STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035095	A. BUILDING _____ B. WING _____	**04/04/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	**1750 WEST FRYE ROAD CHANDLER, AZ 85224**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure 1 of 2 sampled residents (#258) was free from verbal abuse by a staff member. The deficient practice could result in other residents being verbally abuse. Findings include: Resident #258 was admitted to the facility on (MONTH) 25, (YEAR) with a [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 6, (YEAR). Review of the care plan initiated (MONTH) 25, (YEAR) revealed the resident had urinary and bowel incontinence. Interventions included assisting with toileting as needed and pericare as needed. A nursing note dated (MONTH) 27, (YEAR) revealed the resident was alert and able to make needs known verbally and needed the assistance of 1-2 staff. Review of the facility's investigation report dated (MONTH) 30, (YEAR), revealed that on (MONTH) 28, (YEAR) at approximately 5:20 PM resident #258 reported to the Assistant Director of Nursing (ADON) that she felt verbally abused by a Certified Nursing Assistant (CNA/staff #134) who was caring for her that evening. Resident #258 stated that she called the CNA a [***] when she was told that she would need to wait for care. The CNA answered the resident by stating if she needed to see a [***] all she needed to do was look in the mirror. The report included a CNA (staff #41) was working with staff #134. Staff #134 was placed on suspension pending investigation. The report also included the resident was alert and oriented to time, person and place. The facility's report revealed staff #134 employment was terminated after completion of the investigation. A written statement by staff #134 dated November, 28, (YEAR) revealed that after the resident called her a [***] she replied, if you looked in the mirror you would see the same thing. A written statement by staff #41 dated (MONTH) 29, (YEAR) revealed resident #258 was wet when she and staff #134 answered the resident's call light. Staff #134 asked the resident to please give them a few minutes because they were passing dinner trays. Resident #258 responded, You're a [***] . The statement included the resident was clearly agitated so they left the room. The statement also included staff #41 returned alone to change the resident after the dinner trays were passed. An interview was conducted with staff #41 on (MONTH) 2, 2019 at 9:09 AM. She stated that after the resident called staff #134 a [***] , she immediately went and reported it to the nurse and the ADON. She stated that she did not hear a response from staff #134. She stated that she felt very uncomfortable when the resident called the CNA a name. Staff #41 stated that it made her feel like there had been a previous confrontation between the two. An attempt to contact staff #134 by telephone for an interview was unsuccessful. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 4, 2019 at 12:51 PM. She stated that if abuse is witnessed, it needs to be reported immediately to a supervisor. The DON stated that if the alleged perpetrator is a staff member, the staff member would be removed from providing care for residents. She stated they would make sure the resident was okay and would contact the family, doctor and the proper agencies. The DON stated that verbal abuse by staff to a resident is not tolerated. The facility's policy for Protection of Resident: Reducing the Threat of Abuse and Neglect, revised on (MONTH) (YEAR) revealed that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation of any type by anyone. This includes but is not limited to staff, other residents, consultants, volunteers, staff from other agencies serving our resident, family members, the resident representative, friends or any other individuals. The policy included verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of age, ability to comprehend, or disability.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure a summary of the baseline care plan was provided to three residents (#15, #38, #25) and/or the residents' representatives and failed to ensure a baseline care plan was developed within 48 hours for three residents (#59, #209, #317). The sample size was 20. The deficient practice could result in residents' care needs not being met. Findings include: -Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the baseline care plan revealed the care plan was developed on (MONTH) 5, (YEAR), which included the resident's advance directive status, communication status, Activities of Daily Living (ADL) status, fall risk status, and the resident's impaired cognitive ability related to dementia. