Featured Challenge Scenario

TAG F314

TOPIC Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.

SCENARIO In this scenario, the facility failed to ensure that residents who were admitted without pressure ulcers did not develop avoidable pressure ulcers and that residents with existing pressure ulcers received necessary treatment and services. Could this happen at your facility?

For additional details related to this scenario, see page 2

What actions would you and your staff members take to prevent this from occurring in your facility?

NOTES
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Based on observation, interview and record review, it was determined the facility failed to ensure that residents who entered the facility without pressure ulcers did not develop pressure ulcers unless the individual’s clinical condition demonstrated they were unavoidable and residents with pressure ulcers received the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing for three (Residents #6, #9 and #11) of 10 sampled residents reviewed for pressure ulcers.

1. Resident #11 was admitted to the facility with no skin issues. On 4/06/10 (five days after admission), the facility’s Corporate Nurse identified a Stage III pressure ulcer on Resident #11’s coccyx which measured 2.25 cm x 1.5 cm. On 4/08/10, the physician-ordered low air loss mattress and a pressure-relieving device had not been implemented, there was no dressing on the resident’s pressure ulcer on his coccyx and the resident had developed two pressure ulcers on his left buttock, which had merged into one large pressure ulcer on 4/13/10. Pressure ulcer treatments were not documented as being completed.

2. Resident #6 had Stage II pressure ulcers on her right and left buttocks. Many treatments were not documented as being done and assessments related to pain and interventions were not completed.

3. Resident #9 had a fluid-filled blister on the top of her right foot that had not been identified or assessed. Resident #9 also had a Stage II pressure ulcer on the right buttock with no treatment order. There was no documentation regarding whether the physician-ordered pressure ulcer treatment was being provided.

Failure to provide ongoing, accurate and timely skin assessments and interventions resulted in the development of new pressure ulcers and the deterioration of existing pressure ulcers for Residents #6, #9 and #11 and could affect the five residents residing in the facility with pressure ulcers as well as the 73 residents receiving preventative skin care.

Findings included:

1. During the initial tour on 4/06/10 at 9:56 a.m., the facility’s only ADON and LVN H both revealed Resident #8 and Resident #25 were the only residents in the facility with pressure ulcers.

   In an interview on 4/06/10 at approximately 11:00 a.m. with the ADON, it was revealed skin assessments were done weekly. The ADON stated the nurse put a “1” on the treatment sheet if there were no skin issues and “2” if there were skin issues. If the nurse recorded a “2” for the presence of skin issues, then the nurse would also complete a skin assessment sheet. When queried what it meant if the skin treatment sheet was blank on the assessment dates, the ADON did not provide an answer.

   Note: During the initial tour on 4/06/10, the surveyors identified a wound on the side of Resident #11’s right foot and a fluid-filled blister (Stage II pressure ulcer) on Resident #9’s foot. These findings resulted in corporate personnel performing skin rounds on every resident on the evening of 4/06/10, which resulted in pressure ulcers being identified on Resident #11 and Resident #12.
2. The facility’s face sheet reflected that Resident #11 was not admitted with pressure ulcers. The face sheet reflected no diagnoses.

Review of an admission nursing assessment revealed Resident #11’s skin was warm, dry, clear and that no breakdown, bruises or skin problems were present.

Review of a nurses’ progress note revealed “Was not assessed.” There was no documentation present.

Review of the nurses’ notes dated 4/03/10 through 4/06/10 revealed there was no documentation of any skin breakdown or pressure ulcers for Resident #11.

Review of Resident #11’s treatment sheet dated April 2010 revealed a weekly skin assessment that reflected no adverse skin issues.

Review of the Skin Report dated 4/06/10 reflected a Stage III Deep Tissue pressure ulcer on the coccyx that measured 2.25 cm x 1.5 cm. The Skin Report included further assessment that revealed the pressure ulcer was red in color with no drainage or odor, the current progress was new, the resident had no pain and the treatment was to cleanse the pressure ulcer with wound cleanser, pat dry and apply calcium alginate. Interventions to be implemented included a low air loss mattress and positioning. There was no nurse signature to indicate who performed the assessment.

Note: The Stage III pressure ulcer was identified five days after Resident #11 was admitted to the facility.

Resident #11’s Comprehensive Care Plan, dated 4/07/10, reflected the resident had a Stage III pressure area on his coccyx. Approaches included providing a pressure-relieving device for his bed and wheelchair and performing treatment per order. If no improvement was seen within two weeks, the physician was to be alerted. An interview on 4/08/10 at 11:05 a.m. with the ADON revealed, “We just got the air mattress order yesterday and it wouldn’t hold air. Night shift switched him to the A bed until we get the new mattress. I’m working on it.”

Observation on 4/08/10 at 11:06 a.m. revealed Resident #11 was lying in Bed A (Resident #11’s bed was the B bed). There was no air mattress on Bed A.

