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S 000	Initial Comments Licensure Post Visit to survey date 12/9/20	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 d)5) 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. These requirements are not met as evidenced by: Fair Havens Senior Living failed to follow their plan of correction for the survey of 12/9/20. Based on observation, interview, and record review, the facility failed to implement a physician ordered recommendation of a pressure relieving mattress, implement physician ordered pressure ulcer treatments and recommendations, and notify a physician of a pressure ulcer for three of	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 three residents (R102, R120, R121) reviewed for pressure ulcers on the sample list of three (3). Findings include: The facility's Plan of Correction (POC) to Licensure Post Visit to Survey of 12/9/20 documents: The residents will be assessed for skin injuries at least weekly and physician treatment orders will be obtained as needed and the facility reviewed policies and procedures related to wound care, assessments, and treatments of wounds. The Director of Nursing will ensure compliance with the facility's policy/procedure by conducting daily audits for two weeks and then weekly for four months, and the audits will be reviewed during the facility's monthly Quality Assurance (QA) meetings. The facility alleges it will be in substantial compliance with this requirement on or before the completion date of March 1, 2021. The facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised August 2008, documents to assess resident's skin for skin conditions or Stage I pressure ulcers that have not yet ulcerated the surface, and document the skin condition assessment. The facility's undated Notification of Resident Change in Condition policy documents to notify the resident's physician of changes in the resident's health including a significant change in the resident's physical health and the need to alter treatment. The facility policy "Pressure Ulcer Treatment", dated revised 8/8/12, documents the following: "Purpose: The purpose of this procedure is to provide guidelines for the care of existing	S9999		

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pressure ulcers and the prevention of additional pressure ulcers. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. 2. Assemble the equipment and supplies as needed. General Guidelines: 1. The pressure ulcer treatment program should focus on the following strategies: a. Assessing the resident and the pressure ulcer(s). b. Managing tissue loads. c. Pressure ulcer care. The same policy documents the following: "PRESSURE ULCER AND WOUND PREVENTION/MANAGEMENT PROGRAM, Purpose: To identify residents who are at risk for pressure ulcers and skin breakdown. To prevent pressure ulcers and skin breakdown. To provide a guideline for the appropriate nursing management of skin breakdown when it occurs. Responsibility: Director of Nursing, Licensed Nurses, Certified Nursing Assistants, Restorative Nursing, Care Plan Coordinator, Dietician, Physician, and Medical Director. Policy: It is the policy of this facility to: Ensure that residents who enter the facility without pressure ulcers do not develop pressure ulcers unless the individual's clinical condition demonstrates that the pressure ulcers were unavoidable. Ensure a resident who has been admitted with pressure ulcers or develops pressure ulcers in-house receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, when possible. To prevent and manage wound care through a group of health care professionals."

1.) R120's Care Plan, dated 1/8/21, documents the following pressure ulcer intervention updated on 2/7/21: "(R120) has unstageable pressure injury to (R120's) coccyx. Created on: 02/07/2021. Created by: (V14), Bachelor Science / Registered Nurse/ (Previous) Wound Nurse.

