STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035296	A. BUILDING _____ B. WING _____	**11/22/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELBROOK SENIOR LIVING FLAGSTAFF LLC	**1521 NORTH PINE CLIFF DRIVE EAST FLAGSTAFF, AZ 86001**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews and review of policy and procedures, the facility failed to ensure that one resident (#178) who was unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal hygiene. The deficient practice could result in hygiene needs not being met. Findings include: Resident #178 was admitted on (MONTH) 8, 2019, with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 22, 2019. Review of an activity of daily living (ADL) deficit care plan dated (MONTH) 9, 2019 included the resident had a right shoulder fracture. The goal was to improve the current level of function. Interventions included for physical therapy (PT) and occupational therapy (OT). A limited physical mobility care plan dated (MONTH) 9, 2019 related to a right shoulder fracture included goals to increase level of mobility, maintain current level of mobility, and remain free from complications related to immobility, including skin breakdown. Interventions were for PT and OT referrals as ordered, as needed. Review of the Certified Nursing Assistant (CNA) task documentation for (MONTH) 2019 regarding ADL-bathing, revealed that the resident did not receive any showers. A physician's orders [REDACTED]. Review of the 14-day Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019 revealed the resident scored 15 on the Brief Interview for Mental Status, indicating intact cognition. The MDS also indicated the resident required limited one-person physical assistance for ADLs, including personal hygiene. Review of the CNA task documentation for (MONTH) 2019 revealed that the resident only received one shower on (MONTH) 22. The facility was unable to provide any additional documentation that the resident was provided at least two showers per week in (MONTH) and (MONTH) 2019. On (MONTH) 19, 2019 at 1:47 p.m., an interview was conducted with the Director of Nursing (DON/staff #55). She stated that shower and bed bath documentation is located in the electronic record, in the CNA task documentation. She said that her expectation is that residents will be offered 3 showers per week. She stated that if a resident refuses a shower, her expectation would be that the refusal should be documented in the nurses' notes. She stated that during the time that resident #178 was in the facility, she was not sure that showers were being completed according to her expectation. On (MONTH) 20, 2019 at 12:01 p.m., an interview was conducted with a CNA (staff #22), who stated that his protocol was to administer showers to residents 2-3 times per week, or more if they request it. He said he documents the shower every time he gives one. An interview was conducted on (MONTH) 20, 2019 at 12:16 p.m., with a Registered Nurse (staff #16). She stated that her expectation is that residents receive showers every other day or as requested. She stated that the CNAs usually tell her when they have assisted a resident in the shower or she could look in the electronic record under task documentation to ensure the resident had received their shower. Review of the facility's policy titled, Shower/Tub Bath revealed the purpose was to provide comfort to the resident and to observe the condition of the resident's skin. The policy stated that the information that should be recorded in the resident's ADL record and/or the resident's medical record should include the date and time the shower/tub bath was performed, the name and title of the individual(s) who assisted the resident, all assessment data obtained during the shower/tub bath, and if the resident refused the shower/tub bath, the reason(s) why and the intervention taken. Additionally, the supervisor should be notified if the resident refused the shower/tub bath, and other information should be reported in accordance with facility policy and professional standards of practice.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on observation, clinical record reviews, staff interviews and policies and procedures, the facility failed to ensure treatment and services were provided in accordance with professional standards of practice for two residents (#21 and #15). The deficient practice could result in a delay in identifying wound deterioration and implementing additional treatment, and a worsening of a skin fungal infections. Findings include: -Resident #21 was admitted to the facility on (MONTH) 10, 2019 and readmitted on (MONTH) 17, 2019 with [DIAGNOSES REDACTED]. Review of the physician admission orders [REDACTED]. Review of a nurse progress note dated (MONTH) 10, 2019 revealed the resident had skin impairment to the left buttock and to see the admission/readmission nursing evaluation for further information. Review of the admission/readmission nursing history and physical dated (MONTH) 10, 2019, revealed the resident was admitted with a left gluteal abscess. However, there was no description of the wound bed or surrounding skin, if any drainage was present, nor were there any measurements of the wound or any documentation if the wound was open. A baseline admission care plan dated (MONTH) 10, 2019 revealed the resident had an infection to the left