

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  010001	<b>(X3) Date Survey Completed</b>  11/06/2020
<b>Name of Provider or Supplier</b>  Southeast Health Medical Center	<b>Street Address, City, State</b>  1108 Ross Clark Circle, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>A0392</b>	<p><b>STAFFING AND DELIVERY OF CARE</b> CFR(s): 482.23(b)</p> <p>The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records (MR), facility policy, and interviews, it was determined the facility failed to ensure staff: 1. Turned at risk patients every 2 hours as ordered by the physician to prevent pressure injuries. 2. Documented wound assessments, measurements and wound care as directed per facility policy. 3. Obtained orders for all wound care provided. 4. Provided wound care as ordered by the physician. 5. Notified the physician of changes in patient condition/wounds as directed per facility policy. This affected 4 of 5 MR's reviewed of patients at risk for pressure injuries, including Patient Identifier (PI) # 5, PI # 2, PI # 1, PI # 4, and had the potential to affect all patients at risk for pressure injuries. Findings include: Policy: Skin and Wound Care Last revised: 3/4/2020 Policy Statement: A comprehensive Skin Assessment should be completed on admission and during every shift for all patients (see attachment). The Braden Scale Risk Assessment Tool ... should be completed every shift by a licensed nurse. A patient will be considered at risk for pressure ulcers if the total score is 18 or less. Skin care shall consist of special attention to areas susceptible to breakdown. It is the responsibility of all direct care staff to ensure that patients receive appropriate preventive interventions (e.g. turning, nutrition, moisture control). Any lesions that are identified on assessment should be documented and reported to the admitting physician. The wound care order set should be implemented for wound care management and dressing changes. Wound care</p>

consults should be placed for open and/or necrotic wounds. Wounds should be measured length and width on admission, weekly, and with any changes. Attachment for Skin Assessment: The assessment should consist of: 1. A head-to-toe skin assessment including assessment of the skin over all bony prominences... Assess the skin beneath bandages and dressings... 2. For patients found to be at risk for pressure ulcers, the nurse identifying the risk may initiate the measures indicated below: ... Reposition every two hours and PRN (as needed). All position changes should be documented. ... 3. If a lesion or wound is identified, the following procedure may be performed. Complete documentation to include location, color, approximated size (length and width only), odor, drainage, peri-wound skin, and dressing status if applicable. Notify physician on identification of wound and any changes. Implement wound care order set for management and dressing changes. ... Wound Care Order Set: Physician Orders Only the boxes checked apply. ...Red or Purple discolored skin: 1. Wound Management - clean with soap and water. Apply Moisture Barrier Skin Protectant now and q (every) week. Do Not Cover Or Massage Red/Purple Areas. 2. Moisture Barrier Skin Protectant. Open Wound: 1. Wound Management - clean site with soap and water, pat dry. Apply Moisture Barrier Skin Protectant. Cover with Duoderm dressing. Change q 5 days and PRN (as needed) for peeling. 2. Moisture Barrier Skin Protectant 3. Duoderm 4. Wound Management - clean with NS (normal saline). Apply/pack NS wet to moist dressing, change daily and PRN for drainage. 5. Wound Care Consult - Open wound, moist, necrotic, yellow or brown. Dry Wound: 1. Wound Management - clean with soap and water. Pat dry. Apply skin prep wipe. 2. COL (brand) Skin Prep Wipes 3. Wound Care Consult (Dry wound, scabbed or eschar) 1. PI # 5 was admitted to the facility on 4/26/2020 with diagnoses of Altered Mental Status, Possible Ingestion Error, Dehydration, Non ST Elevated Myocardial Infarction. Review of the Physician's orders dated 4/26/2020 at 5:06 PM revealed orders for "activity: bedrest" and "if nonsurgical wound present, implement wound care order set." Review of the Medical Record, including the Daily Focus Assessment Report (DFAR) Activities of Daily Living Notes and Physical Therapy (PT) Notes revealed PI # 5 needed assistance to turn and reposition in bed. The facility staff failed to turn and document PI # 5 was turned every 2 hours as ordered to prevent skin