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident scored a 5 on the Brief Interview for Mental Status (BIMS), indicating the resident had severe cognitive impairment. Review of the clinical record revealed no evidence that a summary of the resident's baseline care plan had been provided to the resident's legal representative. -Resident #38 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. The baseline care plan included the resident's communication status, ADL status, fall risk, hydration, and nutritional status. Review if the admission MDS assessment dated (MONTH) 13, (YEAR) revealed the resident scored a 13 on the BIMS, indicating the resident was cognitively intact. Review of the clinical record revealed no evidence that a summary of the resident's baseline care plan had been provided to the resident. An interview was conducted on (MONTH) 4, 2019 at 11:40 a.m. with a licensed practical nurse (LPN/staff #128). Staff #128 stated the admission nurse will develop a baseline care plan upon admission. Staff #128 stated the baseline care plan includes diagnoses, wounds, ADLs, and other care needs. Staff #128 stated the care plan is developed within 24-48 hours of

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035095	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	1750 WEST FRYE ROAD CHANDLER, AZ 85224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) admission. Staff #128 further stated the charge nurse or Director of Nursing (DON) will print a copy of the baseline care plan and review it with the resident or resident representative. The LPN stated the resident or representative will then sign a copy which will be kept in the medical record and a copy will be given to the resident or the resident's representative. An interview was conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON (staff #32). The DON stated that on admission, the admitting nurse is responsible for developing a baseline care plan inclusive of advance directives, diagnoses, potential and actual skin breakdown, and falls. The DON further stated a copy of the baseline care plan is reviewed and given to the resident or representative within 48 hours and a signed copy is kept for the clinical record. A copy of the signed baseline care plan was requested for residents (#15 and #38). At 2:11 p.m., the DON stated the signed copies of the baseline care plans for the two residents (#15 and #38) were unable to be located. -Resident #25 was admitted on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the baseline care plan dated (MONTH) 24, (YEAR), included the resident's advance directive status, ADL status, communication status, medications, fall risk status, and oxygen therapy. Review of the admission MDS assessment dated (MONTH) 31, (YEAR) revealed a score of 10 on the BIMS which indicated the resident had moderate impaired cognition. The nurse progress note dated (MONTH) 12, (YEAR), revealed the resident had a medical power of attorney (MPOA). Continued review of the clinical record revealed no evidence that a summary of the resident's baseline care plan had been provided to the resident's legal representative. During an interview conducted with the resident's MPOA on (MONTH) 2, 2019 at 1:18 p.m., the MPOA stated that even after multiple requests, no information had been provided regarding the resident's care plan. An interview was conducted with Director of Social Services (staff #112) on (MONTH) 3, 2019 at 1:37 p.m. Staff #112 stated the baseline care plans are initiated upon admission by the nurse. She stated that the case managers and nurses review the care plans with the residents' representatives. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 3, 2019 at 2:02 p.m. The DON stated that the Assistant Director of Nursing (ADON) was the one responsible for making sure the baseline care plans were complete and reviewing the care plans with the resident and/or the resident's representative. Staff #32 stated the ADON was no longer at the facility. -Resident #59 was admitted to the facility on (MONTH) 14, 2019 with a [DIAGNOSES REDACTED]. Review of the clinical record did not reveal a baseline care plan for resident #59. An interview was conducted with the Medical Records Director (staff #56) on (MONTH) 3, 2019 at 11:40 AM. Staff #56 stated a baseline care plan was never developed for resident #59 and that the resident was not there long enough for the comprehensive care plan. An interview was immediately conducted with a Licensed Practical Nurse (LPN/staff #106). She stated the floor nurse develops the baseline care plan on admission and that it should be completed in 24 hours. