STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963982	**07/18/2018**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE COLONIAL PARK**	STREET ADDRESS, CITY, STATE, ZIP CODE **4730 BEE RIDGE ROAD SARASOTA, FL 34233**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced complaint survey for CCR# 2018007867 was conducted on through at Brookdale Colonial Park, an assisted living facility (license #7439) in Sarasota, Florida.

Complaint CCR# 2018007867 had 2 allegations one of which was substantiated with deficiencies.

The following is description of the deficiencies.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on policy review, observations, record review, and staff interview, the facility failed to evaluate 2 (Resident #2 and #3) of 3 sampled residents for continued residency and provide a discharge notice related to pressure injuries. Because of this failure, the residents continued to remain in the facility and their pressure injuries worsened. Resident #2 required a higher level of care and was ultimately sent to the emergency evaluation and treatment recommendation of her wounds.

The findings included:

1. Review of the facility's policy titled, "Admission/Discharge Policy" (revised) included: "The community may admit, retain or discharge older adults per [facility] and state regulatory criteria...An Individual must meet the following minimum criteria in order to be admitted into the residence: j) Not have any or 4 pressure injuries. A resident requiring care of a pressure injury, may be admitted provided that: (1) The community has a LNS [limited nursing services] license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; (2) The condition is documented in the resident's record; and (3) If the resident's condition fails to improve within 30 days, the resident should be discharged from the community in accordance with the Residency Agreement..."

2. Review of the residency agreement dated for Resident #2 included: "... We may terminate this Agreement, upon providing you or your legal representative forty-five (45) days written notice, for any of the following events, as determined by us: 1. You require care or services that we are unable to provide or which requires staff that are not available at the Community..."

Review of the Home Health Agency (HHA) visit coordination note dated completed by the Home Health Registered Nurse (HHRN) documented Resident #2's left heel was red.

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Review of the HHA assessment visit notes dated documented, "...left heel broken ....foam dressing applied by an LPN [licensed practical nurse] last night..." There were no notes in the record to reflect when the developed to Resident #2's left heel. The record failed to show the was evaluated, the physician was notified, and there were no orders to apply a foam dressing to the open .

On , the HHRN documented, " on left heel now open, 2.5 x 4 x 0.1 cm [centimeter], drainage, red, skin re-approximated [closed together]..." The HHRN documented the as a pressure injury (skin is broken, leaving an open).

On , the HHRN documented the left heel digressed; however, there was no description of the by either the HHRN or the licensed facility staff.

On , HHRN notes showed Resident #2 and the left heel showed signs of . The was tender to touch and measured 11 x 4 centimeters (cm) and with , drainage, odor, and redness. The left foot was edematous. The HHRN documented the resident sits in her chair all day, her were reddened, and an order for barrier cream (a , medication to place a physical barrier between the skin and contaminants) was noted.

The record failed to reflect the cream was ordered or applied to Resident #2's reddened .

Log Notes dated documented Resident #2 was sent out to the hospital for a left heel .

On , coordination notes by the HHRN showed the left heel measured 11 x 4 x 0.1 cm and with a foul odor, moderate , (yellowish fluid with small amounts of) drainage and a large amount of to the top of the left foot, painful to the resident. The HHRN referred Resident #2 to a care clinic, then documented there was no transport available. The notes did not reflect any intervention to assist the resident to a care clinic or notes to reflect the resident's legal representative was notified the was deteriorating.

The HHRN continued to treat the left heel . There were no notes by the facility they were aware of the deterioration of the . Documentation provided by the facility failed to show a new Skin Observation Form or Open Area Flow Sheet was completed. The documentation failed to show the executive director or health and wellness director/designee were made aware of the digression.

On , HHRN documentation found Resident #2's reddened and a dressing (a

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specialized dressing that seals the and promotes healing) was to be changed when soiled twice weekly. The record failed to show the licensed staff followed this treatment.

On , in addition to the left heel and reddened , another in-house acquired pressure injury to the right was documented by the HHRN. The measured 0.3 x 0.3 x .1 cm and skin to the area was dry, flaking and peeling. There was no documentation the legal representative was notified of the development of another new pressure injury. There was no indication the Executive Director (ED) or Health and Wellness Director (HWD) were aware of the development of a second in-house acquired pressure injury.

On , notes by the HHRN documented, "red area on is now open. 1 x 1 x 0.1 cm...cleanse with NS [normal] and gauze, apply skin prep, 2 x weekly until healed..." The HHRN documented a pressure injury to the . Again, the record failed to reflect the facility licensed staff treated the and failed to reflect the resident's legal representative was notified of another in-house acquired pressure injury.

The record failed to show Resident #2 was evaluated by the Executive Director (ED) for continued appropriateness of residency related to the failure of the left heel pressure injury to heal or show signs of improvement within 30 days. Review of the record failed to show Resident #2 was deemed ill. A new pressure injury developed to the . There was no documentation Resident #2 or her legal representative were provided a discharge notice.

3. On at 11:50 a.m., observation in the presence of the HHRN and LPN Staff C found an open area to Resident #2's with yellow sticky tissue adhered to the base of the and the periphery of the was a deep reddish-purple. To the right of the was a second small open area with a deep red base. The HHRN said it was a new area.
The HHRN peeled away a foam dressing from the resident's left heel. An open area with grayish-white tissue was observed on the inner aspect of the left heel. Above this area on the inner left ankle was deep red abraded skin. The HHRN acknowledged the new abraded skin and covered the areas with the same dressing. The HHRN said the had worsened.

In an interview on at 2:30 p.m., the HWD, who is a registered nurse (RN), stated, "...it may be partly my fault because I don't know what's going on with the wounds ....I'm just learning ..."

The record showed as of , a pressure injury to the left heel and the pressure injury deteriorated to a (a through the second layer of skin).

