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	175414	A. BUILDING _____ B. WING _____	C 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VILLAGE	86 TWENTY-SECOND AVENUE MOUNDRIDGE, KS 67107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The follow citations represent the findings of complaint investigations 166646 and 166516. On 10/26/21 at 2:30 PM the facility was provided a copy of the "Immediate Jeopardy (IJ) Template" and was notified of the IJ for Resident (R) 1. On 10/12/21, Certified Medication Aide (CMA) R and Licensed Nurse (G) identified significant bruising to Resident (R)1's inner thighs. Both staff failed to identify as possible abuse and report to Administrative Staff A. On 10/13/21 Certified Nurse Aide (CNA) M noted the bruising to R1's inner thighs and failed to report it to Administrative Staff. On 10/17/21 LN H identified bruising to R1's inner thighs and bloody urine but failed to identify and report as possible abuse. On 10/19/21 Consultant Physician GG referred R1 to a local hospital to evaluate for a possible sexual assault. This deficient practice placed R1 in immediate jeopardy. The 2567 was electronically sent to the facility on 11/01/21.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/01/2021

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.

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deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:

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F 580	Continued From page 2	F 580	Past noncompliance: no plan of correction required.	

The facility had a census of 70 residents. The sample included one resident. Based on observation, record review, and interview, the facility failed to notify the physician in a timely manner when staff discovered large bruises (injuries of unknown origin) on Resident (R) 1's inner thighs on 10/12/21 and 10/17/21.

Findings included:

- R1's "Physician's Orders," dated 09/29/21, documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety disorder.

The "Annual Minimum Data Set" (MDS), dated 08/10/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of six indicating severely impaired cognition, inattention that comes and goes, delusions, and physical behavioral symptoms directed toward others for one to three days during the lookback period. The MDS documented the resident rejected cares daily and required supervision of one staff with most activities of daily living (ADLs), except for bathing. The MDS recorded the resident was frequently incontinent of urine, had no skin issues, and did not receive a blood thinner during the look back period.

The 08/18/21 "Care Plan" documented the resident had impaired decision making related to her diagnosis of cognitive impairment with dementia, directed one staff to assist with supervision, provide stand by assistance with

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ADLs, and to be flexible with interventions. The "Care Plan" directed one staff to offer stand by assistance to the bathroom whenever the resident was observed to be awake at night, to offer and provide assistance with perineal cares as the resident would allow, and check her room for soiled linens/briefs as resident would hide soiled items. It further directed staff to offer the bathroom every two hours while the resident was awake.

Review of the "Skin Integrity Sheets" for R1 revealed the following:
08/02/21 through 09/27/21 - No skin concerns or bruises were identified for the resident.
10/11/21 and 10/14/21 - The resident refused a head to toe assessment.
10/17/21 The resident had unmeasurable purple bruising to her right and left inner thighs with no drainage and no pain noted.

The "Facility Investigation" dated 10/19/21 revealed on 10/12/21 Certified Medication Aide (CMA) R identified bruising to the resident's inner thighs and reported to Licensed Nurse (LN) G sometime between 06:00 - 08:00 PM. LN G assessed R1 and found fairly significant bruises to the resident's inner thighs, did not document anything or notify the family, physician, or Director of Nursing (DON) about the injury of unknown origin as she intended to do it after her medication pass. LN G had a seizure prior to the end of her shift at 09:30 PM and never made the notifications. On 10/17/21 LN H and an unidentified CMA observed R1's bruising and noted bleeding/blood in the resident's urine during a bath. There was no documentation of notifications to family, physician, administrator or DON. LN H completed a skin sheet and placed it

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in the skin book at the nurse's station.

The "Interdisciplinary (ID) Note," dated 10/18/21 at 04:05 PM, documented a telephone call to Consultant Physician GG regarding bleeding and a possible urinary tract infection (UTI).

The "ID Note," dated 10/18/21 at 08:29 PM, documented the facility received a fax from Consultant Physician GG instructing staff to start the resident on Cipro (antibiotic) 500 milligrams (mg) twice a day for seven days for UTI and collect a urine sample for a urinalysis (evaluation of urine).

The "ID Note," dated 10/19/21 at 10:06 AM, documented the resident had dark purple bruising to both inner thighs, excessive bleeding from perineal area, and the facility called the physician to schedule an appointment for the resident.