breakdown and/or progression of pressure injuries. The facility policy, Skin and Wound Care, directed preventive interventions, such as turning and moisture control, were to be implemented for a Braden score of 18 or less. The admission nursing assessment dated 4/26/2020 at 10:45 PM revealed skin assessment documentation of scattered abrasions and/or bruises and "... reddened area on buttocks." The Braden Scale Risk Assessment score was 15, indicating PI # 5 was at risk for pressure injury. There was no documentation of a skin assessment of the buttocks each shift on 4/30/2020, 5/1/2020 and 5/2/2020 as directed per facility policy. Review of the PT note dated 5/1/2020 at 11:14 AM revealed "turning over in bed...total assist..." On 5/3/2020 at 11:30 AM, nursing documentation revealed "sacral pad in place to reddened area on coccyx/coccyx pink and blanchable." There was no documentation of a physician's order for a sacral pad or that the wound care order set was implemented as directed per facility policy. On 5/4/2020 at 12:45 PM revealed PT note documentation of "turning over in bed...total assist..." On 5/6/2020 at 9:43 AM, nursing documentation revealed "purple/red coccyx; friction pad in place." Braden Risk Assessment score of 12 indicating PI # 5 was at risk for pressure injury. A wound care consult was ordered 5/6/2020 at 11:13 AM for "purple/red coccyx and fragile skin with tears" Nursing documentation dated 5/7/2020 at 6:17 AM revealed "...coccyx, deep purple in color...R buttock red/purple, denuded...L buttock redness, no open area,...Buttock Interventions...Cleaned with soap and water..." There was no documentation of wound measurements or that the wound care order set was implemented. On 5/7/2020 at 11:21 AM, the wound care nurse documentation

revealed a sacral deep tissue injury (DTI) purple and reddened in color measuring 2 (length) x 0.5 (width) x 0 (depth) centimeters (cm) which was left open to air, Right buttock DTI with sanguineous, serious fluid drainage, purple and reddened in color measuring 6 x 8 x 0 cm which was left open to air, Left buttock DTI purple and reddened in color measuring 1.5 x 3 x 0 cm which was left open to air. The wound care recommendations were to "...turn q (every) 2 (hours) avoid supine position... Advanced skin protectant to buttock and cover with sacral friction pad." Review of the physician's order dated 5/7/2020 at 11:39 AM revealed "clean with soap and water. Apply moisture barrier skin protectant now and q (every) week...Apply Sacral friction pad. Turn patient every 2 hours avoiding supine position." On 5/7/2020 at 8:45 PM documentation revealed the patient was "turned to right side." Further review revealed the patient was not documented as turned from the right side position until 5/8/2020 at 12:36 AM when the patient was "turned to left side." There was no documentation the patient was repositioned from the right side position for 3 hours and 51 minutes. On 5/8/2020 at 12:36 AM documentation revealed the patient was "turned to left side." Further review revealed the patient was not documented as turned from the left side position until 5/8/2020 at 6:36 AM when the patient was "turned to right side." There was no documentation the patient was repositioned from the left side position for 6 hours. On 5/9/2020 at 8:43 AM, nursing documentation revealed "...Right buttock pressure sore with dark red/black center...Sacral midline vertical pressure sore that is reddened...Buttocks interventions...open to air." There was no documentation a sacral friction pad was applied to the sacral wound. Review of the physician's order dated 5/9/2020 at 10:31 AM revealed "discontinue Duoderm 4 x 4." There was no documentation from what wound the Duoderm was discontinued. On 5/9/2020 at 4:01 PM, nursing documentation revealed "...Buttock pressure sores cleaned with NS and 4 x 4 Duoderm applied to left buttock as well as midline sacral area...Cleaned with saline, Cleaned with soap and water..." There was no documentation of a physician's order for the use of NS to clean the wounds and to apply Duoderm. Review of the physician's order dated 5/9/2020 at 4:06 PM revealed "clean site with soap and water, pat dry. Apply Moisture Barrier Skin Protectant. Cover with Duoderm dressing. Change q 5 days...". The wound care order failed to include the location/identification of the wound. On 5/10/2020 at 11:48 AM, nursing documentation revealed "Ordered a sacral friction reduction pad per MD (Medical Doctor) order for