DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) . A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and staff interview, the facility failed to ensure staff notified	F157	The facility will ensure that staff notifies the residents family of the development of pressure ulcers in a timely manner. A. All staff, including travelers, will be instructed to notify the family if any pressure ulcers develop for resident #2. B. All residents have the potential to be affected by the facilities failure to notify family if a resident develops pressure ulcers or of any other change of condition. C. Education will be provided to all nursing staff of the need to notify family members of any significant change including the development of pressure ulcers for all residents. The Nursing Director will perform random audits monthly to ensure that family and physician have been notified of significant changes including pressure ulcers.	

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

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.

This POC accepted C corrections on 10/25/11 @ 1345 per phone conversation between Jason Sidney, DON, acting for Chasity Demandel VP of Resident Care Services and Betty Nelson, RN, Health Surveyor.

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F 157	Continued From page 1 the family of the development of pressure ulcers in a timely manner for 1 of 6 sample residents (#2) who had pressure ulcers. The findings were: Review of the 8/18/11 nursing notes written at 6 AM, a CNA reported resident #2 had four large open areas on his/her coccyx. Review of the medical record for the resident showed no evidence his/her family member was notified of the four pressure ulcers that developed and ultimately required surgical debridement until 8/30/11, one day prior to surgical intervention. Review of the 8/30/11 nursing notes written at 10 AM showed the physician called the resident's family member to discuss surgical debridement of the pressure ulcers. Interview with the wound care nurse and MDS coordinator on 9/21/11 at 2:40 PM revealed the nursing staff had not let the family, physician, or management know about the worsening pressure ulcers but should have.	F 157	D. The Nursing Director will aggregate the random monthly data and report the results to the Care Center Administrator the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 10/21/2011 F 309 The facility will ensure that all necessary assessments and monitoring are implemented for preventive pain management.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the facility's policy on pain management, the facility failed to ensure all necessary assessments and monitoring were	F 309	A. 1a. Nursing staff will be educated that pain medication must be obtained as soon as possible from pharmacy after receiving a physicians order to prevent a delay in care 1b. A standardized assessment will be performed prior to resident #2 receiving pain medications and pain will be reassessed within two hours following administration. 1c. Resident #2's pain will be reassessed following the administration of pain medication.	

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F 309	Continued From page 2 Implemented for preventive pain management for 2 of 3 sample residents (#2, #58) who had pain. The findings were: 1. Review of the medical record for resident #2 showed s/he had diagnoses including coronary artery disease, anemia, diabetes, osteoporosis, and urinary incontinence. Review of the nursing and physician progress notes from 8/16/11 through 9/18/11 showed this resident experienced pain from the development of multiple pressure ulcers on the coccyx and buttocks which required surgical debridement on 9/1/11 and a five day stay at the hospital. Continued review showed the resident was re-admitted to the facility on 9/6/11 around 12:30 PM. Review of the medical record and MAR showed the resident had a Fentanyl patch 50 micrograms (mcg) in place upon re-admission. Review of the September 2011 physician orders showed, in addition to the Fentanyl patch, there was an order dated 9/6/11 for Dilaudid 2 milligrams (mg) every four hours as needed for pain. The following concerns were identified: a. Review of the 9/6/11 nursing notes written at 11:44 PM, showed the resident stated at 6 PM his/her back was "killing" him/her. Although there was an order for Dilaudid, it had not yet been delivered from the pharmacy so the resident had to wait until 6:55 PM (nearly one hour) to receive the pain medication. b. Review of the nursing notes showed at 8:30 AM on 9/7/11 the resident was "yelling, screaming, and complaining of pain and discomfort." Review of the nursing notes and September 2011 MAR showed s/he received two tablets of Dilaudid (4 mg) at 8:30 AM. However, there was no evidence an assessment using a	F 309	F309 (cont) 1d. Resident#2's pain assessments will include intensity and description. Reassessments will be performed to assess for symptom relief. 1e. A pain scale will be used in assessment of pain. The facility will ensure that enough pain medication is available to provide the appropriate dose to the resident and the resident will be reassessed within 2 hrs following treatment to evaluate symptom relief. If necessary, Powell Valley Pharmacy will be accessed to provide pain medication if not readily available from an outside pharmacy. 2. An assessment and reassessment of pain to include intensity, quality, and response to treatment will be performed for resident #58 & all other residents that have pain to be each time pain medication is administered. 3. The facilities pain assessment and management policy will be followed for every pain control mechanism. for all residents to be B. All residents have the potential to be affected by failure to assess pain before and after treatment to determine symptom relief.	

