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	355031	A. BUILDING _____ B. WING _____	C 08/04/2016

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F 000	INITIAL COMMENTS For the unannounced complaint survey conducted August 3-4, 2016, the sample included eight sampled residents, one closed record, and seven supplemental residents for focused review.	F 000		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 03/25/15, 12/30/15, and 05/04/16. Based on information provided by the complainant, review of the Resident Council Meeting minutes, review of facility policy, and resident/family interviews, the facility failed to ensure action upon and resolution of grievances from residents/families regarding call light response times for 11 of 11 interviewable residents (A, B, C, D, E, F, G, H, I, J, and K) and two family members (#1 and #2) interviewed during the survey. This failure resulted in avoidable incontinence (Resident C, J, and K), and may result in avoidable falls, increased behaviors, and/or a decreased quality of life. Findings include:	F 244	Residents were identified by alphabet characters and were not named in the resident listing. Residents are at risk of not having their needs met and of having untoward outcomes when there is a delay in answering call lights. The facility has been addressing and auditing this concern since the annual survey completed in May, 2016. Improvements have been noted in call light response times when audits are completed. Concerns were voiced by residents in interviews. Concerns that had been brought to the attention of the facility had been written on concern forms and followed up by the DON. A PIP has been developed and the facility will be trialing the use of two way radios	9/7/16

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

Electronically Signed | 08/29/2016

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F 244	Continued From page 1 Information provided by the complainant indicated staff failed to answer call lights in a timely manner. Review of the facility policy titled "CALL LIGHT RESPONSE" occurred on 08/04/16. This undated policy stated, "All staff members are expected to respond to call lights. . . . The staff member responding to the light is responsible for meeting the need or for locating a staff member who can meet the need. In the event the staff member who responds cannot meet the need the call light is left on . . . until the need is met. . ." Interview of eleven residents identified as interviewable by the facility occurred during the survey. The residents made the following comments in regards to the length of time they have waited for staff to respond to their call lights: * Resident A - "The facility is short staffed. Staff will turn [the call] light off and not come back. Had to wait over an hour about July 1st. Last week waited 35-45 minutes. I call my son and daughter to telephone the facility to assist me." * Resident B - "At maximum it takes an hour and a half to answer." * Resident C - "They're [staff members] busy all the time, it can take 30 minutes, so I go in my brief. Sometimes I sit on the toilet 20-30 minutes with my call light going." * Resident D - "I feel they'er [staff members] busy and I'm bothering them. Can take 20 minutes." * Resident E - "Didn't answer my call light in the bathroom a couple of times in July. My light can be on for 30-45 minutes." * Resident F - "I have waited an hour for a call light to be answered" * Resident G - "It takes 20-30 minutes for staff to	F 244	to determine if this has a positive impact on call light response time. It is believed the use of the two way radios will result in improved communication and prompt notification of resident needs. A guideline has been developed regarding the use of two way radios and was presented to nurses by the DON on August 29 and will be presented to CNAs by the DON on August 31st and September 1st. Radios will be put into use on September 2nd. Additional education was provided to staff on the responding to call lights by their department managers or designee and/or the DON in meetings held August 25th, August 29th, August 30th, August 31st, and September 1st. Audits were initiated on 08/27/2016 and will be completed by the Administrator or designee five times weekly for four weeks with call light observations and five times weekly for four weeks with face to face resident interviews regarding satisfaction with care, response to grievances, and with call light response. Ongoing audits will be completed three times weekly for six months. Results of audits will be submitted to the QA committee for review and recommendations.	

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F 244	Continued From page 2 answer." * Resident H - "Sometimes they've been slow. They can't help it. They're so short-staffed. It makes a difference depending upon time of day. [It's] not easy, they need more help." * Resident I - "Sometimes a half an hour." * Resident J - "Hour and something. [I've had] several accidents, [the] poopy kind. I would have been able to make it to the bathroom. [I was] mad, embarrassed. I've told a few of them [staff members] off already." * Resident K - "Slow . . . up to 20 minutes. I've peed my pants. Sometimes you just can't help it. I don't think anything of it anymore. I'm used to it." Residents A, B, E, J, and K all confirmed, within the past two months, they've witnessed facility staff fail to answer call lights in a timely manner. Interview of two family members (#1 and #2) occurred during the survey. The family members made the following comments in regards to the length of time they have witnessed residents waiting for staff to respond to their call lights: * Family member #1 - "Can take 20-30 minutes before the call light is answered. Call lights in hallways are usually on, and residents also complain." * Family member #2 - "Can be a 30 minute wait. I have received telephone calls from [Resident A] that call lights are not being answered and telephoned the facility to assist. [Resident A] has thrown garbage in the hallway to get attention to use the bathroom." Review of the Resident Council Meeting minutes occurred on 08/04/15. The meeting minutes, dated 07/18/16, identified, ". . . Concerns: call	F 244		

