STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035120	A. BUILDING _____ B. WING _____	**12/19/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MI CASA NURSING CENTER	**330 SOUTH PINNULE CIRCLE MESA, AZ 85206**

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** > Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#316) who developed a pressure ulcer received treatment and services consistent with professional standards of practice. The deficient practice could result in care not being provided to residents with pressure ulcers. Findings include: Resident #316 was readmitted on (MONTH) 25, 2019, with [DIAGNOSES REDACTED]. The Braden Scale for predicting pressure ulcer risk and risk factors dated (MONTH) 25, 2019 revealed a score of 12 which indicated the resident was at high risk for pressure ulcers. Review of the clinical record revealed a physician order [REDACTED]. The weekly skin integrity data collection form dated (MONTH) 29, 2019 revealed the resident skin was not intact, there was blanchable redness to the coccyx area, and barrier cream was applied as ordered. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident was independent regarding cognitive skills for daily decision making. The assessment included the resident did not have any pressure ulcers but was at risk for developing pressure ulcers. A weekly skin integrity data collection form dated (MONTH) 6, 2019 revealed the resident's skin was intact. The document included the resident had some redness on the coccyx area, barrier cream was applied, and no open areas were observed. The weekly skin integrity data collection form dated (MONTH) 13, 2019 revealed the skin was intact and that there were no new skin issues. Review of the physician orders [REDACTED]. The skin integrity data collection forms dated (MONTH) 19, 20, and 27, 2019 revealed the resident's skin was not intact, and that there was an open area/wound on the resident's right buttock. The notes also included a treatment was in place. Review of the Treatment Administration Record (TAR) dated (MONTH) 2019 revealed the treatment was provided as ordered to the open area. However, further review of the clinical record revealed no documentation that the right buttock wound was ever thoroughly assessed to include a description of the wound, staging, and measurements. Additional review of the clinical record revealed there was no care plan developed which addressed the pressure ulcer to the right buttock. There was also no intervention on any care plans regarding the care and treatment for [REDACTED]. The discharge MDS assessment dated (MONTH) 30, 2019 revealed the resident was discharged to an acute hospital and had no unhealed pressure ulcers at Stage 1 or higher. An interview was conducted with the Licensed Practical Nurse (LPN/staff #96) who is the wound nurse on (MONTH) 18, 2019 at 2:47 p.m. Staff #96 stated that once she is notified a resident has a break in skin integrity, she assesses the area, initiates a Wound Observation Tool, obtains an order for [REDACTED]. Regarding resident #316, the LPN stated she was not notified the resident had a wound. She stated information regarding skin status is supposed to be passed on during report. However, the LPN stated that she was aware [MEDICATION NAME] was being used for the resident's wound. She also stated that [MEDICATION NAME] is used for pressure ulcers stage 2 and above. On (MONTH) 18, 2019 at 3:20 p.m., an interview was conducted with the Director of Nursing (DON/staff #161). For a resident that has developed a wound, the DON stated her expectation would be for nursing to document the wound on a nursing progress note or complete a skin integrity assessment and notify the physician to obtain a treatment order. The DON stated she would expect the wound care nurse to be notified. She said her expectation would be for the wound care nurse to assess the wound, ensure the appropriate treatment and determine whether or not she would follow the wound. Review of the facility's policy titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management effective (MONTH) 3, 2019, revealed a comprehensive skin inspection/assessment is conducted on admission and re-admission to the facility. The policy included the facility will utilize the Lippincott procedures for pressure injury management, long term care. The Lippincott procedure for pressure injury management, long term care revealed documentation should include the size, location, depth, and stage of the pressure injury; the condition of the wound bed, the presence of eschar, and the status of the peri-wound area. The procedure included the presence and signs of infection and pain, wound care provided and the resident's response to the interventions should be documented. The procedure also included teaching should be provided to the resident and/or family members and their understanding of the teaching, and whether they require follow-up teaching should be documented as well.

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