The late entry "ID Note," dated 10/19/21 at 02:35 PM, documented on 10/17/21 an unidentified CMA gave the resident a bath and notified LN H the resident had blood in her urine and purple bruising to the inside of the right and left thighs. The resident could not tell staff how the bruising occurred.

On 10/25/21 at 03:47 PM, observation revealed R1 seated in her wheelchair with a long-sleeved shirt like dress and white towel covering her thighs. The resident wore non-skid tennis shoes, had a pleasant affect, and no bruises noted on exposed skin on lower legs and hands. R1 smiled, talked freely, and when asked if she had any bruises she lifted up the towel covering her thighs and revealed numerous large and small bruises on both right and left inner thighs with

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dark purple centers and yellow edges. R1 stated the bruises did not hurt.

On 10/25/21 at 11:51 AM, Administrative Nurse D stated skin checks would be completed at least one time a week and if a resident refused she would expect staff to approach the resident later and reattempt. Administrative Nurse D stated she expected to be notified immediately of any injury of unknown origin including any fractures or any large bruising of unknown origin and the physician and family should also be notified. She verified the bruising found on 10/12 and 10/17 was not relayed to administrative nursing staff in a timely manner and the bruising she observed in pictures was very concerning to her due to being close to the resident's private area. Administrative Nurse D stated she expected the CMAs on 10/12/21 to relay the bruising information to the nurse ..

On 10/25/21 at 01:10 PM, Administrative Staff A stated on 10/18/21 he was informed of the blood in the resident's urine, but was not told about any bruising to her thighs during the morning meeting. From 10/12 to 10/17 there was nothing documented about the resident's bruises in the skin book or ID notes. On 10/17/21 a staff member convinced the resident to take a shower and the bruises were assessed by LN H. Staff were expected to complete an incident report and notify family and physician, which LN H did not complete. On 10/19/21 the resident was sent to Consultant Physician GG for bleeding and bruising and sexual assault was suspected so the resident was sent for further evaluation at another hospital.

On 10/25/21 at 04:14 PM, LN G stated she

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worked on 10/12/21 from approximately 04:30 - 09:30 PM. CMA R told her the resident had bruising on inner thighs and needed to be assessed. The resident was seated on the toilet and her thighs were together so very difficult to assess. The resident's bruises were approximately half dollar size, blue gray in color with yellow tint to them, and she did not feel they were new. LN G stated she did not feel the bruises were an emergent situation that needed to be reported immediately and was not able to complete her charting for her shift.

On 10/26/21 at 09:18 AM, LN H stated she worked on the resident's hall on 10/17/21 and the resident agreed to let the medication aide give her a bath. The medication aide found bruises and called LN H in to do an assessment. The bruises ran down R1's inner thighs to the back of her legs and not in one solid spot so they were difficult to measure. LN H asked the resident what happened, and the resident said she got those all of the time. LN H stated she documented the bruises on the skin integrity sheet and the sheets went into the skin book at the nurse's station. LN H stated she did not make an ID note in the computer or notify the physician or the family as she had been educated.

On 10/26/21 at 09:47 AM, LN K stated she attempted to do a head to toe skin assessment on the resident on 10/11 and 10/14 and the resident refused. LN K stated the resident would often refuse cares and assessments and LN K would ask other staff to approach the resident. LN K stated on 10/19/21 she observed the bruising on the resident's thighs and the resident stated they had been there a long time. LN K checked the skin book and found the documentation from

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F 580	Continued From page 7 10/17/21 and notified LN I to observe the bruising. LN K stated she called Consultant Physician GG and reported the blood in the urine and bruises. The facility's "Skin Care Protocol" policy, dated 06/16/14, documented nurses would document skin assessments in the skin book accordingly. This includes a drawing of any skin variances and a narrative on their general skin condition. The nurse will complete an ID note indicating that the skin assessment was done and to refer to the skin book documentation for details. If a new skin variance is noted the nurse will notify the physician, the family, and the life care specialist, who will notify the Director of Nursing. The facility failed to notify the physician in a timely manner when staff discovered large bruises on R1's inner thighs (injuries of unknown origin) placing the resident at risk for abuse/neglect.	F 580		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		