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F 309	Continued From page 3 standardized pain scale was performed. In addition, there was no evidence the resident's pain was re-assessed within two hours, as directed in the facility's pain management policy dated April 2011, to determine the effectiveness of the pain medication in resolving or relieving the resident's pain. c. Review of the 9/7/11 nursing notes showed at 11:20 AM the resident was "very uncomfortable, yelling and complaining of pain during..." the dressing change. The resident required and was administered additional Dilaudid 4 mg for the unrelieved pain at 11:20 AM. On this same date, 9/7/11, the physician order Roxanol 2.5 mg every two hours as needed for pain in addition to the Dilaudid and Tylenol orders for severe breakthrough pain. Again, there was no evidence the resident's pain level was re-assessed after administration of the Dilaudid 4 mg at 11:20 AM. d. Review of the 9/9/11 nursing notes written at 7:30 AM revealed the resident complained of pain at 2:30 AM and was administered 4 mg of Dilaudid. Review of the nursing notes and September 2011 MAR revealed no evidence the resident's level of pain of description of the pain was assessed. Additionally, the resident's pain was not re-assessed until 5:10 AM (two hours and 40 minutes) at which time the resident said s/he was still hurting. The resident was administered Roxanol 5 mg for the unrelieved pain at 5:10 AM. Review of the 9/9/11 nursing notes written at 9:05 PM showed the resident required Dilaudid 4 mg for pain at 7:40 AM, 11:40 AM and at 4:30 PM and Roxanol 5 mg for pain at 1:30 PM for pain at the surgical sites. Continued review of these notes showed no evidence the pain was assessed as to intensity or description	F 309	F309 (cont) C. All nursing staff will be educated to assess and document pain including a description of the quality, intensity, standardized scale and reassessment of pain 2 hours within administering pain medication. The Nursing Director will conduct random audits monthly to ensure nursing staff assess, reassess, and document pain. D. The Nursing Director will aggregate the audit data and report the results monthly to the Administrator and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 10/21/2011	

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F 309	Continued From page 4 or re-assessed for symptom relief at any of these times, e. Review of the 9/14/11 nursing notes written at 9 PM showed Dilaudid 2 mg was administered for pain in the lower back. Review revealed the resident verbally said s/he had pain but there was no documentation to show a pain scale was used to determine the intensity. The note indicated that only one Dilaudid 2 mg tablet was given instead of the two the resident usually received for pain because there was only one tablet available in the facility. The pharmacy was called to deliver additional tablets but the time of arrival was undocumented. Again, there was no evidence the resident's pain was re-assessed after administration of the one Dilaudid 2 mg tablet. d. Interview with the two DONs on 9/21/11 at 3:10 PM revealed this resident had breakthrough pain which was why they called the physician on 9/7/11 to obtain the order for Roxanol. However, they also confirmed the policy should be followed and pain should be assessed and reassessed accordingly. 2. Review of the 7/4/11 quarterly MDS assessment for resident #68 showed s/he had occasional pain rated at 2 on a 0 to 10 pain scale, with 10 being the worst. Review of the physician's orders for September 2011 revealed an order for Norco 5/325 mg two tablets every four hours for pain. Review of the September 2011 MAR showed the resident was administered the pain medication 22 times from 9/1/11 through 9/18/11. However, continued review of the nursing notes showed 21 times out of the 22 times, the pain medication was administered there was no evidence an assessment or re-assessment of pain was performed, 95% of the time. Interview	F 309		

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F 309	Continued From page 5 with the two DONs on 9/21/11 at 3:10 PM revealed the policy should be followed and pain should be assessed and reassessed accordingly. 3. Review of the facility's pain assessment and management policy, reviewed April 2011, revealed the following instructions: "It is the responsibility of all clinical staff to assess and periodically re-assess the patient/resident for pain and relief from pain, including the intensity and quality (i.e. character, frequency, location and duration of pain), and response(s) to treatment. ...The patient/resident pain will be re-assessed after every pain control mechanism ...The reassessment will be 2 hours for oral [medications] and will be documented."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO 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 medical record review and staff interview, the facility failed to ensure 3 of 6 sample residents (#2, #12, #58) at risk for pressure ulcers were assessed, monitored and treated with the appropriate nursing measures to prevent pressure ulcers. This lack of monitoring	F 314	F314 The facility will ensure that residents at risk for pressure ulcers are assessed, monitored, and treated with the appropriate nursing measures to prevent pressure ulcers. A. 1a. The lack of follow thru on 8/16/2011 for resident # 2 is a past event and cannot be corrected. 1b.A process will be implemented (Treatment Administration Record) to aide in the assessment, treatment and follow-up of pressure ulcers. The wound care nurse or other qualified RN will do an initial assessment, documenting wound measurement and treatment recommendations. This nurse will also collaborate with the physician regarding treatment orders. Wound care nurse or other qualified RN will collaborate with nursing staff that provide primary care to the residents. The wound care nurse or qualified RN will make follow-up visits as	