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 3, 2019 at 1:44 PM. The DON stated the baseline care plan is developed by the floor nurse on admission and should be completed within 24 hours. She stated that she did not know what had happened with the baseline care plan for resident #59. The DON stated she was very involved with the family and actually thought she had completed that one herself. -Resident #209 was admitted to the facility on (MONTH) 27, 2019 with [DIAGNOSES REDACTED]. Review of the baseline care plan revealed the resident's care plan had been initiated but not completed. The focus for pain was left blank in the area of the specific type of pain. It was also left blank in the area that states what the pain is related to. No goals were in place and the care plan contained only one intervention which included evaluating the effectiveness of pain interventions. An interview was conducted with the DON on (MONTH) 4, 2019 at 12:51 PM. The DON stated the nurse that does the admission is responsible for making sure the baseline care plan is complete. She also stated that chart reviews are regularly conducted. After viewing the care plan for resident #209, the DON stated that the care plan was not complete. -Resident #317 was admitted (MONTH) 24, 2019, with [DIAGNOSES REDACTED]. During an initial observation conducted of the resident on (MONTH) 1, 2019 at 11:09 a.m., the resident was observed to have oxygen on at 2 liters per nasal cannula. Review of the clinical record did not reveal a physician's orders [REDACTED]. Further review of the clinical record did not reveal a baseline care plan had been developed for oxygen therapy. An interview was conducted with a Licensed Practical Nurse (LPN/staff #120) on (MONTH) 4, 2019 at 1:25 p.m. The LPN stated that a physician's orders [REDACTED]. Review of facility's policy regarding baseline care plan revealed the baseline care plan will be developed for every resident within 48 hours of admission to provide an initial set of instructions needed to provide effective and person-centered care of the resident that meet professional standards of care. The policy also included reviewing the baseline care plan and the physician orders [REDACTED].
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure barrier cream was consistently applied to one of three sampled residents (#15) and failed to ensure three of three sampled residents (#15, #208, and #308) with pressure ulcers consistently received treatment and services consistent with professional standards of practice. The deficient practice could result in the development and worsening of pressure ulcers. Findings include: -Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the baseline care plan initiated on (MONTH) 5, (YEAR) revealed the resident was at risk for skin break down related to immobility and incontinence. The goal was for the resident to maintain intact skin. Interventions included keeping the skin clean and dry after each incontinence episode, a pressure reducing mattress, completing weekly skin checks, and providing treatments as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident had severely impaired cognitive skills for daily decision making and required extensive assistance with all activities of daily living (ADLs). The MDS assessment included the resident had no unhealed pressure ulcers but was at risk for pressure ulcer development. The Braden Scale dated (MONTH) 22, (YEAR) revealed a score of 15 indicating the resident was at mild risk for pressure ulcer development. Review of the weekly skin checks revealed no evidence of pressure ulcers prior to (MONTH) 24, (YEAR). A weekly skin check dated (MONTH) 25, (YEAR) revealed the resident's skin remained intact, however, there was a non-blanchable area noted to the sacrum. Review of the physician orders [REDACTED]. A weekly skin check dated (MONTH) 15, (YEAR) revealed the sacrum was red and barrier cream was applied. The Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed no evidence [MEDICATION NAME] cream was applied during the day shift on (MONTH) 20, (YEAR). Review of the progress notes for (MONTH) 20, (YEAR) revealed no evidence the cream was administered or refused by the resident. A weekly skin check dated (MONTH) 22, (YEAR) revealed there was redness to the left and right buttock. Review of the weekly skin checks for (MONTH) (YEAR) revealed the resident's skin remained intact with no new findings. Review of the TAR for (MONTH) (YEAR) revealed the [MEDICATION NAME] cream was applied as ordered. A communication note dated (MONTH) 29, (YEAR) revealed that while changing the resident's brief, the resident's family identified and notified the nurse of an opening to the resident's left buttock. The note included the Assistant Director of Nursing (ADON) was notified and an order for [REDACTED].