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On at 2:30 p.m., the ED said he was unaware of the length of time Resident #2 had the pressure injuries or the severity of the wounds. The ED admitted he had not evaluated Resident #2 for continued residency or provided a discharge notice based on the non-healing pressure injuries.

4. Review of the residency agreement for Resident #3 dated included: "...We may terminate this Agreement, upon providing you or your legal representative forty-five (45) days written notice, for any of the following events, as determined by us: 1. You require care or services that we are unable to provide or which requires staff that are not available at the Community..."

Review of the health assessment (undated) for Resident #3 documented she is impulsive and forgets her limitations. The Log Notes dated found Resident #3 off of a piano bench, yelling of hip pain and was sent to the hospital.

Resident log notes dated revealed Resident #3 returned to the facility and on , 2 days after admission, the HWD documented she notified Resident #3's daughter of the resident's return with a left heel "pressure ." The HWD notified the home health agency who would treat and follow for care. There was no other documentation related to whether the was assessed by the HWD, or whether the physician was notified and orders obtained to treat the .

Review of the HHA visit coordination notes dated documented by the HHRN found the left heel measured 2.5 x 3 cm with an unstageable depth and scant maceration.

Further review of the HHRN visit coordination notes included the following:
-"left heel 1.5 x 0.8 x 0.2, partial maceration 50%, surrounding skin purplish, scant drainage, white tissue covering 50%, changed order to add [medication that breaks up tissue] ..."
-" not available yet, order in bridge [computer] disappeared, re-entered today ...."
- "left heel, cleanse with NS [normal], apply dry gauze until available ..."
There was no documentation in the resident's record as to why there was a delay in obtaining the needed medication to treat the unstageable pressure injury to Resident #3's left heel.
-"left heel, 0.8 x .5 x 0.3 90% [tissue], now with tan drainage ..."
-" care left heel, still unstageable due to necrosis covering 100% of ..."

Review of the record showed on , Resident #3 remained with an unstageable pressure injury to her left heel.

5. On at 11:10 a.m., Resident #3 was observed sitting in the common area with other residents.

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She said she had a small on her left heel but did not know where it was from. She lifted her left leg up, removed her tight fitting left shoe and removed a piece of paper from her left heel. She showed a beige callus in the middle of deep purple tissue on the back of her heel. She poked the callus and said it was . The purplish color of the heel did not change in color when she poked the tissue near the callus. Resident #3 said she placed the piece of paper on the back of the after she got out of her shower. The HWD walked up and asked her why her cut out shoes weren't on and where the dressing was to her left heel. Resident #3 said she didn't know. Resident #3 said when she presses her heel, it is . The HWD assisted Resident #3 back to her .

On at 2:09 p.m., the HWD admitted she did not assess the pressure injury when it was identified 2 days after Resident #3's re-admission to the facility and failed to notify the physician and obtain orders for treatment. She said she and the licensed staff are responsible for following up on orders and could not explain why there was a 10 day delay in getting the , for the left heel pressure injury. She acknowledged staff were unaware Resident #3 was without a foam dressing to her heel and failed to ensure she was wearing the shoes that were cut out at the back of the heel.

On at 2:35 p.m., the ED said he was unaware Resident #3 developed an unstageable pressure injury to her left heel 2 days after admission and was unaware the pressure injury was unresolved. The ED admitted he had not evaluated Resident #3 for continued residency or provided a discharge notice based on the non-healing .

6. A meeting was conducted with the consulting District Director of Clinical Services (DDCS) and HWD on at 11:00 a.m. The HHA comprehensive visit note reports on Residents #2 and #3 were reviewed by the DDCS or HWD until the time of the survey. Both DDCS and HWD confirmed they were unaware of the content of the notes. The HWD said the HHA leaves a summary of the visit, but not in detail. The HWD confirmed she does not document what's been discussed about the pressure injuries. The HWD said she thought the HHA was supposed to monitor and treat all of the pressure injuries. The DDCS was not aware the HWD failed to ensure she consistently monitored and documented a level of awareness of the status of the pressure injuries on Resident #2 and #3. The DDCS and HWD confirmed there was no evidence to show the ED, HWD or licensed staff demonstrated an awareness of how the pressure injuries of Residents' #1, #2, and #3 developed and/or whether they were healing or whether staff were adequately supervised to follow appropriate interventions to avoid pressure injury development and healing. The DDCS and HWD said the monitoring tools per facility protocol were not followed.

7. On at 2:00 p.m., the ED said he had no idea the wounds were not being closely monitored by the HWD and stated, "Obviously we had a breakdown in communication."

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0011 - Admissions - Discharge - 58A-5.0181(5) FAC

Based on policy review, observations, record review and staff interview, the facility failed to meet the needs for care for and failed to provide a discharge notice for 2 (Resident #2 and #3) of 3 sampled residents. Because of this failure, the residents remained in the facility and their pressure injuries worsened. Resident #2 required a higher level of care and was ultimately sent to the emergency evaluation and treatment for her wounds.

The findings included:

1. Review of the facility's policy titled, "Admission/Discharge Policy" revised included: "The community may admit, retain or discharge older adults per [facility] and state regulatory criteria...An Individual must meet the following minimum criteria in order to be admitted into the residence: j) Not have any or 4 pressure injuries. A resident requiring care of a pressure injury, may be admitted provided that: (1) The community has a LNS [Limited Nursing Services] license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; (2) The condition is documented in the resident's record; and (3) If the resident's condition fails to improve within 30 days, the resident should be discharged from the community in accordance with the Residency Agreement..."

2. Review of the residency agreement dated for Resident #2 included: "...We may terminate this Agreement, upon providing you or your legal representative forty-five (45) days written notice, for any of the following events, as determined by us: 1. You require care or services that we are unable to provide or which requires staff that are not available at the Community..."

