STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165487	A. BUILDING _____ B. WING _____	C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES	3520 GRAND AVENUE DES MOINES, IA 50312

(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
F 000	INITIAL COMMENTS Correction Date 10/4/21 The following deficiencies relate to the investigation of facility reported incidents 97449-I and 99401-I, and complaints 97423-C and 99271-C conducted on August 24 - September 8, 2021. Facility reported incidents 97449-I and 99401-I and complaints 97423-C and 99271-C were substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, and staff interviews, the facility failed to assure staff complete and thorough assessment and intervention at the time of a fall, for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 66 residents. Findings Include:	F 684	F(684), 483.25 **PLAN OF CORRECTION** This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because the provisions of federal and state law require it. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (684), Regulation 483.25. Wesley Acres immediately corrected the deficiency related to notifying the charge nurse in the event of a fall or near fall by educating Staff A and Staff B on 4/29/2021 at the time of the incident. Wesley Acres re-educated all staff on 8/26/21 regarding reporting falls or near falls to the charge nurse immediately. Resident #3 has not had any falls or near falls and the care plan is being followed for transfers.	10/4/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandon Kranovich
TITLE: Administrator
(X6) DATE: 10/4/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 According to the Minimum Data Set (MDS) assessment tool dated 5/4/21, Resident #3 scored 15 of 15 possible points on the Brief Interview for Mental Status (BIMS) test, which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident required extensive physical assistance of 1-2 staff for bed mobility, transfers, ambulation (walking) in the room, and toilet use. The MDS documented diagnoses of congestive heart failure (CHF), hypertension (HTN), osteoarthritis, and age related osteoporosis. The Care Plan with an initiation date of 4/22/21, identified the resident displayed an activities of daily living (ADL) self-care performance deficit related to fatigue and the disease processes of COPD (chronic obstructive pulmonary disease), CHF, lung cancer, and recent onset of pneumonia with hospitalization. The care plan directed staff to provide the following interventions: a. Front wheeled walker (FWW) initiated on 4/22/21, resolved on 4/29/21 b. Manual wheelchair w/assist of 1 staff initiated on 4/22/21 c. Walk short distances w/assist of 1 staff and FWW (initiated on 4/22/21, resolved 4/29/21), d. Transfer with assist of 2 staff and FWW (initiated on 4/22/21, resolved on 4/29/21), e. Transfer with Hoyer lift (full body mechanical lift initiated 4/29/21), f. Non-ambulatory, non-weight bearing (initiated 4/29/21), g. CAM boot (used to immobilize the foot due to injury) at all times, may remove for skin check and cares (initiated 4/29/21) h. Transfer with Hoyer lift and assist of 2 staff for	F 684	2. To ensure the problem does not recur, the Nursing Leadership team will continue to meet regularly to review incident reports, appropriate interventions, and changes in condition. 3. As part of Wesley Acre's ongoing commitment to quality assurance, the DON and/or designee will conduct audits monthly for three months then randomly to monitor for compliance and review any concerns through the QAPI Committee.	

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F 684	Continued From page 2 all transfers (initiated 4/29/21). The care plan with initiation date of 4/22/21, identified the resident at high risk for falls related to gait and balance problems, and incontinence. The care plan interventions included: a. Ensure the resident wears appropriate footwear when ambulating or when mobile in the wheelchair (initiation date 4/22/21 and resolved 8/26/21) b. Follow facility fall protocol (initiated 4/22/21) c. Encourage and assist the resident to wear nonskid footwear for all mobility (4/22/21) d. Assist of 1 plus 1 with Hoyer (initiated 5/21/21), e. Non-slip strips applied next the resident's bed and recliner (initiated 4/22/21). f. Non-weight bearing (initiated 4/22/21). Observation on 8/29/21 at 11:03 AM, revealed Resident #3 sat in her recliner with feet elevated and CAM boot to right lower leg. During an interview at the time, Resident #3 stated 2 staff assisted her to bed one evening about 4-5 months ago. Her foot got caught, twisted, and then nursing staff assisted her to the floor. Resident #3 stated the two nursing staff assisted her up and into the bed. Observation on 8/29/21 at 8:27 AM, revealed Resident #3 lay in bed with CAM boot to right lower leg. The resident again stated she had been lowered to the floor at the time of the incident. Resident #3 stated she sat there and the 2 nursing staff assisted her into bed. Resident #3 stated she did not have pain at the time and a nurse did not come to assess her. Resident #3 stated later during that night, her right ankle hurt and she called for the nurse.	F 684		

