STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. BUILDING _____ B. WING _____	03/01/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEE HEALTHCARE	620 LAUREL STREET LEE, MA 01238

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on records reviewed and interviews, for one of three sampled residents (Resident #2), the Facility failed to ensure that an allegation of physical abuse was reported to the Department of Public Health within two hours, when it was alleged that Nurse #1 held Resident #2's lips shut, to avoid his/her medications from being spit out. Resident #2 complained of posterior neck pain from being held down and forced to take his/her medication, which was reported to the facility on [DATE] and reported to the Department of Public Health on 2/14/19 . Findings include: The Facility Policy titled, Abuse Investigation and Reporting, dated 12/2017, indicated abuse prevention included that all violations of abuse, neglect, exploitation or mistreatment will be reported immediately but not later than two hours if the alleged violation involve abuse. The Facility investigation, indicated on 2/12/19 at approximately 2:20 P.M., the Facility received a telephone call from the Ambulance Company about a situation that occurred on 2/11/19, when the Ambulance Staff spoke with Nurse #1 when they came to the Facility to transport Resident #2. Nurse #1 told the ambulance staff she held Resident #2's mouth shut while attempting to give the resident his/her medications to avoid Resident #2 from spitting out the medications. The Ambulance staff said that Resident #2 also alleged that Nurse #1 held him/her (Resident #2) down and forced him/her to take the medications. The Health Care Facility Reporting System (HCFRS) indicated on that 2/12/19, the Facility received an allegation of abuse. The allegation was not reported to Department of Public Health (DPH) until 2/14/19, 2 days later. The Surveyor interviewed the Director of Nurses (DON) at 10:45 [NAME]M. on 3/1/19. The DON said that the allegation of Resident #2's physical abuse was not reported to the Department of Public Health within two hours, as required.
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** > Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure that Resident #1 received adequate care to prevent and promote the healing of a pressure injury on the right ischium (the large bony protuberance from the pelvis bone, which the body rests on when sitting, buttocks) which progressed to an infected Stage 3 (full-thickness loss of skin, in which adipose (fat) is visible in the ulcer). Findings include: The Facility Policy, Pressure Ulcer/Injury Assessment, dated, 11/2017, indicated information to identify pressure injury factors and treatment interventions for specific risk factors. -Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. -Identify any signs of developing pressure injuries. -Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance and the resident's stated preferences. -Reposition residents who are chair bound or bed bound. -At least every two hours, reposition residents who are reclining and dependent on staff or repositioning. The Facility Policy, Pressure Ulcer/Injury Assessment, dated, 4/2018, indicated to develop a resident centered care plan intervention based on the risk factors identified in the assessment, the condition of the skin, the resident's overall clinical condition. Documentation should be recorded in the resident's medical record utilizing forms. Initiation of a pressure of non-pressure form related to the type of alteration in skin if new skin alteration was noted. 1. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #1 was moderately cognitively impaired, required an extensive assist of 2 persons for bed mobility and transfers, was non-ambulatory, had a [DIAGNOSES REDACTED]. The MDS indicated Resident #1 was at risk for developing pressure injuries, did not have any pressure injuries and had pressure reducing devices for the chair and bed and applications of ointments/medications. The Pressure and Non-pressure Injury Care Plan, dated 3/30/18 interventions for Resident #1 included: -Apply barrier cream to buttocks, hips and coccyx every shift and as needed. -Reposition him/her every 2 hours with the assistance of two staff members. -Pressure relieving seat cushion in the wheelchair. -Alternating