STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385181	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Cascade Retirement Community	175 NE 16th Street Madras, OR 97741

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on interview and record review it was determined the facility failed to notify a physician and obtain orders for a worsening pressure ulcer for 1 of 3 sampled residents (#6) reviewed for pressure ulcers. This placed resident at risk for worsening wounds. Findings include: Resident 6 was admitted to the facility in 12/2023 with diagnoses including dementia and peripheral vascular disease. A 12/30/23 Admission Skin Observation Tool assessment revealed Resident 6 had a right heel Stage 1 (intact skin with non-blanchable redness) pressure ulcer which measured 0.1 cm x 0.1 cm. The resident's skin was warm, dry, and intact. Both heels were dry and scaly. A care plan initiated 1/2/24 revealed Resident 6 required one-person extensive assistance with repositioning in bed every two hours. The care plan had no information regarding Resident 6's risk of pressure ulcers or any interventions to address pressure ulcer risk. The Admission MDS dated [DATE], with a review date of 1/6/24, revealed Resident 6 had severe cognitive impairment and was at risk for pressure ulcers. A 1/11/24 physician order directed staff to cleanse the right heel with wound cleanser, paint with betadine, and cover with a silicone dressing every night shift for wound care. A review of the TARs from 1/11/24 through 2/5/24 revealed staff provided wound treatments as ordered. A 2/1/24 Weekly Wound Observation revealed Resident 6 admitted with a Stage 1 pressure ulcer to the right heel. The wound measured 2.0 cm x 3.0 cm x 0.1 cm. The wound had maceration (breaking down of the skin) on the immediate perimeter, and was red and boggy but blanchable outside the maceration. The wound worsened since admission with offloading using a pillow to float the heel. Staff were to place a wedge to elevate the heels and special boots were en route. A report was sent to the physician, Staff 4 (Medical Director), and the family was notified. A 2/6/24 physician order directed staff to cleanse the right heel with wound cleanser, fill the open area with Medi honey (aids and supports debridement), cover with Hydrofera (topical adhesive) blue, apply u-shaped foam around the perimeter, and cover with a 5 x 5 foam dressing. Staff were to wrap with Kerlex (dressing) and Coban (wrap) for light compression. Staff were to change the dressing when three-quarters of the dressing showed drainage and as needed for soiling. A review of the TAR from 2/6/24 through 2/19/24 revealed staff provided wound treatments as ordered. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 2/7/24 Weekly Wound Observation revealed Resident 6's right heel worsened to a Stage 3 (full thickness tissue loss) pressure ulcer. The wound measured 3.5 cm x 4.5 cm x 0.1 cm and indicated, Suspected cellulitis [bacterial] infection with increased heat, redness, shiny appearance and painful to touch. Closed DTI [deep tissue injury] open with fluid filled pockets that drained down to heel. Those had been debrided [removal of dead tissue] and painted with iodine. Staff were to place a wedge to elevate the heels, utilize special boots and open heel foam to prevent pressure. Staff faxed a report of the heel to Staff 4 and notified family. A 2/8/24 Physician Visit note, by Staff 4, revealed Resident 6 had a Stage 2 (partial thickness loss of dermis) pressure ulcer over the entire heel, with edema, bruising, and erythema (reddening of the skin) up to the mid-shin. A referral to the wound clinic was initiated. There were concerns of cellulitis to the bilateral lower extremities and antibiotics were initiated for 10 days to treat the cellulitis. A facility 2/14/24 Weekly Wound Observation revealed Resident 6's right heel worsened to an Unstageable (full thickness tissue loss) pressure ulcer, with 100% necrotic (dead) tissue, without drainage or odor. The wound measured 4.5 cm x 5.0 cm. Inflammation was present and treated with antibiotics for cellulitis. There was maceration around the wound with boggy, blanchable skin outside of the macerated area. The wound was debrided with wound cleanser and gauze to remove non-viable skin, from the foot and leg. A report of the heel was sent to Staff 4 and family was