STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395319	A. Building B. Wing	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manatawny Center for Rehabilitation and Nursing	30 Old Schuylkill Road Pottstown, PA 19465

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 - 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** 30934 Based on clinical record, facility policy and procedure, hospital record reviews and staff interview, it was determined the facility failed to monitor and assess a pressure ulcer present upon readmission causing actual harm to Resident 1 when the wound deteriorated and became infected causing septic shock for one of three residents reviewed. (Resident 1) Findings Include: Review of facility policy and procedure titled Prevention of Pressure Ulcer/Injuries, revised July 2017, revealed conduct a comprehensive skin assessment upon admission, including skin integrity- any evidence of existing or developing pressure ulcers or injuries. Skin assessments should be done weekly by a licensed nurse. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. Review of Resident 1's clinical progress notes revealed nursing entry dated August 17, 2023 at 7:15 p.m. stating Resident 1 was readmitted to the facility from the hospital and the left buttock noted to have an open area 1.2 x 1 x 4. Other wounds noted upon admission included the residents left foot, left ankle, right foot, and excoriation (skin becomes red and often painful and begins to come off) to the buttock and sacrum (bone at the base of the spine in the middle of the lower back). Further review of Resident 1's clinical record including readmission documentation failed to document condition, or stage for wound of the left buttock. Review of Resident 1's documentation from the hospital upon readmission to the facility on [DATE] revealed the resident had left ischial (lower and back region of the hip bone) deep tissue injury (DTI-an injury to the soft tissue under the skin due to pressure and is usually over bony prominence). Review of Resident 1's Nursing Admit/Readmit assessment, dated August 17, 2023, the skin integrity section had no documentation of wounds with a comments section stating left buttocks measuring 1.2 x 1 x 4. Additional review of Resident 1's assessments revealed Weekly Skin assessments completed on August 20, 2023, September 2, 2023, September 10, 2023 and September 14, 2023. (continued on next page)

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.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's skin assessments mentioned above revealed in the section for observation of skin wound or open ulcers (indicate even if being treated) were documented as no indicating the resident had no current wound. Review of Resident 1's progress notes revealed a Skin/Wound note dated August 29, 2023 at 1:29 p.m. revealed the other wounds noted upon readmission were addressed but failed to mention the left ischial wound documented on admission. Review of Resident 1's progress notes revealed a Skin/Wound note dated September 9, 2023 at 2:26 p.m. stating wound rounds with wound physician assessed sacrum MASD (Moisture Associated Skin Damage-superficial irritation and damage caused by long term exposure to moisture) continue current tx (treatment) and interventions. Further review of Skin/Wound note dated September 9, 2023 failed to mention the left ischial wound documented on admission. Review of Resident 1's progress notes revealed a Skin/Wound note dated September 12, 2023 at 1:16 p.m. revealed the wounds the resident was admitted with were addressed but failed to indicate the left ischial wound documented on admission. Review of Resident 1's progress notes revealed a nursing note dated September 13, 2023 at 11:21 p.m. stating L (left) ischium wound measuring 2.8x4x2, wound bed with slough (dead tissue with a yellow/white color that can be wet or dry) and necrosis (dead tissue) and moderate drainage. Wound cleansed with NSS (Normal Saline Solution- sterile salt water), gently packed with hydrogel gauze (used to keep the wound moist to promote healing), applied triad (paste applied directly to skin to provide protection to area) to peri (surrounding) wound and covered with border gauze (sterile gauze with adhesive surrounding to hold to the skin). Further review of Resident 1's clinical record revealed there was no documented evidence whether the wound had a deterioration documented in the same location on admission or identified a new wound. Review of the entire clinical record revealed there was no physician's order for the wound care provided as stated in the progress note of September 13, 2023 and no documented evidence the physician was notified of the wound status. Further review of Resident 1's progress notes revealed a Skin/Wound note dated September 14. 2023 stating wound rounds with wound physician .assessed left ischium/buttock area. Review of the wound physician consult report, dated September 14, 2023 revealed left buttock is an Unstageable pressure ulcer injury (bed sore that occurs due to prolonged pressure on a specific area where the depth of the wound or bed sore is completely obscured by eschar in the wound bed) .measurements are 2cm (centimeter) length x 3cm width x 2cm depth .there is moderate amount of sero-sanguineous (thin watery fluid pick or red in color due to presence of blood) drainage noted which has no odor) with 100% slough. Further review of Resident 1's progress notes revealed a nursing entry dated September 19, 2023 at 5:40 p. m. stating assessed the resident and noted temperature 102.3 resident diaphoretic (sweating). Resident B/P (Blood Pressure) has been running low, call placed to 911 to send to hospital. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's hospital documentation from his admission on September 19, 2023 revealed an Infection Disease consult on September 20, 2023 at 9:34 a.m. with an impression of septic shock/severe sepsis (widespread infection causing organ failure and dangerously low blood pressure) secondary to presumed infected left buttock and sacral decubitus ulcer (pressure ulcer) with probable osteomyelitis (infection of the bone). Stage 4 (extend below the subcutaneous fat into your deep tissues, including muscle, tendons, and ligaments) left buttock/sacral decubitus ulcer/presumed osteomyelitis I believe the patient has severe sepsis to primarily be from secondary to his necrotic stage 4 sacral and left gluteal wound which will need debridement (surgical removal of dead tissue) as soon as possible- hopefully once he is more hemodynamically stable (the blood pressure and heart rate are at safe levels). Interview with the Director of Nursing and the Nursing Home Administrator on October 3, 2023 at 1:00 p.m. confirmed the resident clinical record has no complete documentation of the wound upon readmission from the hospital on August 17, 2023 until seen by the wound consultant on September 14, 2023 which the ischial wound was documented as an unstable wound and a larger size then what was documented on readmission. The facility failed to thoroughly assess Resident 1's wound upon readmission from the hospital on August 17, 2023 so a clinical baseline was unable to be established to determine the need of changes to the status of the residents wound to determine proper care of the wound. The facility also failed to assess weekly, per policy, to determine the appropriateness of the current wound treatment and whether healing was being achieved or not. This caused harm to Resident 1 when they were admitted to the hospital with a diagnosis of septic shock and osteomyelitis secondary to a presumed infected stage four pressure ulcer present when admitted to the hospital needing surgical debridement when stable. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.10(d) Resident Care Policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services