STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	12/16/2021

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SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 12/16/21. Intake #'s: MI00124073, MI00124279, MI00124301, MI00124624, MI00124645, and MI00124777. Census: 149	F0000		
F0583 SS= D	Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as	F0583	Element 1 Resident 503 was seen by the Social Worker, and she did not verbalize any signs and symptoms of emotion distress or mental anguish. Element 2 All like residents were interviewed to ensure no photographs or recordings of the resident and/or private space without the resident□s or designated representative□s written consent. No residents reported any unauthorized photographs or recordings of the resident and/or private space. Element 3 The Photographing and Video Recording policy was reviewed and deemed appropriate. By 1/11/21 the facility staff will be in-service on the Photographing and Video Recording and annually thereafter. New hires will be in service during orientation and annually thereafter. Element 4 The Administrator/designee will conduct random audits through interview and observation on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure resident have not had unauthorized photographs or recordings of the resident and/or private space. The	1/11/2022

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

Electronically Signed | 01/10/2022

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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	evidenced by: This citation pertains to intake #MI00124301 Based on observation, interview, and record review, the facility failed to protect the privacy of one resident (R#503) of five residents reviewed for privacy, resulting in a cell phone video of R503 being posted to social media. Findings include: On 12/14/21 at 1:02 PM, an interview was conducted with the complainant who alleged a staff member had taken a video of R503 and posted it on social media without the resident's consent. The complainant said a friend of a family member saw the video and made them aware of the video. The complainant was asked if they talked to R503 about the video and said they did. The complainant reported R503 was upset when they found out and R503 didn't realize what the staff member was doing. The complainant further reported R503 was "mistrustful" of the staff and afraid they might do it again. A review of a facility provided document titled, "Photographing and Video Recording" updated 7/23/19 was conducted and read, "...1. No photographs or recordings of a resident and/or his/her private space without the resident's, or designated representative's, written consent will be taken..." On 12/15/21 at 9:00 AM, an interview was conducted with Certified Nursing Assistant (CNA) 'C' on whether they had knowledge of any videos of residents being posted on any social media platforms. CNA 'C' said a family member of R503 told them a video of R503 had been posted on social media, and they reported it to the facility's administrator. CNA 'C' was asked if they		results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 1/11/22 and for sustained compliance thereafter.	

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	had seen the video and said they did not. CNA 'C' was also asked if they knew who the staff member was that posted the video to social media and said they did not. On 12/15/21 at 9:05 AM, an interview was conducted with the facility's Administrator and Director of Nursing (DON). They were asked if they were aware of a video of R503 that had been posted to social media. They said they were aware of and had reviewed a cell phone video taken on 11/12/21 by CNA 'D' that had been posted to social media. They said when they learned of the incident, they immediately suspended CNA 'D' and later terminated them. At that time, the DON still had a copy of the video saved to their phone and it was reviewed. The video did clearly reveal R503 present in the video socializing with CNA 'D' and other staff members at the nurses station. On 12/15/21 at 10:00 AM, an interview was conducted with R503, and they did not recall the incident of them being video-taped on 11/12/21. A review of CNA 'D's personnel file provided by the facility was conducted and revealed an "Employee Termination Form" for CNA 'D' that read, "STATEMENT:...after investigation we were made aware and saw a video you posted on social media on 11/12/2021 that you videotaped <sic> residents...The Family members of the residents are not happy...photo and photography of residents is a company violation...we must move forward with termination at this point..."			
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,	F0600	Element 1 Resident 506 and resident 505 was seen by the Social Worker, and they did not verbalize any signs and symptoms of emotion distress or mental anguish. Element 2	1/11/2022

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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00124645 and MI00124777 Based on observation, interview, and record review the facility failed to keep residents safe from staff abuse for two residents (R505 and R506) out of four reviewed for abuse, resulting in R505 being verbally abused by Certified Nursing Assistant (CNA) "H" and R506 being treated roughly by CNA "H". Findings include: The facility's "Abuse and Neglect" policy (revised 6/17/19) documents, in part, the following: "Policy: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse ...neglect, or mistreatment ...Instances of abuse ...cause physical harm and mental abuse ...Abuse includes: 1.) Physical. 2) Verbal ...5)Neglect ...is the failure to provide necessary and adequate (medical, personal, and psychological care). Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful ...Verbal abuse includes but not limited to the use of oral ...language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing ...". R505		All like residents has the potential to be affected were interviewed to ensure the residents are free from abuse, verbal abuse and being treated roughly. Staff have been in-serviced on abuse to ensure facility residents are free from abuse. During rounding, residents will be interviewed regarding safety and comfort to ensure there is no reoccurrence. Element 3 The Abuse and Neglect policy was reviewed and deemed appropriate. By 1/11/22 the facility staff will be in-service on the Abuse and Neglect policy and annually thereafter. New hires will be in service during orientation and annually thereafter. Element 4 The Administrator/designee will conduct random audits through interview and observation on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure resident have not experienced verbal abuse and being treated roughly. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 1/11/22 and for sustained compliance thereafter.	