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F 609	Continued From page 8 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 70 residents. The sample included one resident reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure staff identified an injury of unknown origin as an alleged violation potentially involving abuse, neglect or mistreatment. The facility further failed to ensure staff immediately reported the alleged violation (injury of unknown origin) to the facility administrator. On 10/12/21, Certified Medication Aide (CMA) R and Licensed Nurse (G) identified significant bruising to Resident (R) 1's inner thighs. Both staff failed to identify R1's injury as possible abuse and report to Administrative Staff A. On 10/13/21 Certified Nurse Aide M noted the bruising to R1's inner thighs and failed to report it to Administrative Staff. On 10/17/21 LN H identified bruising to R1's inner thighs and bloody urine, but failed to identify and report as possible abuse. On 10/19/21, Consultant Physician GG referred R1 to a local hospital to evaluate for a possible sexual assault. This deficient practice placed R1 in immediate jeopardy.	F 609	Past noncompliance: no plan of correction required.	

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Findings included:

- R1's "Physician's Orders," dated 09/29/21, documented diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety disorder.

The "Annual Minimum Data Set" (MDS), dated 08/10/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of six indicating severely impaired cognition, inattention that comes and goes, delusions, and physical behavioral symptoms directed toward others for one to three days during the lookback period. The MDS documented the resident rejected cares daily and required supervision of one staff with most activities of daily living (ADLs), except for bathing. The MDS recorded the resident was frequently incontinent of urine, had no skin issues, and did not receive a blood thinner during the look back period.

The 08/18/21 "Care Plan" documented the resident had impaired decision making related to her diagnosis of cognitive impairment with dementia, directed one staff to assist with supervision, provide stand by assistance with ADLs, and to be flexible with interventions. The "Care Plan" directed one staff to offer stand by assistance to the bathroom whenever the resident was observed to be awake at night, to offer and provide assistance with perineal cares as the resident would allow, and check her room for soiled linens/briefs as resident would hide

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soiled items. It further directed staff to offer the bathroom every two hours while the resident was awake. The intervention, dated 10/19/21, directed two staff to assist the resident with all ADLs and supervise the resident when she was in common areas.

Review of the "Skin Integrity Sheets" for R1 revealed the following:
08/02/21 through 09/27/21 - No skin concerns or bruises were identified for the resident.
10/11/21 and 10/14/21 - The resident refused a head to toe assessment.
10/17/21 The resident had unmeasurable purple bruising to her right and left inner thighs with no drainage and no pain noted.
10/19/21 - The resident had unmeasurable dark purple bruising with yellowing around the edges to right and left inner thighs with no drainage or pain noted.

The "Facility Investigation" dated 10/19/21 revealed on 10/12/21 CMA R identified bruising to the resident's inner thighs and reported to LN G sometime between 06:00 - 08:00 PM. LN G assessed R1 and found fairly significant bruises to the resident's inner thighs, did not document anything or notify the family, physician, or DON about the injury of unknown origin as she intended to do it after her medication pass. LN G had a seizure prior to the end of her shift at 09:30 PM and never made the notifications. On 10/17/21 LN H and an unidentified CMA observed R1's bruising and noted bleeding/blood in the resident's urine during a bath. There was no documentation of notifications to family, physician, administrator or DON. LN H completed a skin sheet and placed it in the skin book at the nurse's station.

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The "Interdisciplinary (ID) Note," dated 10/18/21 at 04:05 PM, documented a telephone call to Consultant Physician GG regarding bleeding and a possible urinary tract infection (UTI).

The "ID Note," dated 10/18/21 at 08:29 PM, documented the facility received a fax from Consultant Physician GG instructing staff to start the resident on Cipro (antibiotic) 500 milligrams (mg twice a day for 7 days for UTI and collect a urine sample for a urinalysis (evaluation of urine).

The "ID Note," dated 10/19/21 at 10:06 AM, documented the resident had dark purple bruising to both inner thighs, excessive bleeding from perineal area, and the facility called the physician to schedule an appointment for the resident.

The "ID Note," dated 10/19/21 at 10:42 AM (7 days after the bruises were originally identified), documented LN I called in to check on the resident as her nurse noted this morning the resident had purple bruising to both thigh areas with yellowing at outer edges. After speaking with another nurse who worked the evening shift it was noted the resident had an incontinent brief twisted around her thighs the night before, while she was seated in common area and staff assisted her to change her undergarment and dress for bed.