>Review of the physician orders [REDACTED]. The first documentation of the wound measurements was a health status note dated (MONTH) 3, 2019 that the open area to the left buttock measured 0.5 centimeters (cm) in length by 0.4 cm in width and 0.2 cm in depth. The note included the wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035095	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	1750 WEST FRYE ROAD CHANDLER, AZ 85224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) treatment was provided and the wound nurse was notified. However, the note did not include a description of the wound. Review of the weekly skin check for (MONTH) 6, 2019, revealed the resident had an open area to the left gluteal fold. A health status note dated (MONTH) 9, 2019 revealed the Nurse Practitioner (NP) communicated to the wound nurse to have the wound care team follow the resident for the stage two pressure ulcer to the left buttock. Review of the nursing health status notes for (MONTH) 9, 2019 revealed the family refused to let staff reposition and change the resident. The notes included the nurse was concerned and spoke to the family about the wound and repositioning the resident and that the family showed no concern for the wound. A care plan was initiated on (MONTH) 9, 2019 and revised on (MONTH) 22, 2019 for the stage two pressure ulcer to the left ischium. The goal was for the resident to have intact skin, be free from redness, and for the pressure ulcer to show signs of healing and remain free from infections. Interventions included using two staff with repositioning, keeping the bed flat to reduce shearing, observing and reporting changes in skin status, and following policies for prevention and treatment of [REDACTED]. Review of the Care conference notes dated (MONTH) 11, 2019 revealed the family was upset that the CNAs were coming into the resident's room in the middle of the night to reposition and change the resident. The note included the family was informed of the increased risk to the skin and the detrimental effect of not changing positions. The weekly skin check for (MONTH) 12, 2019 revealed there was an open area to the left gluteal fold. Review of the quarterly MDS assessment dated (MONTH) 12, 2019 revealed the resident had severely impaired cognitive skills for daily decision making and required extensive assistance with all ADLs. The assessment included the resident had a stage two unhealed pressure ulcer. Further review of the clinical record from (MONTH) 29, (YEAR) through (MONTH) 14, 2019 revealed no thorough assessment of the pressure ulcer which included a description of the wound bed, any drainage, the surrounding skin, or any odor. A skin/wound note dated (MONTH) 15, 2019 revealed the resident had a stage three left ischium ulcer measuring 0.6 cm in length by 0.7 cm in width with minimal slough with mild drainage. The note included the resident had an alternating pressure mattress present on the bed and a Roho cushion in the wheelchair. Review of the provider's progress note dated (MONTH) 15, 2019, revealed the wound was a ischial ulceration with an irregular shaped superficial ulceration extending to the subcutaneous tissue with minimal slough, mild granulation, mild serous drainage, and no peri-wound inflammation. Review of the weekly skin check for (MONTH) 20, 2019 revealed the resident had an open area/wound. The weekly skin check for (MONTH) 25, 2019 revealed there was no new finding. Review of the TAR for (MONTH) 2019 revealed no evidence the [MEDICATION NAME] cream was applied on the day shift on (MONTH) 14,16, 25, and 28 and the evening shift of (MONTH) 25, 2019. Review of the progress notes for these dates revealed no evidence the cream was administered or refused by the resident. Additional review of the TAR for (MONTH) 2019 revealed no evidence the left ischium treatment was provided as ordered on (MONTH) 14, 16, 21, 23, and 25, 2019. Review of the progress notes for these dates revealed no evidence treatment was administered or refused by the resident. The weekly pressure ulcer tracking report dated (MONTH) 29, 2019 revealed the pressure ulcer to the left ischium measured 0.4 cm in length by 0.3 cm in width by 0.1 cm in depth. The report included the wound was a superficial ulceration extending through the subcutaneous tissue with no odor, minimal slough, and mild drainage. Review of the provider's progress note dated (MONTH) 5, 2019 revealed the bilateral ischial ulceration was 100 percent re-[MEDICATION NAME] and had resolved. Review of a wound note dated (MONTH) 5, 2019, revealed the ulcer had resolved and to continue applying the cream to the buttock as ordered. The TAR dated (MONTH) 2019 revealed no evidence the [MEDICATION NAME] cream was applied on the day shift on (MONTH) 1, 7, and the 22, 2019. Review of the progress notes for the corresponding dates revealed no evidence the cream was administered or refused by the