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A Facility Reported Incident (FRI) was reported to the State Agency (SA) that alleged on 11/24/21, CNA "H" treated R505 rudely and called her a "B!tch".

A review of R505's clinical record documented the resident was initially admitted on 3/17/18 with diagnoses that included: coronary artery disease, end stage renal failure and anxiety/depression. A review of the resident's Minimum Data Set (MDS) dated 9/25/21 indicated the resident was cognitively intact.

On 12/15/21 at approximately 9:49 AM an interview was conducted with R505. R505 was alert and able to answer questions. When asked about feelings of safety and the alleged incident that occurred on 11/24/21, R505 reported that CNA "H" entered into her room and had a bad attitude, acting "surly", when the resident asked for assistance. R505 further stated that when the CNA refused to help, R505 called her a "B!tch" and then CNA "H" responded, "You are a b!tch too and I can do whatever I want."

An Incident and Accident Report (I/A) documented, in part the following:

"R505 asked CNA "H" to remove her lunch tray from the overbed table and CNA "H" replied the cart for trays has already been taken to dietary and that she would have to wait ...R505 stated she was not happy with the response and admitted calling the CNA a b!tch. CNA responded by saying "If you can call me a b!tch, I can call you a b!tch" and left the room ...CNA"H" said she went in the resident's room and the resident asked her to remove the lunch tray ...she told R505 that the cart had gone down to the kitchen and that she would have to wait until the dinner trays came up. CNA said that R505 called her a b!tch and CNA "H" did not respond and left the room

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	...Conclusion: we were unable to substantiate the incident as there were no witnesses to the exchange ...We have decided that CNA could have used better judgement in accommodating R505's request ...therefore made the decision to terminate CNA's employment." A review of CNA "H" s, Disciplinary Action Record revealed, the following: "Termination - effective date 12/1/21 ...Date of Infraction 11/24/21. Describe the reason for disciplinary action ...Not showing acceptable standards of respect to a coworker or resident ...resident stated that (CNA "H") said "If you can call me a b!tch, I can call you a b!tch." R506 A complaint was filled with the State Agency that alleged on 11/23/21, R506 was getting ready to go to get her covid shot, and a CNA (unknown name) was going to use a rough cloth to transfer the resident from bed to wheelchair and refused to listen to the resident and dropped her on the floor. On 12/15/21 at approximately 10:30 AM, R506 was observed lying in bed and was able to answer all questions asked. The resident indicated that she had a horrible experience with a CNA about three weeks ago and was waiting to talk with two local ombudsmen about the incident. R506 reported that on the date in question she was supposed to receive a covid shot and the CNA (the resident was not able to provide the CNA's name) tried to get her out of bed using a rough cloth and a slide board and told her to scoot. She stated that she told the CNA she couldn't use the cloth because she had thin skin and also needed to be transferred by a second person. The CNA then grabbed her roughly under her arms and lifted her off the bed and she fell to the ground. R506 further reported that the CNA then went to get a			

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	Hoyer lift to put her in her wheelchair but got the wrong one and then just lifted her and placed her in the wheelchair. The resident reported that she hurt her bottom and had bruising on her legs following the fall and continued to have pain on her bottom. She then showed several pictures that were taken and told the Surveyor to talk to Staff "I" who would be able to tell her about the incident because that was the person who knew everything. She also asked that the Surveyor to speak with the Ombudsmen when they came to the facility. R506's clinical record was reviewed and revealed R506 was admitted to the facility on 8/19/2019 with diagnoses that included: chronic kidney disease, traumatic brain injury and systemic lupus. A review of the resident's MDS (11/25/21) indicated the resident was cognitively intact and required extensive two person assist for bed mobility and transfers. Further review of R506's clinical record documented, in part the following: 11/27/21 -General Progress Note (Authored by Agency Nurse "K"): "Resident notified writer of bruises on arm and leg when the CNA tried to get me into the wheelchair" *It should be noted that this note was struck out as a "duplicate" entry. A fall assessment dated 11/23/21 and authored by Nurse "J" documented, in part: "A. Is there a previous history of fall? NO ...C. Was this fall an assisted fall? NO. D. Injuries related to this fall? YES ...T. Wrote an Incident Note in PCC? YES. W. Documented fall in the 24-hour book? YES ....". An I/A pertaining to the fall revealed the following, "Date: 11/23/2021 ...Incident Description: Resident informed writer during			

