**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

**STATE SURVEY REPORT**



**NAME OF FACILITY: Regal Heights**

**DATE SURVEY COMPLETED: March 10, 2022**

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|---|
| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced complaint survey was conducted at this facility from March 3, 2022, through March 10, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 150. The survey sample totaled four (4) residents. | | |
| **3201** | **Regulations for Skilled and Intermediate Care Facilities** | | |
| **3201.1.0** | **Scope** | | |
| **3201.1.2** | **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>This requirement is not met as evidenced by:<br><br>Cross Refer to the CMS 2567-L survey completed March 10, 2022: F657 and F686. | | |

Provider's Signature Sonya J. Thompson MHA Title Administrator Date 3/25/2022

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| | 085006 | A. BUILDING _____ B. WING _____ | C 03/10/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REGAL HEIGHTS HEALTHCARE & REHAB CENTER | 6525 LANCASTER PIKE HOCKESSIN, DE 19707 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced complaint survey was conducted at this facility from March 3, 2022 through March 10, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census on the first day of the survey was 150. The survey sample totaled four (4) residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>ADON - Assistant Director of Nursing;<br>Alternating low air loss mattress - mattress designed to prevent and treat pressure ulcers;<br>BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 -15:<br>13-15: Cognitively Intact<br>8-12 Moderately Impaired<br>0-7 Severe Impairment;<br>b & b (bowel and bladder);<br>Braden Scale - a standardized, evidence-based assessment tool commonly used in health care to assess and document a patient's risk for developing pressure injuries (ulcers);<br>cm (centimeter) - unit of measure;<br>CNA - Certified Nursing Assistant;<br>Coccyx - tailbone;<br>COVID-19 - a respiratory illness that can be spread person to person;<br>D (depth);<br>DON - Director of Nursing;<br>Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard | F 000 | | |

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

Electronically Signed | 03/25/2022

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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| F 000 | Continued From page 1 | F 000 | | |

scab; usually black in color;
Exudate - accumulation of fluid or matter that penetrates through vessel walls into adjoining tissue or the passing out of pus or serum OR accumulation of fluids in a wound;
Friction - friction is exerted when a patient is moved or repositioned in bed by being pulled or allowed to slide down in bed (skin and muscle slide, capillary blood flow decreases, the tissue capillaries are compressed and severed by pressure);
Gastrostomy - giving liquid foods/nutrients via a tube inserted into the stomach or intestine;
Heel boots - provides heel offloading with the heel portion open to eliminate heel pressure by suspending the heel in the air;
IDT - Interdisciplinary Team;
L - length;
LPN - Licensed Practical Nurse;
MDS (Minimum Data Set) Assessment - standardized assessment form used in nursing homes;
MDSAC (Minimum Data Set Assessment Coordinator);
Moisture barrier - skin protectant cream;
Necrotic - tissue death, usually due to the interruption of blood supply or injury OR dead, non-viable tissue;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
NSS (Normal Saline Solution ) -normal saline solution, a sterile mixture of salt and water with a salt concentration similar to tears, blood, and other body fluids;
Offloading - removal of pressure from an area;
Perineal - area between the thighs, the external genitals and anus;
Periwound - the area immediately around the wound;

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| F 000 | Continued From page 2<br>po - by mouth;<br>Pressure ulcer (PU) - sore area of skin that develops when blood supply to it is cut off due to pressure;<br>PRN - as needed;<br>RN - Registered Nurse;<br>Roho - a pressure reducing cushion;<br>Sacral/sacrum - the area of the large triangular bone at the base of the spine;<br>Santyl - a type of medication that cleans and promotes wound healing;<br>Shearing - force generated when the skin is moved against a fixed surface; a combination of downward pressure and friction;<br>Skin prep -a liquid film-forming dressing that forms a protective film when applied to intact skin;<br>Slough - yellow, tan, gray, green or brown dead tissue;<br>Tunneling - channels that extend from a wound into and through the tissue or muscle;<br>Undermining - skin edges have lost supporting tissue under intact skin;<br>W (width);<br>WCN (Wound Care Nurse);<br>Zinc guard - a protectant paste indicated to protect minor skin irritation associated with diaper rash and to help seal out wetness;<br># (Pound) - unit of weight. | F 000 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that | F 657 | | 3/29/22 |