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F 244	Continued From page 3 lights . . ." The minutes failed to include further details regarding the residents' specific concerns with the call light system and what the facility planned to do to resolve the grievance.	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of the Resident Council Meeting minutes, and resident/staff interviews, the facility failed to provide reasonable accommodation of needs regarding call lights for 3 of 4 sampled residents (Resident #5, #6, and #7) residing on the first floor. Failure to place call lights within the residents' reach does not allow them to request/obtain assistance in a timely manner. This failure did result in an fall (Resident #7), and may result in avoidable incontinence, increased behaviors, and/or a decreased quality of life. Findings include: Information provided by the complainant indicated staff fail to ensure call lights are placed within the residents' reach.	F 246	Call light clips were implemented for Resident #5,#6, and #7 and staff were educated on the need to ensure call lights are within reach prior to leaving the room. Residents have the potential to be negatively impacted if their call lights are not within reach and they are unable to notify staff of needs. An audit was completed to ensure clips were in place for each call light and clips were added when indicated. Staff education on ensuring the call light is in reach prior to leaving a resident's room was provided by the DON to licensed nurses on August 25th and August 29th and will be provided to CNAs and ancillary staff on August 31st and September 1st. Audits of call light placement were initiated on 08/27/16 and will be	9/7/16

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F 246	Continued From page 4 - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included bilateral amputation of lower extremities, weakness, and history of falls. The current Minimum Data Set (MDS), dated 06/15/16, identified intact cognition and total assistance from two or more people required for transfers. The current care plan/kardex identified, ". . . Reinforce need to call for assistance . . . allow consistent access to call light. . . ." The progress notes identified the following: * 05/08/16, "Resident found on floor face down small scant of red blood noted to (L) [left] hand/wrist. after assessing resident a 0.5 cm [centimeter] laceration noted above R) [right] eyebrow. Cleansed with NS [normal saline] and paper tape applied. Nuero [sic] checks . . . States he rolled over to retrieve his call light which was clipped to his night stand. . . ." * 05/09/16, ". . . Have an injury on the (R) eyebrow d/t the fall. . . . Reinforce/remind resident to use call light." * 05/10/16, ". . . Small cut above the right eye . . ." * 05/11/16, ". . . Has a small cut about the right eye. . . ." * 05/12/16, ". . . No s/s [signs/symptoms] of infection on the injured site around the (R) eyebrow. . . ." The progress notes failed to identify when the laceration healed. The Resident Council Meeting minutes, dated 07/18/16, identified, ". . . Concerns: call lights . . ." The minutes failed to include further details regarding the residents' specific concerns with	F 246	completed by the Administrator or designee three times weekly for four weeks and then weekly for six months. Results of audits will be forwarded to QA committee for review and recommendations.	

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F 246	Continued From page 5	F 246		

the call light system.

- Review of Resident #5's medical record occurred on all days of survey. Diagnoses included a history of falls. The current Minimum Data Set (MDS), dated 07/18/16, identified intact cognition and extensive assistance required from two or more people for transfers.

During the initial tour on 08/03/16 at 10:10 a.m., Resident #5 stated, "[The call light is] not always within reach. My son gets after them." At 3:56 p.m., Resident #5 further stated, "The other night, I didn't have my [call] light. I found out it was under the bed."

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included a history of falls. The current Minimum Data Set (MDS), dated 06/16/16, identified intact cognition and extensive assistance required from one person for transfers.

The current care plan identified, ". . . Reinforce need to call for assistance. . . ."