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	transfer from bed to wheelchair her legs gave way and she fell on the floor and did not hit her head this was reported on 11/29/21 ....resident informed writer she did not tell anyone until today ...Injuries observed at time of accident: Injury type: bruise: Injury location: Right thigh, Right knee, Left knee and Right upper arm ...Notes: 11/29/21: Investigation was conducted. The resident stated the cena transfer <sic>. The resident legs gave way and she fell to the floor. The cena then transfer the resident from the floor using a Hoyer lift. The facility attempted to contact the cena for a statement multiple times and she did not return the call ...". A request for additional investigation documents was requested. An undated document signed by Nurse "J" read as follows: "On 11/29/21 R506 informed writer that during transfer from bed to wheelchair, her legs gave way and she fell to the floor .... Resident informed writer that the bruises on her arms and legs occurred as a result of the fall she sustained. At the time of the fall, the resident states that she did not disclose the fall to any staff member until a few days ago. This was immediately reported to the Abuse Coordinator." On 12/15/21 at 11:15 AM, an interview was conducted with Nurse "J". Nurse "J" reported that someone (Nurse "J" could not recall the name) told her to talk with R506. Nurse "J" then went to see R506 who told her she was bruised following a one person transfer by CNA "H" who had lifted her under her arms and then she fell to the ground. Nurse "J" reported that CNA "H" could not be reached for an interview as she was suspended and terminated following an incident with R505 on 11/24/21 (see above). She acknowledged that R506 should not have been lifted under her armpits and that CNA "H" should have reported the fall. When asked why a fall assessment was dated 11/23/21 when she was not aware of the incident to 11/29/21, Nurse "J"			

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	reported it was dated that way because the resident knew that it happened on 11/23/21. On 12/16/21 at approximately 11:00 AM, Ombudsman "M" and "N" reported that they had spoken with R506 who had reported she received rough treatment during a transfer resulting in bruising and pain to her bottom. Ombudsman "N" noted that she was very familiar with the resident and had no reason to doubt her allegation. On 12/16/21 at approximately 1:43 PM, a phone interview was conducted with CNA "I". When asked about R506 and any incidents that were either observed or reported, CNA "I" stated that a few weeks ago, R506 was crying and complained that CNA "H" was rude, would not listen to her, took her purse away and did not provide proper transfer causing bruising to her knees, legs, and elbows. CNA "I" stated that she never reported the incident but should have. On 12/16/21 at approximately 1:12 PM an interview was conducted with the Administrator/Abuse Coordinator pertaining to the incidents involving R505 and R506 and CNA "H". The Administrator reported that he was aware of the incident involving R505 and CNA "H" on 11/24/21 and decided to terminate the CNA not for abuse, but for poor customer service. With respect to the incident involving R506 and CNA "H" resulting in a fall on 11/23/21, the Administrator stated that he was not aware of any abuse allegations made by the resident, despite the fact that Nurse "J" had noted that she had reported the incident to the Administrator.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident,	F0684	Element 1 The Wound Care Nurse conducted a head-to-toe skin assessment to ensure resident 501 receives necessary treatment and services to	1/11/2022

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	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: This citation pertains to intake MI000124073. Based on observation, interview, and record review, the facility failed to ensure physician wound care treatments were ordered and performed for one resident, (R501) of one resident reviewed for wound care treatment. Findings include: On 12/14/21 at 10:10 AM, R501 was observed in their bed. R501 was observed to have a tracheostomy and a feeding tube. R501 was alert but did not respond to attempts at verbal communication. It was noted there was a foul odor in the room at that time. An observation of R501's neck revealed a tracheostomy tie (a soft tie around the neck that holds the tracheostomy in place) around their neck and under the tracheostomy tie was a gauze strip saturated with yellow-brown, malodorous drainage. Futher observation of R501 revealed they had an undated dressing of bulky kerlix wrapped around their right foot. A review of R501's clinical record was conducted and revealed they re-admitted to the facility on 8/23/21 with diagnoses that included: chronic respiratory failure, history of cardiac arrest, anoxic brain damage, diabetes, dysphagia, seizures, tracheostomy, and presence of a feeding tube. A review of R501's most recent Minimum Data Set assessment indicated R501 had severely impaired cognition and required total assistance		promote healing, prevent infection and prevent new ulcers from developing. Resident 501 medical record was reviewed to ensure the appropriate treatment orders, treatment administration record and skin care plan were in place. Element 2 The facility conducted skin assessment on all residents to identify residents with wounds. All wound care residents that have the potential to be affected have received a skin assessment and their medical records were reviewed and updated as deemed necessary to ensure the appropriate treatment orders, treatment administration record, wound consult and skin care plan were in place. Any new skin alteration will be reviewed by the wound care nurse to ensure appropriate treatment orders, treatment administration record, wound consult and skin care plan are in place to prevent reoccurrence. Element 3 The Skin Monitoring and Management- Non-Pressure and Skin Monitoring and Management- Pressure policy was reviewed and deemed appropriate. By 1/11/22 the licensed nurses will be in-service on the Skin Monitoring and Management- Non-Pressure and Skin Monitoring and Management- Pressure policy and annually thereafter. New hires will be in service during orientation and annually thereafter. Element 4 The Director of Nursing /designee will conduct random audits through observation on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the facility is following the treatment	