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| F 657 | Continued From page 3<br>includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R1) out of three (3) sampled residents for pressure ulcer (PU) review, the facility failed to review and revise the care plan for an identified resident care area. Findings include:<br><br>Cross refer F686, Example #2.<br><br>Review of R1's clinical record revealed the following:<br><br>11/30/20- R1 was admitted to the facility.<br><br>1/15/21 - R1 was readmitted to the facility from the hospital due to pneumonia from COVID-19 | F 657 | A-Resident R1's care plan has been revised to include low air loss mattress and heel boots.<br><br>B-Current residents with new skin areas of concern have the potential to be affected by this deficient practice.<br><br>C-Staff educator/designee will educate licensed nursing staff on reviewing and revising care plans with any new skin interventions as appropriate.<br><br>RCA: Facility failed to ensure residents care plan was revised and updated to include the alternating low air loss | |

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| F 657 | Continued From page 4<br>and had no PU's.<br><br>1/21/21 - The Significant Change MDS Assessment documented that R1 was moderately impaired for decision making with a BIMS score of 9, required extensive assistance of two plus staff for bed mobility, one person physical assistance for transfers, total assistance for dressing and eating, required total dependence of two plus staff for toileting, was always incontinent of bowel and bladder, and had no PU.<br><br>1/22/21 - R1's Braden Scale score was 12 indicating that R1 was at high risk for the development of PU's.<br><br>2/2/21 - A Skin Evaluation documented a fluid filled intact blister on R1's left heel.<br><br>2/2/21 - The facility's contracted Wound Care Consultant (E11) documented the presence of a stage II (2) PU to the left heel. Interventions in place to address the condition of R1's skin and immobility included an alternating low air loss mattress and to order heel boots which were to be worn at all times while in bed.<br><br>2/2/21 - The care plan for the stage II wound to R1's left heel related to impaired mobility included interventions to administer treatments as ordered and monitor for effectiveness, and educate caregivers as to the causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulation/mobility, and good nutrition.<br><br>There was lack of evidence of revising the care plan to include the alternating low air loss mattress and heel boots which were to be worn at | F 657 | mattress and heel boots.<br><br>D-Don/designee will perform daily audits of any new skin interventions to ensure that care plans have been updated and revised accordingly. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. | |

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| F 657 | Continued From page 5<br>all times while in bed.<br><br>3/10/22 2:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (Director of Clinical Services), and E5 (RN Risk Manager). | F 657 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, review of the clinical record, review of the facility's policy and procedure, review of the facility's guideline, and review of professional clinical resources as indicated, it was determined that for two (R1 and R2) out of three sampled residents for pressure ulcer (PU) reviews, the facility failed to ensure that the residents received the necessary treatment and services, consistent with professional standards of practice, to prevent new pressure ulcers (PU's) from developing. R2 was admitted to the facility with no PU's and the facility failed to implement preventative measures resulting in R2 acquiring | F 686 | A-Deficient practice was unable to be corrected for R2 due to having passed the time of occurrence. Heel boots for resident R1 were put in place.<br><br>B-Current residents at risk for developing a pressure ulcer, based on the Braden Scale, have the potential to be affected by this deficient practice.<br><br>C-Staff educator/designee will educate nursing staff on the Prevention of Pressure Injures, Pressure Ulcers/Skin | 3/29/22 |

