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

PRINTED: 02/25/2016
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
	535024	A. BUILDING _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

(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 A complaint survey was conducted by Healthcare Licensing and Surveys from 2/8/16 through 2/10/16. The survey was prompted by complaint intake WY00002182. The following common abbreviations are used throughout this document: ADLs - Activities of Daily Living ADON - Assistant Director of Nursing CAA - Care Area Assessment DON - Director of Nursing MDS - Minimum Data Set TAR - Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to provide goods and services necessary to promote healing and prevent deterioration of wounds for 2 of 5 sample	F 224	**F224 MISTREATMENT / NEGLECT MISSAPROPRIATION** It is the practice of the facility to strive to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. **CORRECTIVE ACTION** Resident #108 was discharged from the facility on 1/28/2016 to hospice. The wound on resident #97's left buttock was healed on 2/18/2016. A head to toe skin check was completed on 3/2/2016 by licensed nurse and confirms resident #97 is free from skin breakdown at this time.	3/10/2016 3/9/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 3/4/16

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.

RECEIVED
WY Dept of Health
MAR 0 6 2016
Healthcare Licensing and Surveys

3/8/16 - POC is accepted with agreed-to changes. (Alleged date of compliance changed to ~~3/10/16~~ 3/9/16. Date of compliance to be 3/9/16 Jamie VanDyke, Administrator has been notified.

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F 224	Continued From page 1 residents (#97, #108) with pressure ulcers. This neglect caused actual harm to resident #108. The findings were: 1. Review of the 11/20/15 annual MDS assessment showed resident #108 had diagnoses that included diabetes mellitus, hypertension and non-Alzheimer's dementia. The resident required the extensive assistance of 1 person for ADLs including bed mobility, transfers, dressing, and personal hygiene. Further review showed the resident was deemed to be at risk for developing pressure ulcers, but did not have unhealed pressure ulcers at the time of the assessment. Review of the CAA for pressure ulcers revealed the resident did not "...present with any pressure ulcers, but [s/he] does have an arterial ulcer on [his/her] right malleolus [ankle]..." The following concerns were identified: a. Review of the 12/7/15 head to toe skin check showed the resident had an existing wound to the right ankle. Further review of the medical record showed no additional head to toe skin checks were completed between 12/7/15 and 1/28/16. b. Interview with the administrator and corporate nurse on 1/10/16 at 2:20 PM revealed the facility had recently become aware the new electronic charting system was not notifying nursing staff when head-to-toe skin checks were due to be completed, and because of this, head-to-toe skin checks had not been done. c. Review of the 1/1/16, timed 5:37 PM, progress note showed: "Physician Order Note - Left hip/flank DTI [deep tissue injury] - Cleanse area with vashe [wound cleanser], pat dry with gauze, apply sure prep to area and place hydrocolloid. Change Q [every] 5 days and prn...Dressing in place, current measurements to	F 224	**IDENTIFICATION OF OTHERS** Facility residents had head to toe skin checks completed between 2/09/2016 to 2/15/2016 to identify any skin concerns. Documentation was completed on any identified wounds and appropriate interventions put into place. An additional audit will be completed by date of compliance to verify that head to toe skin checks are completed and wound documentation and assessments are completed. Follow up will be completed as needed. **SYSTEMIC CHANGES** The nursing staff was be educated on skin management policies, including weekly wound evaluation and documentation on weekly pressure ulcer record and weekly non pressure ulcer record, obtaining physician orders and timely and accurate completion of head to toe skin checks by the Director of Nursing or designee on 2/18/16. Treatment sheets in electronic medical record have been amended to include weekly head to toe skin checks. Treatment sheets will be amended to include daily monitoring of pressure ulcers and monitoring each ulcer for status of dressing and surrounding skin	

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F 224	Continued From page 2 area of erythema [redness] 2.4 cm x [by] 1.8 cm x UTD [unable to determine]. No open area, center of erythema with DTI [deep tissue injury] purple in color." Further review of progress notes showed no additional information on this wound, such as additional assessments of the wound. d. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 1 occasion between 1/3/16 and 1/21/16. e. Review of the January TAR showed the treatment order for the left hip wound changed on 1/23/16 to the following: "Left Hip DTI- Cleanse area with vashe, pat dry with gauze, apply sure prep to area, barrier cream to wound edges, tenderwet to wound bed, secure with large foam, one time a day..." f. Further review of the January TAR showed the physician-ordered dressing change was documented as completed on 3 days between 1/23/16 and 1/28/16. g. Review of the 1/1/16, timed 5:35 PM, progress note showed: "Physician Order Note - Left knee Abrasion - Cleanse with VASHE, pat dry with gauze, apply sure prep to peri wound, calazime cream to wound margins, hydrogel gauze fold to fit wound bed and secure with border foam. Change Q day... Dressing in place and no s/sx [signs or symptoms] of infection. Current measurements 1.8 cm x 1 cm x UTD blood tinged scab to area, erythema to edges, non tender." Further review of progress notes showed no additional information on this wound, such as additional assessments. h. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 7 days between 1/2/16 and 1/21/16 (20 days). i. Review of the 1/22/16, timed 12:35 AM,	F 224	and pain associated with wound. During morning clinical meeting the facility will continue to review the PCC dashboard, 24 hour report for any changes in skin condition, any new wound treatment orders, assigned head to toes skin checks for timely completion and new admissions for any skin concerns. Corrective actions will be taken as needed for any identified concerns. The Director of Nursing or designee will continue to conduct wound rounds weekly and review / complete wound evaluation and documentation. A designated nurse will assist with wound rounds weekly for consistency and will complete rounds in absence of Director of Nursing for consistency. The Director of Nursing or designee will audit current wounds weekly for 3 months. The audit will include evaluation and staging/classification and measurement of wound and documentation, appropriate treatment orders and completion of head to toe skin checks. Corrective actions will be taken as needed.	