gluteus/buttock, with a goal that the resident would be free from complications through the review date. An intervention included to administer antibiotics as ordered. Another baseline care plan identified that the resident had actual skin impairment to the sacrum/buttocks related to impaired mobility, with a goal that the resident would maintain or develop clean and intact skin. The interventions included to keep skin clean and dry, and for the weekly treatment documentation to include measurements of each area of skin breakdown's for width, length, depth, type of tissue and exudate, and any other notable changes or observations. A physician's orders [REDACTED]. with tape, change twice daily, and watch for signs and symptoms of infection every day and night shift. A nurse progress note dated (MONTH) 11, 2019 revealed the resident had an abscess on the left gluteal that required incision and drainage times two and closure at the hospital. An skin wound note dated (MONTH) 11, 2019 stated that the provider was called due to a change in appearance of the resident's left buttock surgical incision. The note included there were openings between sutures, with a moderate amount of

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

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) light pink drainage and that the resident was on antibiotics. However, the wound note did not contain any further description of the wound or any measurements. Review of a nurse progress note dated (MONTH) 12, 2019 revealed that the surgeon was notified of the change in appearance of the wound and facility was advised to keep the scheduled follow up appointment on (MONTH) 21, 2019 and if there were concerns for infection, then go to the emergency room . Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed the treatment to the left gluteal wound was not completed on the night shift on (MONTH) 12. A nurse progress note dated (MONTH) 13, 2019 revealed the dressing change was done to the resident's right gluteal wound (although the above documentation indicated the wound was on the left gluteal). Per the note, the incision had three sutures with openings between sutures with minimal amount of serosanguinous clear drainage, no redness or swelling, no foul odor and the width of the wound was smaller than the tip of a q-tip. The note did not include any measurements of the left gluteal wound. Review of a Consultation Request form dated (MONTH) 16, 2019 revealed a follow up of the left buttock wound, with recommendations for daily wound care and dressing changes. An admission Minimum Data Set (MDS) assessment dated (MONTH) 17, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The assessment included the resident had an abscess to the buttock/surgical wound and was receiving wound care. Further review of the clinical record revealed there was no documentation of a thorough assessment of the left gluteal abscess/surgical wound from (MONTH) 14 through 22. A nurse progress note dated (MONTH) 23, 2019 revealed the dressing to the left buttock was changed and there were no signs or symptoms of infection, redness or swelling. A provider progress note dated (MONTH) 23, 2019 revealed the resident presented to the hospital on (MONTH) 30, 2019, with complaints including a red and painful left buttock which the patient reported was from doing a transfer and possibly sitting down hard on a chair and possible developing a wound or a bruise to the left buttock. Per the note, the hospital records and the history and physical included septic shock and that the resident was taken to the operating room emergently for a washout and delayed primary closure of the wound with three interrupted vertical mattress sutures, with dry gauze packing between the sutures. The note included the resident had a second incision and debridement procedure on (MONTH) 5, 2019 and had to go back to the operating room on (MONTH) 6, 2019, due to bleeding at the wound base at which time a hematoma was evacuated. The physician note included that the left buttock incision was healing well, with well approximated wound edges with three sutures and no drainage, however, there is still induration around the wound without redness and the wound was minimally tender on palpation. In the assessment section, the provider [MEDICAL CONDITION], secondary to a left buttock abscess that cultured positive for [MEDICAL CONDITION] Sensitive Staphylococcus Aureus and to continue local wound care and follow up with general surgery on (MONTH) 25, 2019. The note did not include any measurements. Review of the (MONTH) 2019 TAR revealed that wound treatment to the left gluteal wound was not provided on the night shift on (MONTH) 23, or on the day and night shift on (MONTH) 26. A nurse's progress note dated (MONTH) 27, 2019 included the resident was went to the surgery clinic, but was transported back to the facility as the clinic reported that the resident did not have an appointment at that clinic. The note included the resident's appointment had been at a clinic which was at a different location. Further review of the (MONTH) 2019 TAR revealed that wound care was not provided on the night shift on (MONTH) 29 and 30. Review of a provider progress note dated (MONTH) 1, 2019 revealed a right buttock wound (later in the note it referred to the left buttocks abscess). The note included that the