The late entry "ID Note," dated 10/19/21 at 02:35 PM, documented on 10/17/21 an unidentified CMA gave the resident a bath and notified LN H the resident had blood in her urine and purple bruising to the inside of the right and left thighs. The resident could not tell staff how the bruising occurred.

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The "ID Note," dated 10/19/21 at 10:44 PM, documented the resident returned to the facility at 10:15 PM accompanied by family and had new orders to continue antibiotics as ordered, recheck urine in 2-3 days, and if blood continued in urine to have a scan of abdomen and pelvis and see urologist.

On 10/25/21 at 03:47 PM, observation revealed R1 seated in her wheelchair with a long-sleeved shirt like dress and white towel covering her thighs. The resident wore non-skid tennis shoes, had a pleasant affect, and no bruises noted on exposed skin on lower legs and hands. R1 smiled, talked freely, and when asked if she had any bruises she lifted up the towel covering her thighs and revealed numerous large and small bruises on both right and left inner thighs with dark purple centers and yellow edges. R1 stated the bruises did not hurt.

On 10/25/21 at 11:51 AM, Administrative Nurse D stated the resident was very independent with her cares, rejected a lot of cares, and staff were directed to try different approaches with the resident. Administrative Nurse D stated the resident was incontinent of urine, would place things in her incontinent brief to soak up the moisture, and would refuse bathing. Administrative Nurse D was out of the facility the week of 10/17 to 10/23/21 stated skin checks would be completed at least one time a week and if a resident refused she would expect staff to approach the resident later and reattempt. Administrative Nurse D stated she expected to be notified immediately of any injury of unknown origin including any fractures or any large bruising of unknown origin. She verified the bruising found

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	175414	A. BUILDING _____ B. WING _____	C 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VILLAGE	86 TWENTY-SECOND AVENUE MOUNDRIDGE, KS 67107

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on 10/12 and 10/17 was not relayed to administrative nursing staff in a timely manner and the bruising she observed in pictures was very concerning to her due to being close to the resident's private area. Administrative Nurse D stated she expected the CMAs on 10/12/21 to relay the bruising information to the nurse who took over for the nurse who had a seizure.

On 10/25/21 at 01:10 PM, Administrative Staff A stated on 10/18/21 he was informed of the blood in the resident's urine, but was not told about any bruising to her thighs during the morning meeting. On 10/19/21 Nurse K observed the thigh bruises and notified Nurse I and he overheard their conversation and started and investigation. The resident liked to do her own ADL cares and was found to have been wearing several briefs at a time. During investigation he found that CNA M and CMA R reported the bruising to LN G on 10/12/21 and LN G assessed the bruising, but did not document the information due to having a seizure. During interviews with CNA M and CMA R he found they were not aware what LN G did with the assessment information of the resident's bruises. From 10/12 to 10/17 there was nothing documented about the resident's bruises in the skin book or ID notes. On 10/17/21 a staff member convinced the resident to take a shower and the bruises were assessed by LN H. Staff were expected to complete an incident report and notify family and physician, which LN H did not complete. Administrative Staff A stated staff should report any injury of unknown origin to him and/or the Director of Nursing immediately. On 10/19/21 the resident was sent to Consultant Physician GG for bleeding and bruising and sexual assault was suspected so the resident was sent for further evaluation at another

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hospital.

On 10/25/21 at 04:14 PM, LN G stated she worked on 10/12/21 from approximately 04:30 - 09:30 PM. CMA R told her the resident had bruising on inner thighs and needed to be assessed. The resident was seated on the toilet and her thighs were together so very difficult to assess. The resident's bruises were approximately half dollar size, blue gray in color with yellow tint to them, and she did not feel they were new. LN G stated she did not feel the bruises were an emergent situation that needed to be reported immediately and was not able to complete her charting for her shift as she had a seizure.