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F 314	Continued From page 6 and implementation of nursing measures resulted in development of multiple pressure ulcers which required surgical debridement for resident #2. The findings were: 1. Review of the September 2011 physician's orders recapitulation for resident #2 showed s/he had diagnoses including coronary artery disease, anemia, diabetes, and urinary incontinence. Review of the 7/25/11 annual MDS assessment for the resident revealed s/he was at risk for pressure ulcer development but had none at that time. Review of the July 2011 care plan showed interventions included: prevent skin to skin and direct contact with pads and pillows, use pressure-redistributing mattress and chair cushion, and encourage or provide small shifts in position while sitting every two to three hours. The following concerns were identified: a. Review of the 8/16/11 nursing notes written at 6 AM showed the CNA reported the resident had "several large open areas on the coccyx." Further review showed the nurse would like the day shift nurse to notify the wound care nurse about the open areas. Interview with the MDS coordinator and wound care nurse on 9/21/11 at 2:40 PM revealed the nursing staff had been notified the wound care nurse would be unavailable for two weeks. The wound care nurse said, in this interview, that staff nurses were supposed to follow through with notifying and working with the physician on treatment and monitoring of the pressure ulcers. Continued review of the nursing and interdisciplinary progress notes showed the next notation in regard to the development of multiple pressure ulcers was not written until 8/25/11 at 10:45 AM (nine days later). Review of these notes showed	F 314	F314 (cont) needed and make recommendations for further treatment as necessary. Photographs will be taken upon identification of wounds and the follow-up frequency will be determined by the wound care nurse or qualified RN. 1d. A log identifying residents with pressure ulcers and/or wounds will be put into place for monitoring residents and will include resident #2. + all other residents with wounds. 2a. The lack of follow-up for resident #58 beginning with the 2/23/2011 nurses note is a past event and cannot be corrected. 2b. The lack of monitoring for resident #58 from 7/6/11 to 9/18/2011 is a past event and cannot be corrected. 2c. The wound care nurse or other qualified RN will do an initial assessment, documenting wound measurement and treatment recommendations. This nurse will also collaborate with the physician regarding treatment orders. Wound care nurse or other qualified RN will collaborate with nursing staff that provide primary care to the residents. The wound care nurse or qualified RN will make follow-up visits as	

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F 314	Continued From page 7 the open areas remained and they were tender when the Desitin ointment was applied. b. According to the physician progress notes, he saw the resident on 8/29/11, thirteen days after the pressure ulcers were identified. Due to the wound care nurse being on leave, the physician asked the MDS coordinator to assess the condition of the resident's pressure ulcers the following day, 8/30/11, at 10 AM. The MDS coordinator performed the assessment and the notes showed the pressure ulcers had "worsened." Continued review of the nursing notes showed the physician consulted with an orthopedic surgeon about debridement of the necrotic ulcers on 8/30/11. Review of the 8/31/11 nursing notes written at 4 PM showed an additional new sore was noted on the resident's right buttock. On 9/1/11 the resident had surgical debridement of the multiple pressure ulcers and was admitted to the hospital for five days. c. Observation on 9/21/11 from 9 AM until 12 noon showed staff were re-positioning the resident and following the care plan in regard to pressure redistributing devices in the bed and the chair. However, interview with the wound care nurse and the MDS coordinator on 9/21/11 at 2:40 PM revealed there was no official log of pressure ulcer or wounds maintained for monitoring purposes, but nursing staff should know who had pressure ulcers. The wound care nurse said the nursing staff did not but should have followed through with assessing, monitoring, and treating the resident's pressure ulcers while she was unavailable. 2. Review of the 7/4/11 quarterly MDS assessment for resident #58 showed s/he was at risk for skin breakdown. Review further showed	F 314	F314 (cont) needed and make recommendations for further treatment as necessary. Photographs will be taken upon identification of wounds and the follow-up frequency will be determined by the wound care nurse or qualified RN. A log identifying residents with pressure ulcers and/or wounds will be put into place for monitoring residents and will include resident #58. & all other residents & wounds 3a. The lack of follow-up for resident #12 beginning with the identification of a pressure ulcer on 1/15/11 is a past event and cannot be corrected. 3b. The lack of follow-up for resident #12 from 3/29/11 to 6/19/11 is a past event and cannot be corrected. 3c. The incorrect application of the sacral dressing for resident #12 is a past event and cannot be corrected. 3d. The lack of follow thru for Resident #12 is a past event and cannot be corrected.	

