STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075341	A. Building B. Wing	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pendleton Rehabilitation and Nursing Center	44 Maritime Drive Mystic, CT 06355

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents, (Resident #1), reviewed for pressure ulcers, the facility failed to notify the physician of pressure injuries. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included fracture of the left tibia, diabetes type II and morbid obesity. The care plan dated 6/9/23 identified Resident #1 had a fracture of the left tibia shaft with interventions that included to checking circulation, sensation and motion of the affected extremity every shift. A skin check dated 6/9/23 identified no skin alterations and a left lower extremity cast in place for fractured tibia surgery. Physician's orders dated 6/9/23 directed to monitor skin integrity under/around the cast every shift, monitor circulation, mobility, sensation and pulse to Left Lower Extremity (LLE) every shift, and directed diabetic foot checks every evening shift. A physician's order dated 6/10/23 directed to apply Vitamin A & D ointment to the feet and heels every evening shift in accordance with diabetes protocol. The admission MDS dated [DATE] identified Resident #1 had no impairments in cognition, required extensive assistance of two staff for bed mobility and transfers, did not have any unhealed pressure ulcers/injuries, was at risk of developing pressure ulcers/injuries and had a surgical wound. A subsequent care plan dated 6/20/23 identified Resident #1 was at risk of skin breakdown related to diabetes mellitus, impaired mobility and a surgical incision with interventions which included to assess for and provide pressure relieving devices as per PT/OT recommendations, complete skin risk assessments per facility policy and provide protective/preventative skin care. An outpatient orthopedic consultation report dated 6/22/23 identified Resident #1's sutures were removed, the cast was removed and a full cam boot was placed to the LLE, and to remove the boot for hygiene and Range Of Motion (ROM) and to follow up in four weeks. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin check dated 6/23/23, completed by RN #1, identified no skin issues, Resident #1's cam boot was in place to the LLE and the surgical incision was clean, dry and intact. A nursing progress note written by RN #4 dated 7/1/23 at 2:29 AM identified no new skin issues. A skin check dated 7/2/23 identified Resident #1 refused the skin check. Review of the Treatment Administration Record for July 2023 identified that the facility was removing the cam boot every shift to check the skin integrity and the resident's bilateral heels were elevated while in bed. A skin check dated 7/5/23 identified a new skin impairment was noted, Resident #1 had a left heel abrasion, and left toe abrasion of 2nd and 3rd digit, the supervisor was made aware. A facility wound note dated 7/5/23 identified Resident #1 was seen for newly noted areas of impaired skin integrity. Resident #1 had an abrasion to the left dorsal foot measuring 1.1 centimeters (cm) x 0.9 cm with no drainage or odor. The Left heel measured 0.5 cm x 0.3 cm and Left toes measuring 0.3 cm x 0.2 cm with no drainage or odor noted. The physician ordered skin prep twice a day until the areas were resolved. A nursing progress note dated 7/6/23 identified a message was left for the orthopedic surgeon to notify him of the new skin irritation to Resident #1's left heel/toes/foot. An occupational therapy encounter note dated 7/12/23 identified Resident #1's family member reported skin integrity concerns about Resident #1's left foot, and identified nursing was made aware. A wound note dated 7/12/23 identified Resident #1's dorsal foot, left heel and left toes were resolved. Review of the clinical record for Resident #1 failed to identify any further documentation of wounds and/or pressure ulcers. Review of the out of facility release form for Resident #1 identified on 7/13/23 Resident #1's family member signed Resident #1 out of the facility and returned at 2:00 PM. An outpatient orthopedic consultation report dated 7/13/23 identified Resident #1 was seen in the clinic for follow up to a left leg injury. Resident #1 returned to the clinic earlier than scheduled because he/she reported pressure sores developing secondary to the cam boot. The note further identified a pressure ulcer noted to the dorsal mid-foot as well as a large pressure ulcer noted to the posterior heel which appeared to have eschar. Although review of Resident #1's medical record identified Resident #1 had no skin impairments documented after Resident #1's areas resolved on 7/12/23, Resident #1's orthopedic surgeon identified on 7/13/23 