Observation on 4/08/10 at 11:25 a.m. with the ADON revealed a Stage III pressure ulcer on Resident #11’s coccyx. There was no dressing on the pressure ulcer. Measurements were 3 cm x 1.5 cm, with a pink/white wound bed and no drainage. Further observation revealed two new pressure ulcers on the left buttock. The ADON stated they were “not there yesterday.” Measurements for one area were 0.3 cm x 0.2 cm, and the other area measured 0.2 cm x 0.2 cm. The ADON completed the wound care treatment to the three pressure ulcers, even though she only had a treatment order for the Stage III pressure ulcer on the coccyx.

Review of a nurses’ note dated 4/08/10 at 2:30 p.m. revealed “report of new open areas on left buttock #1 0.3 x 0.2 cm; #2 0.2 cm x 0.2 cm.”

Review of the current Skin Report revealed Resident #11’s new pressure ulcers were not documented and there was no mention of pain.

Resident #11’s Treatment Sheet dated April 2010 reflected the 4/08/10 coccyx wound care was not documented as completed.
Observation on 4/12/10 at 7:55 a.m. revealed the low air loss mattress for Resident #11 was unplugged and not inflated.

Observation on 4/12/10 at 7:56 a.m. revealed Resident #11 was sitting up in a hard-back chair next to his bed. The chair did not have a pressure-relieving device.

Observation on 4/13/10 at 9:35 a.m. of Resident #11’s coccyx pressure ulcer revealed a measurement of 6 cm x 3 cm, and his left buttock pressure ulcer measured 3 cm x 1 cm. The pressure ulcer to the left buttock had been previously been two pressure ulcers, which had now merged into one.

Observation on 4/13/10 at 9:35 a.m. revealed no pressure-relieving device in the chair, which was next to Resident #11’s bed.

Review of Resident #11’s Skin Condition Report dated 4/13/10 revealed a Stage III Deep Tissue pressure ulcer to Resident #11’s coccyx, which measured 3 cm x 1 cm. The report reflected that the pressure ulcer was red in color, had scant serous drainage with odor, was not healing, that the resident had pain and to continue the treatment. Interventions were not addressed. Also included on this form was a picture of the location of the pressure ulcer and a second picture of the lower right of the Stage III pressure ulcer with measurements of “6 cm long x 2 cm” with no further description or treatment information.

3. Resident #6’s most current MDS assessment reflected the resident had short- and long-term memory deficits, had moderately impaired decision-making abilities, could make herself understood sometimes and sometimes understood others. The MDS also reflected Resident #6 required total assistance from two people to physically assist her with transfers, was incontinent of bladder and bowel, had two Stage II pressure ulcers, had other skin problems and that her skin was desensitized to pain or pressure. The MDS further reflected skin treatments, which included a pressure-relieving device for her chair, nutrition or hydration interventions to manage skin problems, ulcer care, application of dressings (with or without topical medications) other than to feet and application of ointments/medications (other than to feet).

Observation on 4/06/10 at 1:20 p.m. of Resident #6’s buttocks revealed a Stage II pressure ulcer on the right buttock, approximately 2.5 cm x 3 cm in size. The pressure ulcer was beefy red. A Stage II pressure ulcer to the left buttock was approximately 1 cm x 2 cm and beefy red in color.

Resident #6’s Skin Condition Reports over a range of dates reflected the following regarding the left buttock:

- Measurements of 3 cm x 1 cm, red in color, no drainage or odor, progress was new, treatment with medication, no pain and interventions were not addressed.
- Measurements of 3 cm x 2 cm, red in color, small amount of serous drainage, no odor, progress deteriorated, the treatment was changed, intervention was positioning and pain was not assessed.
- Measurements of 3 cm x 2 cm, red in color, small amount of serous drainage, no odor, progress not changed, continue treatment, pain and interventions were not addressed.

On 4/06/10 following surveyor inquiry, the assessment reflected measurements of 1.5 cm x 0.75 cm, surrounding 4 cm x 3 cm area of redness, red in color, drainage, progress, treatment not assessed, no odor, no pain, interventions (pressure-relieving mattress, pressure-relieving cushion and positioning), no nurse signature.
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Resident #6’s Skin Condition Reports over a range of dates reflected the following regarding the right buttock:

- Measurements of 3 cm x 1 cm, red in color, no drainage or odor, progress was new, treatment with medication, no pain and interventions were not addressed.
- Measurements of 3 cm x 2 cm, red in color, small amount of serous drainage, no odor, progress deteriorated, treatment changed, intervention was positioning and pain was not assessed.
- Measurements of 3 cm x 2 cm, red in color, small amount of serous drainage, no odor, progress not changed, continue treatment, intervention was positioning, and pain was not assessed.

No assessment was completed for the pressure ulcer on the right buttock on 4/06/10.