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3/7/16

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F 224	Continued From page 3 showed: "Left knee Abrasion - Cleanse with VASHE, pat dry with gauze, apply sure prep to peri wound, calazime cream to wound margins, colagen fold to fit wound bed and secure with border foam. Change Q day, one time a day..." The reason for the change in wound care orders was shown as "..Upon wound assessment, need new tx [treatment]." j. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 3 days between 1/23/16 and 1/28/16. The resident was discharged from the facility on 1/28/16 k. Review of the 1/23/16, timed at 5:38 PM, phone order showed: "Left ischium - Cleanse with Vashe, pat dry with gauze, apply sure prep to peri wound, calcium alginate to wound bed, secure with border foam, change Q day..." l. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 2 days between 1/23/16 and 1/28/16. m. Review of wound logs provided by the facility on 2/8/16 at 1:30 PM showed the following: i. The weekly non-pressure ulcer QA & A [Quality Assessment and Assurance] log dated 1/13/16 showed the resident had three wounds: a left knee wound that measured 2.6 cm x 1.2 cm, an ankle wound (not identified as either right or left) that measured 1.4 cm x 0.7 cm, and a right hip wound that measured 1.5 cm x 1.5 cm. No other information about the wounds, such as the type of wound, the depth of the wound, and presence of odor or drainage was included. ii. The weekly pressure ulcer QA & A log dated "week of 1/20/16" showed the resident had three wounds: an ankle wound (not identified as either right or left) that measured "1.5 cm," a right	F 224	MONITORING The Director of Nursing or designee will track and trend the wound audits monthly for any trends / patterns for 3 months. The audit results will be reported to the Quality Assurance Performance Improvement Committee (QAPI). The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 224	Continued From page 4 knee wound that measured 2 cm x 1.5 cm, and a right hip wound that measured 4 cm x 1.5 cm. No other information about the wounds, such as the actual date the wound was assessed, the stage of the wound, depth, odor, or drainage was included. iii. The weekly non-pressure ulcer QA & A log dated "wk [week] of 1/29/16" showed the resident had three wounds: a left hip deep tissue injury attributed to trauma that measured 4 cm x 6.4 cm x UTD, had no odor, and did have drainage; a left ischial pressure ulcer that measured 3.2 cm x 1.1 cm x UTD, had no odor, and did have drainage; and a left knee wound attributed to trauma that measured 2 cm x 1.5 cm x UTD, had no odor, and did have drainage. Further review of the medical record failed to show a date of onset, or any assessment regarding a left ischial pressure ulcer. iv. The weekly non-pressure ulcer QA & A log dated "wk of 2/1" showed the resident had three wounds: an ankle wound (not identified as either right or left) that measured "1.5 cm," a right knee wound that measured 2 cm x 1.5 cm, and a right hip wound that measured 4 cm x 1.5 cm. No other information about the wounds, such as the actual date the wound was assessed, the depth of the wound, odor, or drainage was included. Review of progress notes showed the resident was discharged from the facility on 1/28/16 and was not in the facility the week of 2/1/16. n. The facility provided updated copies of the wound logs on 2/8/16 at 3:35 PM, 2/9/16 at 8:30 AM, and 2/9/16 at 5 PM to clarify which resident wounds were pressure ulcers, which were non-pressure wounds, and whether wounds were actually located on the right or left. Interview with the corporate nurse on 2/8/16 at 3:35 PM confirmed the resident had wounds on the left	F 224		