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	for activities of daily living. A review of R501's physician's orders was conducted and revealed a wound care order dated 12/6/21 for calcium alginate with silver (an absorbent soft woven non-occlusive dressing impregnated with silver) to be applied and then covered with a hydrocolloid (an occlusive dressing that creates a moist healing environment) dressing to R501's posterior neck. Continued review of R501's orders did not reveal any treatment orders for any skin impairments to R501's right foot. A review of R501's progress notes was conducted and revealed a note dated 12/12/21 at 7 PM by Licensed Practical Nurse (LPN) 'E' that read, "...skin tear to left foot. cleaned with normal saline and covered md (doctor) book notified..." On 12/14/21 at 12:05 PM, an observation of R501 was conducted with Registered Nurse (RN) 'F'. R501 was up in their geri-chair and the soiled gauze remained to the malodorous wound on their neck. It was also observed the wound drainage had soiled the pillowcase behind R501's head. RN 'F' was asked if the gauze was the right treatment for R501's neck wound and said it was not, R501 was supposed to have calcium alginate with a hydrocolloid dressing. On 12/14/21 at 12:15 PM, an observation of R501 was conducted with Wound Care Nurse (WCN) 'A'. At that time, WCN 'A' was asked about the malodorous, soiled gauze on R501's neck and they indicated the right treatment was not applied to the wound and the soiled gauze was "unacceptable." At that time, WCN 'A' removed the soiled gauze under the tracheostomy ties and revealed an open wound with malodorous drainage approximately 4 centimeters in length, 2 centimeters in width, and 1 centimeter deep. After WCN 'A' applied the correct treatment to R501's		orders, completing the treatment administration record, wound care consult and skin care plan. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will be responsible for assuring substantial compliance is attained through this plan of correction by 1/11/22 and for sustained compliance thereafter.	

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	posterior neck an observation of R501's right foot was conducted with WCN 'A'. WCN 'A' removed the dressing from the right foot and under the bulky wrapped kerlix, a xeroform (a fine mesh gauze with petroleum) gauze was in place over a skin tear with serosanguineous (pink/yellow) drainage that measured approximately 3 centimeters long, 1 centimeter wide, and less than 1 centimeter deep. At that time, WCN 'A' was asked if they were aware of the skin tear and said they were. They went on to explain that on 12/13/21 R501's family member said they reported a skin tear on R501's right foot to R501's assigned nurse, LPN 'E' the previous day, 12/12/21. WCN 'A' said they expected LPN 'E' to have reported the skin tear to physician and receive an order for a treatment. WCN 'A' further said the wound would be assessed on 12/14/21 during the weekly wound care rounds with the wound care physician. At that time, it was brought to WCN 'A's attention that LPN 'E' only logged the wound in the physician's book, did not make a call and did not receive, or enter an order for a treatment, and had documented the wound in the progress notes as being on the left foot, when it was on the right foot. On 12/14/21 at 3:55 PM, an interview was conducted with the facility's wound care consultant Dr. 'G' about the wound to R501's posterior neck. Dr. 'G' said the wound started as an abscess that had opened up and he ordered the calcium alginate dressing to be covered with a hydrocolloid to create padding in between the wound and R501's tracheostomy ties. At that time, the observations of R501's posterior neck wound with the soiled, malodorous gauze was shared with Dr. 'G'. Dr. 'G' expressed his displeasure with the situation and said nursing should be following his treatment orders. On 12/15/21 at 2:40 PM, an interview was conducted with the facility's Director of Nursing			