During the initial tour on 08/03/16 at 10:30 a.m., Resident #6 stated, ". . . I can't find mine [call light]. I don't know where it is. Out of my reach, I know that!" Observation showed the call light was not within view and/or reach of Resident #6. After exiting the room, this surveyor notified an unidentified certified nursing assistant (CNA) of Resident #6's missing call light.

Observation on 08/03/16 at 3:06 p.m., showed a CNA (#1) offered Resident #6 a drink of water after she completed cares. After declining the

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F 246	Continued From page 6 water, Resident #6 asked, "Where is my call light?" The CNA (#1) searched for Resident #6's call light, before replying, "It looks like it is down here [indicating the call light was on the floor near the head of the bed]." Resident #6 asked, "How am I supposed to reach it down there?" The CNA (#1) placed the call light on the bed near Resident #6 prior to exiting the room. - During an interview on 08/04/16 at 4:10 p.m., two administrative staff members (#2) and (#3) confirmed they expect staff to ensure call lights are placed within the residents' reach.	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		9/7/16

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F 278	Continued From page 7 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the RAI (Resident Assessment Instrument) User's Manual (Version 3.0), the facility failed to ensure the Minimum Data Sets (MDS) accurately reflected the resident's status for 2 of 8 sampled residents (Resident #7 and #8). Failure to accurately code Section M (Skin Conditions) does not allow the residents' assessments to reflect their current status/needs, and may affect the development of a comprehensive care plan, and affect the care provided to residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, pages M-2 to M-4 and M-7 to M-8 stated, "M0100: . . . Pressure ulcer risk factors . . . exposure of skin to urinary and fecal incontinence . . . M0150: . . . It is important to recognize and evaluate each resident's risk factors . . . If the medical record reveals that the resident currently has a Stage 1 or greater pressure ulcer, a scar over a bony prominence . . . the resident is at risk for worsening or new pressure ulcers. . . . M0210: . . . Definition Pressure Ulcer . . . localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure. . . . Definition Stage 1 pressure ulcer, an observable,	F 278	Modification/correction requests were completed for Resident #7 and Resident #8 on August 26, 2016 to ensure section M of the assessment accurately reflected the residents' status during the MDS look back period. Residents with a history of pressure ulcers, current pressure ulcers, or scar tissue over a bony prominence as well as those coded on the MDS as having nutritional interventions to manage skin have the potential for inaccurate information being submitted in section M. Review of like residents most recent MDS entries has been initiated and will be completed by September 2, 2016. Modification/correction requests will be submitted as needed for these residents. The Resident Assessment Coordinator attended a webinar hosted by CMS on August 24th that included information on several RAI/MDS sections including detailed information on Section M. The Resident Assessment Coordinator educated the DON on this information on August 25th and will educate the MDS Assistant on this information on August 29th. The Food Service Manager was educated by the DON on the need for a	

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F 278	Continued From page 8 pressure-related alteration of intact skin . . . include . . . persistent redness in lightly pigmented skin . . . M0300B: . . . Definition Stage 2 pressure ulcer, partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister. . . ." - Review of Resident #8's medical record occurred on all days of survey. The most recent quarterly MDS, dated 06/27/16, identified Resident #8 required one person physical assist for bed mobility, not at risk for developing pressure ulcers, had no pressure ulcers, and had pressure reducing devices for bed or chair and the application of nonsurgical dressings. A progress note, dated 06/05/16, stated, ". . . a small, triangle-shaped skin alteration on her left, upper buttock measuring approximately 1 CM (centimeter) X (by) 1 CM. Site cleansed with normal saline, pat dry and Tegaderm with Foam Dressing applied to site." A progress note, dated 06/22/16, stated, "Requesting orders for the following for skin alteration: . . . Mepilex with Borders dressing change every 3 days and PRN. . . . Wound team to eval and treat. . . . evaluation of left buttock wound. . . . small, now oval-shaped skin alteration on her left, upper buttock measuring approximately 1.2 CM X 2 CM. Site is blanchable with very slow refill. Wound bed is now moist. . . serosanguineous drainage noted. Site cleansed with normal saline, pat dry and now Mepilex with borders dressing is applied to site. . . . requires limited assist of X1 (one) staff to reposition in bed."	F 278	nutritional assessment during the MDS look back period if nutritional support to manage skin is coded on the MDS on August 24th. This information will be reviewed by the DON with the contracted dietitian by September 6, 2016. Audits of section M of the MDS were initiated on 09/02/16. Three reviews will be completed by the DON weekly for four weeks then monthly for six months. Results of audits will be submitted to the facility QA committee for review and recommendations.	