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S9999	Continued From page 3 Nursing staff will complete treatments as ordered by Wound MD (V5, Physician). Patient (R120) sees Wound Physician (V5) for evaluation and treatment of wounds. Date Initiated: 02/07/202, Created on: 02/07/2021, Patient (120) will use alternating pressure mattress as tolerated. Date Initiated: 02/07/202, Created on: 02/07/2021,Created by: (V14) BSN, RN." R120's "SPECIALTY PHYSICIAN WOUND EVALUATION & MANAGEMENT SUMMARY", dated 2/8/2021, signed by V5, Wound Physician, documentation summary includes the following: "MUSCULOSKELETAL SYSTEM, Deconditioning, Support Surface, Bed, Group 1 (pressure reducing), Chair, Pressure Reduction, Feet socks." The same physician wound evaluation summary documents the following: "Focused Wound Exam (Site 1), UNSTAGEABLE (DUE TO NECROSIS) COCCYX Etiology (quality) Pressure, MDS 3.0 Stage Unstageable Necrosis, Duration > (greater than) eight days, Objective Healing, Manage Exudate.Wound Size: Length (L) 2.7 x (by) Width (W) 0.7 x Not Measurable cm (centimeters). Surface Area: 1.89 cm², Exudate: Moderate Sero - sanguinous. Slough: 60 % (percent), Granulation tissue: 40 %. This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. Wound progress: Improved, DRESSING TREATMENT PLAN, Primary Dressing (s), Alginate calcium (medicated pad) w (with)/silver apply, once daily for 23 days, Secondary Dressing(s), Foam with border apply once daily for 23 days. PLAN OF CARE REVIEWED AND ADDRESSED, Recommendations; Off-load (pressure re-distribution) wound; Reposition per facility protocol."	S9999		

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R120's "SBAR (Situation-Background-Assessment-Recommendation) Physician/NP (Nurse Practitioner/PA (Physician Assistant) Communication + (and) Progress Note", dated 3/12/21, documents the following: "Change in condition, pressure ulcers worsening.
Decline noted from 3/8/21 to 3/12/21."

R120's "SPECIALTY PHYSICIAN WOUND EVALUATION & MANAGEMENT SUMMARY" dated 3/15/2021, signed by V5, Wound Physician, documentation summary includes the following: "Focused Wound Exam (Site 1), STAGE 4 (four) PRESSURE WOUND COCCYX, Etiology (quality) Pressure, MDS 3.0 Stage 4, Duration > 45 days
Objective Healing, Manage Exudate, Wound Size (L x W x D): 6.6 x 3.7 x Not Measurable cm Surface Area: 24.42 cm^2, Exudate: Moderate Serous, Thick adherent devitalized necrotic, tissue: 100 %, This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm. Wound progress: Deteriorated."

On 4/8/21 at 11:10 AM, V3, Licensed Practical Nurse (LPN), and V4, LPN/Wound Nurse, entered R120's room. V4, LPN, prepared pressure ulcer treatment dressing supplies on R120's bedside table. R120 laid on a standard foam mattress in bed. V3 and V4 positioned R120 to a right side lying position. R120 had a peripherally inserted intravenous (PICC) medication line inserted in R120's right upper arm. V4, LPN/ Wound Nurse, stated, "(R120) is receiving intravenous antibiotics" for R120's coccyx wound infection. R120 had a large absorbent cotton wound treatment pad laid

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across R120's bilateral buttocks and coccyx. V4 removed the absorbent pad. R120 had a silver dollar sized diameter, red, raw one-inch deep wound cavity on R120's coccyx. R120's coccyx pressure ulcer wound had yellow drainage that saturated a medicated alginate pad inside R120's coccyx cavity.

On 4/8/21 at 4:10 PM, V4, Licensed Practical Nurse/Wound Nurse, stated "(R120's) coccyx pressure ulcer has gotten much worse over the last month. He (R120) really should have the alternating air mattress on his bed. I am not sure why he doesn't. (V5, Wound Physician) documents (R120) is to have a support surface for his (R120's) bed. It says (documents) group one (V4 points to R120's wound progress note above). Group one, is a low air flow alternating mattress specifically for reducing pressure. His (R120's) care plan lists the better mattress as an intervention specifically for his pressure ulcers."

On 4/9/21 at 1:00 pm V1, Administrator, provided and undated (Private Company) manufacturers warning pamphlet for R120's foam mattress. V1, Administrator, acknowledged R120's regular foam mattress was not meant for R120's Stage IV pressure ulcer.

The facility "(Private Company) FOAM MATTRESS, Owner's Manual" documents the following: "WARNING - This mattress is not intended for stage III or IV pressure ulcers. Mattress wound stage ratings are general usage guidelines. A User-specific assessment performed by a medical professional could alter your particular usage of this mattress."