notified. Progress Notes revealed the following information regarding the right heel pressure ulcer: -2/11/24 The right heel had a large blister which extended from the pressure ulcer to the top of the foot. When changing the dressing, one section of the blister was open with drainage proximal to the open area on the medial foot. The dressing was fitted to cover the whole area with Medi honey. The heels were floated in bed to alleviate pressure off the heels. -2/16/24 The large blister that extended from the pressure ulcer to the top of the foot was all open with mostly dry drainage on the dressing. The open areas were mostly dark red and drying. -2/17/24 The large blister on top of the foot had yellow drainage on the dressing. It was turning dark and drying except for a new moist edge that was red. -2/18/24 The large blister on the top of the foot had yellow drainage on the dressing. It was turning dark like necrotic (dead) tissue, except for a moist edge which was red at the top of the foot. A review of Resident 6's medical record from 2/9/24 through 2/18/24 (ten days) revealed no indication that staff communicated or notified Staff 4 of Resident 6's worsening wound. On 2/19/24 (11 days after the resident's wound was last seen by a physician), Resident 6 was sent to the hospital regarding the worsening wound. On 2/22/24 Resident 6 returned from the hospital on hospice services with diagnoses including atherosclerosis (build-up or blockage), venous (improper functioning of the vein valves in the leg) of the lower extremity, and dry gangrene (when the blood supply to the tissue is cut off). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/8/24 at 11:30 AM Witness 17 (Complainant) and at 11:35 AM Witness 18 (Complainant) stated Resident 6's right heel wound was not addressed timely, and the resident was sent to the hospital due to her/his worsening wound. Interviews on 7/9/24 revealed the following: -9:51 AM Staff 5 (Former LPN) stated Resident 6 had a pressure ulcer to her/his right heel and she recalled a huge blister on the top of her/his foot. The wound on the right heel and leg progressed quickly, and the resident was sent to the hospital for further evaluation. Staff 5 stated the resident was not painful and she recalled offloading the resident's heels with pillows but did not recall utilizing the wedge or boot protectors. -6:47 PM Staff 6 (Former LPN) stated Resident 6's heels were boggy and got dark quickly. Staff 6 stated she attempted to float the resident's heels as she/he allowed. She did not recall any other interventions for the resident's wound to the heel. -9:27 PM Staff 8 (RN) stated she did not provide wound treatment to Resident 6's right heel but recalled offloading the heels as the resident allowed. The resident had pillows but she did not recall any boot protectors or a wedge. On 7/10/24 at 4:00 PM and 7/11/24 at 9:45 AM Staff 2 (DNS) stated she completed weekly wound observations but was unaware of the new blister on the top of Resident 6's foot. Staff 2 stated she expected staff to notify the physician or her regarding Resident 6's worsening wound. Staff 2 acknowledged the care plan had no information or interventions regarding Resident 6's risk for pressure ulcers. Staff 2 stated Resident 6 was supposed to go to the wound clinic on 2/19/24 but went to the hospital due to the wound worsening. On 7/11/24 at 8:59 AM Staff 13 (Former LPN) stated she recalled Resident 6's right heel wound and the large blister that appeared on top of the resident's foot, which progressed quickly. Staff 13 stated she reported her concerns numerous times to the charge nurse but did not inform Staff 4 or Staff 2 regarding the worsening of the wound because she worked night shift. Staff 13 stated the resident did not report pain and allowed her to provide treatments to the area. On 7/11/24 at 9:00 AM Staff 4 stated she saw Resident 6 on 2/8/24 due to concerns with her/his wound to the right heel and possible cellulitis. Staff 4 stated the resident had edema since admission, her/his right ankle had bruising, erythema and was a Stage 2 pressure ulcer. Staff 4 stated the resident had good capillary refill with no acute ischemia and was started on an antibiotic. Staff 4 further stated she had no correspondence related to the resident's worsening wound to the right heel and staff should have informed her of the worsening wound.