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F 684	Continued From page 3 The Fall Risk Assessment dated 4/22/21 documented the resident scored 9 due to requiring assist with ambulation, balance problem standing/walking, use of assistive device, medication use with changes, and diagnosis. The Fall Risk instructed: with a total score 10 or greater, the resident should be considered at high risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan. The Fall Risk Assessment dated 4/29/21 documented the resident scored 17 related to regular incontinence, balance problem standing/walking, use of assistive device, medication use with changes, and diagnosis. The Fall Risk instructed: with a total score 10 or greater, the resident should be considered at high risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan. The progress notes revealed: a. On 4/29/21 at 4:00 AM, Incident Report - Head to Toe Assessment: Neurological/Cognitive: alert & orientated x 3 (person, place, & time), Cardiovascular: within normal limits (WNL), Respiratory: WNL, Pain assessment: complained of right ankle pain with ROM (range of motion) and touch, Gastrointestinal: bowel sounds x 4 quadrants, Musculoskeletal/ROM: limited to right ankle, Skin condition: abrasion to right lower leg with slight discoloration to inner right ankle. Safety measure implemented: resident safe now with call light in reach. b. 4/29/21 at 4:01 AM, Nurse's Note - the resident	F 684		

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F 684	Continued From page 4	F 684		

stated she attempted to walk to the bed and her balance was off; she nicely fell to bottom on the floor. The resident denied hitting her head and stated it happened so fast. The resident reported a tall thin guy and an aide had assisted her at the time; they assisted off the floor and into the bed.

c. 4/29/21 at 4:02 AM, Nurse's Note - assessment completed and noted a scrape to the right lower leg and right ankle slightly swollen on lateral side with purple discoloration to the inner side of the ankle. The resident complained of pain with ROM and touch - elevated ankle on a pillow, applied ice and gave Tylenol for the pain.

d. 4/29/21 at 9:23 AM, Nurse's Note - the resident complained of pain to the right ankle - small amount of swelling noted. The resident fell last night (4/28/21) at bed time. Staff notified the resident's PCP (primary care provider) and received an order to obtain a 2 view x-ray of the right ankle.

e. 4/29/21 at 1:57 PM, Nurse's Note - Received the x-ray results and sent them to the resident's PCP with new orders received: non-weight bearing x 2 weeks, CAM boot to right lower extremity at all times, and follow-up right ankle x-ray in 2 weeks.

f. 4/29/21 at 2:04 PM, Nurse's Note - CAM boot placed to right lower extremity.

g. 4/29/21 at 8:05 PM, Incident Post Follow-up - The Resident's ankle fracture contains bruising to the area. The resident often complained of pain with as needed pain medications given and effective. Bruising noted to the area. Will continue to monitor.

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F 684	Continued From page 5 Review of the resident's record revealed no documentation to show nursing staff lowered Resident #3 to the floor on the evening of 4/28/21. The record also failed to contain an assessment by a licensed nurse before staff transferred the resident to bed. The Post-Fall Assessment Process policy last revised on 03/21 directed staff to complete and document an assessment after a fall with the procedure as follows: a. Gather necessary equipment and go to the area of the fall b. Visually inspect the area and the resident. c. Begin palpation of the resident head and body d. Assess for proper limb alignment and also complaints of pain by providing passive range of motion e. Complete head to toe assessment. f. Obtain account of the incident from the resident &/or any eyewitnesses g. Treat any minor injuries, first aid as necessary h. Assist the resident to comfortable position. If contraindicated (example hip fracture) and emergency services if warranted; do not move the resident until ambulance arrives. i. Report the incident and findings to the physician and obtain any new orders j. Inform the resident &/or resident representative in the risk management section of the medical record of the incident and any instructions from the physician k. Document the incident and reference in the progress notes. Complete incident: post follow up assessment every shift x 72 hours.	F 684		