2.) R102's Care Plan, revised on 12/7/20, documents R102 has unstageable pressure

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S9999	Continued From page 6 ulcers to left ankle with an intervention for nursing staff to complete treatments as ordered by the physician and as tolerated by R102. R102's Order Review History Report, dated 4/8/21, documents the following orders: Continue to use a pressure relieving cushion in R102's wheelchair with a start date of 7/20/20. Apply compression stocking every morning to right lower extremity and remove every night with a start date of 1/19/21. Apply compression wrap to left lower extremity every morning to left lower extremity from knees to toes and remove every night with a start date of 2/8/21. Zinc Oxide 20 % cream apply to left buttocks every 24 hours as needed with a start date of 5/1/20. Clotrimazole (Antifungal) cream 1 % topically daily to surrounding skin of left ankle wounds with a start date of 3/1/21. R102's Wound Clinic Progress Notes, by V17, Advance Practice Nurse, document: On 2/1/21 R102's Stage III pressure ulcers to the left, lateral, superior ankle measured 2.5 cm (centimeters) long by 3.1 cm wide by 0.3 cm deep and left distal ankle measured 0.7 cm by 1.2 cm by 0.2 cm. The Progress Notes from 2/1/21, 2/8/21, 2/15/21, 2/22/21, 3/1/21, 3/8/21, 3/15/21, 3/22/21 and 4/5/21 document to apply antifungal cream to the periwound of R102's left ankle wounds daily, apply compression stocking to right lower leg apply every morning and remove at night, apply compression wrap to left lower leg every morning and remove at night, and apply protective barrier cream to buttocks as needed. These notes also document "Wound improved with current treatment, he (R102) has increased swelling to right lower leg, patient reports compression stockings were only applied once by SNF (Skilled Nursing Facility) staff. This needs to	S9999		

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be utilized every morning and removed every night to improve swelling and reduce risk of wound occurrence." The notes beginning on 2/8/21 document to inflate R102's wheelchair cushion. On 2/22/21 R102 had a Stage II pressure ulcer to the left gluteal fold that measured 0.2 cm by 1 cm by 0.1 cm and Stage III pressure ulcer to the 4 cm by 4 cm by 0.1 cm. R102's left superior ankle wound measured 0.9 cm by 0.7 cm by 0.1 cm and the distal ankle wound measured 0.9 cm by 0.7 cm by 0.1 cm. On 4/5/21 R102's left gluteal fold wound measured 1 cm by 0.3 cm by 0.1 cm, left lateral, superior ankle wound measured 1.2 cm by 1.5 cm by 0.2 cm, and the left distal ankle wound measured 0.7 cm by 0.4 cm by 0.1 cm.

R102's February, March, and April 2021 Medication Administration Records (MARs) and Treatment Administration Records (TARs) do not document that Zinc Oxide was applied to R102's left buttock between 2/1/21 and 4/8/21, or that R102's compression wrap to the left leg and compression hose to the right leg were removed every night as ordered until 2/8/21. R102's TARs document: The antifungal cream treatment was not implemented as ordered until 3/1/21. There is no documentation in R102's medical record that the inflation of R102's wheelchair cushion was routinely monitored.

On 4/8/21 at 11:40 AM, V3, Licensed Practical Nurse (LPN), and V4, LPN/Wound Nurse, entered R102's room to administer R102's pressure ulcer treatments. V4 removed R102's left lower leg elastic wrap, exposing a gauze wrap and two wounds to the left lateral leg.

On 4/12/21 at 9:05 AM, V16, Wound Clinic Registered Nurse (RN), stated R102 came in to

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the office on 2/8/21 with R102's wheelchair cushion deflated. We (V16 and V17) continued to document in the wound clinic progress notes to check the inflation of R102's wheelchair cushion to remind the facility to regularly check the inflation. V16 stated V16 has had ongoing concerns that the facility has not been applying and removing R102's compression wrap and compression stockings, and R102 has arrived at the Wound Clinic not wearing the compression wrap and stocking.