pressure mattress. The Weekly Skin Evaluation, dated 10/17/18, indicated Resident #1 had a shearing (friction from the mechanical force exerted on skin that is dragged across any surface, causing tissue damage) of the right buttocks. Barrier cream was applied with incontinence care, an intervention already in the plan of care. . There was no description of the pressure on the pressure injury documentation form as required according to their policy. The physician's orders [REDACTED]. There was no evidence that a pressure injury measurement form was used for monitoring, per facility policy. The Significant MDS, dated [DATE], indicated Resident #1 had an unhealed pressure injury, which was an unstageable (not able to stage due to coverage of the wound bed by dead tissue) deep tissue injury (a deep red or purple skin discoloration resulting from intense and/or prolonged pressure and shear forces at the bone-muscle. Review of the Certified Nurse's Aide Flow Sheets, dated 11/03/18 through 11/09/18, indicated that the intervention for turning and repositioning every 2 hours to off load pressure, was not documented (form left blank) as having been performed every day for Resident #1 as follows: - on 11/3/18 for 8 hours, - on 11/4/18 for 6 hours, - on 11/5/18 for 6 hours, - on 11/6/18 for 8 hours, - on 11/7/18 for 8 hours, - on 11/8/18 for 8 hours, - on 11/9/18 for 8 hours. The Alteration in Skin Integrity Care Plan, dated 11/9/18, indicated there was a wound on the right ischium measuring 2

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	(continued... from page 1) centimeters (cm) in length by 1 cm in width by 0.1 cm in depth. A description of the wound bed was not included The goal was that the ischium wound would not become infected or worsen over time and would resolve, with interventions which included: - Resident #1 will be in bed on either side when not eating to relieve pressure to the right ischium - Wound will be kept clean and dry with frequent skin care and repositioning. Review of the Certified Nurse's Aide Flow Sheets, dated for 11/11/18 through 11/12/18, indicated the intervention for turning and repositioning every 2 hours to off load pressure, was not documented (form left blank) as having been performed for Resident #1 on 11/11/18 and 11/12/18 for 8 hours every day. The Weekly Skin Evaluation, dated 11/15/18, indicated Resident #1 had a open area on the right buttocks with some necrotic area, measured 2.8 centimeters (cm) by 1.2 cm (dead, devitalized tissue). The pressure injury was documented as having increased in size from 11/9/18. The physician's orders [REDACTED]. Review of Resident #1's Treatment Administration Record, dated 11/2018, indicated to apply a [MEDICATION NAME] dressing and change every 3rd day, but it was not documented as being performed on 11/15/18. The Certified Nurse's Aide Flow Sheets, dated 11/16/18 through 11/30/18, indicated the intervention for turning and repositioning every 2 hours to off load pressure, was not documented (form left blank) as having been performed every day for Resident #1 as follows: - on 11/16/18 for 16 hours, - on 11/17/18 for 6 hours, - on 11/20/18 for 8 hours, - on 11/21/18 for 8 hours, - on 11/22/18 for 8 hours, - on 11/24/18 for 8 hours, - on 11/26/18 for 8 hours, - on 11/28/18 for 6 hours, - on 11/30/18 for 8 hours. The physician's orders [REDACTED]. The description of the pressure does not describe if this has necrotic tissue (an unstagable pressure injury) or this is deep tissue trauma. The Alteration in Skin Integrity Care Plan, dated 11/29/18, indicated interventions included that Resident #1 would be in bed when not eating (for meals) on either of his/her sides. Review of the Certified Nurse's Aide Flow Sheets, dated for 12/2018, indicated the intervention for turning and repositioning every 2 hours to off load pressure, was not documented (form left blank) as having been performed for Resident #1, on 12/4/18, 12/5/18 and 12/6/18, with 8 hours each day having incomplete documentation. The physician's orders [REDACTED]. Santyl is usually applied to an unstagable pressure injury, no documented staging of the pressure injury to monitor for healing or deterioration of the wound. The Weekly Skin Evaluation, dated 12/5/18, indicated Resident #1 had an open area on the right buttocks which measured 5.4 cm by 3 centimeters (cm) in length. A description of the wound bed was not provided. The skin evaluation indicated that the injury had increased in size and the stage of the pressure injury was not documented. The Pressure Ulcer Evaluation Form, date 12/7/18, indicated Resident #1 had an unstageable pressure injury of the right ischium measuring 4.6 cm in length by 3.2 cm in width with an unknown depth. The wound bed had an eschar and slough (dead tissue) covered the wound bed, with no drainage or odor with no signs and symptoms of infection. The Nurse Progress Note, dated 12/7/18, indicated Resident #1's dark area on the buttock was cleansed, pat dry and Santyl Ointment (a [MEDICATION NAME] agent) was applied to debride (get rid of dead tissue) the wound and covered with a dry protective dressing. The Surveyor interviewed Family Member #1 at 9:25 [NAME]M. on 3/5/19. Family Member #1 said that Resident #1's plan of care to heal the right buttocks pressure injury was to have him/her put back to bed after every meal (to offload the pressure on the ischium when sitting), but several times a week, Resident #1 was left up sitting in the wheelchair from breakfast to after lunch. The Dietary Note, dated 12/11/18, indicated Resident #1 has a Stage 2/3 pressure injury. His/her intake was variable and was somewhat decreased for a brief period of time. Resident #1 was now eating 50 to 100 % of her meals, treated with a multi-vitamin for nutritional support and will give him/her larger portions of protein with meals to promote healing. The Surveyor interviewed the Facility Wound Nurse at 1:30 P.M. on 3/1/19. The Facility Wound Nurse said the Nurse Progress Note of 12/7/18, refers to the right buttock pressure injury with an eschar (dead tissue) and based on the documented description and treatment, this was deep tissue pressure injury (which is tissue with deep red, maroon or purple discoloration, resulting from intense and/or prolonged pressure and shear forces at the bone-muscle interface. That isn't what was documented on 10/17/18 which indicated shearing on the right buttock, this deteriorated further. The physician's orders [REDACTED]. Normal Saline, pat dry and cover with [MEDICATION NAME] (a honprey based wound product) to the center of the wound bed and cover with a border dressing (a foam dressing with adhesive edges) change every 3 days. Although the Physician describes the pressure injury as a dark area, all other documentation indicates necrotic unstagable pressure injury and not a deep tissue injury The Physician's Progress Note, dated 12/12/18, indicated that off-loading (of pressure) was critical for Resident #1. Review of the Certified Nurse's Aide Flow Sheets, dated for 12/2018, indicated the intervention for turning and repositioning every 2 hours to off load pressure, was not documented (form left blank) as having been performed for Resident #1, as follows: - on 12/20/18 for 16 hours, - on 12/21/18 for 8 hours, - on 12/22/18 for 8 hours, - on 12/23/18 for 8 hours, - on 12/24/18 for 8 hours, - on 12/26/18 for 8 hours. The physician's orders [REDACTED]. The Pressure Ulcer Evaluation Form, date 12/24/18, indicated Resident #1 had an unstagable pressure injury of the right ischium measuring 5 cm in length by 5.5 cm in width with 1 cm in depth with moderate drainage and a foul odor. The Physician's Progress Note, dated 12/26/18, indicated that Resident #1 had a stage 3 pressure injury to the sacrum, with increased odor, treat (for an infection) with [MEDICATION NAME] (an antibiotic medication) 500 milligrams three times a day for 7 days. Refer to the Wound Clinic. The Wound Documentation Sheet, undated, indicated during the second week of 12/2018, Resident #1's had a facility acquired wound, Resident #1's pressure injury to right buttocks measured 4.4 cm by 2 cm, with no documented depth with no description of the wound bed. The Wound Documentation Sheet, undated, indicated during the third week of 12/2018, Resident #1's pressure injury to right buttocks measured 5.4 cm by 3 cm, and 1 cm in depth with no description of the wound bed. The Wound Documentation Sheet, undated, indicated during the fourth week of 12/2018, Resident #1's pressure injury to right buttocks measured 5.7 cm by 5 cm and 1 cm in depth, which was increased in size and depth and was being treated with an antibiotic due to an infection. The