staff member L stated the residents are supposed to get at least one shower a week. She stated she had worked at the facility for several months, and the facility usually only had two CNAs on the 100 unit. Staff member L stated that two CNAs are not enough to provide the daily care and assistance the residents needed. | F 725 | | |

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| F 725 | Continued From page 38<br><br>During an interview on 11/10/21 at 7:20 a.m., resident #11 stated he understood the lack of staff at the facility, and that staff did not say anything to him when he did not get his shower/bath as scheduled. Resident #11 stated it made him feel terrible when he was unable to get his showers.<br><br>Record review showed resident #11 did not receive or refuse showers for the following days:<br><br>7/29/21 through 8/11/21, 14 days;<br>8/13/21 through 8/24/21, 12 days; and,<br>9/11/21 through 9/22/21, 12 days.<br><br>During an interview on 11/10/21 at 7:30 a.m., staff member K stated that she "gets pulled to the floor one or two times a week" when short staffed. Staff member K stated she had been pulled from showers to work the floor on Tuesday and Wednesday that week due to staffing, and would probably have to work the floor the rest of the week due to staffing. | F 725 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention | F 880 | | 12/10/21 |

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| F 880 | Continued From page 39 | F 880 | | |

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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| F 880 | Continued From page 40<br>by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record review, a facility staff member failed to use proper hand hygiene practices while performing a dressing change for 1 (#2 ) of 4 residents observed; staff failed to identify and clean three soiled lifts used for resident transfers; and staff failed to identify a soiled cart in need of cleaning and clean the cart prior to using it to pass fresh ice to the residents in their rooms. Findings include:<br><br>1. During an observation on 11/10/21 8:45 a.m., staff member M performed a dressing change to resident #2's right heel. Staff member M had gathered the needed supplies and entered resident #2's room, placed supplies on the bed side table, and washed her hands. Staff member M donned a pair of gloves, explained to resident #2 she needed to change her dressing to the right heel, and opened the closet door to retrieve a heel cup. Staff member M then removed her gloves, raised the bed, put clean gloves on, and removed resident #2's heel dressing. There was | F 880 | DIRECTED PLAN OF CORRECTION<br><br>This Directed Plan of Correction is required by the Centers for Medicare and Medicaid, and the Montana State Office of Inspector General, Certification Bureau, related to the identification of deficient practice for F880 - Infection Control, cited at the Severity and Scope of E. Corrections are to be completed by the date noted in Criteria Five - the Date of Completion/Compliance (X5 date). At a minimum, the facility will carry out and complete the following plan:<br><br>1. Criteria One: Corrections<br><br>a. The facility administrative team will review/assess the deficient practices identified in the Form CMS-2567 as related to the soiled lifts and drink carts, for infection control prevention, and determine contributing factors. On | |

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| F 880 | Continued From page 41<br>sanguineous drainage observed on the dressing. Staff member M cleansed the right heel, removed her gloves, donned clean gloves, applied a new dressing to the right heel, removed her gloves, placed the supplies in the closet, lowered the bed, and then washed her hands. Staff member M did not wash or sanitize her hands each time she removed her gloves.<br><br>During an interview on 11/10/21 at 8:45 a.m., staff member M stated the staff are supposed to wash or sanitize their hands after removing gloves. She stated she should have washed her hands each time she removed her gloves.<br><br>2. During an observation on 11/9/21 at 9:15 a.m., two mechanical lifts were in one of the four 100 halls, by room 111, with food crumbs and debris on the base of the lift.<br><br>During an observation on 11/9/21 at 9:20 a.m., another mechanical lift was on one of the other 100 halls, by room 134, with food crumbs and debris on the base of the lift.<br><br>During an observation on 11/9/21 at 12:00 p.m., there was a mechanical lift with food and debris on the base of the lift, next to room 132.<br><br>During an interview on 11/9/21 at 9:35 a.m, staff member L stated the mechanical lifts were to be cleaned after each use by the CNAs (certified nurse assistant). Staff member L stated she tried to clean the base of the mechanical lifts after each use. Staff member L stated she had not used the mechanical lifts that day, and that the mechanical lifts were dirty with food and debris on the base. | F 880 | completion, the facility will plan and implement corrections for the soiled lifts and cleaning of drink carts used by staff, to include who is responsible for the cleaning, and the process to be used.<br><br>b. Any and all potential staff members providing wound treatments for resident #2 will be trained on infection control used during wound care procedures. Training will be documented and completed by a staff member with the knowledge necessary as related to infection control and wound care.<br><br>2. Criteria Two: Identification of Others<br><br>The facility will review/assess all residents with wounds, and those residents who use mechanical lifts, to identify if any have been affected by failed IC practices used by staff.<br><br>The facility DON/IP will use the current infection control monitoring system to determine if a spread of infection occurred due to staff going room to room and failing to uphold safe infection control procedures, as related to the soiled drink cart.<br><br>3. Criteria Three: Systems<br><br>a. The facility administrative team will review the policy and procedure for cleaning lifts and drink carts, and ensure the policies and procedures are up to date and being followed, that staff are aware of the policies and procedures via provided | |