On 10/25/21 at 04:41 PM, CMA R stated the resident was very private, wanted to be independent with all ADLs and staff attempted to toilet the resident every two hours as the resident would put on several briefs at times and they could all be soiled. CMA R saw R1's bruises on both of her inner thighs for the first time on 10/12/21 between 06:00 and 08:00 PM when she observed the resident seated on the toilet. CMA R immediately asked LN G to come into the bathroom and observe the bruising. CMA R stated the bruises were approximately 2 inches x 4 inches and purple/dark purple in color. The resident was asked if she fell and the resident stated she did not and did not know how she obtained the bruises. CMA R stated at the end of LN G's shift around 09:30 PM, LN G had a seizure. CMA R stated she had not observed R1's skin again until 10/21/21 when the resident returned from the emergency room and she assisted to give the resident a bath and she had not reported the bruising to any other staff after

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10/12/21.

On 10/26/21 at 09:18 AM, LN H stated she worked on the resident's hall on 10/17/21 and the resident agreed to let the medication aide give her a bath. The medication aide found bruises and called LN H in to do an assessment. The bruises ran down R1's inner thighs to the back of her legs and not in one solid spot so they were difficult to measure. LN H asked the resident what happened, and the resident said she got those all of the time. LN H stated she documented the bruises on the skin integrity sheet and the sheets went into the skin book at the nurse's station. LN H stated she did not make an ID note in the computer or notify the physician or the family as she had been educated.

On 10/26/21 at 09:47 AM, LN K stated she attempted to do a head to toe skin assessment on the resident on 10/11 and 10/14 and the resident refused. LN K stated the resident would often refuse cares and assessments and LN K would ask other staff to approach the resident. LN K stated on 10/19/21 she observed the bruising on the resident's thighs and the resident stated they had been there a long time. LN K checked the skin book and found the documentation from 10/17/21 and notified LN I to observe the bruising. LN K stated she called Consultant Physician GG and reported the blood in the urine and bruises.

On 10/26/21 at 11:31 AM, CNA M stated she observed R1's bruises on her inner thighs on 10/12/21, when she assisted CMA R to toilet the resident. CNA M stated the bruises were very dark and very big and LN G came and looked at the bruises while the resident was seated on the

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toilet. On 10/18/21 when CNA M arrived for her shift the resident was seated in the commons area and had a brief on each of knees. CNA M stated she assisted the resident to the bathroom, found the resident had 3 soiled briefs on, and the bruises were not as dark as before. There were splotchy bruises on the outside of the resident's thighs also. CNA M stated she reported all of the bruises to LN J and CMA S the morning of the 13th at the end of her shift, but no other staff after that day.

On 10/26/21 at 11:44 AM, LN J stated on 10/13/21 she did not receive any information about bruises on R1 found on 10/12/21. LN J stated she received report from the previous shift nurse who did not report any bruising to the resident.

On 10/26/21 at 11:54 AM, CMA S stated she received report from CNA M on 10/13/21 regarding residents on 10/12/21 and was not told about any bruising on the resident's thighs. CMA S stated the first time she was notified about the resident's bruises was in report on 10/18/21 at 05:00 AM and she never saw the bruises on the 18th as the resident does not allow the staff to assist her to the bathroom very often.

The facility's Resident Abuse, Neglect and Exploitation policy, dated 12/11/17, documented in the event of any evidence of cause to believe that a resident has suffered any of the above definitions of abuse, neglect or exploitation, the employee, visitor or family member is requested to report all allegations, suspicions, and/or incidents to the director of nursing, charge nurse, a nurse manager and/or administrator. All injuries will be reported on the skin assessment form to

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be given to the DON or designee. The incident/accident reports are filled out by all witnesses or persons associated with the incident. The DON and the administrator review all reports and will determine if further evaluation is needed.

The facility failed to ensure staff identified an injury of unknown origin on 10/12/21 and 10/17/21 and immediately report as possible abuse to the facility administrator. This deficient practice placed R1 in immediate jeopardy.

On 10/21/21, the facility completed the following actions to remove the immediate jeopardy:
Educated all employees on Abuse, Neglect and exploitation policy.
Re-educated all licensed nursing staff on skin care policy.
Educated all nursing staff on investigating injuries of unknown origin and investigating suspected sexual abuse of an elder.
Administrator and wound nurse reviewed all resident skin reports from 10/11 - 10/18 to assure not a widespread problem.
For the next 4 months the wound/skin nurse/or designee will do weekly random audit with visual check on 3 residents per neighborhood (total of 12 resident audits weekly). From weekly skin assessment done by license nurses to assure proper skin assessments are being conducted correct and accurate.

The deficient practice was cited as past noncompliance.