resident. The TAR dated (MONTH) 2019 revealed no evidence the [MEDICATION NAME] cream was applied on the day shift on (MONTH) 11, 2019. Review of the progress notes for (MONTH) 11, 2019 revealed no evidence the cream was administered or refused by the resident.An interview was conducted on (MONTH) 3, 2019 at 10:25 a.m. with a Register Nurse (RN/staff #74). Staff #74 stated that once a wound is identified, the nurse will notify the doctor and obtain a treatment order. Staff #74 stated the wound nurse will stage, measure, and assess the wound weekly. The RN stated that the nurses complete the weekly skin assessments and administer the treatments. She also stated that the nurses are to document wound treatment on the TAR and that if it is not documented on the TAR, it is assumed the treatment was not provided. An interview was conducted on (MONTH) 4, 2019 at 8:20 a.m. with the wound nurse (staff #107). Staff #107 stated that the wound nurse is notified when a new skin opening is identified. Staff #107 stated that the wound nurse will obtain a treatment order and assess and measure the wound weekly. Staff #107 also stated that the wound provider will assess and determine the stage of a pressure ulcer. Staff #107 stated the administration of a treatment is record on the TAR by the nurse. On (MONTH) 4, 2019 at 10:37 a.m., the Director of Nursing (DON/staff #32) stated that all copies of the wound assessments and documentation for this resident had been provided. During an interview conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON (staff #32), the DON stated that the nurses complete the weekly skin checks and the wound nurse completes the weekly pressure ulcer measurements and assessments along with the wound doctor. The DON further stated treatments administered to the resident are documented on the TAR. -Resident #208 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 16, (YEAR). Review of the admission nursing assessment dated (MONTH) 7, (YEAR), revealed the resident had skin tears on the right elbow, right trochanter, and left and right shoulders. The assessment also included the resident had a wound on the coccyx and scars on the front of the right and left knees. The admission assessment did not include any documentation of skin breakdown on the resident's heels. Review of the care plan dated (MONTH) 8, (YEAR), revealed the resident was at risk for skin integrity breakdown. The goal was for the resident to maintain intact skin with no skin breaks. Interventions included a pressure reducing mattress, treatments as ordered, and weekly skin checks. Review of the resident's wound assessments revealed an assessment described as a first observation dated (MONTH) 8, (YEAR) which described a stage 2 pressure ulcer located on the resident's sacrum. The assessment did not include any wounds on the resident's heels. A skin/wound note dated (MONTH) 9, (YEAR), stated, Patient's skin checked for a second time .a stage 2 ulcer to the right heel noted. New orders put in place . Review of the clinical record revealed no evidence of an initial wound assessment for the resident's right heel wound. The physician's orders [REDACTED]. heel to be cleansed and dressed daily. Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR), revealed the resident received treatments for the right heel wound daily from (MONTH) 9 through (MONTH) 14, (YEAR), and on (MONTH) 16, (YEAR). The treatment was not documented on the TAR as being provided to the resident's right heel on (MONTH) 15, (YEAR). Review of the 5 day MDS assessment dated (MONTH) 13, (YEAR), revealed the resident had one stage 2 unhealed pressure ulcer present on admission. A provider's progress note dated on the day of the resident's discharge on (MONTH) 16, (YEAR), revealed the resident was receiving an evaluation of the right heel blister and coccyx ulcer which were present on admission. However there was no documentation of the right heel wound in the resident's admission assessments. Although the resident was discharged from the facility on (MONTH) 16, (YEAR), a wound assessment signed (MONTH) 22, (YEAR), revealed the resident had an unstageable deep tissue injury on the right heel. The assessment described the wound as a small intact blister and a small area of purplish discoloration. The wound assessment did not include the presence of any slough tissue or necrotic tissue and/or eschar. The assessment included the wound was present on admission; however there was no documentation of the right heel wound in the resident's admission assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035095	A. BUILDING _____ B. WING _____	**04/04/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	**1750 WEST FRYE ROAD CHANDLER, AZ 85224**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) An