Physician's Note, dated 1/2/19, indicated that Resident #1 was seen by evaluated and was unresponsive, this change in mental status could be related to the new [MEDICATION NAME] order (a narcotic pain medication) or concern for a systemic infection with the source being the Stage 3 ischial pressure injury, with green drainage. Transfer to the Emergency Department for infection workup. The Hospital Discharge Summary, dated 1/7/19, indicated Resident #1 was admitted to the hospital on [DATE] for an infected ischial pressure injury which required treatment with intravenous antibiotics. The Wound Clinic Progress Note, dated 12/28/18, indicated that the right buttock pressure injury measured 4.5 cm in length, 5.5 cm in width and 2.5 cm in depth. There is a moderate amount of purulent drainage that has an odor.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Referral to Rehabilitation Therapy to evaluate for a new wheelchair cushion and resident's position due to his/her wound dated 1/7/19. The Surveyor interviewed the Facility Wound Nurse at 1:30 P.M. on 3/1/19. The Facility Wound Nurse said on 12/28/18, Resident #1 had an initial consultation at the Wound Clinic due to deterioration in the right ischial (buttocks) pressure injury. In addition, the Facility Wound Nurse said the turning and positioning sheets to off load pressure every 2 hours, were not documented as being performed in 11/2018 and 12/2018 for being repositioned as care planned. B. Review of the Treatment Administration Record, dated 2/2019, indicated the physician's orders [REDACTED]. The physician's orders [REDACTED]. Cover with non-woven 4 inch by 4 inch dressing. Apply barrier cream to the peri wound, change the dressing twice a day. The Treatment Administration Record, dated 2/2019, indicated to cleanse the right ischial wound with normal saline, apply Dakins solution (a bleach solution) of 0.125 percent and pack the wound. Cover with non-woven 4 by 4 dressing. Apply barrier cream to the peri wound, cover with an abdominal pad dressing twice a day at 9:00 [NAME]M. and at 9:00 P.M. The signature space for this wound treatment was not documented (form left blank) as being performed at 9:00 [NAME]M. on 2/3/19, 2/4/19, 2/5/19, 2/7/19, 2/8/19 and 2/11/19 and at 9:00 P.M. on 2/12/19. The Surveyor interviewed the Director of Nurse (DON) at 1:10 P.M. on 3/1/19. The DON said when Resident #1 returned from the wound clinic, they were informed that the twice a day dressing change ordered by the Physician was not being performed. The Facility Investigation, dated 2/20/19, indicated a Nurse failed to perform the wound dressing as ordered by the Physician on 2/11/19 and wound treatments were not signed off on (or documented anywhere in the medical record) 2/3/19, 2/4/19, 2/5/19, 2/7/19 and 2/8/19 as being completed. The Witness Statement from the staff Nurse who did not change the ischial dressing on 2/11/19, indicated when she worked on 2/11/19, she did not perform Resident #1's dressing change because she did not know his/her Wound Vac (a negative pressure wound therapy, using a vacuum type dressing to promote healing) had been discontinued. The Surveyor interviewed the Clinical Manager of the Wound Clinic at 10:52 [NAME]M. on 3/4/19. The Clinical Manager of the Wound Clinic said that at Resident #1's 2/12/19 appointment, four dressing changes were not performed for the right ischial pressure injury. The Wound Assessment Details sheet, dated 2/12/19, indicated Resident #1 had a stage 3 right ischial pressure sore that measured 5 centimeters in length by 4 centimeters in width with no measurable depth, 26% to 50% of the wound had slough. There was a large amount of green wound drainage (can indicate an infection) with a mild odor. The Surveyor interviewed the Clinical Manager of the Wound Clinic at 10:42 [NAME]M. on 3/4/19. The Clinical Manager of the Wound Clinic also said that Resident #1's right ischial dressing had the date 2/9/19, written on all of them, as to when the dressings were last changed. The right ischial dressing was ordered twice a day, the dressing had not been changed as ordered, four dressing changes were not performed on 2/10/19 at 9:00 [NAME]M. and at 9:00 P.M. and on 2/11/19 at 9:00 [NAME]M. and at 9:00 P.M. In addition, Resident #1 frequently arrives to the Wound Clinic incontinent of urine and feces and needs to be changed.