Review of the Home Health Agency (HHA) visit coordination note dated completed by the HHRN (Home Health Registered Nurse) documented a red left heel on Resident #2's foot.

Review of the HHA assessment visit notes dated documented, "...left heel broken ....foam dressing applied by an LPN [licensed practical nurse] last night..." There were no notes in the record to reflect when the developed to Resident #2's left heel.

On , the HHRN documented, " on left heel now open, 2.5 x 4 x 0.1 cm [centimeter], drainage, red, skin re-approximated [closed together]..." The HHRN documented the as a Stage

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II pressure injury (skin is broken, leaving an open).

On , the HHRN documented the left heel digressed; however, there was no description of the by either the HHRN or the licensed facility staff.

On , HHRN notes showed Resident #2 and the left heel showed signs of . The was tender to touch and measured 11 x 4 cm with , drainage, odor, and redness. The left foot was edematous. The HHRN documented the resident sits in her chair all day, her were reddened, and an order for barrier cream (a , medication to place a physical barrier between the skin and contaminants) was noted.
The record failed to reflect the cream was ordered by the facility or applied to Resident #2's reddened .

Log Notes dated documented Resident #2 was sent out to the hospital for a left heel .

On , coordination notes by the HHRN showed the left heel measured 11 x 4 x 0.1 cm and with a foul odor, moderate , (yellowish fluid with small amounts of) drainage and a large amount of to the top of the left foot, painful to the resident. The HHRN referred Resident #2 to a care clinic and then documented there was no transport available. The notes did not reflect any intervention to assist the resident to a care clinic or notification of the resident's legal representative the was deteriorating.

The HHRN continued to treat the left heel . There were no notes by the facility they were aware of the deterioration of the . Documentation provided by the facility failed to show a new Skin Observation Form or Open Area Flow Sheet was completed. and whether the executive director (ED) and health and wellness director/designee (HWD) were aware of the digression, and determined why the forms were not completed.

On , HHRN documentation found Resident #2's , reddened and a dressing was to be changed when soiled twice weekly. The record failed to show the licensed staff followed this treatment.

On , in addition to the left heel and reddened , another in-house acquired pressure injury to the right was documented by the HHRN. The measured 0.3 x 0.3 x .1 and skin to the area was dry, flaking and peeling. There was no documentation the legal representative was notified of the development of another new pressure injury. There was no indication the ED or Health

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and Wellness Director (HWD) were aware of the development of a second in-house acquired pressure injury.

On , notes by the HHRN documented, "red area on is now open. 1 x 1 x 0.1 cm...cleanse with NS [normal] and gauze, apply skin prep, 2 x weekly until healed..." The HHRN documented a pressure injury to the . The record failed to reflect the facility licensed staff treated the and failed to reflect the resident's legal representative was notified of another in-house acquired pressure injury.

Review of the record failed to show Resident #2 was deemed ill. The record failed to show Resident #2 was evaluated by the Executive Director (ED) for continued appropriateness of residency related to the failure of the left heel pressure injury to heal or show signs of improvement within 30 days. A new pressure injury developed to the . There was no documentation Resident #2 or her legal representative were provided a discharge notice.

3. On at 11:50 a.m., observation in the presence of the HHRN and LPN Staff C found an open area to Resident #2's with yellow sticky tissue adhered to the base of the and the periphery of the was a deep reddish-purple. To the right of the was a second small open area with a deep red base. The HHRN said it was a new area.

The HHRN peeled away a foam dressing from the resident's left heel. An open area with grayish-white tissue was observed on the inner aspect of the left heel. Above this area on the inner left ankle was deep red abraded skin. The HHRN acknowledged the new abraded skin and covered the areas with the same dressing. The HHRN said the had worsened.

The record showed as of , a pressure injury to the left heel and the pressure injury deteriorated to a (a through the second layer of skin).

On at 2:30 p.m., the ED said he was unaware of the length of time Resident #2 had the pressure injuries or the severity of the wounds. The ED admitted he had not evaluated Resident #2 for continued residency or provided a discharge notice based on the non-healing pressure injuries.

4. Review of the residency agreement for Resident #3 dated included: "...We may terminate this Agreement, upon providing you or your legal representative forty-five (45) days written notice, for any of the following events, as determined by us: 1. You require care or services that we are unable to provide or which requires staff that are not available at the Community..."

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5. Log Notes dated revealed Resident #3 returned to the facility from the hospital after a . On , 2 days after admission, the HWD documented she notified Resident #3's daughter of the resident returned with a left heel "pressure ." The HWD notified a home health agency who would treat and follow for care. There was no other documentation related to whether the was assessed by the HWD, or whether the physician was notified and orders obtained to treat the .

Review of the HHA visit coordination notes dated documented by the HHRN found the left heel measured 2.5 x 3 (cm) with an unstageable depth and scant maceration.

Further review of the HHRN visit coordination notes included the following:

-"left heel 1.5 x 0.8 x 0.2, partial maceration 50%, surrounding skin purplish, scant drainage, white tissue covering 50%, changed order to add [medication that breaks up tissue] ..."

-" not available yet, order in bridge [computer] disappeared, re-entered today ...."

- "left heel, cleanse with NS [normal], apply dry gauze until available ..."

There was no documentation in the resident's record as to why there was a delay in obtaining the needed medication to treat the unstageable pressure injury to Resident #3's left heel.

-"left heel, 0.8 x 0.5 x 0.3 90% [tissue], now with tan drainage ..."

-" care left heel, still unstageable due to necrosis covering 100% of ..."

Review of the record showed on , Resident #3 remained with an unstageable pressure injury to her left heel.