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| F 880 | Continued From page 42<br>3. During an observation on 11/9/21 at 9:30 a.m., staff member N was passing ice to all the residents who lived on the four 100 halls. The cart had dirt and reddish/brown dried liquid on the bottom shelf of the cart.<br><br>During an interview on 11/9/21 at 9:30 a.m., staff member N stated it was not her responsibility to clean the the ice cart, and she was not sure who cleaned the ice cart.<br><br>During an interview on 11/9/21 at 10:30 a.m., staff member O, stated it is the CNAs responsibility to clean the ice cart.<br><br>4. Review of the facility policy titled Standard Precautions, showed the following:<br><br>- Section 1. Hand Hygiene, ... d. Wash hands after removing gloves (see below) ...,<br><br>- Section 2. Gloves, showed, ... e. Change gloves, as necessary, during care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one). ... g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments.;<br><br>- Section 5. Resident-Care Equipment, showed, ... b. Ensure reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and singleuse items are properly discarded ... | F 880 | training updates, and the staff have the tools necessary to carry out the cleaning tasks.<br><br>b. The facility will identify all licensed staff in need of wound care training and infection control during wound care, and provide training to these individuals as needed for compliance. For the training, the instructor, who should be qualified in wound care/infection control, should ensure return demonstration of items learned, content of training, and roster, are well documented.<br><br>c. The nursing administrative team will review the policies and procedures related to wound care and lift cleaning, and determine and establish a visual monitoring system for infection control prevention. Monitoring will be no less than weekly for 2 months for each area of concern (lifts/carts), and then bi-weekly for 2 months. All monitoring will include the gathering of measurable data for review by QAPI. The DON will hand the monitoring results over to QAPI monthly, or as needed if sooner, for timely corrections.<br><br>Criteria Four: Monitoring<br><br>a. The nursing administrative team will review the policies and procedures related to wound care and lift cleaning, and determine and establish a visual monitoring system for infection control prevention. Monitoring will be no less than weekly for 2 months for each area of | |

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| F 880 | Continued From page 43 | F 880 | concern, and then bi-weekly for 2 months. All monitoring will include the gathering of measurable data for review by QAPI. The DON will hand the monitoring results over to QAPI monthly, or as needed if sooner, for timely corrections.<br><br>b. The facility will identify who will monitor and visually check the drink cart cleanliness on a regular basis, at least 2 times each week, for 4 months. The visual checks will be documented, and concerns identified addressed timely by administration.<br><br>c. The QAPI committee will review the Form CMS-2567 and actions taken by the facility, to ensure all quality deficient practices as related to infection control are addressed timely. The QAPI committee will continue to meet monthly for 4 months for discussion, evaluation, and to determine if compliance is maintained, or if future corrections are necessary.<br><br>Criteria Five: Date of Completion/Compliance - 12/10/21<br><br>F 880- Infection Prevention and Control<br>1. Resident #1 no longer resides in the center. Residents #2 and #3 will have skin evaluations (including measurements and stage of wound as appropriate), Braden scales, and physician orders requested and/or implemented for treatment and care plan for skin integrity completed by 11/11/2021. Wound care nurse ensured that the current wound treatments in place | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275140 | A. BUILDING _____ B. WING _____ | C 11/11/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ASPEN MEADOWS HEALTH AND REHABILITATION CENTER | 3155 AVE C BILLINGS, MT 59102 |

| (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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| F 880 | Continued From page 44 | F 880 | were accurate per physician ' s orders on 11/11/21. Nurse Practitioner visually assessed both residents, validated that assessments were correct, and that treatment orders are in place on 11/11/21.<br>2. Staff Development Coordinator has been identified as a full time RN who has the skillset necessary for wound care, and who will oversee the wound program for all facets of care related to wounds. Assistant Director of Nursing will be Staff Development Coordinator ' s back up should a need arise. Wound care nurse is a BSN with 19 years of experience in acute care trauma and orthopedics which dealt extensively with wounds. She was a supervisor for 8 years in the acute care setting as well.<br>3. All residents will have skin evaluations completed by licensed nurses, physician orders for treatment requested, if needed, by 11/11/2021. On 11/11/21 confirmed that there are no new pressure ulcers in the center, and she verified the treatments were accurate for the two identified by the survey agency. Any residents identified with skin impairments will have Braden scales and care plans for skin integrity completed by 11/12/2021. Responsible parties and physicians were notified of wound status and treatment on 11/10/21 and 11/11/21.<br>4. AGACNP-BC, MSN (Adult Gerontology Acute Care Nurse Practitioner-Board Certified, Masters of Science in Nursing), Vice President of Clinical Operations for Empres Healthcare educated Divisional Directors of Clinical Operations on Empres Skin Integrity | |

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| F 880 | Continued From page 45 | F 880 | Policy, Skin Integrity Definitions, Pressure Ulcer Stages Grid, Wound Care Protocols per CDC, CMS Regulations on 11/11/21. Director of Nursing Services was re-educated on 11/11/21 by DDCO on the procedure for submitting the Weekly Skin Report-Pressure Ulcers to the DDCO. On 11/10/2021, the Divisional Director of Clinical Operations provided education to Director of Nursing using: Empres Skin Integrity Policy, Skin Integrity Definitions, Pressure Ulcer Stages Grid, Wound Care Protocols per CDC, CMS Regulations. Director of Nursing (Jon Gjersing) educated the following RN ' s on 11/10/2021: MDS Coordinator (Ginger Carrig), Staff Development Coordinator and Assistant Director of Nursing. These staff will complete education with all licensed staff nurses using the aforementioned tools prior to their next scheduled shift. The aforementioned management nurses will provide education for CNAs regarding their role in skin care to include reporting skin deficits to a licensed nurse before their next scheduled shift using Medline Skin Care Guidelines. Center has supplied binder with skin care policy and procedures for both nursing stations which include all the aforementioned training documents. All residents records are electronic and all required forms are available to all nursing staff. On 11/11/21, the Divisional Director of Clinical Operations re-educated the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and MDS coordinator were re-educated on the Daily Clinical Meeting Policy. | |

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