patient. Central Supply called and said they are out of stock. Messaged (MD identified)...regarding situation and asked if she/he would like to leave wound open to air for now or place a Duoderm. There was no documentation of a return call from the MD or a follow up call to the MD. On 5/10/2020 at 2:30 PM, nursing documentation revealed "Buttock...applied duoderms per MD order." There was no documentation the wound was cleaned with soap and water, a moisture barrier was applied. There was no documentation of a physician's order for the Duoderm to the buttock wounds. On 5/11/2020 at 4:29 PM, nursing documentation revealed "...redness noted to both buttocks, to right side buttocks there is a large black area with redness that does not blanch surrounding it, Duoderm placed over this area. To left buttocks, there is redness that is draining small amount serosanguinous drainage, OTA (open to air). Down the midline of sacral area is a reddened area that is OTA. Wanded bottom with Cavilon wand (moisture barrier)..." There was no documentation the wound was cleaned with soap and water and a sacral friction pad was applied. There was no documentation of a physician's order for the Duoderm to the buttock wounds. On 5/12/2020 at 7:05 AM, 5/12/2020 at 8:50 PM, and on 5/13/2020 at 9:21 AM, nursing documentation revealed "redness noted to both buttocks, to right side buttocks there is a large black area with redness that does not blanch surrounding it, Duoderm placed over this area. To left buttocks, there is redness that is draining small amount serosanguinous drainage, OTA. Down the

midline of sacral area is a reddened area that is OTA." There was no documentation the wound was cleaned with soap and water, a moisture barrier was applied and a sacral friction pad was applied. There was no documentation of a physician's order for the Duoderm to the buttock wounds. On 5/13/2020 at 5:08 PM, nursing documentation revealed "black spot to pt right side buttocks with red skin that does not blanch directly outside the black spot. Redness noted to entire buttocks and between butt cheeks down into groin area that does blanch. To left buttocks is open pressure sore area with redness that blanches surrounding it. Applied Duoderm to this area on left buttocks and applied Duoderm to right buttocks covering the black area. Then applied Sacral foam pad over both duoderm and sacrum. Wanded entire bottom with Cavilon wand. There was no documentation the wound was cleaned with soap and water and no documentation of a physician's order for a Duoderm to the buttock wounds. On 5/13/2020 at 7:30 PM documentation revealed the patient was "turned to supine." Further review revealed the patient was not documented as turned from the supine position until 5/13/2020 at 9:30 PM when the patient was "turned to left side." The patient was documented in the supine position for 2 hours when physician orders were to "avoid supine position." On 5/14/2020 at 10:25 AM, nursing documentation revealed "redness noted to both buttocks, to right side buttock - large black area with redness that does not blanch surrounding it, Duoderm placed over this area. To left buttocks, there is redness that is draining small amount serosanguinous drainage, OTA. Down the midline of sacral area is a reddened area that is OTA." There was no documentation the wound was cleaned with soap and water, a moisture barrier was applied and a sacral friction pad was applied. There was no documentation of a physician's order for the Duoderm to the buttock wounds. Review of the PT note documentation dated 5/14/2020 at 11:21 AM revealed "turning over in bed... total assist..." On 5/15/2020 at 11:00 AM, nursing documentation revealed "right buttock pressure sore that is red with a dark black center...Left buttock pressure sore /skin laceration is red and open with serosanguinous drainage...Midline sacral pressure sore is open, red...Duoderm currently on left and right buttock with sacral friction reduction pad on sacral area..." There was no documentation of a physician's order for the Duoderm to the buttock wounds. There was no documentation the wounds to the buttocks and sacral area were measured weekly for the week of 5/10/2020 through 5/16/2020 as directed per policy. On 5/18/2020 at 6:11 AM, nursing documentation revealed "R buttock has eschar noted, L buttock is moist red, open...buttock interventions...wound care...cleaned with soap and water..." There was no documentation a moisture barrier and sacral friction pad was