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F 684	Continued From page 6 During an interview on 8/30/21 at 12:21 PM, Staff A Certified Nurse Aide (CNA) stated he had not worked with Resident #3 on the evening of 4/28/21 until he assisted Staff B CNA to transfer the resident to the bed. Staff A stated Staff B had placed a gait belt on the resident and the 2 CNA's attempted to transfer the resident with the walker to the bed. Staff A stated Resident #3 had informed the nursing staff she could not walk any farther and went down to her knees. Staff A stated he and Staff B assisted Resident #3 back up into wheelchair. The resident denied any complaints of pain or discomfort, so they then assisted her into the bed with the use of a sit-to-stand mechanical lift. Staff A reported he did not notify the nurse on duty of Resident #3 going to her knees during the transfer because he had asked Staff B to inform the nurse. In an interview on 8/30/21 at 12:43 PM, Staff B CNA confirmed she worked with Resident #3 on 4/28/21. Staff B stated she positioned the gait belt and walker for the resident and asked Staff A to help her assist the resident into the bed. Staff B stated as they walked to the bed, the resident's legs buckled, but they held her, kept her knees from hitting the floor, and did not allow her to fall. Staff B reported they then transferred her into bed. Staff B commented she made a mistake when she had forgotten to inform the nurse on duty about the incident. Staff B denied she saw the resident's knees touch the floor and added Resident #3 did not complain of pain during the remainder of her shift. On 09/821 at 9:29 AM, the Interim Director of Nursing (DON) stated she would have expected staff to notify the nurse when they lowered	F 684		

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F 684	Continued From page 7 Resident #3 to her knees during the transfer to bed because that was a change for the resident.	F 684	**F (686), 483.25(b)(1)** **PLAN OF CORRECTION** This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because the provisions of federal and state law require it. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F (686), Regulation 483.25(b)(1)(i)(ii). Resident #1 is no longer a resident at Wesley Acres. To correct the deficiency, Wesley Acres' Director of Nursing conducted a nurse in-service on 9/10/2021 regarding the prevention and treatment of skin breakdown, assessing for change of condition, and family/physician/ responsible party notification. 2. To ensure the problem does not reoccur, Wesley Acres initiated an agreement with a skin and wound company to provide wound services and education for Wesley Acres in house. On 9/21/2021, Wesley Acres implemented a dedicated wound Nurse to complete weekly skin assessments.	9/24/2021
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, facility policy review, staff interviews, family interview, and physician interview; the facility failed to prevent and thoroughly assess a pressure ulcer for 1 of 3 residents reviewed (Resident #1). The facility failed to assess the area to the resident's left heel when identified on 7/21/21. The facility failed to notify the physician, the resident, and/or the resident representative with a change to the ulcer on the left heel when identified on 8/4/21. Upon admission to the facility on 7/14/21, and weekly thereafter, the facility failed to assess areas on the resident's right first 1st and 2nd toes. The facility identified the resident as at risk for pressure sore development according to the Braden Scale assessment tool and noted the resident required staff assist for	F 686		