6. On at 11:10 a.m., Resident #3 was observed sitting in the common area with other residents. She said she had a small on her left heel but did not know where it was from. She lifted her left leg up, removed her tight fitting left shoe and removed a piece of paper from her left heel. She showed a beige callus in the middle of deep purple tissue on the back of her heel. She poked the callus and said it was . The purplish color of the heel did not change in color when she poked the tissue near the callus. Resident #3 said she placed the piece of paper on the back of the after she got out of her shower. The HWD walked up and asked her why her cut out shoes weren't on and where the dressing was to her left heel. Resident #3 said she didn't know. Resident #3 said when she presses her heel, it

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is . The HWD assisted Resident #3 back to her .

7. On at 2:09 p.m., the HWD admitted she did not assess the pressure injury when it was identified ( ) 2 days after Resident #3's re-admission to the facility and failed to notify the physician and obtain orders for treatment. She said she and the licensed staff are responsible for following up on orders and could not explain why there was a 10 day delay in getting the , for the left heel pressure injury.

On at 2:35 p.m., the ED said he was unaware Resident #3 developed an unstageable pressure injury to her left heel 2 days after admission and was unaware the pressure injury was still unresolved (more than 2 months later). The ED admitted he had not evaluated Resident #3 for continued residency or provided a discharge notice based on the non-healing .

8. A meeting was conducted with the consulting district director of clinical services (DDCS) and HWD on at 11:00 a.m. The HHA comprehensive visit note reports on Residents #2 and #3 were not reviewed by the DDCS or HWD until the time of the survey. Both DDCS and HWD confirmed they were unaware of the content of the notes. The HWD said the HHA leaves a summary of the visit, but not in detail. The HWD confirmed she does not document what's been discussed about the pressure injuries. The HWD said she thought the HHA was supposed to monitor and treat all of the pressure injuries. The DDCS was not aware the HWD failed to ensure she consistently monitored and documented a level of awareness of the status of the pressure injuries on Resident #2 and #3. The DDCS and HWD confirmed there was no evidence to show the ED, HWD or licensed staff demonstrated an awareness of how the pressure injuries of Resident #2 and #3 developed and/or whether they were healing or whether staff were adequately supervised to follow appropriate interventions to avoid pressure injury development and healing. The DDCS and HWD said the monitoring tools per facility protocol were not followed.

On at 2:00 p.m., the ED said he had no idea the wounds were not being closely monitored by the HWD and stated, "Obviously we had a breakdown in communication."

Class II

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on policy review, observations, record review and staff interview, the facility failed to provide adequate supervision and a general awareness of the health condition of 3 (Resident #1, #2, and #3) of 3 sampled residents. The failure resulted in the residents acquiring in-house pressure injuries, a

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worsening of their wounds, and the transfer of Resident #1 and #2 to the emergency a higher level of care to treat the wounds.

The findings included:

1. Review of the facility's policy titled, "Open Area Documentation" (revised) included: "...Residents with open areas should have regular documentation of the status of those areas by the community nurse regardless of third party involvement...1. Within 24 hours of move-in of the first noted appearance of the open area, an Open Area Flow Sheet form should be completed by a nurse in the [facility's] Skin Management System...2. If any individual resident has more than one open area, a separate Open Area Flow Sheet-should be started for each open area...3. The Open Area Flow Sheet should be completed at a minim of weekly by the nurse until the open area has resolved/healed...4. The Open Area Flow Sheet should be reviewed for completion and awareness by the Executive Director, Health and Wellness Director (HWD)/designee on a weekly basis...5. The resident's physician/healthcare provider and legally responsible party should be informed of any decline or lack of improvement in the open area(s)...6. A copy of the Open Area Flow Sheet should be filed in the Resident Record..." An incident report should be completed for a , 4, or unstageable pressure injury.

Review of the facility's policy titled, "Skin Integrity Documentation Policy" (revised) included: "...Residents should have documentation of their Integumentary (skin) system upon move in/admission and periodically... b. Notify the physician/healthcare provider (HCP) and family of the skin concern as soon as possible... c. Notify the District Director of Clinical Services if a delay in treatment or orders occurs... Pressure injuries will be staged by a third party provider, registered nurse or physician/HCP... A new Skin Observation Form should be completed at a minimum...upon a change of condition, and upon return from a hospitalization/emergency department/rehab visit. Skin observation may be completed more frequently, after a change of condition..."

2. Review of the home health agency (HHA) visit coordination note dated completed by the home health registered nurse (HHRN) documented a red left heel to Resident #2's foot.

Review of the HHA assessment visit notes dated documented, "...left heel broken ....foam dressing applied by an LPN [licensed practical nurse] last night..." There were no notes in the record to reflect when the developed to Resident #2's left heel. The record failed to show the was evaluated, the physician was notified, and there were no orders to apply a foam dressing to the open .

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On , the HHRN documented, " on left heel now open, 2.5 x 4 x 0.1 cm [centimeters], drainage, red, skin re-approximated [closed together]..." The HHRN documented the as a pressure injury (skin is broken, leaving an open).

On , the HHRN documented the left heel digressed; however, there was no description of the by either the HHRN or the licensed facility staff.

On , HHRN notes showed Resident #2 and the left heel showed signs of . The was tender to touch and measured 11 cm x 4 cm with , drainage, odor, and redness. The left foot was edematous. The HHRN documented her were reddened and noted an order for barrier cream (a , medication to place a physical barrier between the skin and contaminants).

The record failed to reflect the cream was ordered by the facility and applied to Resident #2's reddened .

The Log Notes dated documented Resident #2 was sent out to the hospital for a left heel .

On , coordination notes by the HHRN showed the left heel measured 11 x 4 x 0.1 cm with a foul odor, moderate , (yellowish fluid with small amounts of) drainage and a large amount of to the top of the left foot, painful to the resident. The HHRN referred Resident #2 to a care clinic and then documented there was no transport available. The notes did not reflect any intervention to assist the resident to a care clinic or notes to reflect the resident's legal representative was notified the was deteriorating.