applied to the buttock wound per the physician's order. On 5/18/2020 at 8:25 AM, there was a physician's order for a "wound care consult...please re-assess decubitus ulcers..." On 5/18/2020 at 12:14 PM documentation revealed the patient was "turned to supine." Further review revealed the patient was not documented as turned from the supine position until 5/18/2020 at 2:22 PM. The patient was documented in the supine position for 2 hours and 8 minutes when the physician's order was to avoid supine position. On 5/18/2020 at 11:42 PM documentation revealed the patient was "turned to supine." Further review revealed the patient was not documented as turned from the supine position until 5/19/2020 at 2:00 AM when the patient was "turned to right side." The patient was documented in the supine position for 2 hours and 18 minutes and the physician order was to avoid supine position. On 5/19/2020 at 6:00 AM documentation revealed the patient was "turned to supine." Further review revealed the patient was not documented as turned from the supine position until 5/19/2020 at 8:00 AM when the patient was "turned to right side." The patient was documented in the supine position for 2 hours. On 5/19/2020 at 10:05 AM, wound nurse documentation revealed: a sacral Stage III pressure ulcer draining serous fluid with slough measuring 2 x 0.4 x 0.2 cm and a new hydrocolloid dressing was applied

to the wound, a right buttock "ulcer now unstageable, covered w/ dark black eschar and slough, periwound skin reddened, scant small serosanguinous drng (drainage)" with measurements of 6.3 x 5.8 cm and "cleaned, covered w/ NS-moist gauze then small folded ABD pad, secured w/ paper tape", a left buttocks stage II pressure ulcer draining sanguineous and serous fluid, measuring 2 x 3 x less than 0.2 cm and "cleaned, dried, skin protectant applied, covered w/ Duoderm..." Further review of the wound nurse documentation dated 5/19/2020 revealed the right buttock wound changed from a purple and red DTI documented on 5/7/2020 to a Unstageable pressure ulcer with dark black eschar and slough. PI # 5 was discharged from the facility on 5/19/2020. The staff failed to consistently implement preventative interventions and failed to follow physician orders and facility protocols for wound management resulting in wound deterioration. An interview was conducted on 10/16/2020 at 12:53 PM with Employee Identifier (EI) # 2, Quality Outcomes Team Leader, and EI # 3, Clinical Nurse Educator, who confirmed the wound care order sets were not implemented by the facility staff, the wounds were not measured and assessed per the facility policy and the staff failed to follow the physician's order to avoid supine position when turning and repositioning PI # 5. Interviews were conducted on 11/4/2020 from 2:46 PM to 4:16 PM with 2 Patient Care Assistants (PCA), EI # 9 and EI # 10, who cared for PI # 5. When asked about the management of every 2 hour turn patients, both PCAs described the "new" process of Turn Teams and Universal Turns. This was described as 2 staff members are assigned a specific time to turn all the patients on the unit. The charge nurse makes the assignment on a paper sheet at the beginning of each shift. Patients are turned to the right, left, then supine. They both stated if the patient was not to be in the supine position it was noted on the assignment sheet and those patients would be turned right, left, right. Neither PCA could remember exactly when the new process began and both stated within the last 6 months. 2. PI # 2 was admitted to the facility on 10/3/2020 with diagnoses of Acute Intracranial Hemorrhage, Hypothermia, Acute Kidney Injury and Possible Sepsis. Review of the admission DFAR dated 10/4/2020 at 12:07 AM revealed documentation of an "Open and draining wound(s)-implement Wound Care Order set. WOCN (Wound, Ostomy, Continence Nurse) consult needed....8 x 5 red/black unstageable wound to coccyx...both heels soft red/discholorred unstageable..." Review of the physician order dated 10/5/2020 at 1:11 PM revealed an order to turn the patient every 2 hours with instructions to "avoid supine positioning d/t (due to) sacral ulcer." Review of the Wound Nurse assessment dated 10/7/2020 at 11:50 AM revealed documentation of a Stage III sacral pressure ulcer with a length of 6.5 cm, width of 5.7 cm, and depth 2.4 cm. The nurse documented "pt (patient) s/p (status post) surgical I&D (Incision and drainage)...there is still adherent slough to wound bed, there are scattered