resident has a follow-up with general surgery tomorrow. The note included the buttock had significantly less induration, there was no [DIAGNOSES REDACTED] or warmth, there was a moderate amount of serous sanguinous drainage on the dressing, three sutures were still in place, and the wound was superficially open. The plan included to continue wound care and offloading. The note did not include any measurements. A nurse progress note dated (MONTH) 3, 2019 revealed the dressing to the left buttock was changed by the wound nurse and there was a moderate amount of yellow serous drainage on the old dressing. A provider progress note dated (MONTH) 4, 2019 revealed the incision on the left buttock continues to have serous drainage on the dressing, there are sutures in place, and that minimal induration and [DIAGNOSES REDACTED] remained. No measurements were documented. The note also included that the resident was due to see surgery for [REDACTED]. The note included to continue wound care until that appointment. Review of the (MONTH) 2019 TAR revealed the same order from (MONTH) 9 to cleanse the left gluteal wound with wound cleanser, pat dry, cover with 2 by 2's, then 4 by 4's, secure with tape, change twice daily, and watch for signs and symptoms of infection every day and night shift. Per the TAR, the wound treatment was not documented as completed on the night shift on (MONTH) 1 and 6. Nurse's progress notes dated (MONTH) 10, 2019 revealed the resident appeared tired and was not interested in eating and orders were received to transfer the resident to the emergency room and was admitted to the hospital. Review of the entry tracking record revealed the resident was readmitted back to the facility on (MONTH) 17, 2019. Review of the hospital documentation revealed the resident had an incision and drainage [MEDICAL CONDITION] bacteremia of a left buttock wound and included daily treatment/dressing instructions and to keep the wound clean and dry. Review of an admission/readmission nursing History and Physical with an effective date of (MONTH) 17, 2019 revealed the resident had an admitting [DIAGNOSES REDACTED]. The assessment did not include any further description of the wound. Further review of the admission/readmission nursing History and Physical revealed it was signed on (MONTH) 13, 2019. In an interview with the Director of Nursing on (MONTH) 22, 2019 at 9:19 a.m., she stated that on the resident's return from the hospital on (MONTH) 17, 2019, the re-admission history and physical for resident #21 was not done as expected on the resident's return. She said that when she found out it had not been completed she tried to complete the assessment in November. As a result, the left gluteal abscess/surgical wound was not thoroughly assessed on readmission to the facility on (MONTH) 17, 2019. Physician orders [REDACTED]. A nurse progress note dated (MONTH) 20, 2019 revealed that wound care was done, the sites look good and are healing well. A physician's orders [REDACTED]. A care plan dated (MONTH) 24, 2019 included the resident had a potential for nutritional problems due to increased nutrient needs related to wound healing. However, there was no further documentation regarding the buttock wound. Review of the clinical record revealed there was no documentation that the left gluteal abscess/surgical wound was thoroughly assessed by a nurse or the provider for 11 days, from (MONTH) 18 through (MONTH) 28, which included a description of the wound, any measurements, if any drainage was present, the condition of the surrounding skin or if the wound was open. A nurse skin wound progress note dated (MONTH) 29, 2019 documented that the resident returned from a wound appointment regarding the buttock and that undermining was noted at approximately 5 cm and new orders were received for dressing changes. This is the first documentation that the wound had any undermining and it was the first documentation of any measurements of the left gluteal wound. Review of a nursing note dated (MONTH) 29, 2019 revealed the resident had an appointment for the buttock wound. The note included there was no foul odor and no drainage. There was no further description of the buttock wound, nor any measurements. A physician's orders [REDACTED]. A nurse progress note dated (MONTH) 4, 2019 revealed that wound care was done and the site had brownish yellow drainage. Review of a provider's note dated (MONTH) 7, 2019 revealed the resident had a left buttock wound, with packing in place. The note included the resident was admitted to the hospital from the facility where he was recovering from an Incision and Drainage of a buttocks abscess. The documentation included a [DIAGNOSES REDACTED]. The note did not include a description of the wound, any measurements or if undermining was present. Review of the TAR for (MONTH) 2019 revealed no documentation that the wound care was completed on (MONTH) 12. A nurse progress note dated (MONTH) 13, 2019 revealed the wound to left buttock continues to receive daily dressing changes, the peri-wound is pink and dry, and there were no signs or symptoms of infection. The note did not included a description