On 4/12/21 at 9:14 AM, V17 stated: V17 has had concerns with the facility not implementing V17's orders as instructed for wound dressing changes and compression to R102's lower legs, especially to the right leg. R102's wounds were macerated at times due to the nurses covering the good skin with the wound dressing. If R102's wheelchair cushion was not properly inflated it would contibute to the development of pressure ulcers. The facility should have applied antifungal cream to the periwound of R102's left ankle wounds daily beginning on 2/1/21. V17 expects V17's recommendations and orders to be implemented no later than the day after R102 was seen in the clinic.

On 4/12/21 at 12:14 PM, V20, Physical Therapist, stated R102's pressure relieving wheelchair cushion has been "low" at times and required inflation. V20 stated if the resident is currently receiving therapy services then V20 regularly checks the wheelchair cushion inflation, otherwise it is the responsibility of the nursing staff.

On 4/12/21 at 1:44 PM, V4, Wound Nurse, stated: Therapy staff are responsible for checking the inflation of the wheelchair cushions and V4

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S9999	Continued From page 9 was unsure how often the checks should be performed. V4 confirmed the antifungal cream treatment order for R102's left ankle wounds was not initiated until 3/1/21, and not on 2/1/21 as ordered. On 4/12/21 at 2:01 PM, V2, Director of Nursing (DON), stated V2 would expect physician's orders to be implemented as written. The (pressure relieving wheelchair cushion) Operational Manual, with a revised date of 7/2/19, documents to inflate the cushion until all of the air cells feel firm. After overinflating the cushion adjust to the Proper Cushion Inflation Setting by sliding your hand between the individual, lift the leg slightly to feel for the bony prominence, lower the leg, release the inflation valve to release air until you are barely able to move your fingertips, and close the inflation valve. 3.) R121's Care Plan, revised on 4/6/21, documents R121 has a deep tissue injury to R121's right buttock. R121's shower sheet, dated 3/26/21, signed by V19, CNA, and V21, LPN, documents "redness nurses aware" and does not document the location of the redness. R121's shower sheet, dated 3/30/21, signed by V19, CNA, documents "red area applied cream" and the coccyx area is circled. R121's shower sheet, dated 4/2/21, signed by V18, CNA, documents "resident has red and open area to top of bottom crack, nurse aware resident had cream applied to his (R121's) bottom." This shower sheet is not signed by a nurse. R121's Skin/Wound Flow Sheet, dated 4/5/21, documents R121 had a stage I pressure ulcer to	S9999		

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the right buttock that measured 1 cm by 1 cm. R121's Situation Background Assessment Recommendation (SBAR) tool, dated 4/5/21, documents V22, Physician, was notified of R121's right buttock wound on 4/5/21 at 10:00 AM. There is no documentation V22 was notified on 3/26/21 or 3/30/21 of the reddened area to R121's right buttock, or on 4/2/21 when R121's right buttock was open.

R121's Wound Care Telemedicine Follow Up Evaluation, dated 4/10/21, documents R121's right buttock wound is moisture related and measured 1.8 cm long by 0.8 cm wide by 0.1 cm deep. This evaluation documents a treatment to apply Zinc Oxide three times daily to R121's right buttock. R121's Order Recap Report, dated 4/12/21, documents an order on 4/6/21 to apply Zinc Oxide 40 % cream to buttocks every shift. R121's April 2021 TAR documents Zinc Oxide cream was applied to R121's buttocks twice daily beginning on 4/5/21. There is no documentation in R121's medical record that a treatment was administered to R121's buttock wound prior to 4/5/21.