Resident #1 had a pressure ulcer on his/her's dorsal mid-foot and posterior heel. A skin check dated 7/16/23, completed by RN #3 identified Resident #1's skin was intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the out of facility release form for Resident #1 identified on 7/19/23 Resident #1's family member signed Resident #1 out of the facility and returned at 4:29 PM. Review of the after-visit summary from the outpatient wound clinic, maintained in Resident #1's medical records, dated 7/19/23 identified Resident #1 had a pressure injury of the left anterior foot and the left heel that was to be dressed 3 times a week with santyl and a foam cover. Review of the outpatient wound clinic consultation dated 7/19/23 identified Resident #1 had a pressure injury to the left anterior foot that was red, ecchymotic and measured 1.4 cm x 2 cm x 0.1 cm. Resident #1 also had a pressure injury to the left heel that was staged as a deep tissue pressure injury that was black and measured 4 cm x 4.7 cm x 0.1 cm. The discharge instructions identified for the left anterior foot to apply xeroform and foam three times a week and for the left heel to apply santyl and foam cover three times a week and to offload heels when in bed. Review of Resident #1's medical record failed to identify Resident #1 had a pressure ulcer to the dorsal mid-foot and posterior heel as identified in the consultation report on 7/13 and 7/19/23, failed to identify monitoring and treatment of the pressure ulcers. Review of the physician orders failed to identify the outpatient wound clinic recommendations for treatment of Resident #1's pressure ulcers were followed. Interview with the outpatient wound physician on 11/22/23 at 12:58 PM identified she assessed Resident #1 on 7/19/23. She identified Resident #1 had a thick, black, unstageable deep tissue injury to the left heel. She identified Resident #1's injury had a thick crusted black eschar that would not have developed in a few days and would have been present for a few weeks. She identified when she saw Resident #1 on 7/19/23 his/her pressure injury was deep, and they were just trying to salvage Resident #1's heel at that point. She identified Santyl was ordered as a debridement three times a week to allow for the scab to come off slowly and let the wound heal below. She identified the heel is close to bone and could have gotten worse if not treated properly. She further identified the visit report was sent with Resident #1. Interview with the facility Wound Care RN (WCRN) on 11/29/23 at 11:45 AM identified on 7/5/23 Resident #1 was seen after wound rounds for abrasions to the left dorsal foot, left heel and left toes. Resident #1 was not seen by MD #1, the wound physician. The WCRN further identified that she assessed the areas on the left foot to be resolved on 7/12/23. The WCRN further identified that she was not aware of the wound report from 7/19/23 did not see Resident #1 after his/her skin areas were resolved on 7/12/23 because no new skin issues were reported to her. Interview with MD #1, contracted wound physician, on 11/29/23 at 11:45 AM identified he did not see Resident #1 during Resident #1's stay in the facility. He identified he would made rounds one time a week and the facility nurses would tell him what residents needed consultations. Interview with Resident #1 on 11/29/23 at 12:30 PM identified on 7/12/23 physical therapy identified a black area on his/her heel. Resident #1's family member called the orthopedic surgeon on 7/12/23. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with OT #1 on 11/29/23 at 1:10 PM identified she worked with Resident #1 on 7/12/23 and identified the family member reported a new skin integrity concern to Resident #1's left foot, although could not remember if she saw Resident #1's left foot. OT #1 identified she told Resident #1's nurse, however, she could not remember who she told. Interview with RN #3, who completed the skin check dated 7/16/23 and was one of Resident #1's primary nurses during the 7:00 AM to 3:00 PM shift, on 11/29/23 at 2:26 PM identified she could not remember if she looked at Resident #1's heels when completing his/her skin check and diabetic foot checks, and further identified she could not remember if Resident #1 had any skin impairments. RN #3 identified that when doing a diabetic foot check the ideal process was to check the skin on the top of the foot, lift the foot and assess the bottom and in-between the toes. She further identified if a new skin concern was identified, a change in condition would be done and the wound team would be notified. Interview with LPN #3, who was one of Resident #1's primary nurses during the 3:00 PM - 11:00 PM shift, and Resident #1's nurse on 7/12/23 from 7:00 AM - 11:00 PM, on 11/29/23 at 2:30 PM identified