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F 686	Continued From page 8 bed mobility and transfers. However, the care plan failed to identify additional interventions to prevent pressure ulcers. Resident #1 admitted to the local hospital on 8/6/21 due to a Stage 2 pressure ulcer on the left heel with gangrene (localized death and decomposition of body tissue) present. The facility reported a census of 66 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 7/27/21, Resident #1 scored 12 of 15 possible points on the Brief Interview for Mental Status (BIMS) test. A score of 12 indicated the resident demonstrated mildly impaired cognitive abilities. The MDS documented the resident required extensive physical assist of 1 staff for bed mobility and toilet use, and limited physical assist of 1 staff for transfers and personal hygiene. The MDS identified the resident as at risk of developing pressure ulcers. The MDS documented the resident had a diabetic foot ulcer and required the application of dressings to the feet, with or without topical medications. The MDS documented the resident had diagnoses that included atrial fibrillation, coronary artery disease, diabetes mellitus, cellulitis of the right lower limb, polyneuropathy, and abscess of the right foot. The MDS identified the following descriptions of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it	F 686	3. As part of Wesley Acre's ongoing commitment to quality assurance, the nurse leadership team will the DON and/or designee will conduct audits monthly for three months then randomly to monitor for compliance and review any concerns through the QAPI Committee.	

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F 686	Continued From page 9	F 686		

may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

The Care plan with a date initiated of 7/14/21, revealed the resident had an ADL (activities of daily living) self-care performance deficit related to fatigue and weakness. Interventions included: the resident ambulated with assist of one, walker, and wheelchair to follow (7/14/21), required assist of one for bed mobility (7/14/21), skin inspection per facility policy (7/14/21), the resident required skin inspection; observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse (7/14/21), and transfer with assist of one and walker (7/14/21).

The care plan initiated on 7/14/21, identified the resident as at risk for nutritional problems related to pleural effusion, cellulitis, left ventricular heart failure, atrial fibrillation, diabetes, and wounds to left medial foot. The care plan directed staff to provide the following interventions:

a. Invite the resident to activities that promote additional intake (7/14/21)
b. Provide and serve nutritional supplements as

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F 686	Continued From page 10 ordered (7/14/21) c. The Registered Dietician will evaluate and make diet recommendations as needed (7/14/21). The care plan initiated on 7/14/21, identified the resident as at risk for pressure ulcer development related to immobility and directed staff to provide the following interventions: a. Administer treatments as ordered and monitor for effectiveness (7/14/21) b. Assist/instruct the resident to shift weight as needed to maintain comfort (7/14/21) c. Follow facility policies/protocols for the prevention/treatment of skin breakdown (7/14/21) d. Inspect skin during routine cares and report any abnormalities to the charge nurse (7/14/21) e. Monitor pressure ulcer for signs and symptoms of infection to include drainage, odor, redness, warmth, or pain (7/14/21) f. Monitor/document/report as needed any change in skin status: appearance, color, wounding, signs & symptoms of infection, wound size, or stage (7/14/21) g, Document weekly and include the measurement of each area of skin breakdown; width, length, depth, type of tissue, and exudate (7/14/21). The following Braden Scales for predicting pressure sore risk documented: a. On 7/14/21, the Braden Score measured 19: not at high risk for developing a pressure ulcer. b. On 7/21/21, the Braden Score measured 18: at risk for developing a pressure ulcer.	F 686		

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F 686	Continued From page 11 c. On 7/30/21, the Braden Score measured 17: at risk for developing a pressure ulcer. The Progress Notes contained the following entries: a. On 7/17/21 at 11:22 PM, a Nurse's Note documented the resident complained about the moon boots, nursing staff directed on how to put on and off properly. The resident suggested putting the right boot on upside down. b. On 7/18/21 at 10:54 PM, a Nurse's Note revealed staff noted resident sleeping and did not complete the treatment to the resident's right foot moon boots in place. c. On 7/20/21 at 11:55 AM, a Nurse's Note showed family requested that podiatry (wound clinic) see the resident prior to the current appointment scheduled for 7/23/21. Call placed to clinic, but they could not see the resident on an earlier day. d. On 7/20/21 at 2:48 PM, a Social Service Note revealed on 7/15/21, the social worker spoke with the resident's daughters. Family concerned the nursing staff did not know how to apply the resident's soft boots; they reiterated that the wound to the right foot caused concern if it does not heal due to the consequences. The family said the dressing had not been changed in 24 hours. e. On 7/21/21 at 5:19 PM, a Physician Visit note documented the ARNP (Advanced Registered Nurse Practitioner) saw the resident and wrote new orders.	F 686		

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f. On 7/23/21 at 3:18 PM, a Nurse's Note revealed the resident saw the physician at the wound clinic and returned with new orders regarding his right foot.

g. On 8/6/21 at 1:13 PM, a Nurse's Note showed the resident saw the physician at the wound clinic and then the facility received call that the resident admitted directly to the hospital because the wounds had deteriorated.