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) of the wound, any measurements, if any drainage was present or if any undermining or tunneling was present. Further review of the clinical record revealed no evidence that a thorough assessment of the left gluteal abscess/incision wound had been completed from (MONTH) 29, 2019 (when the undermining was first documented) through (MONTH) 13, 2019. A provider note dated (MONTH) 14, 2019 revealed the resident was seen as a consultation for evaluation of a wound to the left buttock, which was present at the time of the resident's admission. The note included the resident had been hospitalized for [REDACTED]. The wound was described as a surgical wound that measured 0.19 centimeters (cm) in length by 2.34 cm in width by 0.9 cm depth, with undermining at 3:00 to 9:00 with a maximum distance of 6.5 cm. The note included there was a moderated amount of green drainage and the wound bed had 76-100% pink granulation tissue. The plan included for a culture of the wound and for follow up in one week. This was the first assessment which included the length, width and depth of the wound and the location of the undermining. According to a skin and wound evaluation dated (MONTH) 14, 2019, the resident had a surgical wound with dehiscence to the right buttock, (instead of the left). The size of the wound was 0.2 cm in length by 2.3 cm in width by 0.9 cm depth with 6.5 cm undermining and the wound bed was 100% granulation, with moderate serous drainage with a faint odor, and that the wound was slow to heal and was improving. Review of the physician's orders [REDACTED]. Despite the resident having a left gluteal abscess/incision wound with undermining, there was no comprehensive care plan developed that addressed the resident's care, treatment and needs related to the presence of a wound. An interview was conducted with resident #21 on (MONTH) 18, 2019 01:20 p.m. He stated that the wound on his left buttock happened prior to his (MONTH) admission to the facility and was a result of him sitting on something sharp, causing a wound that got infected and needed surgery. A wound care observation was conducted on (MONTH) 20, 2019 at 1:40 p.m. with a Licensed Practical Nurse (LPN/staff # 77) and a Registered Nurse (RN/staff #16). The wound on the left buttock was open with serous drainage, the wound bed was red with no slough or eschar, the wound edges were rolled, and the peri wound was intact without redness. During the observation, the nurse was observed probing under the wound edges with a Qtip and undermining was present. The nurse did not measure the wound at this time. Clarification with a Licensed Practical Nurse (LPN/staff #77) was conducted on (MONTH) 21, 2019. Staff #77 said the wound location on the skin and wound evaluation dated (MONTH) 14 was in error, as the wound was on the left buttock, not the right. Another interview was conducted with staff #77 on (MONTH) 21, 2019 at 1:19 p.m. She stated that nursing should complete a history and physical within two hours of the resident's admission and the assessment should identify and include an assessment of any wounds present. She stated that resident #21 should have had a wound evaluation done on admission on (MONTH) 10, which included a description of the wound. She also stated that the history and physical should have been completed within two hours of the resident's re-admission on (MONTH) 17, and not done on (MONTH) 13, 2019, as reflected by the nurse signature. She stated there should be weekly assessments of the wound starting with the (MONTH) admission. She further stated that treatments should be done as ordered by the floor nurse or the wound nurse and they are expected to be documented on the TAR/MAR or there should be documentation of why the care was not done. She stated that if the nurse did not document the care, then the care was not given. She stated if wound care was not done as ordered, it would put the resident at risk for infection, worsening wound status and increased pain. On review of the resident's clinical record she said that it did not meet facility policy/expectations for documentation, wound care or wound assessments. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 22, 2019 at 9:19 a.m. She stated that she expects a head to toe assessment to be completed on the admission/readmission nursing history and physical within 2 hours, but not later than 24 hours of admission. She stated the assessment should identify any wounds present on admission and that a skin and wound evaluation should be initiated with the identification of any wounds. She stated that once a wound is identified, the wound should be assessed every seven days and documented on a skin and wound evaluation. She stated the nurses do the wound treatments and are expected to sign off the treatment in the TAR. She stated if the care was not documented, the care was not done. She stated the admission history and physical for resident #21 for (MONTH) was not done correctly, as it should have had a description of the left buttock wound that was present on admission. She stated that there should be weekly skin and wound evaluations for resident #21 since the (MONTH) admission, but she was only able to locate one evaluation and that the location of the wound was inaccurate. The DON said that on review of the (MONTH) MAR/TAR there were areas without documentation of dressing completion. She stated that any identified wounds should be included in the comprehensive care plan, along with interventions, which were added during the survey