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	(DON) regarding R501's neck wound and skin tear to their right foot. At that time, the DON indicated the wound treatment to the neck should have been done per physician's orders and when LPN 'E' discovered the skin tear on R501's right foot they should have called the physician and received a treatment order, not just document it in the physician's logbook.			
F0686 SS= H	Treatment/Svcs to Prevent/Heal Pressure Ulcer §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: This citation pertains to intake #'s: MI00124073, MI00124279 & MI00124624 Based on observation, interview, and record review, the facility failed to: consistently perform skin assessments, implement and perform pressure ulcer prevention interventions, ensure wound care consults were placed, ensure appropriate wound care treatments were ordered, and ensure attending physician/physician extenders were aware of their resident's skin status for four residents (R#'s 502, 504, 509, and 510), of six residents reviewed for pressure	F0686	Element 1 Resident 502 and 504 no longer resides in the facility. The Wound Care Nurse conducted a head-to-toe skin assessment to ensure resident 509 and 510 receives necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. Resident 509 wounds have resolved. Resident 510 medical record was reviewed to ensure the appropriate treatment orders, treatment administration record, weekly skin assessment, wound consult and skin care plan were in place. Element 2 The facility conducted skin assessment on all residents to identify residents with wounds. All wound care residents that have the potential to be affected have received a skin assessment and their medical records were reviewed and updated as deemed necessary to ensure the appropriate treatment orders, treatment administration record, wound consult and skin care plan were in place. Any new skin alteration will be reviewed by the wound care nurse to ensure appropriate treatment orders, treatment administration record, wound consult and skin care plan are in place to prevent reoccurrence. Element 3 The Skin Monitoring and Management- Non-Pressure and Skin Monitoring and	1/11/2022

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	ulcers, resulting in the development of unstageable pressure ulcers and transfers to acute care facilities. Findings include: A review of a facility provided policy titled, "Skin Monitoring and Management-Pressure ulcer) dated 7/11/18 was conducted and read, "POLICY: It is the policy of this facility that: A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable; and A resident having pressure ulcers receives the necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing..." R502 A complaint was filed with the State Agency (SA) that alleged R502 entered the facility on 9/1/21 for rehabilitation following a fall and noted the resident did not have any pressure sores upon entry. The Complainant alleged R502 acquired a pressure ulcer on her buttocks at the facility which became infected, and the resident was sent to (name redacted) Hospital on 10/28/21. The Complainant reported that R502 expired at the hospital on 10/30/21. A review of R502's hospital records revealed, in part the following: "10/28/2021...Disposition: Admission: Patient presented today from SNF (skilled nursing facility) in notably dehydrated state...On full exam multiple ulcers noted...including stage IV disease and obvious necrotic tissue." A surgical wound care consult notes documented, in part: "...Patient has wound of sacral region as well a bilateral heels and right hip...Wound Sacrum measuring 10x10 cm (centimeters) Full thickness skin loss with depth indeterminable at this time secondary to necrotic		Management- Pressure policy was reviewed and deemed appropriate. By 1/11/22 the licensed nurses will be in-service on the Skin Monitoring and Management- Non-Pressure and Skin Monitoring and Management-Pressure policy and annually thereafter. New hires will be in service during orientation and annually thereafter. Element 4 The Director of Nursing /designee will conduct random audits through observation on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the facility is following the treatment orders, completing the treatment administration record, weekly skin assessments, wound care consult and skin care plan. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will be responsible for assuring substantial compliance is attained through this plan of correction by 1/11/22 and for sustained compliance thereafter.	

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slough tissue: Base: 100% necrotic slough...Drainage: scant serous drainage...Odor: Foul....Assessment...Open unstageable (obscured full thickness tissue loss) sacral pressure injury. Suspected deep tissue injury to bilateral heel. Suspected deep tissue injury right posterior thigh...urinary incontinence. Fecal incontinence. Dementia. Pain...Recommendations: Sacrum - Dakin's dressing...turn q 2 hours with placing pillow between knees and ankles. Specialty mattress...Antibiotics...".

A review of R502's clinical record revealed the resident was admitted to the facility on 9/1/21 with diagnoses that included: non-displaced fracture of upper end of right humerus (upper arm), nondisplaced fracture of olecranon process (elbow), dementia, hypertension and repeated falls. A review of the Minimum Data Set (MDS) dated 9/7/21 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10/15 (moderately cognitively impaired) and required extensive two person assist for bed mobility and transfers. MDS Section M (skin conditions) revealed "No" to question A "Resident has a pressure ulcer/injury...over bony prominence."

A "Nursing Admission Screening History" (9/1/21) form, section L (skin) was reviewed and was blank on section 1. Note all skin issues and included a note "skin is intact no notable skin issues".

A Braden Scale for Predicting Pressure Sore Risk development (9/1/21) indicated a score of 18 (At Risk).

9/2/21: General Progress Note: "...CNA (certified nursing assistant) call for writer to see buttocks during pm care. Writer noted fluid filled blister to right buttock excoriation and redness to B/L

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buttocks. Barrier cream applied to buttock...".

A review of the Treatment Administration Record (TAR) from 9/1/21 through 9/24/21 revealed no skin treatments were administered to the resident. A review of the R502's Kardex/Task description did not indicate the resident's turning and repositioning needs.