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| F 686 | Continued From page 6<br>an avoidable unstageable PU of the sacrum on 2/6/21 and an avoidable deep tissue injury (DTI) PU to his left heel on 2/7/21. R1 was readmitted to the facility on 1/15/21 with no PU's and the facility failed to implement interventions to relieve pressure from R1's heels. R1 subsequently acquired an avoidable stage II (2) PU of the left heel on 2/2/21 that resolved on 3/2/21. Findings include:<br><br>Review of the facility's policy and procedure (P & P) titled Prevention of Pressure Injuries [Ulcer], with a revision date of April 2020, stated, "...The purpose of this procedure is to provide information regarding the identification of pressure injury risk factors and interventions for specific risk factors...Risk Assessment 1. Assess the resident on admission (within 8 hours) for existing pressure injury (ulcer) risk factors. Repeat the risk assessment weekly and upon any change in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. 3. Supplement the use of a risk assessment tool with assessment of additional risk factor...".<br><br>Review of the facility's Braden Scale Guideline, with a revision date of March 2018, stated that the facility would utilize this guideline to implement interventions for the prevention of PU's based on the score from the Braden Scale, a standardized PU screening tool:<br>AT RISK (15-18): Repositioning, protect heels, manage moisture, friction and shear, pressure-reduction support surface to bed and chair, moisture barrier for incontinence.<br>MODERATE RISK (13-14): All the above interventions [as noted for AT RISK] and lateral positioning devices and dietary consult if oral | F 686 | Breakdown/Clinical Protocol, and Braden Scale Guidelines.<br><br>RCA: The facility failed to identify and implement interventions to prevent new pressure ulcer development on R1 and R2.<br><br>Unit managers completed new Braden Scales and skin sweeps on all residents in the facility. New interventions, as appropriate, were implemented according to Braden Scale guidelines.<br><br>Facility reviewed and updated the Braden Scale guidelines to include the risk levels for proper interventions if appropriate, to prevent pressure ulcers.<br><br>D-Don/designee will perform daily audits of Braden Scales to ensure proper preventative interventions have been put into place to prevent new pressure ulcer development. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. | |

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| F 686 | Continued From page 7<br>intake less than 50%.<br>HIGH RISK (10-12): All the above interventions [as noted for AT RISK and MODERATE RISK] as well as small repositioning shifts between the scheduled turning and repositioning and a resident nap between lunch and dinner.<br><br>Review of the facility's P & P titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, with a revision date of April 2018, stated, "Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for development of pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissues; b. Pain assessment...".<br><br>According to the National Pressure Ulcer Advisory Panel (April 2019), the stages of pressure injuries/ulcers (categorization system used to describe the severity of PUs):<br>Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated.<br>Unstageable - Tissue loss in which the actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage is more severe than slough in the wound bed).<br>Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceeded by tissue that is painful, mushy, firm, | F 686 | | |

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| F 686 | Continued From page 8<br>boggy (wet, spongy feeling), warmer or cooler than adjacent tissue.<br><br>1. Review of R2's clinical records revealed the following:<br><br>8/12/20 - R2 was admitted to the facility with no PU's and weighed 193 pounds (#).<br><br>8/12/20 - The Admission Nursing Assessment documented that R2's skin was intact and had no PU's.<br><br>8/12/20 - R2 was assessed as not being at risk for the development of a PU with a Braden Scale score of 19.<br><br>8/13/20 (Initial date and revised on 2/24/21) - A care plan for risk for further skin breakdown related to decreased mobility, fragile skin, and incontinence included the following interventions:<br>- apply lotion to skin to prevent dryness everyday with AM and PM care.<br>- monitor alterations in nutrition and notify Medical Doctor and Dietician.<br>- Roho pressure relief cushion to wheelchair (initiated 2/21/21).<br>- pressure relief cushion to wheelchair (initiated 8/13/20).<br>- turn and reposition, check skin and monitor pressure points every two hours and report changes to nurse.<br>- weekly skin assessments by a nurse.<br><br>8/18/20 - The Admission MDS Assessment documented that R2 was moderately impaired for decisionmaking with a BIMS of 12, required extensive assistance of two plus staff for bed mobility and transfers, required extensive | F 686 | | |