A Wound Evaluations form dated 8/4/21 documented:

a. New, facility acquired diabetic wound, left heel, that measured 3.15 cm x 1.78 cm. Wound bed: no evidence of infection, pink or red. Exudate (drainage): light amount of bloody drainage. Peri wound: edges attached, surrounding tissue normal in color, no swelling or edema. The resident had used a diabetic post-op shoe for ambulation for ambulation and used bunny boots in bed. No notifications, blank. Picture included.

b. New, facility acquired blister, right heel, that measured 1.33 cm x 1.13 cm. Wound bed: no evidence of infection. No drainage. Peri wound: edges attached, surrounding tissue normal in color, and no swelling or edema. The resident had used a diabetic post-op shoe with ambulation and used bunny boots in bed. No notifications, blank. Picture included.

c. New, facility acquired blister, right ankle that measured 1.41 cm x 1.09 cm. Wound bed no evidence of infection. No drainage. Peri wound: edges attached, normal skin surrounding, and no swelling or edema. The resident had used

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F 686	Continued From page 13 diabetic post-op shoe with ambulation and used bunny boots in bed. No notifications, blank. Picture included. A Treatment Administration Record (TAR) dated July 2021 contained the following treatment orders: a. Apply Edema wear/TED hose to bilateral lower extremities in the morning and remove them at bedtime for edema and fluid maintenance. Start date 7/15/21. b. Soak gauze in Betadine, apply to right lower extremity ankle, and then apply kerlix and ace wrap from the foot to just above the ankle for wound care. Start date 7/16/21, stop date 7/23/21. c. Wash right foot with soap and water, and pat dry. Paint ulcers on the top of the right 1st and 2nd toes with Betadine. Dress wounds on the medial right foot with Prisma AG (wound dressing containing silver, which provided antimicrobial protection against bacteria & infection), gauze, and roll gauze. Change dressing daily. Start date 7/24/21. d. Apply Betadine solution to the left heel two times a day for wound care. Start date 7/21/21. A physician progress note dated 7/15/21 revealed Internal Medicine: the resident's primary care provider visited due to admission to skilled therapy. Resident admitted with a right foot ulcer and surrounding cellulitis. Plan: right foot ulcer with cellulitis; status post incision & drain and angiogram on 7/13/21.	F 686		

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F 686	Continued From page 14 A physician progress note dated 7/21/21 documented the Internal Medicine ARNP saw the resident for an acute visit due to increased edema and increase of diuretic on 7/16/21. Noted the resident did not have compression hose on at the time of the visit, and legs were down in dependent position. Daughter present at bedside and reported the resident at risk for pressure area to right heel with issues in the past. Physical exam noted: mild edema to lower extremities and right heel skin discoloration with history of pressure ulcer to that area. Plan: Lower extremity edema - measure and obtain edema wear on in the morning and off at bedtime. Regarding risk for pressure area on right heel; Betadine to right heel daily and monitor daily, the resident needs the pressure taken off the heel - shoes too tight. A physician progress note dated 7/23/21 documented the podiatrist saw the resident at the wound clinic. The resident presented with a grade 2 ulcer on the right foot and Stage 1 pressure ulcer on the left heel. The resident experienced swelling in both legs and had edema wear that could be used and also heel protector boots to use while in bed. The resident used a post-op on the right foot and daughters requested one for the left foot due their concern regarding breakdown of the left heel. Wound assessments revealed: a. Diabetic toe ulcer right 2nd toe. Base non-granulating. 2 wounds measured together, 2.5 centimeters (cm) length x 0.5 cm width x 0.2 cm depth. b. Diabetic toe ulcer right hallux (great toe). Base non-granulating. Measurement: 0.7 cm x 0.4 cm x	F 686		