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A progress note, dated 06/24/16, stated, ". . . Is continent/incontinent of Urine . . . Utilizes briefs as an incontinence product. "

The facility failed to code Resident #8's MDS accurately to indicate the resident had a pressure ulcer and was at risk of an ulcer.

The Long-Term Care Facility RAI User's Manual, revised October 2015, pages M-38 and M-39 stated, ". . . M1200D Nutrition or Hydration Intervention to Manage Skin Problems: The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,' . . ."

- Review of Resident #7's medical record occurred on all days of survey. A quarterly MDS, dated 06/15/16, identified the resident received nutrition or hydration interventions for skin and ulcer treatments. The medical record lacked an individualized nutritional assessment during the

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F 278	Continued From page 10 MDS reference period to indicate Resident #7 required nutrition or hydration interventions to support healthy skin.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans for 1 of 8 sampled residents (Resident #7). Failure to ensure the care plan reflected the resident's current status limits staff's ability to ensure continuity of care. Findings include:	F 280	Resident #7's care plan was modified to reflect current needs and interventions for skin management. Residents who require new interventions to manage their skin condition have the potential to be negatively impacted in these interventions are not added to the care plan. Care plan reviews have been	9/7/16

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F 280	Continued From page 11 Review of the facility policy titled "Care Plans-Comprehensive" occurred on 08/04/16. The policy, revised September 2010, stated, ". . . care plans are revised as information about the resident and the resident's condition change. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included history of an unstageable pressure ulcer to the coccyx. Resident #7's current care plan identified, ". . . has unstageable pressure ulcer to coccyx upon readmission . . . requires supplemental protein, amino acids, vitamins, minerals . . . pressure reduction premiter [sic] mattress & [and] wc [wheelchair] cushion . . ." The progress note identified the following: * 03/25/16, ". . . Instructed staff to please keep resident off his bottom when lying in bed, and to put him on his side with a pillow underneath. . . ." * 06/07/16, ". . . fortified cereal at breakfast . . ." * 07/03/16, "New orders: . . . turn frequently, wound team to follow . . ." Resident #7's current care plan failed to reflect the interventions identified on the 03/25/16, 06/07/16, and 07/03/16 progress notes. During an interview on 08/04/16 at 12:15 p.m., an administrative staff member (#3) confirmed "the care plans need to be updated."	F 280	or will be completed for these residents by the interdisciplinary team. Care plans will be updated to ensure interventions are identified and followed. A clinical morning meeting agenda was implemented on August 29, 2016 and includes validation of updates to care plans for residents with changes in condition that are reviewed during the weekday morning meeting. This practice will be ongoing to ensure system changes are sustained. Changes to the morning meeting agenda were reviewed by the DON with the interdisciplinary team on August 29, 2016. Education on updating care plans to include new interventions was provided to the interdisciplinary team by the DON on August 29th. Education on updating care plans as changes occur was presented to licensed nurses by the DON on August 25th and will be repeated to additional licensed nurses by the DON on August 29th. In addition to the validations completed during the weekday clinical meetings formal audits were initiated on 09/02/16 by the DON. Audits will continue to be completed by the DON or designee will complete audits of the morning meeting minutes and validation of required care plan updates weekly for twelve weeks and then monthly for three months for a total of six months of auditing. Results of audits will be submitted to the QA committee for review and recommendations.	
F 314	483.25(c) TREATMENT/SVCS TO	F 314		9/7/16