process. She stated that care planning, documentation and wound assessments did not meet her expectations or facility policies and that as a result, the wound got worse. She stated that on admit it was a clean surgical wound and on (MONTH) 21, 2019, she went with the nurse practitioner and on assessment of the wound, it had green drainage and adherent slough and required order changes. -Resident #15 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the admission MDS assessment dated (MONTH) 9, 2019 revealed a BIMS score of 15, which indicated the resident had intact cognition. Review of the TAR for (MONTH) 2019 revealed no documentation that the [MEDICATION NAME] ointment was administered at 8:00 a.m. on (MONTH) 15 and 28, and at 8:00 p.m. on (MONTH) 10, 11, 13, 16, 17, 18, 19, 24, 25, 30 and 31. Review of the TAR for (MONTH) 2019 revealed no documentation that the [MEDICATION NAME] ointment was administered at 8:00 a.m. on (MONTH) 13, and at 8:00 p.m. on (MONTH) 5, 7, and 8. An interview was conducted with the DON on (MONTH) 22, 2019 at 9:37 a.m. She stated the expectation is that medications and treatments be administered as ordered by the physician and documented on the Medication Administration Record (MAR) and TAR. She stated that if the documentation was not done on the MAR or TAR or on a progress note, the facility would be unable to prove that the care was given. Review of a policy titled, Conformity with Laws and Professional Standards revealed the facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided. A policy for pressure ulcers/skin breakdown revealed that staff will examine the skin of a new admission for ulcerations or alterations in skin. Review of a policy for wound care revealed to review the resident's care plan to assess for any special needs of the resident. The documentation requirements included to document: the type of wound care given; the day and time the wound care was given; the name and title of the individual performing the wound care; and all assessment data (i.e. wound bed color, size, drainage, etc.) obtained when inspecting the wound. Review of a policy for Charting and Documentation revealed that all services provided to the resident shall be documented in the resident's medical record and the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The policy included that medications administered and treatments or services performed are to be documented in the medical record. In addition, the policy stated that documentation of procedures and treatments will include care-specific details including the assessment data obtained during the procedure/treatment. According to a policy on administering medications, all medications shall be administered in a safe and timely manner and as prescribed. The policy included the individual administering the medication will record in the resident's medical record the signature and title of the person administering the drug, and topical medications used in treatments must be recorded on the resident's treatment record.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** > Based on resident and staff interviews, facility documentation and policy review, the facility failed to ensure there was sufficient nursing staff to meet the needs of the residents. The deficient practice resulted in resident needs not being

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) met timely. The resident census was 16. Findings include: During the initial phase of the survey 2 out of 8 residents reported concerns of not having enough staff. Residents reported they had to wait from 45 minutes to over an hour for staff to answer their call light during the night shift. They stated that they have had incontinent episodes due to the wait time and have been left sitting on the toilet for 15-30 minutes or longer than needed. Review of the Facility Assessment Tool dated (MONTH) 15, 2019 revealed the approach to staffing was to ensure that sufficient staff is meeting the needs of residents at any given time. The assessment included the staffing ratio for the Certified Nursing Assistants (CNAs) was: Days 1 (CNA):8 (residents), Evenings 1:8-10, and Nights 1:12-15. Review of the facility's staffing documentation and staff sign-in sheets revealed the following: September 1, 2019: one CNA on the night shift who left at 3:15 a.m.; census was 24. September 8, 2019: two CNAs on the day shift; census was 27. September 9, 2019: one CNA on the night shift; census was 28. September 22, 2019: two CNAs on the day shift; census was 23. An interview was conducted with the Staffing Coordinator/Central supply (staff #54) on (MONTH) 21, 2019 at 2:25 p.m. She stated that she did not know about a nursing staff to resident ratio and that she had never seen the facility assessment. Additionally, she stated that frequent call-offs from staff have created an on-going staffing concern. On (MONTH) 21, 2019 at 3:09 p.m., an interview was conducted with the Director of Nursing (DON/staff #55). She stated she was aware that the facility had been short staffed on occasion and that her expectation is for the facility to be fully staffed on a daily basis. Review of the facility's policy titled Nursing Services Policy and Procedure Manual revised (MONTH) 2006 revealed services provided to the residents are performed in accordance with current acceptable standards of clinical practice.