she could not remember if Resident #1 had any skin concerns. She identified when completing a foot check she would look for open wounds, cuts, assess the toes. She would then hold the resident's legs up to apply the skin prep. She identified if there were new skin concerns identified, she would tell the supervisor and complete a change in condition form. Interview with the DNS on 11/29/23 at 10:00 AM identified she was not aware of Resident #1's medical appointments and consultations reports from 7/13/23 and 7/19/23. She identified Resident #1's post visit report from 7/19/23 was scanned into the resident's chart on 7/21/23 (a Friday) and Resident #1 was discharged on [DATE] (a Monday). She identified she does not know who Resident #1 and/or his/her family member gave the 7/19/23 wound consultation summary report to. She identified the process for the summary to be placed in the MD bin for review where it is then signed and uploaded into the resident's chart. She identified it was not signed by the physician; therefore it was never placed in the MD bin for review. She further identified a pressure ulcer/injury is different from a skin abrasion and would be a change in condition and although the physician should have been notified, the clinical record lacked the documentation. Review of the notification of changes policy directed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification.

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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** 44675 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for pressure ulcers, the facility failed to assess, monitor, and treat the resident's pressure ulcer. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included fracture of the left tibia, venous insuffiency, diabetes type II and morbid obesity. The care plan dated 6/9/23 identified Resident #1 had a fracture of the left tibia shaft with interventions that included to check circulation, sensation and motion of the affected extremity every shift. A skin check dated 6/9/23 identified no new skin alterations and Resident #1 had a left lower extremity cast in place for fractured tibia surgery. Physician's orders dated 6/9/23 directed to monitor skin integrity under/around the cast every shift, monitor circulation, motion, sensation and pulse to Left Lower Extremity and diabetic foot checks every evening shift. A physician's order dated 6/10/23 directed Vitamin A & D ointment to feet and heels every evening shift in accordance with diabetes protocol. The admission MDS dated [DATE] identified Resident #1 had no impairments in cognition, required extensive assistance of two staff for bed mobility and transfers, did not have any unhealed pressure ulcers/injuries, was at risk of developing pressure ulcers/injuries and had a surgical wound. The care plan dated 6/20/23 identified Resident #1 was at risk of skin breakdown related to diabetes mellitus, impaired mobility and a surgical incision. Interventions included to assess for and provide pressure relieving devices as per PT/OT recommendations, complete skin risk assessments per facility policy and provide protective/preventative skin care. An outpatient orthopedic consultation report dated 6/22/23 identified Resident #1's sutures were removed, the cast was removed and a full cam boot was placed to the left lower extremity (LLE). It identified Resident #1 could remove the boot for hygiene and ROM and to follow up in four weeks. A physician's order dated 6/22/23 directed tall cam boot in place to LLE, may remove for shower and hygiene and to monitor skin integrity every shift. A skin check dated 6/23/23, completed by RN #1, identified no new issues, Resident #1's cam boot was in place to the LLE and the surgical incision was clean, dry and intact. A nursing progress note written by RN #4 dated 7/1/23 at 2:29 AM identified no new skin issues. A skin check dated 7/2/23 identified Resident #1 refused the skin check. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment Administration Record for July 2023 identified that the facility was removing the cam boot every shift to check the skin integrity and the resident's bilateral heels were elevated while in bed. A skin check dated 7/5/23 identified a new impairment was noted, a left heel abrasion, left toe abrasion of 2nd and 3rd digit, the supervisor was made aware. A wound RN note dated 7/5/23 identified Resident #1 was seen for newly noted areas, an abrasion to the left dorsal foot measuring 1.1 cm x 0.9 cm with no drainage or odor. The note further identified areas to the left heel measuring 0.5 cm x 0.3 cm and left toes measuring 0.3 cm x 0.2 cm with no drainage or odor noted. The physician was notified and ordered skin prep twice a day until the areas were resolved. A physician's