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F 314 SS=D	Continued From page 12 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of the facility's written staff education regarding skin conditions (Pathway), and staff interview, the facility failed to provide the necessary treatment and services to prevent the occurrence of/promote the healing of pressure ulcers for 2 of 2 sampled residents (Resident #7 and #8) and one closed record (Resident #9) with a pressure ulcer, and had the potential to cause further deterioration of existing pressure ulcers for Resident #7, #8, and #9. Findings include: Information provided by the complainant indicated staff failed to follow the physicians' orders when treating pressure ulcers. The facility failed to provide a policy on pressure ulcers per request. During an interview on 08/04/16 at 12:15 p.m., an administrative staff member (#3) confirmed the	F 314	The care plan for Resident #7 was updated to reflect current interventions to meet his needs. The open area for Resident #8 has resolved. Preventative measures have been validated and care plan updated when indicated for this resident to reduce the risk for recurrent skin breakdown. Resident #9 no longer resides at the facility. Residents with skin breakdown have the potential to be affected by the deficient practice. Residents with existing pressure related skin breakdown have been identified, care plans reviewed, and treatment orders validated. Residents were reviewed for risk of skin breakdown and orders for preventative skin treatment were obtained for those residents newly identified at increased risk for skin breakdown. Care plan updates were completed for residents when indicated. Licensed nurses were instructed to give report from the TAR and validate that	

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F 314	Continued From page 13 facility currently did "not have a policy on pressure ulcers." The administrative staff member (#3) did provide a copy of a "Pressure Ulcer Prediction, Prevention and Treatment Pathway, www.primaris.org, July 2008," which outlined the assessment process following admission/readmission to the facility (Step One) and the process for developing a care plan for skin conditions (Step Two). The pathway also stated, "Remember, if a patient is at risk or has a pressure ulcer, repeat Step One on a weekly basis. . . . Adjust care plan as needed. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included history of an unstageable pressure ulcer to the coccyx. The quarterly Minimum Data Set (MDS), dated 06/15/16, identified intact cognition, at risk of developing pressure ulcers, pressure reducing devices for the bed and chair, and nutrition/hydration interventions to manage skin problems. Resident #7's current care plan identified, ". . . has unstageable pressure ulcer to coccyx upon readmission . . . potential for pressure ulcer development . . . Assess/record/monitor healing weekly Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. . . . Follow facility policies/protocols for the prevention/treatment of skin breakdown . . . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. . . ." The progress notes identified the following:	F 314	treatments were completed and documented prior to leaving at the end of the shift. Skin Management Guidelines were developed by the DON to establish a system for managing skin integrity for those residents identified as at risk for skin breakdown and for those with actual skin breakdown. This guideline includes the process for managing skin integrity including the management of pressure ulcers. Supplemental information on obtaining accurate measurements and documenting wound assessments is included as part of the guideline. Weekly wound rounds guidelines have been developed and implemented. The DON reviewed the Skin Management Guidelines with the interdisciplinary team on August 8th and with the QA Committee for approval on August 16th. The DON presented information of Skin Management Guidelines, obtaining treatment orders, documenting weekly skin assessments, measuring wounds, documenting wound assessments, completing the PUSH tool, updating care plans, and validating TARs during shift to shift report to licensed nurses on August 25th and will repeat the presentation to licensed nurses on August 29th. The DON or designee will present the CNA's Role In Skin Management to the CNAs on August 31st and September 1st. Shift to shift audits of TARs will be an ongoing process to ensure system changes implemented are sustained. Validation of shift to shift audits will be	

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F 314	Continued From page 14 * 03/18/16, "Readmission after hospitalization with DX [diagnosis]: right AKA [above knee amputation]. . . . Has a non-stageable [sic] pressure ulcer coccyx/buttocks area. . . ." * 03/19/16, ". . . Mepilex dressing replaced to moisture related open area to coccyx. No drainage . . ." * 03/21/16, " Resident has a sore to coccyx area . . . No drainage . . ." * 03/22/16, ". . . Mepilex dressing replaced to moisture related open area to coccyx. Scant serous drainage noted from coccyx area. . . ." * 03/22/16, ". . . He has a stage 2 sacral wound. . . ." * 03/23/16, ". . . Dressing changed to coccyx area, serosanguinous drainage noted, buttock/cheeks excoriated, reddened. . . ." * 03/24/16, ". . . Mepilex dressing changed to coccyx area. Moisture associated open area on the coccyx has a small amount of serosanguinous drainage. . . ." From March 18-24, 2016, facility staff described Resident #7's pressure ulcer as a "moisture associated open area, stage 2 wound, and non-stageable [sic] pressure ulcer to his coccyx, buttocks, and sacral areas." A "Wound Assessment Form," date 04/08/16, identified the following: * Date Wound ID'd [identified]: 03/28/16 * Etiology: Pressure * Depth of Tissue Injury: Unstageable, Slough/eschar * Measurements L [length]: 5.2 cm [centimeters], W [width]: 2.1 cm * Exudate: Scant * Consistency: Serous * Wound Bed: Slough	F 314	completed by the DON or designee three times weekly for four weeks then weekly for six months. Audits were initiated on 09/02/2016. Wound Round notes and PUSH tool accuracy will be reviewed by the DON or designee weekly for twelve weeks and then monthly for three months for a total of six months. Audits were initiated on 09/02/16. Results of audits will be submitted to the QA committee for review and recommendations.	