Review of the Treatment Sheets dated March 2010 revealed the treatment, “Stage II shearing to buttocks area; apply Lantiseptic twice a day until healed,” was completed on 3/20/10 by the day shift and on 3/19/10, 3/20/10, 3/22/10 and 3/23/10 by the night shifts. Another treatment, “Routine skin care with lotion or Vitamin A and D ointment every shift,” was also listed. The surveyor could not determine the actual dates on which treatments were done and not done because there were no dates on the top of each column on the form where the date boxes were located.

Review of the Treatment Sheets dated April 2010 revealed the following treatment: “Cleanse areas to buttocks with wound cleanser, pat dry, apply medication, cover with 4x4s, do not tape.”

Review of the Treatment Sheet revealed:

- 4/01/10: No initials on days or evenings the treatment was done
- 4/02/10: No initials on days or evenings the treatment was done
- 4/03/10: No initials on days or evenings the treatment was done
- 4/04/10: No initials on days or evenings the treatment was done
- 4/05/10: No initials on days or evenings the treatment was done
- 4/06/10: No initials on days or evenings the treatment was done
- 4/07/10: No initials on days the treatment was done
- 4/08/10: No initials on days the treatment was done
- 4/09/10: No initials on evenings the treatment was done

4. Resident #9 is a female. Resident #9’s most current MDS assessment reflected the resident has severely impaired decision-making abilities and could not make herself understood. The MDS also indicated that Resident #9 is totally dependent for transfers, requiring two people to physically assist her. The MDS further reflected Resident #9 had no pressure ulcers or other skin problems present.

During the initial tour on 4/06/10 at 10:52 a.m., Resident #9 was observed with a 1.5 cm x 0.5 cm fluid-filled blister on the top of her left foot. LVN EE was not aware of the blister, what caused it or the date of onset. Resident #9 had a scar on the top of her right foot that was the same size and in the same position.
A review of Resident #9’s comprehensive physician’s orders reflected orders to offload the resident’s heels every shift, weekly skin assessments on Wednesdays and to apply skin prep to both right and left heels.

A review of the current care plan dated 9/25/09 revealed Resident #9 had been identified as high risk for skin breakdown due to dependent bed mobility and bowel incontinence. She had a Stage I pressure ulcer on the right heel, a Stage II pressure ulcer on her sacrum and two open areas on her buttocks. Approaches included: Assess skin every day during care and report any redness and/or irritation, pressure relieving device added to chair/bed and additional treatments or interventions as ordered by the physician.

Review of Resident #9’s Skin Condition Report dated 04/05/10 revealed two areas circled on the body diagram on the right buttock. Area “A” was noted as “peeling skin total area 2 cm x 1.5 cm with open area of 0.3 cm at coccyx.” Area “B” was indicated below area “A” on the diagram, and was noted as “peeling skin 4 cm x 2 cm with rough, raised skin.” No documentation of color, drainage, odor, progress, treatment, pain, intervention or a nurse’s signature was included on the skin condition report. There was no documentation regarding Resident #9’s left foot.

Observation of the top of Resident #9’s left foot on 4/13/10 at 9:50 a.m. revealed the fluid in the blister (observed on 4/06/10) had absorbed. The overlying skin of the blister was intact.

5. Review of the facility’s current policy and procedure (undated) for “Pressure Ulcer, Decubitus Skin Assessment” reflected:

Purpose:
1. To promote healing of decubitus ulcers
2. To document care provided
3. To provide follow up for each decubitus in a sequential document ...

Procedure:
1. Assess any new decubitus ulcer as soon as discovered
2. Include all pertinent information on pressure sore/decubitus record: Location of ulcer, stage, measurement in centimeters of width and depth, surrounding skin conditions and any drainage should be described
3. Notify physician and obtain orders for treatment
4. Notify the family member or responsible party; include this information in the nurses’ notes …
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Documentation:

1. Nurse’s notes include:
   a. Date and time decubitus ulcer found
   b. Complete description, including:
      • Specific location and description of area
      • Size in cm
      • Stage
      • Color and condition of surrounding skin
      • Any drainage present
   c. Verification that notification was made to:
      • Physician

2. Document record includes:
   a. Complete initial assessment with signature of nurse and diagram of body chart showing areas affected
   b. Weekly follow-up charting which describes progress, including:
      • Site
      • Stage
      • Size in cm (width, length, depth)
      • Presence or absence of drainage
      • Odor
      • Description of appearance
      • Any changes in treatment protocol
      • Nurse’s signature

3. Quality assessment and assurance
   a. A list of all decubitus being treated needs to be reviewed

6. The Resident Census and Conditions of Residents (CMS Form 672) dated 4/08/10 and signed by the DON reflected there was a census of 73 residents, there were five residents with pressure ulcers and 73 residents received preventative skin care.