STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115625	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wynfield Park Health and Rehabilitation	223 W.Third Avenue Albany, GA 31701

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** 21213 Based on observation, interview, record review, and review of the facility's Wound Care manual, the facility failed to ensure that pressure ulcers were thoroughly and routinely assessed for two of 10 residents (R) (R8 and R9). Findings include: Review of the facility's Wound Care manual, with an April 2021 release date, Section Two of the manual Assessments of Wounds included the category of Pressure Ulcers/Injuries. A stage 2 pressure ulcer was described as a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. A Stage 2 pressure ulcer may also present as an intact or open/ruptured blister. A Deep Tissue Injury (DTI) was described as a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. Section Three of the manual Treatment of Wounds included the treatment of pressure ulcers/injuries. The assessment section of the treatment of pressure ulcers included a pressure ulcer assessment is completed on admission, readmission, weekly, and with any major change. 1. R8 admitted to the facility 2/22/2024, most recent reentry was 5/15/2024, diagnoses included but were not limited to, type 2 diabetes mellitus, chronic kidney disease, flaccid neuropathic bladder, and spinal stenosis. Review of the clinical record revealed a nurse's note with entry date 3/30/2024 that documented R8's family member called the nurse to the room, and a blister was noted on R8's heel with a purple discoloration to the area. The nurse's note further documented that a skin prep treatment was applied to the blister and the on-call physician was notified. An Initial COC (change of condition) Report to MD form was also completed on 3/30/2024 and review of the Assessment or Appearance section of the form documented the problem may be a new or worsened pressure ulcer. On 4/1/2024, Treatment Nurse BB documented in a nurse's note that R8 was noted to have a blood blister to the right heel. The Nurse Practitioner was notified, and an order was received, to apply skin prep to the area three times a week until resolved. Review of the April 2024 Treatment Administration Record (TAR) revealed an order dated 4/1/2024 to cleanse the area to the right heel with normal saline, pat dry, apply no sting skin protectant, and allow 30 seconds to dry, three times per week on Monday, Wednesday, and Friday. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the initial assessments dated 3/30/2024 and 4/1/2024, of the ulcer to R8's right heel, did not include measurements or staging of the ulcer. In addition, after 4/1/2024, there was no further assessment of the ulcer until 4/19/2024. Review of the clinical record revealed a nurses note dated 4/19/2024 by Treatment Nurse BB who documented the area to the right heel was no longer fluid filled and was now a DTI. The Nurse Practitioner was notified. The note further documented that the treatment would remain the same until resolved. Review of an entry on 4/19/2024 of the Weekly Wound section of R8's clinical record documented the right heel area was a pressure ulcer and described as a DTI. Review of a nurse's note, and weekly wound note, both dated 4/19/2024 did not include a measurement of the DTI to the right heel. In addition, after 4/19/2024, there was no further assessments of the right heel DTI. Review of the April 2024 and May 2024 Treatment Administration Record (TAR) revealed that treatment to the right heel pressure ulcer continued until R8 was hospitalized on [DATE]. Review of the hospital history and physical form dated 5/16/2024, revealed a skin exam that documented bogginess of the right heel without wound. Interview on 7/10/2024 at 2:10 pm, Regional Nurse Consultant FF stated there was no additional wound tracking documentation for the right heel pressure ulcer. She stated that when treatment nurse BB was questioned about assessments of the right heel wound, Treatment Nurse BB said she did not think she had to measure it weekly because it was not a pressure ulcer. Interview on 7/10/2024 at 4:10 pm, Treatment Nurse BB confirmed she was the person who measured and assessed wounds weekly. She further stated that there were two places she could document the wound assessments in the clinical record, in the nurse's notes and weekly wound section. When questioned about when R8's right heel pressure ulcer healed, treatment nurse BB responded that it went away when R8 went to the hospital. She stated that he came back with dry skin in the same area that peeled off. 2. Review of the clinical record for R9 revealed he was admitted to the facility on [DATE] and had diagnoses that included paraplegia, Type 2 diabetes mellitus, and hypertension. A nurse note entry after admitted d 5/17/2024 documented R9 was admitted to the facility and had a wound to the left ankle. Review of a nurse's note dated 5/20/2024 Treatment Nurse BB documented that a skin assessment was completed and included R9 had a wound to the left lateral foot. The Nurse Practitioner was notified, orders were documented and verified. Review of the Weekly Wound section of R9's clinical record documented an assessment dated [DATE] of the left lateral ankle wound. The wound was assessed as a stage 2 pressure ulcer, measured 1.5 centimeters (cm) x 1.5 cm x 0.1 cm, with a granulation wound base, intact wound margins, and macerated surrounding skin. (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 physician's orders, and the May 2024 TAR, revealed an order dated 5/20/2024 to cleanse the left lateral ankle with normal saline, pat dry, apply no sting skin protectant to the peri wound, allow 30 seconds to dry, apply calcium alginate to the wound bed, and cover with Coban adhesive dressing three times per week on Monday, Wednesday, and Friday. Further review of the Weekly Wound report for R9 revealed after 5/20/2024, the stage 2 left lateral pressure ulcer was assessed on 5/31/2024, 6/7/2024, 6/14/2024, and 6/21/2024. There were no further assessments of the pressure ulcer after 6/21/2024. However, review of the June 2024 and July 2024 TARs revealed that treatment to the left lateral ankle pressure ulcer continued. Interview on 7/10/2024 at 4:10 pm, Treatment Nurse BB stated that R9 had a wound to the left lateral ankle and described the wound as a soft, open area that R9 was admitted with. Observation of wound care on 7/10/2024 at 4:30 pm, with Treatment Nurse BB, R9 was observed to have a stage 2 pressure ulcer to the left lateral ankle with a granulation wound base, intact wound margins, and small amount of bloody drainage. Interview on 7/11/2024 at 1:45 pm, Regional Nurse Consultant FF stated there were no further assessments of the left lateral ankle pressure ulcer after 6/21/2024.