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F 314	Continued From page 15 * Wound Edges: Irregular wound edges, Macerated * Dressing Change Protocol: Cleanse [with] wound cleanser, apply Mepilex dressing, change every 3 days [and] prn (as needed) This was the first skin assessment found in Resident #7's medical record related to the pressure ulcer identified upon admission on 03/18/16. A "Wound Rounds" note, dated 04/15/16, identified, "Wound to coccyx assessed. Wound is an 'L' shape. Measurements were taken from two areas, 1. 2.0 cm x (by) 0.8 cm, 2. 1.0 cm x 2.0 cm. Tissue is 100% slough. Periwound skin pink and intact. Wound has a scant amount of non-odorous, serous drainage. . . . New orders obtained . . . Cleanse wound with normal saline, apply Aquacel AG, then Mepilex dressing, change every 72 hours and PRN until healed. . . ." The "Pressure Ulcer Healing Chart" identified facility staff measured Resident #7's pressure ulcer on a weekly basis during the month of April. On 04/29/16, facility staff identified the length x width of Resident #7's wound within the range of 4.1 - 8.0 cm with granulation tissue. The progress note, dated 04/29/16, identified, ". . . Coccyx area with L-shaped open area, measures 3.25 x 3.25. Surrounding skin pinkish, slowly improving. Cleansed and Mepilex dressing reapplied. . . ." The progress note identified Resident #7's wound within the range of 8.1 - 12.0 cm. This note conflicts with the measurements documented on the "Pressure Ulcer Healing Chart," which indicated the wound	F 314		

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F 314	Continued From page 16	F 314		

was smaller in size.

The "Pressure Ulcer Healing Chart" identified facility staff measured Resident #7's pressure ulcer on a bi-weekly basis during the month of May. On 05/18/16, facility staff identified the length x width of Resident #7's wound as 0.3 cm x 0.6 cm with granulation tissue. Facility staff failed to reassess Resident #7's pressure ulcer on a weekly basis in June.

The progress note, dated 06/07/16, identified, ". . . [Resident #7] continues to have an open area that is noted to be slowly improving. . . ." This was the only entry in Resident #7's medical record regarding the pressure ulcer identified upon admission. Facility staff failed to identify when Resident #7's coccyx ulcer healed.

The July-August progress notes identified the following:
* 07/03/16, ". . . Resident found to have a small open area on his left upper buttock, approximately 1 CM in diameter. Site has no drainage noted. Surround[ing] tissue has slight blanching noted. Resident has some pain noted to the affected area. . . . New orders: . . . Mepilex with Borders Dressing every three days and PRN . . . Chart weekly . . ."
* 07/12/16, ". . . Resident has no open areas . . . Resident has a 1 CM moisture associated skin disorder noted to his left, upper buttock. Site is red and has no drainage noted. Surrounding tissue does blanch slightly. Mepilex with Borders Dressing placed. . . ." Facility staff failed to reassess Resident #7's wound on a weekly basis per the physician's order dated 07/03/16.
* 07/16/16, The record identified no new open

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F 314	Continued From page 17 areas. * 07/17/16, The record identified two areas of concern; 1 x 0.5 cm and a 0.8 x 0.5 cm in diameter. * 07/19/16, The record identified no new open areas. * 07/31/16, The record identified one area of concern to the left upper buttock; 0.6 cm in diameter. * 08/04/16, ". . . Area examined presents as intact light pink scar tissue with no open areas noted. Uncertain where open area had been noted as all skin in this area is intact. . . ." Observation at 1:10 p.m. confirmed Resident #7's pressure ulcer had healed. The March-August Treatment Administration Record (TAR) identified the following: * March: "Tx [Therapy] to coccyx (non-stageable pressure ulcer) Mepilex Dressing. [Change] Q [every] 3 days and prn." The TAR indicated facility staff failed to complete 1 of 4 dressing changes. * April: "Mepilex Dressing apply to coccyx. [Change] Q 3 days [and] prn. The TAR indicated facility staff failed to complete 7 of 10 dressing changes. * May: "Change coccyx ulcer dressing [and] cover wound base w [with]/Aquacel foam [and] cover w/Mepilex dressing." The TAR indicated facility staff failed to complete 6 of 10 dressing changes. * June: The TAR indicated facility staff failed to complete 1 of 1 dressing change. * July: "Mepilex [with] Border Drsg [Dressing] every 3 days [and] prn." The TAR indicated facility staff failed to complete 4 of 9 dressing changes.	F 314		