The HHRN continued to treat the left heel . There were no notes by the facility they were aware of the deterioration of the . Documentation provided by the facility failed to show a new Skin Observation Form or Open Area Flow Sheet was completed and whether the Executive Director (ED) and Health and Wellness Director/designee HWD were aware of the digression.

On , HHRN documentation found Resident #2's reddened and a dressing was to be changed when soiled twice weekly. The record failed to show the licensed staff followed this treatment to the .

On , in addition to the left heel and reddened , another in-house acquired pressure injury to the right was documented by the HHRN. The measured 0.3 x 0.3 x .1 cm and

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skin to the area was dry, flaking and peeling. There was no documentation the legal representative was notified of the development of another new pressure injury. There was no indication the ED or Health and Wellness Director (HWD) were aware of the development of a second in-house acquired pressure injury.

On , notes by the HHRN documented, "red area on is now open. 1 x 1 x 0.1 cm...cleanse with NS [normal] and gauze, apply skin prep, 2 x weekly until healed..." The HHRN documented a pressure injury to the . The record failed to reflect the facility licensed staff treated the and failed to reflect the resident's legal representative was notified of another in-house acquired pressure injury.

-"Right 1 x 1 x 0.1 no drainage no pain, ... 3 x 2 x 0.2 small amount (25%) white tissue no drainage no pain surrounding skin is red, left heel 4.0 x 2.3 x 0.1. [The deteriorated from]..." In spite of the tissue present on the , the HHRN documented the pressure injury as a .

-"Left heel, healing 25% white nonviable [ ] tissue 50% (illegible) ... 50% nonviable yellow tissue attempted debridement...applied ....right dry change..."

-" care to left calf, left heel, right and ...all stable except...heel NEEDS pressure relief. There was no on ...educated ...on offloading heel while on chair ...she [staff member] was not familiar with patient, put sign on wall for patient instruction ..."

-" care...NEW left heel [ ] to existing 0.2 x 0.2 x 0.2 cm...0.1 cm undermining around. left heel 0.8 x 2 x 0.2, red periwound, same tx as above... undermining at 12-3 (3-4 cm), right no change, 1.5 x 0.5 x 0.1 25% yellow tissue, surrounding tissue red, blanch..."

The notes by the HHRN reflect the left heel was not improving, a second above this pressure injury developed, and there was no documentation by the facility if they were aware of the severity and types of wounds that developed or what interventions were put into place, if any, to keep wounds from developing or worsening.

On , HHRN notes documented the right pressure injury healed, however, the left heel and remained.

On , the HHRN coordination note documented, "... care left heel 0.5 x 1 x 0.1, healing scant

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ss [ ] drain [drainage] .... 1 x 0.5 x 1 cm now has undermining 1 cm from 12:00 to 9:00 ....new wc [care] order in effect ..."

3. On at 9:22 a.m., Resident #2 was observed in a recliner with both legs resting on top of the extended leg rest. A sign on the wall above the resident's recliner read: "Attention 's [Resident Assistants]...Left heel MUST be suspended using pillows under leg ... should be on at all times." Resident #2's spouse was present who said his wife was just showered and "tucked in." There were no pillows under her left leg and to the left foot was not in place.

On at 9:27 a.m., Resident Assistant ( ) Staff B said she is a med tech and admitted she was caring for Resident #2. She did not answer why there weren't any pillows under Resident #2's legs or a in place.

On at 9:38 a.m., Resident #2 was observed in her recliner with her legs extended and without pillows under her left foot or a in place.

On at 10:28 a.m., Resident #2 was observed in the same position as noted at 9:38 a.m. Her eyes were closed and her spouse was nearby reading directions off of a box of batteries.

On at 10:36 a.m., Resident #2 was observed in her recliner with her legs extended and without pillows under her left leg or on left foot.

On at 11:00 a.m., Resident #2 was observed in a recliner with both legs resting on top of the extended leg rest. A large foam dressing was observed on the left heel. There were no pillows under the left leg. A left was not in place.

On at 11:20 a.m. Staff B exited Resident #2's . Staff B re-confirmed she was assigned to take care of Resident #2. Resident #2 was observed without her left heel suspended on pillows and without a on. Staff B failed to ensure either were in place before exiting the resident's .

On at 11:45 a.m., observation in the presence of Licensed Practical Nurse (LPN) Staff C found Resident #2 in the same position observed earlier. LPN Staff C stood next to the resident who was sitting in her recliner. Resident #2's left heel was not suspended on pillows and a was not in place. Staff C failed to ensure either were in place before exiting the resident's . The sign was clearly visible on the wall above and behind the recliner.

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On at 11:50 a.m., observation in the presence of the Home Health Registered Nurse (HHRN) and LPN Staff C found Resident #2's left heel without a on and her heel was not suspended with pillows. The HHRN and Staff C assisted Resident #2 to a standing position. Staff C pulled Resident #2's brief down and a large foam dressing stained with tan drainage rested on top of the resident's . A strong smell of was noted. HHRN removed the foam dressing and exposed an open area to the left of the . The was very prominent. Yellow sticky tissue was adhered to the base of the and the periphery of the was a deep reddish-purple. To the right of the was a second small open area, and the base was deep red. The HHRN said it was a new area. She wiped both areas with a small and covered the wounds.

