<table>
<thead>
<tr>
<th>F 314: 483.25(c) Treatment/SVCS to Prevent/Heal Pressure Sores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on closed medical record review and interview, it was determined the facility failed to assess an unavoidable pressure ulcer for 1 of 3 (Resident #74) sampled residents with pressure ulcers.

The findings included:

Closed medical record review for Resident #74 documented an admission date of 10/29/04 with diagnoses of Hypertension, End Stage Renal Disease, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Dementia, Ischemic Heart Disease, Peripheral Vascular Disease (PVD), Coronary Artery Disease and History of Cerebral Vascular Accident. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/22/13 and 7/11/13 section K oral and nutritional status was coded for mechanically altered diet and therapeutic diet. Section M skin conditions was not coded for pressure ulcers, section O was coded for dialysis. Review of the care plan dated 7/11/13 did not address the presence of pressure ulcers. Review of the

1. The DON reviewed Resident #74's medical record and interviewed licensed nursing staff regarding Resident #74. Facility records and interviews indicate that resident did not have pressure wounds. The resident had a history of calloused areas on heels that were being treated on an ongoing basis by a licensed podiatrist.

2. The DON reviewed medical records for high risk residents receiving wound treatment to ensure resident wounds were appropriately assessed.

3. The DON in-serviced wound care nurses regarding the use of the facility's unavoidable wound assessment form. Residents will receive weekly skin assessments. Residents identified as having the potential for unavoidable wounds will be assessed using the unavoidable wound assessment form.

4. The DON will monitor for compliance at the monthly wound meeting and will perform monthly wound documentation audits for three months.

RECEIVED
DEC 07 2013

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 patient. (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.
F 314: Continued From page 1

    Braden scale for predicting pressure sore risk
dated 7/11/13 was coded with a score of 12 with
a score of 12 or less represents high risk. The
facility did have preventative measure in place.
Review of the weekly skin assessment form
dated 7/10/13 and 7/17/13 did not document the
presence of any pressure sores. Review of the
weekly skin assessment form dated 7/29/13
documented, "...redness buttocks & [and] hips,
edema right and left leg, Wound Lt [left] heel..."

During an interview at the 200/400 nurses' station
on 9/18/13 at 9:20 AM, Licensed Practical Nurse
(LPN) #1 was asked about Resident #74’s skin
condition. LPN #1 stated, "She had a place on
her foot it wasn’t a pressure ulcer it was a callous.
She had calluses on her foot. Don’t recall any
areas on her bottom or heels but we put stuff on
her bottom and heels as a preventive measure.
We don’t necessarily do a skin assessment
before they go out but we do weekly skin
assessments and they are split between first and
second shift. I was the nurse that did the
treatment on wounds except for one day a week.
She went out because shunt was clotted off had a
lot of problems with shunt. Repositioned every
two hours had heel bows on and heels were
floated..."

During an interview in the MDS office on 9/18/13
at 9:45 AM, the Interim Director of Nursing (DON)
was asked about the resident’s skin condition.
The interim DON stated, "No pressure ulcers
prior to going to hospital. Had a bunion on her
foot and the podiatrist would work on them each
time, would file them down. Last time filled down
put some vaseline on them. Finally got most of
the area off..."
F 314. Continued From page 2

Review of the hospital history and physical documented the following: Date of Admission 7/18/13 CHIEF COMPLAINT: Clotted arteriovenous fistula and abnormal electrocardiogram. HISTORY OF PRESENT ILLNESS: This is a 77-year-old African-American female who is a resident of [name of nursing home]. She has a history of end-stage renal disease and hemodialysis... PHYSICAL EXAMINATION ...EXTREMITIES... There is black eschar appearance to the heels... ASSESSMENT AND PLAN... We will consult [named medical doctor] to evaluate and treat the clotted access... Abnormal electrocardiogram: We will consult cardiology... We will ask wound consult to come and provide local wound care."

Review of a hospital physician's order dated 7/18/13 documented, "...Wound care consult to evaluate and treat heel wounds..."

Review of hospital discharge summary documented an admission date of 7/18/13 "HOSPITAL COURSE 77-year old African-American female with known end-stage renal disease dialyzing on Monday, Wednesday, and Friday... The patient was seen... for thrombosed arteriovenous fistula. Unfortunately due to her unstable vital signs... The patient’s code status...DO NOT RESUSCITATE/ DON NOT INTUBATE and niece has power of attorney. An abnormal EKG was noted on admission form the nursing home... In addition to her decline in quality of life and health, dialysis has been discontinued... DISCHARGE DIAGNOSES: 1. End-stage renal disease. 2. Dementia. 3. Diabetes Mellitus. 4. Bedfast with contractures in the fetal position. DISCHARGE INSTRUCTIONS: 1. continue DO NOT
F 314 Continued From page 3

"RESUSCITATE/DO NOT INTUBATE status, comfort care only. 2. discontinue hemodialysis treatment."

There was no documentation in the medical record of the resident having pressure ulcers on heels prior to going to hospital. Weekly skin assessments were documented and did not document presence of pressure ulcers on heels or buttocks.

During a telephone interview on 10/21/13 at 4:15 PM, the Nurse Practitioner was asked if the patient had pressure ulcers when she arrived at the hospital. The Certified Registered Nurse Practitioner (CRNP) stated, "Yes, there was appearance of eschar on both heels... She is a high risk and due to her condition and PVD the pressure ulcers were unavoidable."