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F 314	Continued From page 18 During two interviews on 08/04/16 at 12:15 p.m. and 2:13 p.m., an administrative staff member (#3) confirmed facility staff are expected to assess a pressure ulcer "right away" and reassess the pressure ulcer on a weekly basis until healed. The administrative staff member (#3) also reported that she personally contacted Resident #7's physician and requested the order for Mepilex dressings be changed to DermaLevin dressings, a generic brand. She explained Mepilex dressings are not available through the facility's current supplier, that they offer a comparable generic dressing. Facility staff failed to notify Resident #7's physician regarding the fact their current supplier does not carry the Mepilex brand of dressings. Facility staff failed to: * Assess Resident #7's pressure ulcer after identifying it upon admission; thereby establishing a baseline, * Consistently identify the characteristics of Resident #7's existing pressure ulcer (ie: number of open areas, stage, size, and location of the ulcer), * Notify Resident #7's physician regarding the fact their current supplier does not carry the Mepilex brand of dressings, * Complete dressing changes as ordered by Resident #7's physician, * Reassess Resident #7's pressure ulcer on a weekly basis, and * Identify/document when Resident #7's coccyx ulcer healed. -Review of Resident #8's medical record occurred on 08/04/16. The quarterly MDS, dated	F 314		

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F 314	Continued From page 19 06/27/16, identified skin tears, pressure reducing devices for the bed and chair, and application of nonsurgical dressings. The current TARs, dated June 22- July 31, 2016, indicated, "Mepilex c (with) borders drsg Q 3 days & prn." The TARs indicated facility staff failed to complete 1 of 3 dressing changes in June and 2 of 11 dressing changes in July. The current treatment administration record, dated June 1- July 31, 2016, indicated, "Skin eval [evaluation]/update skin sheet Saturdays PM". The records identified no weekly skin assessments between June 1-10, 2016 and July 3-15, 2016. The progress notes identified the following: *06/05/16," . . . Upon inspection a small, triangle-shaped skin alteration on her left, upper buttock measuring approximately 1 CM X 1 CM. Site cleansed with normal saline, pat dry and Tegaderm with Foam Dressing applied to site. . . ." *06/22/16,". . . left buttock wound. . . . small, now oval-shaped skin alteration on her left, upper buttock measuring approximately 1.2 CM X 2 CM. Site is blanchable. . . moist with a small amount of serosanguineous drainage." *06/29/16,". . . continues to have an opened and excoriated area on her left upper buttock with small amount of serosanguineous drainage. Site tender and noted decreased in blanching. Resident receives Mepilex with border dressing every three day and prn. . . ." *07/01/16, "3 cm x 3 cm area to left buttock." * 07/30/16, the record identified no new open areas, pink and reddened, excoriated, recieves	F 314		

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F 314	Continued From page 20 Mepilex with/borders dressing every three days and as needed. - Review of Resident #9's closed medical record occurred on 08/04/16. The quarterly MDS, dated 07/12/16, identified an unhealed pressure ulcer, one stage two pressure ulcer, pressure reducing devices for the bed and chair, and pressure ulcer care. Review of the TAR, dated July 5-31, 2016, indicated, "Mepilex c borders dressing apply to blood blister on coccyx daily." The TAR indicated facility staff failed to complete 17 of 27 dressing changes in July. Resident #9 expired on 08/01/16.	F 314		
F9999	FINAL OBSERVATIONS The complaint issues regarding failing to provide appropriate supervision, failing to provide appropriate toileting assistance, and failing to assess a resident following a change in condition, could not be substantiated.	F9999		