Resident #2 became weak and was assisted back into her recliner. The HHRN peeled away a foam dressing from the resident's left heel. An open area with grayish-white tissue was observed on the inner aspect of the left heel. Above this area on the inner left ankle was deep red abraded skin. The HHRN acknowledged the new abraded skin and covered the areas with the same dressing. Both nurses elevated Resident #2's legs on top of a folded blanket resting on her wheelchair. Neither the HHRN or LPN Staff C assured pillows suspended Resident #2's left heel or placed a on her left foot as directed on the sign above the recliner. The HHRN and Staff C exited the . The HHRN said the had worsened.

On at 12:00 p.m., LPN Staff C at 12:00 p.m., directly after this observation revealed they do not treat pressure injuries, the HHRN from the facility's Home Health Agency (HHA) does.

On at 9:30 a.m., Resident #2 was observed resting in her recliner. Her legs were extended and resting on top of a pillow. There was no on her left foot.

On at 9:45 a.m., Resident #2 was sent to the hospital emergency evaluation and admission related to the wounds on her and left heel.

In an interview on at 2:30 p.m., the HWD, who is a Registered Nurse (RN), admitted she was unaware whether or what interventions were being followed by the facility 's or licensed staff to prevent wounds from developing and/or worsening and said she thought the Home Health Agency (HHA) was responsible for pressure injuries and care. She stated, "...it may be partly my fault because I don't know what's going on with the wounds ....I'm just learning ..." She said staff were to make sure the should be on the left heel at all times and left heel suspended using pillows.

4. Review of the health assessment (undated) for Resident #3 documented a medical history which

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included femur , and , . Resident #3 is impulsive and forgets her limitations. The Log Notes dated revealed Resident #3 off of a piano bench, yelling of hip pain and, was sent to the hospital. Log Notes dated revealed Resident #3 returned to the facility; and on , 2 days after admission, the HWD documented she notified Resident #3's daughter of the resident's return with a left heel "pressure ." The HWD notified the home health agency who would treat and follow for care. There was no other documentation related to whether the was assessed by the HWD, or whether the physician was notified and orders obtained to treat the .

Review of the HHA visit coordination notes dated documented by the HHRN found the left heel measured 2.5 x 3 (cm) with an unstageable depth and scant maceration.

Further review of the HHRN visit coordination notes included the following:
-"left heel 1.5 x 0.8 x 0.2, partial maceration 50%, surrounding skin purplish, scant drainage, white tissue covering 50%, changed order to add [, medication that breaks up tissue] ..."
-" not available yet, order in bridge [computer] disappeared, re-entered today ...."
- "left heel, cleanse with NS [normal], apply dry gauze until available ..."

There was no documentation in the resident's record as to why there was a delay in obtaining the needed medication to treat the unstageable pressure injury to Resident #3's left heel.

-"left heel, 0.8 x .5 x 0.3 90% [tissue], now with tan drainage ..."

-" care left heel, still unstageable due to necrosis covering 100% of ..."

-"left heel-obscured by necrosis ...still wears tight leather shoes but did not allow me to cut down the back of the left shoe with shears to relieve pressure..."

The HHRN documented she reported Resident #3 was still wearing her tight leather shoes to a facility RN. The record failed to reflect this was acted upon.

-"left heel unstageable 0.5 x 0.5...no change, still painful, dark, called [podiatrist]..."

-" ...still tender... when cleansed..."

5. On at 11:10 a.m., Resident #3 was observed sitting in the common area with other residents.

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She said she had a small on her left heel but did not know where it was from. She lifted her left leg up, removed her tight fitting left shoe and removed a piece of paper from her left heel. She showed a beige callus in the middle of deep purple tissue on the back of her heel. She poked the callous and said it was . The purplish color of the heel did not change in color when she poked the tissue near the callus. Resident #3 said she placed the piece of paper on the back of the after she got out of her shower. The HWD walked up and asked her why her cut out shoes weren't on and where the dressing was to her left heel. Resident #3 said she didn't know. Resident #3 said when she presses her heel, it is . The HWD assisted Resident #3 back to her .

On at 11:20 a.m., Resident #3 showed a small foam dressing to her left heel and a changed pair of shoes with the left heel cut out from the back. Resident #3 said she often forgets to change out her shoes for the cut out ones.

On at 2:09 p.m., the HWD admitted she did not assess the pressure injury when it was identified 2 days after Resident #3's re-admission to the facility and failed to notify the physician and obtain orders for treatment. She said she and the licensed staff are responsible for following up on orders and could not explain why there was a 10 day delay in getting the for the left heel pressure injury. She acknowledged staff were unaware Resident #3 was without a foam dressing to her heel and failed to ensure she was wearing the shoes that were cut out at the back of the heel.

6. Record review on found notes dated Resident #1 was declining in her ability to perform daily activities. There was no documentation in the record Resident #1's daughter was notified.

On (Sunday) at 12:30 p.m., the HWD documented Resident #1's skin was breaking down on the and there was a red pressure area. There were no other notes regarding the .

On at 12:45 p.m., the HWD documented she notified the HHA to see the Resident on "Monday" (the following day) for assessment and treatment of the .

On at 1:30 p.m., the HWD noted she spoke to Resident #1's daughter about the reddened area to the with a small . Resident #1's daughter asked about a flotation device for her chair to help with pressure to Resident #3's bottom. The notes failed to show the HWD answered or followed through on the request by the daughter or attempted to seek alternative interventions to prevent the from worsening.

On at 6:00 p.m., the HWD documented she spoke to Resident #1's son and informed him about his mother's deteriorating condition, her skin was breaking down and the resident needed skilled care

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with an air mattress and frequent turning while in bed. There was no evidence staff provided interventions to prevent the from worsening.

There were no other notes in the record related to the identification of or treatment for the reddened area and on Resident #3's .