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F 686	Continued From page 15 0.2 cm. Physical exam: rigid hammering of the toes present, no pain to palpation of feet or toes. Pitting edema to bilateral legs and feet. The resident had purple discoloration to the posterior left heel. Eschar (necrotic) with loose edges to the 1st and 2nd toes right foot. Assessment: ulcer of the right foot and pressure injury to the left heel, Stage 1. Plan: a. Paint toe ulcers with Betadine b. Post-op shoe for left foot due to Stage 1 pressure ulcer to prevent further skin breakdown c. Edema wear to help with overall swelling d. Encourage the resident to elevate legs at the nursing facility for a few hours a day. Keep weight off the back of the heel while in the chair or in bed, and use heel protector boots or pillows to evaluate further deterioration. Wound Care: a. Wash right foot with soap and water and pat dry. May take dressings off for bath, then redress after. b. Paint ulcer on the tops of the right 1st and 2nd toe right foot with Betadine. c. Dress wounds on the medial right foot with Prisma, gauze, and roll gauze. d. Use edema wear to both legs from the toes to the knees. e. Change dressings daily. f. Use post-op shoes during the day and heel protector boots at night or when in bed. The clinical record failed to contain an assessment of the left heel after the ARNP	F 686		

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F 686	Continued From page 16 identified the discoloration on the 7/21/21 visit, or weekly thereafter. The clinical record lacked documentation to show staff notified the resident and/or the resident representative, or the physician of the change in the left or right heel identified on 8/4/21. The clinical record also lacked documentation of an initial assessment or weekly assessment thereafter for the skin impairments on the 1st and 2nd toes on the right foot. The Skin Prevention and Treatment of Skin Breakdown policy and procedure with an origination date of 8/2021, directed the facility would properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers/injuries in order to implement preventative measures and to provide appropriate treatment modalities for wounds according to the facility standards of care. Prevention of Pressure Ulcers: Complete Braden Scale - upon admission, weekly for the 1st 4 weeks post admission, quarterly, and with a change in status (pressure ulcer development, change in mobility, continence status, change in condition, nutrition, etc.) Monitoring of Skin Integrity: a. Certified Nursing Assistants (CNA's) will observe skin daily with cares and report and skin concerns immediately to the charge nurse b. Charge nurse will assess any noted skin concerns, complete an incident report, and notify the physician and family c. Initiate or evaluate and revised skin integrity care plan based on response, outcomes, and the	F 686		

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F 686	Continued From page 17 needs of the resident. Nutrition: Notify the dietician with a resident deemed nutritionally at risk, upon discovery of a wound, if a wound declines unexpectedly, or with a wound not showing progress in 2 weeks. The dietician will then review nutritional intake and make recommendations as appropriate. Therapy: request an evaluation for wheelchair seating as appropriate for treatment of pressure or lower extremity ulcers (arterial, venous, neuropathy/diabetic, or mixed) With a resident admitted with a pressure ulcer or with a new development of a pressure or lower extremity ulcer, implement the following procedure: a. Initiate wound care protocol b. Notify Physician/NP (Nurse Practitioner) and family/designee c. Notify supervisor/designee as assigned d. Notify dietary for nutritional interventions e. Notify therapy department for seating surface evaluations and possible treatment interventions and other interdisciplinary team members as appropriate Re-evaluate interventions per risk factors identified: a. Update the Care Plan for skin integrity and CNA Kardex with skin concern, interventions b. Initiate Weekly Wound Documentation to include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full thickness (arterial, venous, neuropathy/diabetic ulcers), length, width, depth; wound base	F 686		