areas of cautery noted to wound edges, serosanguinous drng (drainage)...there is still some slight deep red/purple to distal periwound area at 6:00 only" and the application of a wound V.A.C (Vacuum Assisted Closure) device. Review of the DFAR Activities of Daily Living Note(s) revealed the following: On 10/5/2020 at 8:00 PM, the patient was "turned to right side" the next turn was documented on 10/6/2020 at 11:21 PM when the patient's linen and gown was changed. There was no documentation the patient was repositioned from the right side position for 3 hours and 21 minutes and no documentation of the position the patient was placed in following the linen and gown change. On 10/6/2020 at 5:00 PM, 10/6/2020 at 5:30 PM, 10/6/2020 at 7:10 PM, and 10/7/2020 at 8:30 AM the patient was "turned to left side." Further review revealed on 10/7/2020 at 10:00 AM the patient was "turned to right side." There was no documentation the patient was repositioned from the left sided position for 17 hours. On 10/8/2020 at 6:04 AM and 10/8/2020 at 8:39 AM, the patient was "turned to supine". Further review revealed on 10/8/2020 at 10:28 AM the patient was "turned to right side." There was no documentation the

patient was repositioned from the supine position for 4 hours and 24 minutes, in spite of a physician's order to avoid supine position. On 10/8/2020 at 6:19 PM, 10/8/2020 at 9:14 PM, 10/9/2020 at 12:00 AM, 10/9/2020 at 4:00 AM, and 10/9/2020 at 6:23 AM the patient was documented as "turned to left side." Further review revealed on 10/9/2020 at 9:16 AM the patient was "turned to right side." There was no documentation the patient was repositioned from the left sided position for 14 hours and 57 minutes. On 10/9/2020 at 11:15 AM, the patient was "turned to left side". Further review revealed on 10/9/2020 at 2:50 PM the patient was "turned to right side." There was no documentation the patient was repositioned from the left sided position for 3 hours 35 minutes. On 10/10/2020 at 6:53 PM and 10/10/2020 at 8:32 PM, the patient was "turned to left side". Further review revealed on 10/10/2020 at 10:32 PM the patient was "turned to right side." There was no documentation the patient was repositioned from the left sided position for 3 hours 39 minutes. On 10/11/2020 at 1:35 AM the patient was "turned to left side." Further review revealed on 10/12/2020 at 8:36 AM the patient was "turned to right side." There was no documentation the patient was repositioned from the left sided position for 7 hours and 1 minutes. Review of the Wound Care Nursing Assessment dated 10/12/2020 at 9:41 AM, which was the next measurement of the sacral wound, revealed documentation the Stage III sacral pressure ulcer had a length of 7 cm, width of 8.5 cm, and depth of 1.6 cm and contained necrotic tissue and sloughing. PI # 2 was discharge on 10/13/2020 to another facility for rehabilitation. An interview was conducted via email on 10/19/2020 at 1:56 PM with EI # 1, Director of Regulatory Compliance, who confirmed the patient was not turned per the physician order on the above dates and times. An interview was conducted on 11/5/2020 at 1:01 PM with EI # 13, Licensed Practical Nurse (LPN), who provided care to the patient during hospital stay. EI # 13 verbalized the facility educates nurses on performing wound care and skin assessments by having wound care come talk to them and also by computer training. EI # 13 verbalized wounds measured by the nursing staff "at least once a week or if any changes." EI # 13 was asked how patients who require every 2 hour turns are managed. EI # 13 stated, "we just implemented a new turning procedure, where staff is assigned every 2 hours to turn patients. If it's our time to turn then we go, turn them. There is a board in the patient's room that has the last position, so we do the opposite. Started a week ago... Before that the PCA's would turn them and we would remind them." EI # 13 was unable to recall PI # 2 or any information about the patient. An interview was conducted on 11/5/2020 at 2:25 PM with EI # 14, PCA who provided care to the patient during hospital stay. EI # 14 was asked how patients who require every 2 hour turning are managed. EI # 14 stated, "we start shift by giving report and we go over some of the things the patient needs assistance with which includes the turn schedule. You can go into the computer and see when the last turn was. If someone needs to start being turned, we will bring that up with the nurse. We write it on the