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F 314	Continued From page 8 the resident currently had one stage I and one stage II pressure ulcer. Review of the 7/19/11 care plan showed interventions including repositioning, shifting points of pressure every one to two hours or more often, pressure relief in the bed and chair, and the resident to move in bed and to get up in the chair more frequently. The following concerns were identified: a. Review of the 2/23/11 nursing notes written at 8 PM showed the resident had two small open areas on the coccyx. Continued review of the nursing notes showed the next notation regarding skin was written on 3/31/11 (nearly one month later). This note showed there was an open area on the left buttocks the size of a dime and an additional open area just to the right side of the gluteal fold the size of a nickel. The next nursing note in regard to the resident's pressure ulcers was written at 2:53 PM on 4/3/11 (4 days later) and described the pressure ulcers as dark purple with poor blanching. At 9:16 PM on that same day, the nursing note described the area as being a large area that was open and bleeding on the coccyx. The 4/4/11 nursing notes written at 7 AM showed the resident had several open areas to the coccyx and upper buttocks. Review of the 4/24/11 nursing notes showed the sacrum had open areas and Desitin ointment was applied. The wound nurse assessed the resident's pressure ulcers on 7/17/11 at 11:31 AM. Her notes indicated the resident continued to have Stage I and Stage II pressure ulcers bilaterally. She further indicated it was a challenge to get this resident to turn, reposition, move about in bed or get out of bed to take the pressure off the coccyx. The next nursing notes written in regard to the status of the pressure ulcers was on 8/14/11 (nearly one month later) at 11:12 AM. These	F 314	F314 (cont) 3e. The wound care nurse or other qualified RN will do an initial assessment, documenting wound measurement and treatment recommendations. This nurse will also collaborate with the physician regarding treatment orders. Wound care nurse or other qualified RN will collaborate with nursing staff that provide primary care to the residents. The wound care nurse or qualified RN will make follow-up visits as needed and make recommendations for further treatment as necessary. Photographs will be taken upon identification of wounds and the follow-up frequency will be determined by the wound care nurse or qualified RN. A log identifying residents with pressure ulcers and/or wounds will be put into place for monitoring residents and will include resident #12, + all other residents & wounds SW	

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F 314	Continued From page 9 notes indicated the pressure ulcer was still present. b. Review of the nursing notes showed no evidence the pressure ulcers were monitored or treated between 7/6/11 at 11:14 AM through 9/18/11. Interview with the MDS coordinator and the wound care nurse on 9/21/11 at 2:40 PM revealed the resident still had a Stage II pressure ulcer on the buttocks. c. Observation on 9/21/11 from 9 AM until 12 noon showed staff did turn and reposition the resident at intervals of one to one and one-half hours and followed the care plan in regard to pressure redistributing devices in the bed and the chair. However, interview with the wound care nurse and the MDS coordinator on 9/21/11 at 2:40 PM revealed there was no official log of pressure ulcers or wounds maintained for tracking purposes and therefore sometimes nursing staff did not follow through with treatments and monitoring the status of wounds. The wound care nurse was also the nurse manager of the south unit and therefore depended on the nursing staff to follow the pressure ulcers when she was unable to do so. 3. Review of the 9/19/11 quarterly MDS assessment for resident #12 showed s/he was at risk for developing pressure ulcers. Further review of that assessment showed the resident currently had one unhealed stage II pressure ulcer on the coccyx. Review of the nursing notes showed this pressure ulcer was identified on 1/15/11. At that time the ulcer measured 2 to 3 centimeters (cm) and was open according to the nursing notes. Review of the 9/20/11 care plan showed interventions included repositioning every one to two hours or more often, a pressure	F 314	F314 (cont) B. All residents have the potential to be affected by the lack of a process to ensure that pressure ulcers are assessed, monitored, and treated with the appropriate nursing measures to prevent pressure ulcers. C. All nursing staff, including travelers, will be educated about new process with implementation of a log identifying residents with pressure ulcers and or wounds. Education will include completion of assessment, documentation of, treatment, follow-up, and nursing measures in place to prevent pressure ulcers and or wounds. D. The MDS Director will aggregate the random monthly audit data and report the results monthly to the Care Center Administrator and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 10/21/2011	

