| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225689 | A. Building<br>B. Wing | 05/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Royal of Cotuit | 161 Falmouth Road<br>Mashpee, MA 02649 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>37183<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had new physicians orders for wound care treatment to newly developed pressure injuries, the Facility failed to ensure they maintained a complete and accurate medical record when nursing failed to transcribe wound care orders that were obtained on 04/29/24 and 04/30/24, onto his/her Treatment Administration Record (TAR).<br><br>Findings include:<br><br>Review of the Facility's policy, titled Skin Integrity Management, dated December 2023, indicated the following:<br><br>-Residents with actual skin breakdown are identified, assessed and provided treatment according to standards of practice;<br><br>-perform and document wound assessment upon initial identification of altered skin integrity;<br><br>-develop a comprehensive care plan to include wound treatments;<br><br>-document all treatments per facility policy.<br><br>Review of the Facility's policy, titled Medication and Treatment Order and Administration, undated, indicated that orders for treatments will be consistent with principles of safe and effective order writing. The Policy indicated that verbal orders must be recorded immediately in the resident's chart by the person receiving the order.<br><br>Review of the Facility's policy, titled Charting and Documentation, dated May 2023, indicated the following:<br><br>-all services provided to the resident, progress toward the care plan goals, or changes in the resident's physical, functional or psychosocial condition, shall be documented in the resident's medical record;<br><br>-objective observations, treatments and changes in the resident's condition shall be documented in the resident medical record;<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -documentation of treatments will include care-specific details including: date and time treatment was provided, name and title of the individual who provided the care, assessment data obtained during the treatment, how the resident tolerated the treatment, notification of family, physician and the signature and title of the individual documenting.<br><br>Resident #1 was admitted to the Facility in March 2018, diagnoses included dementia, chronic obstructive pulmonary disease, polyneuropathy, cardiac pacemaker, chronic kidney disease -stage 3, palliative care, embolism and thrombosis of deep veins of left upper extremity and peripheral vascular disease.<br><br>Review of Resident #1's Nursing Progress Note, written by Nurse #1, dated as a late entry for 04/29/24, indicated Resident #1 was noted with areas (of skin breakdown) on the top of his/her right and left great toe, areas on his/her right and left heels and an area to his/her right ankle.<br><br>During an interview on 05/29/24 at 1:00 P.M., Nurse #1 said that on 04/29/24 during the day shift (7:00 A.M. through 3:00 P.M.) she was notified that Resident #1 had open areas to his feet. Nurse #1 said that she assessed Resident # 1's wounds and noted that he/she had areas of skin breakdown to his/her right and left heel and right ankle, and his/her left and right great toes had scabs on them.<br><br>Nurse #1 said that she notified the Nurse Practitioner (NP), who gave her treatment orders for wound care and that an order for a wound consultation was also given to her by the NP. Nurse #1 said she performed the treatments to Resident #1's wounds on 04/29/24. Nurse #1 said she could not remember what wound care treatment orders were that the NP gave her, but said she believed she had transcribed them into Resident #1's Electronic Medical Record (EMR) Point Click Care (PCC).<br><br>Review of Hospice Skilled Nurse Progress Note, dated 04/30/24, indicated that Resident #1 was seen to reassess bilateral heels, a wedge cushion was added to the end of bed between mattress and foot board, and heel protectors applied.<br><br>The Hospice Note included the following recommendations were provided related to his/her wound care:<br><br>-normal saline cleanse to bilateral heels and left great toe, apply xeroform (a sterile occlusive, non-adhering protective dressing impregnated with a petrolatum blend) cover with a dry protective dressing and to change dressing daily;<br><br>-apply skin prep (water-proof liquid that forms a transparent film over the skin to protect it from possible irritation) to right lateral malleolus (ankle) and right great toe twice a day.<br><br>The Note indicated that the recommendations were reviewed with Nurse #1 and that Resident #1 was to be seen by the wound physician.<br><br>During an interview on 06/03/24 at 10:44 A.M., the Hospice Nurse said that on 04/30/24, she assessed Resident #1's wounds, notified the physician (who was Resident #1's physician at the Facility as well as the Hospice Medical Director) of the new wounds, obtained orders for wound care, performed the treatments to the wounds and reviewed everything with Nurse #1. The Hospice Nurse said that the Facility Nurse (Nurse #1) was responsible for transcribing the wound orders into the EMR.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's Physician's Orders, dated 4/29/24, indicated there was no documentation to support that the telephone orders that were given by the NP to Nurse #1 on 4/29/24 for the treatment of Resident #1's right and left ankle, right and left great toes and right medial ankle were transcribed in Resident #1's EMR.<br><br>Review of Resident #1's Physician Orders, dated 4/30/24, indicated the following:<br><br>- bilateral heel treatment: clean with normal saline, pat dry, apply xeroform to affected area only, cover with a dry protective dressing daily;<br><br>-right ankle and left big toe blister: cleanse with normal saline, pat dry, apply wound gel, cover with dry protective dressing daily;<br><br>-apply skin prep to right big toe twice daily.<br><br>However, review of Resident #1's Treatment Administration Record (TAR) for the month of April 2024, indicated there was no documentation to support that a physician's orders for wound care to his/her right and left heels, to his/her right and left great toes and right ankle were transcribed onto the TAR on 04/29/24 by Nursing.<br><br>Further review of Resident #1's April 2024 TAR indicated there was no documentation to support that the physician's orders for wound care to his/her right and left heels, to his/her left great toe and right ankle were transcribed onto the TAR on 04/30/24, by Nursing.<br><br>During an interview on 06/05/24 at 10:39 A.M., the Director of Nurses (DON) said that it was her expectation that nursing write a telephone order for wound treatments and transcribed the wound care orders that were obtained on 04/29/24 and 04/30/24 into Resident #1's EMR (which included the TAR). |