white board when we last turned...In the past two weeks we have been doing the turn team every 2 hours. EI # 14 was unable to recall PI # 2 or any information about the patient. An interview was conducted on 11/6/2020 at 9:00 AM with EI # 15, PCA who provided care to the patient during hospital stay. EI # 15 was asked how patients who require every 2 hour turning are managed. EI # 15 stated, "report at start of shift, if I get a total (assist) or if the nurse tells me. Most of the time it's in the report. I try to do left, right, supine. I look at them and turn them the opposite way. Usually the last position is on the board in the room, we sign it every 2 hours and on day shift every hour...turn teams started a week or two ago." EI # 15 was unable to recall PI # 2 or any information about the patient. An interview was conducted on 11/6/2020 at 9:30 AM with EI # 16, RN who provided care to the patient during hospital stay. EI # 16 verbalized he/she received education on performing wound care and skin assessments at the facility by "...CBL (computer-

based learning) on wound care and the nursing skills fair for wound care. EI # 16 verbalized wounds are measured by the nursing staff "on admission and we started every Wednesday or Thursday. That started last week, it's been very recent." EI # 16 was asked how patients who require every 2 hour turns are managed. EI # 16 stated, "mostly the PCA's, the off going nurse mentions it if the patient is a turn and we let the PCA's know they are a turn. We have started the turn teams maybe about 2 weeks ago. A nurse and PCA staff, 2 people, are assigned in 2-hour increments and we go around and turn everyone at one time. The position to turn is on the form, then you go in and chart the patient was turned under the ADL with what side they were turned too." EI # 16 did recall PI # 2 and was asked about the period of time on 10/6/2020 through 10/7/2020 when you there was no documentation the patient was turned. EI # 16 stated, "I'm pretty sure we (EI # 16 and EI # 15) turned her/him together." 41623 3. PI # 1 was admitted on 7/31/2020 with diagnoses including Hypernatremia, Acute Stroke, Non-ST-elevation Myocardial Infarction (NSTEMI), and Obtunded. Review of the DFAR dated 7/31/2020 at 7:00 PM revealed documentation of a Braden Risk Assessment score of 15, indicating the patient was at risk for developing pressure injuries. Interventions included encourage to turn every 2 hours (Q 2 hrs), keep head of bed (HOB) less than 30 degrees and pressure prevention devices including float heels and total care bed. Review of the nursing Admission Assessment Report dated 7/31/2020 at 10:24 PM revealed the nurse documented "Skin lesions on admission, Absent". Review of DFAR dated 8/8/2020 at 8:20 AM revealed a Braden Assessment score of 11. A sacral reduction patch was applied to the sacral area. The nurse documented "skin turgor decreased elasticity". There was no other documentation of skin assessment. Review of the DFAR dated 8/13/2020 at 9:30 AM revealed "open area to sacrum; sanguineous drainage noted; mediplex applied; ... Buttock Interventions wound care...cleaned with soap and water". There was no documentation of the measurements of the wound per policy. There was no documentation the physician was notified of the wound and no documentation of an order for wound care or mediplex dressing. There was no documentation the Wound Care Order Set was implemented. Review of the DFAR dated 8/14/2020 at 8:30 AM revealed documentation "open area to sacrum; sanguineous drainage noted; mediplex applied; ... Buttock Interventions wound care...cleaned with soap and water". There was no documentation of the size of the wound. There was no documentation the physician was notified of the wound. There was no documentation of an order for wound care or mediplex dressing. Review of the DFAR dated 8/14/2020 at 8:40 PM revealed "sacral left butt cheek red/pink in color beefy skin open draining scant amount sanguineous fluid, periwound dry". There was no documentation of the size of the wound. There was no documentation the physician was notified of the wound. Review of the DFAR(s) dated 8/15/2020 and 8/16/2020 revealed no documentation of wound assessment and wound care. Review of the Braden Scale dated 8/17/2020 at 8:17 AM revealed the patient was bedfast and mobility very limited. Review of the DFAR dated 8/17/2020 at 3:52 PM revealed EI # 8, Wound Care Nurse, documented an assessment of an unstageable sacral pressure ulcer