On 4/8/21 at 1:20 PM, V13, CNA, and V4, LPN/Wound Nurse, entered R121's room. R121 stated the wound clinic has healed the wounds on R121's buttocks, and cream is applied. V13 provided incontinence care, V4 cleansed R121s bilateral buttocks with wound cleanser and applied Zinc Oxide cream. R121's buttocks were red.

On 4/8/21 at 10:09 AM, V3, LPN, stated shower sheets are completed by the CNAs and turned in to the nurse. Skin issues such as wounds or red areas are documented on the shower sheet and signed by the nurse. The nurse is responsible for

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completing a full skin assessment if issues are identified, SBAR form, risk management form, notifying the physician and the wound nurse, and obtaining treatment orders.

On 4/12/21 at 12:05 PM, V19, CNA, stated on 3/26/21 and 3/30/21, R121's bottom was red and was not open. V19 stated the nurse was aware of the red area, and barrier cream was applied.

On 4/12/21 at 11:16 AM, V18, CNA, stated V18 gave R121 a shower on 4/2/21. When V18 washed R121's bottom R121 grimaced, and V18 noticed an area to the top of R121's (upper gluteal fold) was red/raised/irritated and had a small open area. V18 notified an unidentified nurse and applied Zinc Oxide cream. A few days later, V4, Wound Nurse, looked at the area and told V18 to reposition R121 at least every 2 hours, use pillows to offload, and to keep R121 clean and dry. Notified the nurse, unsure who the nurse was at the time. Nurse gave him zinc cream to apply. A few days later (wound nurse) looked at the area and told us we needed to be repositioning R121 every 2 hours, using pillows to offload, and keep R121 clean/dry.

On 4/12/21 at 2:42 PM, V21, LPN, stated V19, CNA, reported to V21 on 3/26/21 R121's bottom was red. V21 stated V21 assessed R121's bottom, it was red and not open. V21 applied barrier cream. V21 stated the nurses usually notify the resident's physician and wound nurse of reddened areas or Stage I pressure ulcers and this would be documented on a risk management form and nursing note. V21 was unable to recall if V21 reported R121's reddened area to V22.

On 4/12/21 at 1:44 PM, V4 stated: V4 is responsible for obtaining the wound physician

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

progress notes and implementing orders. R121's right buttock wound is pressure related and began on 4/5/21. V4 was not notified of R121's buttock wound until 4/5/21. The wound was purple in color and was not open when V4 stated V5, Wound Physician, had a televisit on 4/10/21, and V4 was not aware V5 had new orders for R121's buttock wound. V4 stated Zinc Oxide cream was initiated twice daily on 4/6/21, and confirmed V5's order for Zinc Oxide is ordered for three times daily on 4/10/21.

On 4/12/21 at 2:01 PM, V2, DON, stated V2 would expect physician's orders to be implemented as written. On 4/12/21 at 4:17 PM, V1, Administrator, and V2 stated the facility was unable to provide documentation R121's physician was notified of R121's buttock wound and a treatment was initiated prior to 4/5/21.

The facility's QA Tool documenting Wound Audits from 12/8/21 through 4/5/21 provided by V1, Administrator, document daily wound audits were completed on 12/8/21, 12/9/21, 3/8/21, 3/9/21, and 3/10/21. There is no documentation that the facility completed daily wound audits for two weeks per the facility's POC.

On 4/8/21 at 12:37 PM, V2, DON, stated V2 has been completing weekly wound audits by reviewing shower sheets and skin assessments. V2 confirmed V2 has not completed daily wound audits. On 4/8/21 at 2:42 PM, V4, Wound Nurse, stated V4 starting completing weekly wound audits approximately two weeks ago. V4 stated V4 has not completed wound audits daily.

On 4/8/21 at 2:50 PM, V1 stated V1 had no additional audits to provide and confirmed daily audits were not completed for two weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002950	A. BUILDING: _____ B. WING _____	04/12/2021

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S9999	Continued From page 13 (B)	S9999		