**Final Observations**

Statement of Licensure Violations:
- 300.610a)
- 300.1010g(3)
- 300.1010h)
- 300.1210d(5)
- 300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.

The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies
b) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following:

3) Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly known as bed sores), with grade, size and location specified, and orders for treatment, if present.

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan...
of care for the care of treatment of such accident, injury or change in condition at the time of notification.
Section 300.1210 General Requirements for Nursing and Personal Care
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements were not met as evidenced by:
Based on interview and record review the facility failed to provide services to treat and prevent pressure sores by failing to monitor/treat a heel abrasion and failing to ensure prompt Physician treatment for worsening pressure sores. The facility also failed to develop and implement policies regarding of physician visits, Physician Notification of Change in Condition, and Attending Physician Responsibilities for R2 who experienced worsening pressure sores. This affects one of three residents reviewed for pressure sores (R2) in the sample of eight. These failures resulted in R2 being admitted to
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the hospital with gangrenous pressure sores on his foot.

Findings include:

Hospital discharge orders dated 4/29/14 document that R2 was admitted to the facility on that date with instructions to see Z1 Physician at the nursing home. The Facility Pressure Ulcer Report updated 6/20/14 documents that R2 was admitted to the facility with suspected deep tissue injury pressure ulcers on his left great toe, left heel, left alveolus and left knee. R2's Medical Record documents no physician visit notes from 4/29/2014 through 6/16/14.

On 6/24/2014 at 4:30 PM E2 Director of Nurses confirmed that Z1 did not see R2 while he was a resident at the nursing home from 4/29/14 through 6/22/14. E2 explained that Z2 Physician covered for Z1 while Z1 was out of the country. E2 stated that Z2 also did not see R2 at the nursing home.

E2 also stated on 6/24/14 at 4:30pm she did not know R2 was not seen at the facility by a physician until 6/10/14 when E4 Wound Nurse told her that Z1 did not respond to the faxes sent on 5/23/14, 5/30/14 and 6/9/14 regarding R2's worsening pressure sores. E2 stated that on 6/10/14 she sent a text message to Z1 regarding R2. Z1 responded to the text that R2 was not his patient.

The Wound Nurse Notes document that R2's left great toe wound was 100% eschar and increased in measurement from 1.6 centimeters (cm) x 1.6 cm on 5/2/14 to 5.0 cm x 2.8 cm on 6/13/14. The fax sheet dated 5/30/14 documents
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a new black area identified on R2's left heel measuring 2.8 cm x 2.8 cm. Wound Nurse Notes dated 6/13/14 document R2'a left heel wound measured 3.2 cm x 2.8 cm and remained 100% eschar.

Nurses Notes dated 6/17/14 document that R2's wounds were not evaluated by a physician until 6/17/14 when seen by Z4 Wound Doctor. The Physician's Order Sheet dated 6/16/14 documents that Z4 changed R2's left great toe treatment to betadine paint and foam dressing daily, and also started a treatment of betadine paint and cover with foam dressing daily for R2's left heel.

On 6/24/14 at 4:30 PM E2 stated that when Z1 did not respond to the faxes sent on 5/23/14 and 5/30/14, E4 should have called the Medical Director for orders. On 7/1/14 at 11:30 am E2 further stated that E4 should have notified Z1 of R2's worsening pressure areas by telephone and not by fax.

The undated policy for Change in Condition Physician Notification Overview Guidelines states "The nurse should not hesitate to contact the attending physician at any time for a problem in which her judgement requires immediate medical intervention. Should the physician not be available the alternate physician should be contacted. If neither of these physicians are available the Medical Director should be notified."