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F 314	Continued From page 10 relieving cushion in the wheelchair, a pressure redistributing mattress on the bed, good nutrition, and to monitor and document the status of the wound. The following concerns were identified: a. Review of the nursing notes showed the pressure ulcer was identified on 1/16/11, was documented as to status on 1/16/11, 1/17/11, 1/22/11, 1/30/11 but not again until 2/24/11 (over three weeks) when the pressure ulcer was assessed by the wound care nurse. Further review of these wound care nursing notes showed the pressure ulcer was worse and the wound care nurse "...will change the treatment soon. Desitin used at this time..." It was an additional five days before a different wound care nurse assessed the resident on 3/1/11. Review of her notes written on 3/1/11 at 10:12 AM showed there was also a "slit" in the gluteal fold which had gotten deeper. This wound care nurse changed the treatment to Tegaderm dressing to protect the slit as well as the coccyx area. The next wound care notes written at 11:30 AM was by the facility's wound care nurse on 3/16/11 and review of those notes showed "Unfortunately, the dressing was not applied appropriately, and therefore was defeating the purpose....It needs to be occlusive so as not to allow fecal matter, etc. to the wound...This did not begin as a pressure wound, rather from excess moisture, and now..." that the resident was sitting more, the area has increased and worsened. b. Review of the 3/29/11 nursing notes written at 10:47 PM showed there was a reddened area below the dressing on his/her buttocks. Review of the nursing notes showed the next wound notes were written on 4/17/11 and indicated the gluteal cleft was closed. However, review of the 4/22/11 nursing notes written at 10:42 AM showed "...sore	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	C 09/21/2011

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F 314	Continued From page 11 in the gluteal cleft continues to be an issue." Review of the 6/15/11 nursing notes written at 9:02 AM showed the "sacral slit" was unchanged, 54 days later. Review of the 6/17/11 wound care nursing notes timed at 11:38 AM showed the area on the coccyx was open and was determined to be a Stage II pressure ulcer that measured 1.5 cm by 2 mm (millimeters) by 0.3 mm and had scant drainage. The wound was packed with a small piece of Ag Mesh and was covered with Duoderm. Review of the 6/19/11 nursing notes written at 2:29 PM showed the coccyx area was red and had a small amount of yellow drainage. c. Review of the 6/23/11 nursing notes revealed the sacral wound was open and was approximately one-half inch long by one-fourth inches wide. Continued review of these notes showed the nurse would notify the wound care nurse of the status. Review of the 6/24/11 wound care nursing notes showed the wound bed was clean but slightly macerated and did not have the recommended dressing in place. The wound measured 2 cm by 0.1 cm by 0.2 cm. The wound care nurse packed the open area with Tegaderm Ag Mesh and covered it with a strip of thin Duoderm and asked nursing staff to follow the wound. Review of the 6/26/11 nursing notes revealed the wound had no dressing on it at all. The wound was cleansed and xenaderm ointment was applied and covered by a Duoderm strip only because staff "was unable to locate the Tegaderm Ag Mesh." d. Review of the nursing notes on 7/6/11, 7/13/11, 7/19/11, 7/27/11, and 8/6/11 showed the dressing was not in place as recommended. Review of the 8/7/11 nursing notes showed the pressure ulcer was unchanged. The next wound status note was written by the dietician on 9/15/11	F 314		

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F 314	Continued From page 12 and was the quarterly nutrition assessment. Review of that note showed the resident continued to have a stage II pressure ulcer. e. Observation on 9/20/11 from 1 PM until 5 PM showed staff did turn and reposition the resident at intervals of one to one and one-half hours and followed the care plan in regard to pressure redistributing devices in the bed and the chair. However, interview with the wound care nurse and the MDS coordinator on 9/21/11 at 2:40 PM revealed there was no official log of pressure ulcer or wounds maintained for tracking purposes and therefore sometimes nursing staff did not follow through with treatments and monitoring the status of wounds. The wound care nurse was also the nurse manager of the south unit and therefore depended on the nursing staff to follow the pressure ulcers when she was unable to do so.	F 314		