STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285232	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Country Manor	610 224th Street Milford, NE 68405

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** 47733 Licensure Reference Number 175 NAC 12-006.09D2b Based on record review, observation, and interview; the facility failed to monitor a pressure ulcer for 1 (Resident 4) of 3 sampled residents. The facility staff identified a census of 61. Findings are: Record review of Resident 4's face sheet revealed the resident admitted to the facility 11/30/2020. Record review of a late entry progress note for Resident 4 by Registered Nurse (RN)-J revealed the following Late entry for 2/24, treatment completed to right leg lotion applied, noticed a large piece of lose dry skin hanging from the heal. assessing the area there is a 5 cm x 5 cm purple mushy area on his heal. Applied a merplix to protect the heal. Fax to MD and skin assessment done today. Record review of a fax cover sheet dated 2/26/2024 to Resident 4's practitioner revealed Resident 4 Has a fluid filled area 5.0 Centimeters (CM) X 5.0 CM to the right heel, Possible Pressure related. The facility staff requested a treatment order for the right heel. Record review of a returned fax with the sent date of 2/26/24 revealed the Family Nurse Practitioner (FNP) signed the requested order and faxed back to the facility on [DATE]. The order was received 30 days after the Resident 4 initially had a fluid filled blister identified on the right heel. Record review of Resident 4's Braden score (is a standardized, evidence-based assessment tool commonly used in health care to assess and document a resident's risk for developing pressure injuries) assessed on 2/26/24 revealed the score was 15. A Braden score of 15 is considered a moderate risk for potentially developing a pressure wound. Record review of Resident 4's Advanced Practice Registered Nurse-H's (APRN-H) encounter dated 4/18/2024 revealed Resident 4 had the right heel pressure ulcer listed as a stage 3 (STAGE III Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed.) The APRN-H assessed the measurements as L: (Length) 2.0 cm (Centimeters), W: (Width) 2.0 cm, D: (Depth) 0.1 cm. The ARPN described the wound with 100% granulation tissue (Granulation tissue is new connective tissue and microscopic blood vessels that form on the surface of a wound during the healing process) and moderate (Serosanguineous) sero/sang drainage with an odor. (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	Record review of an encounter sheet for Resident 4 dated 5/9/2024 by APRN-H revealed the measurements for the right heel were L: 3.2 cm by W:3.2 cm, D: 0.1 cm, and granulation tissue is 25% with slough (dead tissue, cream or yellow in color) at 75% of the wound bed. The drainage from the wound was documented as moderate sero/sang with an odor, and peri wound (the area around the wound) as macerated (softening and breakdown of the skin as a result of prolonged exposure to moisture). The encounter sheet dated 4/18-2024 revealed Resident 4's APRN-H identified evidence of infection and wound status as having decline. Record review of a fax cover sheet for Resident 4 dated 5/16/24 reveled APRN-H diagnosed Resident 4 with a wound infection and to start Metronidazole (an anti-biotic medication) 500 milligrams (mg) ,twice a day for 7 days. Observation on 5/21/24 at 7:15 AM of dressing change to Resident 4's right heel completed by Registered Nurse-E (RN-E) revealed RN-E removed the dressing. Further observation revealed the dressing was saturated with sero/sang fluid. The area around the wound was macerated and approximate measurements were 3.0 CM by 3.0 CM. RN-E completed the dressing change as ordered to Resident 4's right heel. Interview on 5/21/24 at 11:30 AM was conducted with the Director of Nursing (DON). During the interview the DON verified there were not measurements for Resident 4's right heel wound from 4/18-5/9/24. The DON revealed the staff nurses should measure the wounds weekly when they are completing the weekly skin observation. The DON confirmed that the facility was not following the skin policy and procedure. The DON confirms the wound deteriorated when the wound nurse did not round at the facility. Interview on 5/21/24 at 11:30 AM with the Assistant Director of Nursing (ADON) revealed that the nurse's taking care of the Resident 4, should have been measuring the wound and notifying the practitioner if the wound was declining. The ADON confirms the wound deteriorated when the wound nurse did not round at the facility. Interview on 5/21/24 with Licensed Practical Nurse-F (LPN-F) reveals that LPN-F rounded with the wound nurse weekly. LPN-F verified the wound nurse had not been at the facility between 4/19-5/8/24. LPN-F confirmed the wound deteriorated when the wound nurse did not round at the facility. Record review of the facility's skin policy and procedure dated 1/20 reveled that residents will receive care consistent with professional standards of practice, to prevent pressure ulcers and do not develop pressure ulcers unless clinically unavoidable. Resident with pressure ulcers will receive necessary treatments and services to promote healing, prevent infection and prevent new ulcers from developing. Procedure of this policy confirms that the nursing staff will follow procedures if skin integrity issues that are noted. The nursing staff will obtain measurements for each skin integrity issue, update the responsible party, update the provider, and obtain orders.