Review of the R502's Care Plan Initiated on 9/10/21 revealed: "Resident has potential/actual impairment to skin integrity r/t (due to) impaired mobility: The interventions placed on 9/10/21 were as follows: Elevate heels off bed surface while at rest in bed. Encourage and assist resident to participate in mobility activities per additional plan of care. Use a draw sheet or lifting device to move resident. No further interventions were placed in the care plan until 10/5/21.

A review of Wound Care Nurse (WCN) "B"s progress notes for R502 documented, in part as follows:

9/2/21: "Location: Right olecranon Category II skin tear....". There was no mention of any further skin issues

9/7/21: "Skin: Location: Right elbow...Change/Impairment- intact heal category III skin tear...". There was no mention of any further skin issues.

9/24/21: "Location: sacral. Type of skin Change/Impairment: stage III (full-thickness skin loss, slough or eschar may be visible) bridge pressure ulcer. Measurements 6 x4.5 cm. Current Treatment: Medihoney AG QD/PRN. Treatment Change(s): new. Additional Information: R502 assessed for possible impairment to the integumentary system...stage III pressure ulcer to sacral ulcer bridge together as one treatment and

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	prevention in place for healing. It should be noted that no additional interventions were placed in the resident's care plan. The Medihoney order was not acknowledged or signed by the wound care physician. 10/1/21: Location: sacral. Stage III. Measurement (s) 5X3Xcm...Current Treatments: Medihoney AG QD/PRN...Additional Information: R502 assessed for Stage III pressure ulcer to sacral ulcer wound healing well with wound bed 60% pink epithelium tissue 40% loose soft pale grey slough edges attach. WCN "B" added the following interventions to R502's care plan on 10/5/21: "Follow physician wound care director orders for treatment of skin impairments ... ...". It should be noted there was nothing in the electronic record that Wound Physician "G" had ordered any treatments and/or had seen the resident. 10/7/21: Location: sacral. Type of Skin Change/Impairment: stage III pressure ulcer. Measurement(s) 3x2 5x 0.2cm ...no treatment ... in treatment at this time. 10/12/21: Location: sacrum .... stage III pressure ulcer ...Measurement(s): 5x4 cm ...weekly assessments show signs of decline over the weekend ....". *It should be noted that the residents clinical record had four (4) Skin Observation Tool documents dated 9/25/21, 9/28/21 10/5/21 and10/21/21 and all observations noted that appearance of the resident's skin was normal and contained no notes pertaining to pressure ulcers. 10/22/21: Location: sacrum. Type of Skin Change/Impairment: Stage III sacrum pressure ulcer. Measurements: 6x4 cm ...Additional Information: R502 assessed 10/18/21 for failing			

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stage III pressure ulcer. Wound bed 100% pale grey eschar light serious drainage signs of infection. Call place to (name redacted) Attending Physician "L" possible low dose of antibiotic to help possible infection of wound. It should be noted that there were no documents that indicated an antibiotic was ordered for the resident. Further there was no notes in the resident's electronic record that indicated Attending Physician was treating R502 for pressure ulcers or any further notes that R502 was seen and/or treated by a wound physician.

On 12/15/21 at approximately 5:24 PM a phone interview was conducted with Primary Care Physician "L" regarding R502's wounds and possible notification with WCN "B" pertaining to an antibiotic treatment for a possible wound infection. Physician "L" reported that she could not recall any knowledge of R502's wounds, did not provide treatment for the wound, and did not recall any conversation with WCN "B".

R504

On 12/14/21 at 1:33 PM, an interview was conducted with a family member regarding R504's stay in the facility. R504's family member reported R504 admitted to the facility on 10/4/21 and transferred to the hospital on 10/26/21. They said they were not able to visit R504 in the facility because of the COVID-19 pandemic. They further explained when R504 transferred from the facility to the hospital they were allowed to see them and were "shocked" to learn he had developed two unstageable pressure ulcers (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). They continued to explain R504 had previously been in an LTAC (Long-term acute care) facility and did not have any pressure ulcers

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when they transferred from the LTAC to the skilled nursing facility.

A review of R504's closed clinical record was conducted and revealed they admitted to the facility on 10/4/21 and discharged to the hospital on 10/26/21. R504's diagnoses included: stroke, acute respiratory failure, tracheostomy, hemiplegia, dysphagia, and presence of a feeding tube. R504's Minimum Data Set assessment dated 10/7/21 revealed R504 had severe cognitive impairment, was non-ambulatory, and required total assistance from one to two staff members for all activities of daily living. A review of R504's admission skin assessment dated 10/4/21 revealed their only skin impairment upon admission was redness to their sacrum. A review of R504's Braden Score (a score calculated to determine the risk for the development of pressure ulcers) upon admission was calculated as a 9, which indicated they were a "Very High Risk" for the development of pressure ulcers.