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| F 686 | Continued From page 9<br>assistance of one person for toileting, was frequently incontinent of urine, always incontinent of bowel, and had no PU's.<br><br>11/12/20 - The Quarterly MDS Assessment documented R2 was cognitively intact for daily decisionmaking with a BIMS of 13, required extensive assistance of one person for bed mobility, transfers, and toileting. required supervision of one person assistance for eating, was frequently incontinent of urine, occasionally incontinent of bowel, and had no PU's.<br><br>11/30/20 - The Braden Scale score was 18, indicating that R2 was at risk for the development of PU's.<br><br>Although R2 was assessed to be at risk for the development of a PU, there was lack of evidence that the facility identified and implemented interventions to protect the heels, manage moisture, friction and shear, and to apply moisture barrier for incontinence per the facility's Braden Scale guidelines.<br><br>2/1/21 through 2/6/21- CNA documentation stated that the following interventions were completed:<br>- turned and repositioned and skin assessed every 2 hours.<br>- incontinence care every 2 hours and PRN.<br><br>2/6/21 2:33 PM - The Braden Scale score was 12 indicating that R2 was at high risk for PU development.<br><br>2/6/21 4:19 PM - A Nurse Progress Note documented that at 2:15 PM, a CNA found and reported a wound to R2's coccyx (tailbone) area. R2 was assessed with a dark purple discolored | F 686 | | |

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| F 686 | Continued From page 10<br>area measuring 4 cm x 6 cm with a small superficial opening measuring 2 cm (length-L) x 2 cm (width-W) and the NP was notified. New orders were given to cleanse the area with NSS, apply Zinc Guard around the edges and apply Santyl to the open area and cover with a clean dry dressing. E6 (LPN, WCN) and R1's responsible party (RP2) were notified.<br><br>Despite the fact that R2 was assessed at high risk for the development of a PU, there was lack of evidence that the facility identified and implemented additional measures to include protection of the heels, manage moisture, friction and shear, apply moisture barrier for incontinence, and consult for lateral positioning devices per the facility's Braden Scale guidelines.<br><br>2/7/21 - CNA documentation stated that the following interventions were completed:<br>- turned and repositioned and skin assessed every 2 hours.<br>- incontinence care every 2 hours and PRN.<br><br>2/7/21 12:33 PM - A Skin Only Evaluation documented the following:<br>"...Skin Issue: Deep Tissue Injury. Skin Issue Location: left heel Length: 2 cm Width: 2 cm Wound Bed: Necrotic. Wound Exudate: None. Peri Wound Condition: Fragile. Dressing Saturation: None. No wound odor. No tunneling. No undermining. Tissue: Firm. Tissue: Warm ...".<br><br>Based on the above characteristics of the left heel PU, it would be consistent with an unstageable PU due to the presence of necrotic tissue in the wound bed.<br><br>2/7/21 3:20 PM - A Nurse's Progress Note | F 686 | | |

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| F 686 | Continued From page 11 | F 686 | | |

documented during routine care at 2 PM, a CNA found and reported a bruise to R2's left heel. R2 was assessed with a small dime sized dark purple discoloration/ bruise measuring 2 cm (L) x 2 cm (W) on his left heel. The area was cleansed with NSS and skin prep was applied and the heel was elevated. Notifications were made to E6 (LPN, WCN), E9 (NP) and E10 (MD).

2/7/21 - A NP Progress Note documented that R2 was diagnosed with a urinary tract infection and ordered antibiotics for six days.

2/8/21 - A Health Status Note by E6 (LPN, WCN) documented her wound assessment of the left heel with dry eschar measuring 1.0 cm x 1.0 cm, an unstageable ulceration. The coccyx and bilateral buttocks had necrotic tissue with a split base of the wound that was 100% slough with a necrotic black area to the inner buttocks extending to the left buttock with a non-blanchable area to the left buttock. Santyl was ordered for the buttocks and the skin prep for the left heel. New interventions were to elevate R2's heels up on pillows and a low air loss mattress to the bed frame.