7. In an interview on at 1:41 p.m., the HWD said the techs were doing total care with Resident #1 on and they saw that she had a reddened area with a small . The HWD said she came and looked at the red pressure area to Resident #1's , which had a small . She admitted she did not notify the physician and obtain orders for treatment. The HWD acknowledged pressure injuries could worsen without intervention. The HWD said Resident #1's daughter used to bring in creams to allow the resident to apply to herself. The HWD said they did not get a flotation device as requested by the daughter. The HWD said she held the resident on her side while a tech applied the cream to the entire , and area, including the . The daughter came in the following day, took her mother to the doctor who directly admitted Resident #1 to the hospital.

The HWD said there were no physician's orders to apply cream to the pressure area and and admitted it was beyond the tech's scope of practice to treat the by applying an unknown cream to the affected areas.

Review of the physician's orders, medication observation record, as well as the , treatment record for provided by the facility failed to show any cream was ordered or applied.

Review of the care notes from the hospital dated documented Resident #1 admitted with a dark purple and maroon suspected deep tissue injury to the , measuring 5.2 x 6.5 cm.

8. On at 12:00 p.m., LPN Staff C knew about the pressure injuries of Residents' #2 and #3. She said they (licensed staff) do not treat pressure injuries, the HHRN from the facility's Home Health Agency (HHA) does.

9. A meeting was conducted with the consulting District Director of Clinical Services (DDCS) and HWD on at 11:00 a.m. The HHA comprehensive visit note reports on Residents #2 and #3 were not available or reviewed by the DDCS or HWD until the time of the survey. Both DDCS and HWD confirmed they were unaware of the content of the notes. The HWD said the HHA leaves a summary of the visit, but not in detail. The HWD confirmed she does not document what's been discussed about the pressure injuries. The HWD said she thought the HHA was supposed to monitor and treat all of the pressure injuries. The DDCS was not aware the HWD failed to ensure she consistently monitored and

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documented a level of awareness of the status of the pressure injuries on Resident #2 and #3. The DDCS and HWD confirmed there was no evidence to show the ED, HWD or licensed staff demonstrated an awareness of how the pressure injuries of Residents #1, #2, and #3 developed and/or whether they were healing or whether staff were adequately supervised to follow appropriate interventions to avoid pressure injury development and healing. The DDCS and HWD said the monitoring tools were not followed per facility protocol.

On at 2:00 p.m., the ED said he had no idea the wounds were not being closely monitored by the HWD and stated, "Obviously we had a breakdown in communication."

Class II

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on policy review, observations, record review, and staff interview, the facility failed to coordinate services with third party nursing services for 2 (Resident #2 and #3) of 3 sampled residents for nursing services related to pressure injuries. Because of this failure, the residents continued to remain in the facility and their pressure injuries worsened. Resident #2 required a higher level of care and went to the emergency evaluation and treatment of their wounds.

The findings included:

1. Review of the this assisted living facility license documented a standard license in effect with Limited Nursing Services (LNS).

2. Review of the facility's policy titled, "Admission/Discharge Policy" revised included: "The community may admit, retain or discharge older adults per [facility] and state regulatory criteria...An Individual must meet the following minimum criteria in order to be admitted into the residence: j) Not have any or 4 pressure injuries. A resident requiring care of a pressure injury, may be admitted provided that: (1) The community has a LNS [limited nursing services] license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care; (2) The condition is documented in the resident's record; and (3) If the resident's condition fails to improve within 30 days, the resident should be discharged from the community in accordance with the Residency Agreement..."

2. Review of the home health agency (HHA) visit coordination note for Resident #2 reveled one dated completed by the Home Health Registered Nurse (HHRN). The note documented a red left heel

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to Resident #2's foot.

The HHA assessment visit notes dated documented, "...left heel broken ....foam dressing applied by an LPN [licensed practical nurse] last night..." There were no notes in the record to reflect when the developed to Resident #2's left heel. The record failed to show the was evaluated, the physician was notified, and there were no orders to apply a foam dressing to the open .

On , the HHRN documented, " on left heel now open, 2.5 x 4 x 0.1 cm [centimeter], drainage, red, skin re-approximated [closed together]..." The HHRN documented the as a pressure injury.

The record failed to show Resident #2 physician orders to receive nursing services.

On , the HHRN documented the left heel digressed; however, there was no description of the by either the HHRN or the licensed facility staff.

On , HHRN notes showed Resident #2 and the left heel showed signs of . The was tender to touch and measured 11 cm x 4 cm and with , drainage, odor, and redness. The left foot was edematous. The HHRN documented the resident sits in her chair all day, her were reddened, and an order for barrier cream (a , medication to place a physical barrier between the skin and contaminants).

The record failed to reflect the cream was ordered by the facility and applied to Resident #2's reddened .

Log Notes dated documented Resident #2 was sent out to the hospital for a left heel .

On , coordination notes by the HHRN showed the left heel measured 11 x 4 x 0.1 cm and with a foul odor, moderate , (yellowish fluid with small amounts of) drainage and a large amount of to the top of the left foot, painful to the resident. The HHRN referred Resident #2 to a care clinic and then documented there was no transport available. The notes did not reflect any intervention to assist the resident to a care clinic or notes to reflect the resident's legal representative was notified the was deteriorating.

The HHRN continued to treat the left heel . There were no notes by the facility indicating they

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were aware of the deterioration of the . Documentation provided by the facility failed to show a new Skin Observation Form or Open Area Flow Sheet was completed and whether the executive director (ED) and health and wellness director/designee were aware of the digression.

On , HHRN documentation found Resident #2's reddened and a dressing (a specialized dressing that seals the and promotes healing) was to be changed when soiled twice weekly. The record failed to show the licensed staff followed this treatment to the .

On , in addition to the left heel and reddened , another in-house acquired pressure injury to the right was documented by the HHRN. The measured 0.3 x 0.3 x .1 and skin to the area was dry, flaking and peeling. There was no documentation the legal representative was notified of the development of another new pressure injury. There was no indication the ED or Health and Wellness Director (HWD) were aware of the development of a second in-house acquired pressure injury.