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F 686	Continued From page 18 description, wound edge description, and if present, drainage, odor, undermining, tunneling, and/or pain. Daily pressure wound monitoring should include: a. Evaluation of the ulcer, if no dressing present b. Evaluation of the status of the dressing, if present c. Status of the area surrounding the ulcer (that can be observed without removing dressing) d. Presence of possible complications, such as signs of infection e. Pain if present and adequately controlled f. Document on any changes or concerns in the nurse's notes g. Notify the Physician/NP, family, and supervisor/designee if the ulcer had not shown progress in 2-4 weeks &/or deteriorating unexpectedly. Re-evaluate plan of care as appropriate. Resident Choice: in order for the resident to exercise his or her right to appropriately make informed choices about the care and treatment or to refuse treatment, the community and the resident (or the resident's legal representative) will discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The community will address the resident's concerns and offer alternatives if the resident refuses treatments and interventions and document in the resident's medical record. The Weekly Pressure Ulcer Progress Report policy dated 06/20 documented the practice to provide weekly assessment and documentation of all pressure/stasis ulcers and help prevent	F 686		

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F 686	Continued From page 19 infections and other complications of pressure/stasis ulcers. Procedure: a. Upon assessment of a pressure/stasis ulcer, document on weekly pressure ulcer progress report b. Document complete assessment of the site on the form including; stage, size, depth, presence/absence of drainage, odor/color, if culture obtained, evaluate for and document any risk/causal factors, and document physician family and dietary notification c. Complete Incident/Quality Assurance report d. Document in nurses notes and monitor the area on a weekly basis on the weekly pressure ulcer progress report e. Report any signs/symptoms of infection or poor response to treatment to the Director of Nursing (DON) and to the physician for review for new orders f. Charge nurse will assess the ulcer weekly and document g. Charge nurse or care plan nurse will be responsible to add skin issues to the care plan with each incident to identify interventions to promote healing. The MDS coordinator will be responsible to follow-up and monitor the care plan and add updates as needed. h. Report the updated information regarding the resident's skin condition and care plan to the	F 686		

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F 686	Continued From page 20 CNA's to provide quality care to heal and attempt to prevent further issues Documentation: a. Complete Weekly Pressure Ulcer Progress Report b. Complete Incident/QA report c. Document in Nurses Notes d. Document notification of physician, dietician, and family e. Update the care plan and notify staff of interventions In an interview on 8/24/21 at 2:15 PM, the Resident Representative (family member) for Resident #1 stated the resident admitted from the hospital to the nursing facility on 7/14/21, and then readmitted to the hospital on 8/6/21 due to a gangrenous open area on the left heel. The family member reported the resident received daily dressing changes to the right foot, but the nursing staff wrapped the ace wraps too tightly and did not follow physician orders. When the physician saw the resident on 8/6/21, and informed them of the new open area, the physician and said too much pressure had been applied to the area. The family member stated they were unaware of the new open area to the left heel until the physician identified it at the appointment. The family member stated the resident remained hospitalized for 13 days and received intravenous antibiotics and added although they were aware the resident had decreased circulation and feeling in lower extremities, they thought the nursing staff should have checked areas. The family member stated Resident #1 had been 3 days from returning home prior to re-hospitalization with the	F 686		

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ability to walk 90 feet with the walker, but when they returned to the hospital, they experienced decreased strength and increased weakness, and currently had to use full body mechanical lift for transfers.

On 8/25/21 at 11:43 AM, Staff D Registered Nurse (RN) stated when Resident #1 admitted to the facility, he initially had redness on the left heel, not an open area. She then went on vacation for a couple of weeks and upon her return, found the left heel had deteriorated to an open area from a popped blister. Staff D reported she asked fellow nursing staff what had happened to the resident's left heel. Staff D stated family members visited daily, were concerned about the resident's wounds, on top of the resident's wound care due to his history, and they did not want the resident to lose his feet. Staff D stated she had not been instructed to complete the bottom area of the wound form regarding notification of family, physician, and/or dietary of new skin areas. Staff D reported being unaware of weekly skin assessments, but said CNA's reported areas of concern and then the nurse would complete the assessment. Staff D added once staff identified a new area they notified the physician and the family, completed documentation, took a picture, and re-assessed any skin impairments every 6 days.

