| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495077 | A. Building<br>B. Wing | 09/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tate Springs Health & Rehab | 2200 Landover Place<br>Lynchburg, VA 24501 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875<br><br>Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards regarding wound documentation for one of four residents in the survey sample (Resident #2).<br><br>The findings include:<br><br>Facility staff failed to document assessments for Resident #2 that included measurements, appearance, description and/or status of a wound.<br><br>Resident #2 (R2) was admitted to the facility with diagnoses that included metabolic encephalopathy, diabetes, acute kidney failure, history of sepsis, ulcerative colitis, cognitive communication deficit, bipolar disorder and depression. The minimum data set (MDS) dated [DATE] assessed R2 as cognitively intact.<br><br>R2's clinical record documented a sacral wound on 11/29/24. A physician's progress note dated 11/29/24 documented, .Anorexia - continues to refuse to eat; frequently refuses meds [medications]. Developing sacral wound is due to worsening protein malnutrition due to poor dietary habits. Anticipate wound worsening and possibly additional wounds due to her meds and meals noncompliance .<br><br>A physician's order dated 11/29/24 documented treatment of the sacrum with normal saline, honey fiber and foam dressing each day for wound care. Clinical notes on 11/29/23 documented no descriptive assessment of the sacrum wound indicating the type of wound, stage if pressure injury, wound measurements or any description of the wound's appearance.<br><br>R2's treatment administration record (TAR) documented the treatments were administered as ordered. Nursing notes documented monitoring and treatment changes of the sacrum wound as follows:<br><br>12/2/23 - Physician's order to change wound treatment to zinc cream each day and evening shift for wound care.<br><br>12/11/23 - .Skin observation completed .<br><br>12/13/23 - .Skin observation completed .reddened area on sacral area - zinc was applied as ordered .<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12/20/23 - .skin observation completed .With wound on her coccyx area measuring 1.5 cm in length and 0.5 cm in width. Zinc cream was applied as ordered .<br><br>12/27/23 - .skin observation completed .resident With wound on her coccyx area. Zinc cream applied as ordered .<br><br>1/3/24 - .skin observation completed. Open area to coccyx .coccyx area measuring 1.5 cm in length and 0.5 cm in width. Zinc cream applied as ordered .<br><br>1/6/24 - Physician's order to change wound treatment to normal saline, honey fiber and foam dressing each day<br><br>A nursing note dated 1/10/24 documented R2's sacral wound had deteriorated rapidly and the resident was referred to the wound consultant for evaluation and treatment. The wound consultant diagnosed R2 with a Kennedy terminal ulcer and documented comprehensive assessments of the sacral ulcer weekly, until the resident's discharge on 1/24/24.<br><br>Prior to referral to the wound consultant, R2's wound/skin observations were documented as done but notes did not include thorough assessments of the wound. There was no documented assessment associated with physician ordered treatment changes on 12/2/23 (honey fiber/foam dressing to zinc cream), nor on 1/6/24 (zinc cream to honey fiber/foam dressing). R2's clinical notes dated 11/29/23 and 12/27/23 indicated an open area on the sacrum but documented no measurements of the open area. R2's assessments captured on 11/29/23, 12/11/23, 12/20/23, 12/27/23, and 1/3/24 documented no description of the wound or length/width measurements, only noting open area. These assessments documented no appearance of the wound bed or surrounding skin, presence or absence of drainage, or if odor or pain was associated with the wound.<br><br>On 9/3/24 at 2:20 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about assessment of R2's sacral wound. LPN #2 stated wound assessments were listed in the nursing notes or under the wound assessment tab in the clinical record. LPN #2 stated the wound consultant documented comprehensive wound assessments for wound tracked/treated by the consultant. LPN #2 stated nurses were expected to document the status of all wounds when assessed and with changes in treatment. LPN #2 stated assessments were supposed to provide a description of the wound.<br><br>On 9/4/24 at 9:00 a.m., the director of nursing (DON) was interviewed about R2's documented assessments prior to the wound consultant care on 1/10/24. The DON stated she reviewed the clinical record and did not find complete assessments documented prior to 1/10/24. The DON stated that the unit managers were responsible for wound assessments. The DON stated if there was an open skin area, nurses were expected to document the measurements, appearance of surrounding tissue/skin, a description of the wound and presence of drainage, odor or pain. The DON stated prior to referral to the wound consultant, the physician/medical director provided care orders. The DON stated R2's wound was assessed, the physician notified, and treatments were implemented/changed based upon assessments. The DON stated the assessments completed by nurses prior to 1/10/24, were not thoroughly documented and did not include all required information.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's policy titled Documentation of Wound Treatments (undated) documented, .The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment . The following elements are documented as part of a complete wound assessment .Type of wound (pressure injury, surgical, etc.) and anatomical location . Stage of wound, if pressure injury .or the degree of skin loss if non-pressure .Measurements: height, width, depth . Description of wound characteristics .Color .Type of tissue .Condition of the peri-wound .wound drainage . Presence or absence of odor .Presence or absence of pain .Wound treatments are documented at the time of each treatment .<br><br>These findings was reviewed with the administrator, DON, and nurse consultant during a meeting on 9/4/24 at 10:15 a.m. with no further information presented prior to the end of the survey. |