order dated 7/5/23 directed skin prep to left heel, left toes and top of foot every day and evening shift for abrasions to heel/toes/foot. A nursing progress note dated 7/6/23 at 11:49 AM identified a message was left for the orthopedic surgeon to notify him of the new skin irritation to Resident #1's left heel/toes/foot. An occupational therapy encounter note dated 7/12/23 identified Resident #1's family member reported skin integrity concerns with Resident #1's left foot. It identified nursing was made aware. A Wound RN note dated 7/12/23 identified Resident #1's dorsal foot, left heel and left toes were resolved. Resident #1 had no further documentation of wounds and/or pressure ulcers. Review of the out of facility release form for Resident #1 identified on 7/13/23 Resident #1's family member signed Resident #1 out of the facility and returned at 2:00 PM. An outpatient orthopedic consultation report dated 7/13/23 identified Resident #1 was seen in the clinic for follow up to a left leg injury. Resident #1 returned to the clinic earlier than scheduled because he/she reported pressure sores developing secondary to the boot. It further identified a pressure ulcer noted to the dorsal midfoot as well as a large pressure ulcer noted to the posterior heel and appeared to have eschar. Although the facility was doing skin checks every week, diabetic foot checks every day and daily skin checks around the area of the cam boot, review of Resident #1's clinical record identified Resident #1 failed to identify any skin impairments documented after Resident #1's areas resolved on 7/12/23 Resident #1's orthopedic surgeon identified on 7/13/23 Resident #1 had a pressure ulcer on his/her's dorsal mid-foot and posterior heel. A skin check dated 7/16/23, completed by RN #3, identified Resident #1's skin was intact. Review of the out of facility release form for Resident #1 identified on 7/19/23 Resident #1's family member signed Resident #1 out of the facility and returned at 4:29 PM. Review of the after-visit summary from the outpatient wound clinic, maintained in Resident #1's clinical record dated 7/19/23 identified Resident #1 had a pressure injury of the left anterior foot and the left heel that was to be dressed three (3) times a week with santyl and foam cover. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the outpatient wound clinic consultation dated 7/19/23 identified Resident #1 had a pressure injury to the left anterior foot that was red, ecchymotic and measured 1.4 cm x 2 cm x 0.1 cm. Resident #1 had a pressure injury to the left heel that was stage as a deep tissue pressure injury that was blanchable, black and measured 4 cm x 4.7 cm x 0.1 cm. The discharge instructions identified for the left anterior foot to apply xeroform and foam three times a week and for the left heel to apply santyl and foam cover three times a week and to offload heels when in bed. Review of Resident #1's medical chart failed to identify Resident #1 had a pressure ulcer to the dorsal midfoot and posterior heel and failed to identify monitoring of pressure ulcers. Review of the physician orders failed to identify the outpatient wound clinic recommendations for treatment of Resident #1's pressure ulcers were followed. Review of Resident #1's facility discharge packet dated 7/24/23 identified Resident #1 had special care instructions to apply skin prep to his/her left heel, left toes and top of left foot to protect his/her skin while in the CAM boot. It failed to identified Resident #1 had pressure ulcer/injuries concerns. Interview with RN #1 on 11/9/23 at 2:00 PM, who completed Resident #1's skin check on 6/23/23, identified she would take off Resident #1's cam boot daily to monitor his/her skin. She further identified there were no issues observed on 6/23/23. Interview with RN #4 on 11/14/23 at 2:00 PM, who worked on 7/1/23, identified although he could not remember the exact details of Resident #1's skin check on 7/1/23, his practice would be to remove the cam boot to assess the skin underneath. Interview with LPN #1 on 11/9/23 at 2:30 PM, who worked 7:00 AM - 3:00 PM on 7/4/23, identified there no were skin issues identified on 7/4/23. He further identified he would removed the cam boot to check the skin underneath and check for bogginess. Interview with the outpatient wound physician on 11/22/23 at 12:58 PM identified she saw and assessed Resident #1 on 7/19/23. She identified Resident #1 had a thick, black, unstageable deep tissue injury to Resident #1's left heel. She identified Resident #1's injury had thick crusted black eschar that would not have developed in a few days and would have been present for a few weeks. She identified when she saw Resident #1 on 7/19/23 his/her pressure injury was deep, and they were just trying to salvage Resident #1's heel at that point. She identified Santyl was ordered as a debridement three times a week to allow for the scab to come off slowly and let the wound heal below. She identified the heel is close to bone and could have gotten worse if not treated properly. She further identified the visit report was sent with Resident #1. Interview with the Wound RN on 11/29/23 at 11:45 AM identified on 7/5/23 Resident #1 was seen after wound rounds for abrasions to the left dorsal foot, left heel and left toes. She identified the wound physician, MD #1, did not see Resident #1 because he had already left the building. She identified on 7/12/23 Resident #1's left dorsal foot, left heel and left toes were resolved. She identified the MD #1 did not see Resident #1 on 7/12/23 because his/her areas were resolved. She further identified she was not aware of the wound report from 7/19/23 did not see Resident #1 after his/her skin areas were resolved on 7/12/23 because no new skin issues were reported to her. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 11/29/23 at 12:30 PM identified on 7/12/23 occupational therapy identified a black area on his/her heel with pain. Resident #1's family member called the orthopedic surgeon on 7/12/23. Interview with OT #1 on 11/29/23 at 1:10 PM identified she worked with Resident #1 on 7/12/23. She identified the wife reported a new skin integrity concern to Resident #1's left foot. She identified she could not remember if she saw Resident #1's left foot, she told Resident #1's nurse, however OT #1 could not remember who it was she told. Interview with RN #3, who completed the skin check dated 7/16/23 and was one of Resident #1's primary nurses during the 7:00 AM - 3:00 PM shift, on 11/29/23 at 2:26 PM identified she could not remember if she looked at Resident #1's heels when completing his/her skin check and diabetic foot checks. She further identified she could not remember if Resident #1 had any skin impairments. She identified when doing a diabetic foot check the ideal process was to remove the cam boot and check the skin on the top of the foot, lift the foot and assess the bottom and in-between the toes. She further identified if a new skin concern was identified, a change of condition form would be done and the wound team would be notified. Interview with LPN #3, who was one of Resident #1's primary nurses during the 3:00 PM - 11:00 PM shift, and Resident #1's nurse on 7/12/23 from 7:00 AM - 11:00 PM, on 11/29/23 at 2:30 PM identified she could not remember if Resident #1 had any skin concerns. She identified when completing a foot check she would look for open wounds, cuts, assess the toes. She would then hold the resident's legs up to apply the skin prep. She identified if there were new skin concerns identified, she would tell the supervisor and complete a change in condition Interview with the DNS on 11/29/23 at 10:00 AM identified she was not aware of Resident #1's medical appointments and consultations reports from 7/13/23 and 7/19/23. She identified Resident #1's post visit report from 7/19/23 was scanned into the resident's chart on 7/21/23 (a Friday) and Resident #1 was discharged on [DATE] (a Monday). She identified she does not know who Resident #1 and/or his/her family member gave 7/19/23 wound consultation summary report to. She identified the process for the summary to be placed in the MD bin for review where it is then signed and uploaded into the resident's chart. She identified it was not signed by the physician; therefore it was never placed in the MD bin for review. She further identified a pressure ulcer/injury is different from a skin abrasion and would be a change in condition. Review of the pressure injury prevention and management policy directed after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. It further directed the treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue. The attending physician will be notified of the presence of a new pressure injury upon identification and the progression towards healing, or lack of healing, of any pressure injuries weekly. Review of the notification of changes policy directed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the skin integrity foot care policy directed that the facility will use a systematic approach for the prevention and management of foot ulcers, including efforts to identify risk; stabilize, reduce or remove underlying risk factors; monitor the impact on the interventions; and modify the interventions as appropriate. It further directed RN's and LPN's will participate in the management of medical conditions by following physicians orders, assessment of residents, and reporting changes in condition to the residents' physicians. Referrals to other interdisciplinary team members will be made as appropriate.