2/9/21 - The facility's contracted Wound Care Consultant (E11) documented R2 was seen for an evaluation and management for wounds to the sacrum and left heel. The sacrum measured 9.0 cm (L) x 9.2 cm (W) x 0.2 cm (D) with 60% slough. R2 had no evidence of pain upon the wound being palpated. The left heel measured 1.4 cm (L) x 1.2 cm (W) purple/maroon intact skin. "...Plan: Unstageable pressure ulcer/injury of the left heel due to deep tissue injury...cleanse affected area with NSS...Apply skin prep daily and PRN...Unstageable pressure ulcer/injury of

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| F 686 | Continued From page 12<br>the sacrum secondary to slough...".<br><br>2/9/21 - A Registered Dietician Evaluation by E8 (RD) documented, "Resident showing loss of 11.4 # in 6 days and highly likely related to overall decline in condition (noted to have decline in continence of b & b and requires extensive assistance with eating), noted with reduction in po intake past week...".<br><br>Although R2 had a decline in overall condition and the facility was monitoring R2's nutritional status, the facility failed to reevaluate R2's clinical condition and failed to implement interventions for the prevention of PU's. These failures resulted in R2 acquiring an avoidable PU of the sacrum on 2/6/21 and an avoidable DTI of the left heel on 2/7/21. On 2/8/21, the facility identified that both of the PUs were unstageable.<br><br>3/9/22 1:35 PM - An interview with E6 (LPN, WCN) confirmed that the facility was utilizing the Braden Scale guideline when R2 acquired a new unstageable PU of the sacrum (coccyx) and a DTI of his left heel, however, E6 reiterated that the final interventions were determined by the Interdisciplinary Team.<br><br>Cross refer F656.<br><br>2. Review of R1's clinical record revealed the following:<br><br>11/30/20 - R1 was admitted to the facility with no pressure ulcers (PU's) and weighed 193 pounds (#).<br><br>11/30/20 - The Admission Nursing Assessment documented that R1's skin was intact. | F 686 | | |

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| F 686 | Continued From page 13<br><br>11/30/20 - R1's Admission Braden Score was 18 indicating that she was at risk for the development of a PU.<br><br>12/8/20 - The Admission MDS Assessment documented that R1 was moderately impaired for decisionmaking, with a BIMS score of 9, required extensive assistance of two plus staff for bed mobility, transfers, toileting, was always incontinent of bowel and bladder, and had no PU's.<br><br>12/9/20 (last revised on 12/24/20) - A care plan for the potential for impaired skin integrity related to decreased mobility and incontinence included the goal that the skin would remain intact. Interventions included to provide prompt perineal care following incontinence episodes and to provide turning and repositioning every 2 hours, including checking the skin.<br><br>12/16/20 3:32 PM - A Nurse Progress Note documented that R1 was positive for COVID-19.<br><br>12/1/20 - 12/30/20 - CNA documentation stated R1 was turned and repositioned every 2 hours, including skin checks.<br><br>There was lack of evidence that additional interventions to prevent PU's were implemented to include protecting the heels, manage moisture, friction and sheer, and to apply moisture barrier for incontinence per the facility's guideline.<br><br>12/24/20 12:48 PM - A care plan review note documented that R1's skin was intact and that the interventions implemented were effective. | F 686 | | |