interview was conducted on (MONTH) 4, 2019 at 8:20 a.m., with a Licensed Practical Nurse (LPN/wound nurse/staff #107). She stated that the admission nurse was responsible for completing a full skin assessment when a resident was admitted to the facility. The LPN stated that if the admission nurse identifies a wound, the nurse would leave a note for her to complete a wound assessment. She said a second full skin assessment would also be conducted within 24 hours of admission by herself, the ADON, or the DON. She stated that the wound on the resident's right heel was present on admission because it was not the type of wound that could have developed in 3 days. The LPN said the resident's right heel had significant eschar, and that this amount of eschar would indicate the wound was chronic. She stated the wound documentation, including the provider's initial assessment, measurements, and documentation of the eschar was located in the paper records, not the electronic record. An interview was conducted on (MONTH) 4, 2019 at 8:57 a.m., with the Medical Records Director (staff #56). She stated there were no additional skin assessments, wound assessments, or provider progress notes in the paper records that had not already been provided. Review of the clinical record revealed no evidence of any other wound assessments for the resident's right heel wound. An interview was conducted on (MONTH) 4, 2019 at 12:34 p.m., with the DON (staff #32). She stated the expectation was that the admitting nurse would complete a skin assessment and notify the wound nurse of any areas of concern. She said the wound nurse would follow up and obtain any needed orders for pressure ulcer treatment. The DON stated the expectation is that pressure ulcer treatments be documented on the TAR, and if the documentation was missing it would not be possible to know if the treatment had been provided. She said the the wound provider would assess wounds, make recommendations, and document progress notes. The DON stated that the wound nurse would also complete weekly wound measurements and document along with the provider progress notes. -Resident #308 was admitted on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. Review of the pressure ulcer status records dated (MONTH) 2, (YEAR), revealed the resident was admitted with a sacral deep tissue injury measuring 18.5 centimeters (cm) x 7.0 cm, a right heel deep tissue injury measuring 7 cm x 4 cm, and a left heel deep tissue injury measuring 2 cm x 1.5 cm. Review of care plans dated (MONTH) 2, (YEAR), revealed a care plan for active infection of the wound as evidenced by abnormal culture with a goal that the wound infection will be resolved. Interventions included administering medications as ordered. The admission Minimum Data Set (MDS) assessment dated (MONTH) 9, (YEAR), revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The MDS assessment included the resident had 3 unstageable pressure ulcers Review of a physician progress notes [REDACTED]. A physician order [REDACTED]. However, review of the Medication Administration Record [REDACTED]. Review of the nurse progress note dated (MONTH) 18, 2019, revealed the pharmacist was contacted regarding the [MEDICATION NAME] trough level. The note included that according to the pharmacist the resident should have been on [MEDICATION NAME] 1 gram every 12 hours. The note also included the patient was given [MEDICATION NAME] 1 gram once a day beginning on 2/14/18. An interview was conducted with a RN (staff #74) on (MONTH) 3, 2019 at 12:37 p.m. The RN stated that if the pharmacist is recommending IV [MEDICATION NAME] 1 gram twice a day, a physician's orders [REDACTED]. During an interview conducted on (MONTH) 4, 2019 at 2:23 p.m. with the DON (staff #32), Administrator (staff #132), and the clinical resource nurse, staff #32 stated that if a physician's orders [REDACTED]. Review of the facility's policy regarding Pressure Ulcer/Injury Prevention and Management revealed a comprehensive skin assessment on admission and re-admission may identify pre-existing signs of possible deep tissue damage already present. The policy revealed measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care and included minimizing skin exposure to incontinence using skin barriers and proper positioning and turning at least every 2-4 hours. The policy included that when skin breakdown occurs, it requires attention and a change in the plan of care to appropriately treat the resident. Review of the facility's policy titled General Dose Preparation and Medication Administration revealed that prior to administration of a medication, staff should take all measures required by facility policy and applicable law including but not limited to confirming that the MAR indicated [REDACTED]