On , notes by the HHRN documented, "red area on is now open. 1 x 1 x 0.1 cm... cleanse with NS [normal] and gauze, apply skin prep, 2 x weekly until healed..." The HHRN documented a pressure injury (skin is broken, leaving an open) to the . The record failed to reflect the facility licensed staff treated the and failed to reflect the resident's legal representative was notified of another in-house acquired pressure injury. Review of the record failed to show Resident #2 was evaluated by the HWD.

On at 11:50 a.m., observation in the presence of the HHRN and LPN Staff C found an open area to Resident #2's with yellow sticky tissue adhered to the base of the and the periphery of the was a deep reddish-purple. To the right of the was a second small open area with a deep red base. The HHRN said it was a new area.
The HHRN peeled away a foam dressing from the resident's left heel. An open area with grayish-white tissue was observed on the inner aspect of the left heel. Above this area on the inner left ankle was deep red abraded skin. The HHRN acknowledged the new abraded skin and covered the areas with the same dressing. The HHRN said the had worsened.

The record showed as of , a pressure injury to the left heel and the pressure injury deteriorated to a (a through the second layer of skin).

In an interview on at 2:30 p.m., the health and the HWD, who is a registered nurse (RN), stated, "...it may be partly my fault because I don't know what's going on with the wounds ....I'm just learning ..."

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On at 2:30 p.m., the ED said he was unaware of the length of time Resident #2 had the pressure injuries or the severity of the wounds.

3. Review of the resident Log Notes dated revealed Resident #3 off of a piano bench, yelling of hip pain and was sent to the hospital. Log Notes dated revealed Resident #3 returned to the facility. On , 2 days after admission, the HWD documented she notified Resident #3's daughter of the resident's return with a left heel "pressure ." The HWD notified the home health agency who would treat and follow for care. There was no other documentation related to whether the was assessed by the HWD, or whether the physician was notified and orders obtained to treat the .

Review of the HHA visit coordination notes dated documented by the HHRN found the left heel measured 2.5 x 3 cm with an unstageable depth and scant maceration.

Further review of the HHRN visit coordination notes included the following:
-"left heel 1.5 x 0.8 x 0.2, partial maceration 50%, surrounding skin purplish, scant drainage, white tissue covering 50%, changed order to add [medication that breaks up tissue] ..."
-" not available yet, order in bridge [computer] disappeared, re-entered today ...."
- "left heel, cleanse with NS [normal], apply dry gauze until available ..."
There was no documentation in the resident's record as to why there was a delay in obtaining the needed medication to treat the unstageable pressure injury to Resident #3's left heel.
-"left heel, 0.8 x .5 x 0.3 90% [tissue], now with tan drainage ..."
-" care left heel, still unstageable due to necrosis covering 100% of ..."
Review of the record showed on , Resident #3 remained with an unstageable pressure injury to her left heel.

4. On at 11:10 a.m., Resident #3 was observed sitting in the common area with other residents. She said she had a small on her left heel but did not know where it was from. She lifted her left leg up, removed her tight fitting left shoe and removed a piece of paper from her left heel. She showed a beige callous in the middle of deep purple tissue on the back of her heel. She poked the callus and said it was . The purplish color of the heel did not change in color when she poked the tissue near the callus. Resident #3 said she placed the piece of paper on the back of the after she got out of her shower. The HWD walked up and asked her why her cut out shoes weren't on and where the dressing was to her left heel. Resident #3 said she didn't know. Resident #3 said when she presses her heel, it is . The HWD assisted Resident #3 back to her .

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On at 2:09 p.m., the HWD admitted she did not assess the pressure injury when it was identified 2 days after Resident #3's re-admission to the facility and failed to notify the physician and obtain orders for treatment. She said she and the licensed staff are responsible for following up on orders and could not explain why there was a 10 day delay in getting the for the left heel pressure injury. She acknowledged staff were unaware Resident #3 was without a foam dressing to her heel and failed to ensure she was wearing the shoes that were cut out at the back of the heel.

On at 2:35 p.m., the ED said he was unaware Resident #3 developed an unstageable pressure injury to her left heel 2 days after admission and was unaware the pressure injury was unresolved.

5. On at 12:00 p.m. LPN Staff C was aware of the pressure injuries of Resident #2 and #3. She said they (facility licensed staff) do not treat pressure injuries, the HHRN from the facility's Home Health Agency (HHA) does.

A meeting was conducted with the consulting District Director of Clinical Services (DDCS) and HWD on at 11:00 a.m. The HHA comprehensive visit note reports on Residents #2 and #3 were not available at the start of the survey. The HHA comprehensive visit note reports on Residents #2 and #3 had not been reviewed by the DDCS or HWD until the time of the survey. Both DDCS and HWD confirmed they were unaware of the content of the notes. The HWD said the HHA leaves a summary of the visit, but not in detail. The HWD confirmed she does not document what's been discussed about the pressure injuries. The HWD said she thought the HHA was supposed to monitor and treat all of the pressure injuries. The DDCS was not aware the HWD failed to ensure she consistently monitored and documented a level of awareness of the status of the pressure injuries on Resident #2 and #3. The DDCS and HWD confirmed there was no evidence to show the ED, HWD or licensed staff demonstrated an awareness of how the pressure injuries of Residents' #1, #2 and #3 developed and/or whether they were healing or whether staff were adequately supervised to follow appropriate interventions to avoid pressure injury development and healing. The DDCS and HWD said the monitoring tools per facility protocol were not followed and the residents were not placed on LNS.

5. On at 2:00 p.m., the ED said he had no idea the wounds were not being closely monitored by the HWD and stated, "Obviously we had a breakdown in communication."

Class II