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| F 686 | Continued From page 14<br>12/30/20 8:58 AM - A Nurse Progress Note documented a change in condition including altered mental status and a physician's order was received to send R1 to the emergency room (ER) for an evaluation. R1 was transferred to the ER and was subsequently hospitalized.<br><br>1/15/21 - R1 was readmitted to the facility from the hospital due to pneumonia from COVID-19, had no PU's and weighed 177.3 #.<br><br>1/15/21 - R1's Braden Scale Score was 13 indicating that R1 was at moderate risk for the development of PU's.<br><br>1/21/21 - The Significant Change MDS Assessment documented that R1 was moderately impaired for decisionmaking with a BIMS score of 9, required extensive assistance of two plus staff for bed mobility, one person physical assistance for transfers, total assistance for dressing and eating, total dependence of two plus staff for toileting, was always incontinent of bowel and bladder, and had no PU's.<br><br>1/22/21 - R1's Braden Scale score was 12 indicating that R1 was at high risk for the development of PU's.<br><br>Despite R1 being high risk for the development of a PU, there was lack of evidence that the facility identified and implemented additional interventions to include protection of the heels, manage moisture, friction and sheer, apply moisture barrier for incontinence, and consult for lateral positioning device(s) per the facility's Braden Scale guidelines.<br><br>1/15/21 through 1/31/21 - CNA documentation | F 686 | | |

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| F 686 | Continued From page 15<br>stated that R1 was turned and repositioned every 2 hours and skin was checked.<br><br>1/21/21 - A Registered Dietician Evaluation revealed that R1's current weight was acceptable and the weight loss was due to the recent hospitalization and COVID pneumonia. The plan was to continue weekly weights and closely monitor weight trend.<br><br>2/2/21 - A Skin Evaluation documented a fluid filled intact blister on R1's left heel.<br><br>2/1/21 through 2/2/21-CNA documentation stated that R1 was turned and repositioned and skin was checked every 2 hours.<br><br>2/2/21 - The facility's contracted Wound Care Consultant (E11) documented the presence of a stage II PU to left heel, an intact blister measuring 5.7 cm (L) x 6.0 cm (W). The plan was to cleanse with NSS and to apply skin prep daily and PRN, continue repositioning in accordance to assessed need, offload pressure to the affected area and monitor nutritional intake via gastrostomy tube feeding. Interventions in place to address the condition of R1's skin and immobility included an alternating low air loss mattress and to order heel boots, which were to be worn at all times while in bed.<br><br>2/2/21 - The care plan for actual wounds to the left heel stage II (2) related to immobility was developed and implemented. Interventions included to administer treatments as ordered and monitor for effectiveness and educate caregivers as to the causes of skin breakdown, including transfer/positioning requirements, importance of taking care during ambulation/mobility, and good | F 686 | | |

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| F 686 | Continued From page 16<br>nutrition.<br><br>2/2/21 beginning on the evening shift - 2/28/21 - CNA documentation revealed heel booties were on at all times except during hygiene, in addition to turning and positioning and skin checks every 2 hours.<br><br>3/2/21 - The facility's contracted Wound Care Consultant (E11) documented R1's left heel PU was resolved.<br><br>3/8/22 2:30 PM - An interview with E6 (LPN), the facility's designated Wound Care Nurse (WCN) was asked by the Surveyor if the interventions to prevent PU were revised following R1's readmission to the facility on 1/15/21 prior to the new stage II PU on the left heel. E6 stated she was unable to determine if there were any changes in interventions for the prevention of PU's and confirmed there was no intervention to offload R1's heels. During this interview, it was unclear what the facility's system was to ensure that appropriate preventative interventions were implemented for the prevention of a new PU.<br><br>3/9/22 1:35 PM - The Surveyor was provided the above guideline titled Braden Scale Guideline by E6 (LPN, WCN) who stated this was the guideline which were in place when R1 acquired a new left heel stage II (2) PU. E6 stated that this was the guideline to be utilized, but E6 emphasized that the final interventions were determined by the Interdisciplinary Team.<br><br>3/9/22 2 PM - An interview with E7 (LPN, MDSAC) revealed that the MDSACs did not determine the interventions for PU prevention and it was her understanding that it was the | F 686 | | |

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| F 686 | Continued From page 17<br>responsibility of the Unit Manager.<br><br>The facility failed to ensure interventions were implemented to prevent new PU development, resulting in R1 acquiring a stage II PU on the left heel on 2/2/21.<br><br>3/10/22 2:50 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (Director of Clinical Services), and E5 (RN Risk Manager). | F 686 | | |