measuring 8.5 cm in length by 6.5 cm in width. The nurse documented the wound was moist, necrotic, sloughing, and draining serous fluid. EI # 8 contacted EI # 7, Hospitalist, for orders for wound care. Review of the physician orders dated 8/17/2020 at 3:52 PM revealed orders including; turn every 2 hours, avoid positioning supine, Triad wound dressing paste apply to bilateral buttocks daily. Review of the Activities of Daily Living Note(s) dated 8/17/2020 through 8/24/2020 revealed the following: On 8/17/2020 at 8:00 PM the nurse documented the patient was turned to the right side, on 8/18/2020 at 12:24 the patient was turned to the right side, at 2:51 AM the patient was turned to the right side, and at 4:15 AM the patient was turned to the left side. This was 8 hours 15 minutes on the right side. Review of the Braden Scale dated 8/17/2020 at 9:45 PM

revealed the patient was bedfast and completely immobile. On 8/18/2020 at 12:01 PM the patient was turned to supine, the next documented position change was at 3:12 PM to the right side, which was 3 hours 11 minutes supine and the physician order was to avoid supine. Review of the Braden Scale dated 8/19/2020 at 10:27 AM revealed the patient was bedfast and completely immobile. On 8/19/2020 at 3:37 AM the patient was turned to the right side, at 8:41 AM turned to right side, and at 10:30 AM turned to the left side, which was 6 hours 57 minutes on right side. On 8/20/2020 at 4:00 AM the patient was turned to the left side, at 8:50 AM turned to left side, at 10:18 AM turned to left side, and at 11:11 AM the diaper was changed and linen saver was changed, which was 7 hours 11 minutes on the left side and the physician order was to turn every 2 hours. On 8/21/2020 at 8:00 AM the patient was turned to the right side. At 12:00 PM the patient was turned to the left side, which was 4 hours on the right side. On 8/22/2020 at 5:05 PM the patient was turned to right side, at 6:18 PM turned to right side, at 10:05 PM turned to right side, and at 10:30 PM the linen saver pad was changed. PI # 1 was on the right side 5 hours 25 minutes. The facility staff failed to follow the physician orders to turn PI # 1 every 2 hours avoiding the supine position. PI # 1 was transferred to a rehabilitation facility on 8/24/2020. An interview on 10/16/2020 at 8:10 AM with EI # 1, Director of Regulatory Compliance, EI # 2, Quality Outcomes Team Leader, EI # 3, Clinical Nurse Educator, and EI # 4, Director of NCCU (Neuro Critical Care Unit) confirmed the facility policy was not followed for wound assessment, measuring, physician notification of new or change in wounds, obtaining physician orders for wound care, and following physician orders for patient turning. 4. PI # 4 was admitted to the facility on 7/11/2020 with diagnoses including Corona Virus Pneumonia, End Stage Renal Disease, and Hypotension. Review of the physician order dated 7/12/2020 at 3:42 PM revealed an order for Wound Management including "clean site with soap and water, pat dry, apply moisture barrier skin protectant. Cover with duoderm dressing. Change every 5 days and PRN (as needed) for peeling". Review of the DFAR Braden Scale dated 7/12/2020 at 4:00 PM revealed a score of 14, indicating PI # 4 was at risk for pressure injury. The nurse documented "noted a pink open area to left inner buttocks approximately the size of a pencil eraser, no drainage noted". Review of the DFAR dated 7/19/2020 at 5:00 PM revealed documentation "Buttock...duoderm removed from bottom, skin is very moist and duoderm will not stay in place. Area cleaned, dried, and left open to air...". There was no documentation of the measurements of the wound. There was no documentation the physician was notified of the change of the wound condition. There was no documentation of an order to discontinue duoderm patch and leave area open to air. Review of the DFAR dated 7/20/2020 at 1:44 PM revealed a wound assessment of sacral lesion, draining sanguineous fluid, moist, reddened with area of excoriation over sacrum with small open areas extending to perineal area. The measurements were 10 cm in length, 10 cm in width, 0.0 cm in depth. Review of the DFARs dated 7/21/2020 through 8/13/2020 revealed no documentation of weekly wound measurements as directed per facility policy. An interview on 10/16/2020 at 8:10 AM with EI # 1, EI # 2, EI # 3, and EI # 4 confirmed the physician was not notified of changes in wound condition and weekly wound measurements were not obtained per facility policy.