The undated policy Attending Physician Responsibilities states that prompt notification by direct communication with the physician and not by fax is required for acute problems including pressure sores.
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<tr>
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<tbody>
<tr>
<td>The Emergency Room Documentation dated 6/22/14 documents that R2 was admitted to the hospital on that date with &quot;multiple gangrenous ulcerations to the left foot, left great toe gangrenous and eroded......&quot;</td>
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<td>On 6/30/14 at 8:45 am Z6 Hospital Physician confirmed that R2 was admitted to the hospital with multiple necrotic areas. Z6 stated that lack of physician care at the nursing home contributed to the worsening of R2's wounds. Z6 further stated that it appeared that the nursing home staff neglected R2's wound care.</td>
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<tr>
<td>The Nurses Note date 4/29/14 documents that R2 was admitted to the facility from the hospital with an abraded area to his left heel and a bruise on his left great toe. Physician's Orders dated 5/6/14 document an order for skin prep to R2's left great toe three times daily and no orders for treatment of the left heel abrasion.</td>
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<td>The Wound Nurse Notes dated 5/2/14 documents that R2's left great toe wound measured 1.6 centimeters (cm) x 1.6 cm on that date and that the wound contained 100% necrotic hard eschar.</td>
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<td>The Wound Nurse Notes dated 5/23/14 document that the left great toe wound increased in size to 2.8 cm x 2.6 cm and remained 100% eschar. The same Wound Nurse Notes document that Z1 physician was updated on the status of R2's left great toe wound, and a new treatment was requested on that date.</td>
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<td>The Wound Nurse Notes dated 5/30/14 document that the left great toe wound increased in size to 3.0 cm x 3.0 cm and remained 100% eschar on that date. The same Wound Nurse Notes document that Z1 physician was updated on the status of R2's left great toe wound, and a new treatment was requested on that date.</td>
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Notes document "treatment change to betadine request faxed to medical doctor, nurse awaiting orders."

Wound Nurse Notes dated 5/2/14, 5/9/14, 5/16/14, and 5/23/14 contain no assessment information concerning R2’s left heel abrasion. The Fax dated 5/30/14 documents that E4 Wound Nurse faxed Z1 information regarding a new black area area on R2’s heel which measured 2.8 cm x 2.8 cm, and requested an order for a Betadine treatment to the area.

The Wound Nurse Notes dated 6/6/14 document the following "left great toe measures 3.0 cm x 3.0 cm 100% eschar.....Left heel measures 2.8 cm x 2.8 cm 100% eschar."

The Wound Nurse Notes dated 6/13/14 documents the following "left great toe 5.0 cm x 2.8 cm 100% eschar left heel 3.2 cm x 2.8 cm 100% eschar."

On 6/24/14 at 4:30 PM E4 Wound Nurse stated that she was not aware that R2 had an abraded area on his left heel when he was admitted to the facility. E4 further stated she would have monitored the area if she had known. E4 also stated that when R2’s left great toe wound increased in size she notified Z1 of the changes by fax on 5/23/14 and 5/30/14. Z1 did not respond to those faxes. E4 stated that on 6/9/14 she reported to E2 Director of Nurses that Z1 did not respond to her notifications. and E2 instructed E4 at that time to refax the information to Z1. The Fax from Z1 to the facility dated 6/9/14 documents that R2 "Not our Patient."E4 continued that on 6/13/14 she contacted Z1’s nurse and obtained an order for the Wound Doctor to see R2. Physician’s Order Sheet dated
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6/16/14 documents that Z4 Wound Doctor saw R2 on that date and changed R2’s left great toe treatment to betadine paint and foam dressing daily. Z4 also started a treatment of betadine paint and foam dressing daily for R2’s left heel.

On 6/24/14 at 4:30 PM E2 Director of Nurses could not provide documentation that R2’s left heel wound was monitored from admission on 4/29/14 until 5/30/14. At that time E2 stated that when Z1 did not respond to the faxes sent on 5/23/14 and 5/30/14, E4 should have called the Medical Director for orders. On 7/1/14 at 11:30 am E2 further stated that E4 should have notified Z1 of R2’s worsening pressure areas by telephone and not by fax.

On 6/30/14 at 10:25 AM E2 stated the facility does not have a policy regarding the frequency of physician visits. On 7/1/14 at 11:30 AM E2 stated she did not know that physician visits were required every 30 days for the first 90 days for newly admitted residents.

The undated policy Change in Condition Physician Notification Overview Guidelines states "The nurse should not hesitate to contact the attending physician at any time for a problem in which her judgement requires immediate medical intervention. Should the physician not be available the alternate physician should be contacted. If neither of these physicians are available the Medical Director should be notified."

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<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETE DATE</th>
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<td>S9999</td>
<td>Continued From page 7 The Emergency Room Documentation dated 6/22/14 documents that R2 was admitted to the hospital on that date with &quot;multiple gangrenous ulcerations to the left foot, left great toe gangrenous and eroded.....&quot; On 6/30/14 at 8:45 am Z6 Hospital Physician confirmed that R2 was admitted to the hospital with multiple necrotic areas. Z6 stated that lack of physician care at the nursing home contributed to the worsening of R2's wounds. Z6 further stated that it appeared that the nursing home staff neglected R2's wound care.</td>
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