During an interview on 8/26/21 at 7:50 AM, Staff C stated she had worked during the pandemic as a temporary/emergency RN for a couple of months and had been one of the admitting nurses for Resident #1. Staff C stated Resident #1 admitted to the facility with 2 ulcers on the inner right foot and possibly areas on the 1st and 2nd toes of the right foot. Staff C stated she no longer

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worked as a nurse as of around 7/21/21, and was unaware of any new areas on the resident's heels. She reported Resident #1 preferred to stay in bed on his back and wore bunny boots in bed, as he would remind staff to place them on while in bed. Staff C stated initially the resident wore tennis shoes and then changed to a therapeutic type sandal. Staff C said staff did skin assessments weekly with triggered current areas, but she was unaware of the process with new open areas.

On 8/26/21 at 8:23 AM, Staff D RN stated she recalled Resident #1 had skin issues, and that the resident had redness to left heel. Staff D stated nursing staff applied Betadine to the left heel and when the resident went to an appointment end of July, the resident returned with an off-loading shoe. Staff D said the resident previously had one for the right foot but not the left. Staff D reported she recalled family saying the resident had a history of pressure ulcers on his left heel and did not recall the resident having any open areas there, but she had left for vacation at the end of July. Staff D stated no routine skin assessments are completed, but every 6 days an assessment was completed on identified areas. Staff D stated she checked residents' feet when they are at risk or currently had an area of concern. Staff D said she worked the day shift and the resident either had off-loading shoes on or his feet propped on a pillow.

On 8/26/21 at 8:40 AM, the Wound Physician stated the area to Resident #1's left heel was definitely preventable; the nursing staff were not following orders correctly. The Physician stated the resident's left foot initially had no wounds; edema wear was ordered to be worn from the

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toes to the knees and the nursing staff placed the edema wear from the ankles to the knees. The Physician stated staff applied kerlix dressing, then the edema wear, and then ace wraps on top, which caused increased pressure and injury to the left heel. The Physician stated she had called the facility to confirm the nursing staff had her orders right, but what the nursing staff had reported to her was not what she had ordered. The Physician stated on 7/23/21, she ordered: wash right foot with soap and water and dry; paint ulcer on the tops of the right 1st and 2nd toe right foot with Betadine; dress wounds on the medial right foot with Prisma and gauze; and place edema wear from the toes to the knees. The Physician stated on 8/6/21 Resident #1 admitted to the hospital due to the left heel being open with gangrene present. The Physician stated the resident required intravenous antibiotics due to infection and sepsis.

In an interview on 8/26/21 at 2:20 PM, the Interim DON confirmed Resident #1 admitted to the facility with 2 open areas on the right medial foot and the areas to the tops of 1st and 2nd toes of the right foot, after she reviewed the admission orders and the pictures from the hospital. The Interim DON stated she reviewed Resident #1's chart and was unable to locate any documentation related to the resident's toes while the resident resided at the facility. She reported the physician ordered Betadine and edema wear on 7/21/21 and the nursing staff applied edema wear and ace wraps together from 7/16-7/23/21. The Interim DON added staff did not discontinue the ace wraps after they received the order for the edema wear. The Interim DON said she spoke with the Medical Directors of the facility regarding concerns with the skin program and

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F 686	Continued From page 24 plans to make changes moving forward. The Interim DON stated she expected staff to document a complete assessment weekly for all skin impairments. In a subsequent interview on 9/8/21 at 9:29 AM, the Interim DON stated she was not employed at the facility during the time period when Resident #1 resided there previously. She said her expectation would be for staff to implement weekly skin assessments if they identified a heel with discoloration. The Interim DON also stated if staff noted any changes in a wound they should notify the resident representative and physician to be notified of the change with Resident #1's left and right heels on 8/4/21. The Interim DON reported she expected staff to document interventions on the resident's care plan.	F 686		