R504's weekly skin assessments dated 10/13/21 and 10/20/21 were reviewed and both assessments documented R504 had no new alterations in skin integrity including open areas, tears, bruising, red areas, or rashes. Continued review of R504's record was conducted and revealed that on 10/4/21 wound care had been consulted and on 10/15/21 an order was placed by former Wound Care Nurse 'B' for Triad Hydrophilic Wound Dress Paste (a topical wound care cream/paste) to be applied topically in a thick layer for excoriation to their buttocks. A review of former Wound Care Nurse 'B's progress notes for R504's skin revealed the following:

A note documented 10/15/21 that read, "...Location: bilateral buttock. Type of Skin Change/Impairment: excoriation. Measurement (s): 8x6cm (centimeters). Description:...pink base

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expose epithelium <sic> tissue...

A note documented 10/22/21 that read, "...Location: bilateral buttock. Type of Skin Change/Impairment: excoriation. Measurement (s): 7.6x4cm...Description...:moist pink with new scar formation..."

A review of R504's Certified Nursing Assistant (CNA) Kardex (care guide) and tasks were conducted and did not include any directives that indicated R504 would need frequent turning and repositioning assistance. R504's care plans were reviewed and revealed there were no care planned interventions for turning and repositioning, and a specialty mattress had been added on 10/24/21, two days before their transfer to the hospital.

A review of R504's emergency department hospital records was conducted on 12/15/21 and read, "...Problem List...Pressure injury of back, unstageable. Diagnosis: Pressure injury of back, Noted on: 10/27/2021...Pressure injury of sacral region, unstageable. Diagnosis: Pressure injury of sacral region, Noted on: 10/27/21..."

On 12/15/21 at approximately 2:40 PM, the facility's Director of Nursing (DON) was asked to provide any wound care documentation and evidence R504 had been followed by Dr. 'G', the facility's wound care consultant physician. At 4:15 PM, the DON reported the only information in R504's clinical record about their skin was that R504 had excoriation to their buttocks. The DON further reported they had no documentation to show R504 had been followed by Dr. 'G'.

R509

On 12/15/21 at 3:55 PM, a review of R509's clinical record was conducted and revealed R509 admitted to the facility on 8/18/20 and re-

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	admitted on 11/16/21. R509's diagnoses included: pressure ulcers, quadriplegia, and anxiety disorder. R509's most recent MDS assessment upon re-admission to the facility revealed R509 had intact cognition, was non-ambulatory, and required extensive to total assistance from one to two staff members for transferring, bed mobility, dressing, toilet use, personal hygiene, and bathing. On 12/15/21 at 4:00 PM, R509 was observed in their bed. It was noted R509's bed had a low air mattress in place, however; the machine that pumped the air for alternating pressures was not on and functioning, and a light on the pump indicated it was in "Standby" mode. At that time, R509 was interviewed about the condition of their skin, and they reported they had a pressure ulcer to their buttocks. R509 was asked if staff assisted them to turn and re-position in bed and R509 stated, "Not very often, a couple times a day maybe." R509 was then asked if staff assisted or encouraged them to turn during the overnight hours and shook their head no. A second review of R509's clinical record was conducted and revealed that since their re-admission to the facility on 11/16/21, R509's weekly skin assessments had only been documented as performed on 11/21/21 and 12/13/21. R509's treatment administration records were reviewed and revealed an order for wound dressing paste with a border gauze foam covering the wound every shift and were not signed off as completed on 12/3/21 the 7 PM shift, 12/6/21 the 7 PM shift, 12/7/21 the 7AM shift, 12/8/21 the 7 AM and 7 PM shift, 12/10/21 the 7 PM shift, and 12/12/21 the 7 AM and 7 PM shift. A review of R509's CNA Kardex did not reveal any indication R509 was to be assisted with turning and repositioning. A review of R509's care plan was conducted and included an intervention for the low air loss mattress but did not have any			

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	interventions for turning and repositioning. On 12/16/21 at 9:25 AM, a second observation of R509's low air loss mattress pump was conducted, and it was observed the pump was not functioning and a light on the pump indicated it was on "Standby" mode. R510 On 12/16/21 at 9:45 AM, R510 was observed in their bed. At that time R510 was asked if they had any wounds and said they had a pressure ulcer on their right lateral malleolus (the bony projection of the ankle) and they went out of the facility to a wound care physician once a week. R510's permission was obtained to observe the dressing and when granted, an undated, occlusive, white dressing was in place on their ankle. The dressing was also observed to have shadowing on its exterior from wound exudate that had seeped into the absorbent part of the inside of the dressing. On 12/16/21 at approximately 10:00 AM, a review of R510's clinical record was conducted and revealed a re-admission to the facility on 10/8/21 with diagnoses that included: pressure ulcers, chronic osteomyelitis, heart failure, and falls. R510's most recent MDS assessment revealed R510 had intact cognition. A review of R510's most recent wound care consult dated 12/10/21 from their outside wound care provider was conducted and revealed an order for R510 to have Santyl (a wound ointment that removes dead tissue to promote healing) applied to the right lateral malleolus wound, and the wound covered with a dressing once a day, for two weeks, or until their follow-up appointment. A review of R510's Treatment Administration Records (TAR's) was conducted and revealed R510's order for Santyl had been discontinued on 12/15/21. It was further noted R510's TAR did not have the Santyl			

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	634560	A. BUILDING _____ B. WING _____	12/16/2021

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	treatment documented as completed on 12/7/21, 12/8/21, and 12/12/21. On 12/16/21 at 1:00 PM, an interview was conducted with WCN 'A' about R510's right lateral malleolus pressure ulcer. WCN 'A' said the facility's wound care Nurse Practitioner (NP) resolved R510's ankle wound when they rounded on 12/14/21. On 12/16/21 at 1:05 PM, an observation of R510's right ankle was conducted with WCN 'A'. WCN 'A' observed the undated dressing with the shadowing of exudate. WCN 'A' removed the soiled dressing, and it was observed a small, approximately 1 cm (centimeter) x 1 cm x less than 1 cm round ulceration with a small amount of serous (yellowish) drainage was present on R510s right lateral malleolus. At that time, it was brought to WCN 'A's attention the outside wound care practitioner for R510 had ordered Santyl to be continued for two to three weeks after their 12/10/21 appointment. WCN 'A' said that upon the NP's recommendation, they discontinued the Santyl order after the NP rounded on 12/14/21. When asked why an undated dressing was in place on 12/16/21 without an order, and after the NP resolved the wound, WCN 'A' said they did not know, but they would be looking into what happened. On 12/15/21 at approximately 2:30 PM an interview was conducted with the facility's Director of Nursing (DON). The DON reported that she had been employed by the facility for approximately four months. When asked about any further documents that might explain the acquired pressure ulcer for R502 and any possible wound physician notes, the DON explained that she had completed an audit of residents that had pressure sores and noted that there were some concerns with WCN "B", and she was terminated.			

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	At the time of the interview, the DON did not express the specific concerns as to the termination of WCN "B" but noted she had moved offices and wound attempt to locate her notes and further documentation. A request for Wound Nurse "B's" personnel file was made. A review of WCN "B" personnel record revealed, in part, the following: "Disciplinary Action Record ...Describe the reason(s) disciplinary action ... (name redacted) Nurse "B" was treating and writing treatment orders without a physician consent. The Director of Nursing audited the wound care resident's medical records and wound care log. It was identified that there were incorrect diagnosis and documentation. For example, the diagnosis on the care plan, treatment order, skin progress notes and wound care log did not match. Also, incorrect document on facility acquired vs community acquired. The wound care log was reviewed with Wound Care MD. There were 32 wounds that Nurse "B" was treating without his knowledge. When reviewing the treatment orders for these residents it was identified that Nurse "B" put the orders under the primary care physician, NP (nurse practitioner) and PA (physician assistant) names. The MD/NP/PA were interviewed and stated that they were unaware of treatment orders being written in their names ...Employee is suspended pending investigation ...date 10/26/21 ...". A "Reason for Termination" form dated 10/29/21 documented, in part: "(name redacted) was treating and prescribing medications to 32 wound care residents without physician consent ...10/29/21 ...". On 12/16/21 at approximately 11:15 AM a second interview was conducted with the DON and			

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	Corporate Nurse "M". After asking for additional information pertaining to the 32 residents noted to have received treatment by WCN "B", a document was provided that indicated the names of the residents that were treated by WCN "B" but were not seen by Doctor "G". The DON reported that in an effort to determine the discrepancies they went through the wound log with Doctor "G", and he noted that he had not seen the resident and would not have always approved the orders. The DON reported that she discovered that treatment orders for wounds were signed off by attending physicians or their extenders, but that was not the Policy of the facility. On 12/16/21 at approximately 1:45 PM a phone interview was conducted with Wound Care Physician "G". When asked about R502 and other residents being treated for wounds, Physician "G "reported that Nurse "B" failed to contact him regarding many of the resident wounds. He noted that he found it strange he was only treating approximately eight residents for wounds at such a large facility, where he said he usually followed close to twenty. He was unaware of R502's wounds until 10/26/21 following an audit by the DON. When asked whether he would have implemented different treatments for R502 and other residents with wounds, he reported most likely he would have.			