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F 224	Continued From page 5 hip, left knee, right malleolus and left ischium, and did not have open wounds on the right hip or right knee. o. Interview with the corporate nurse on 2/8/16 at 3:35 PM revealed both pressure and non-pressure wounds were being documented on forms the facility had on hand, because they were no longer ordering the forms. According to the corporate nurse, the facility was phasing out the weekly pressure and non-pressure wound logs as they had changed to electronic charting. p. Review of all skin and wound assessments contained in the electronic charting failed to show any documentation of the left hip, left knee, or left ishial wounds. q. Review of progress notes showed a "Skin/Wound Note" dated 1/23/16 and timed 5:25 PM. The note revealed the resident had a noted decrease in consumption, non-healing wounds, and increased pain. After conversations with the resident's family members and physician the resident was referred for hospice care. r. Review of the hospice agency initial nursing assessment dated 1/24/16 and timed 1:50 PM showed the resident had wounds in the following locations: left hip, left sacral, right hip and buttocks, left knee and right ankle. Further review of the assessment showed "Wounds unable to be seen as SNF [skilled nursing facility] staff are too busy at this time to do wound care dressing change on Pt [patient]. Will follow up on wounds with comprehensive assessment. Reported by [facility LPN] Pt (L) [left] hip wound is eschar, (L) sacral is a deep ulcer, (R) [right] hip and buttocks are intact but reddened that is blanching, also (L) knee is down to the bone, and (R) ankle pressure ulcer is healing well. Pt is having daily dressing changes." s. Review of the hospice agency wound	F 224		

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3/7/16 QN

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F 224	Continued From page 6 assessment and intervention record dated 1/26/16 and timed 2 PM showed the resident had the following wounds: i. A left hip wound that was unstageable, had a moderate amount of purulent drainage, and a foul odor. ii. A left knee wound that was unstageable and had a foul odor. iii. A left buttock wound that was unstageable, had a moderate amount of purulent drainage and a foul odor. iv. A second left hip stage I wound. v. "Left hip reddened, foam dressing applied, right hip had foam dressing on it, not removed. [Facility] nurse reports only redness and no open area on right hip, right malleolus reddened, healing wound, did not not (sic) any skin breakdown to shoulders or back." t. Review of the progress note dated 1/29/16 and timed 6:12 AM showed the resident had been discharged from the facility and admitted to an inpatient hospice facility on 1/28/16. u. Interview with the corporate nurse on 2/8/16 at 3:35 PM revealed the facility DON was in the process of delegating wound care responsibilities to other nursing staff. She further revealed there was not a consistent person doing wound measurements, and there was not a consistent schedule for completing wound assessments. v. Interview with the DON, ADON and corporate nurse on 2/10/16 beginning at 12:10 PM revealed that, as the facility had been transitioning to an electronic medical records system, the DON had delegated some wound duties to the ADON and the unit manager. The DON stated nursing documentation had "been an issue" at the facility. It was confirmed wound assessments were supposed to be completed on	F 224		

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3/7/16 CN

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F 224	Continued From page 7 a weekly basis, and were to include all relevant assessment of the wound such as the site of the wound, type of wound, measurements of the wound including depth, wound odor, and presence of drainage. w. Interview with the DON, ADON, and corporate nurse on 2/10/16 beginning at 3 PM revealed the unit manager had been completing wound assessments for residents located on the secure unit, and the DON further stated that she was not aware of the deteriorating state of the resident's wounds the last week the resident had been in the facility. x. Interview with the unit manager on 2/10/16 at 8:30 PM revealed she had been on vacation beginning on 1/22/16. She did not know who took over wound rounds while she was on vacation. y. Review of the facility's policy and procedure entitled, "Skin Management" last revised August 2012, showed the following: i. "7. Wounds are tracked as acquired (developed in-house or admitted with) and are assessed and documented on the Weekly Pressure Ulcer Record..." ii. "8. The Licensed Nurse will document daily monitoring of all pressure ulcers on the Treatment Administration Record (TAR)." iii. "9. A Physician's Order will be written to monitor each ulcer and documentation on the TAR will reflect the status of the dressing, surrounding skin color and skin and pain associated with the wound." iv. "16. Skin assessments: a. 'Weekly Skin Check' will be transcribed onto the Treatment Record including the day and shift on which the check will be conducted....c. Skin assessment findings will be documented weekly on the Head to Toe Skin Check form. Note: Alterations or change(s) in skin integrity, any	F 224		

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3/7/16

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F 224	Continued From page 8 break in the resident's skin including skin tear, bruises, abrasions, ulcers, rash, surgical wounds etc. are to be recorded on the Head to Toe Skin Check form." v. "18. Pressure ulcers are measured and staged weekly in accordance with the Practice Guidelines." 2. Review of the 12/21/15 quarterly MDS assessment showed resident #97 required assistance with ADLs and did not have pressure ulcers. Review of the resident's care plan, revised 12/22/15, showed the resident had potential skin issues related to possible breakdown from incontinence, wheelchair mobility, oxygen tubing, and thin skin/bruising easily. Further review showed interventions for this problem included skin cheeks weekly per facility protocol, document findings, and notify the physician of changes in wound or emerging wounds. Review of the 12/22/15 pressure ulcer risk assessment showed the resident had a high risk for developing pressure ulcers. Review of the 1/28/16 weekly head to toe skin assessment showed "left buttocks reddened and skin starting to break, hydrocolloid dressing put on to prevent further breaking of skin." Review of the physician's order, dated 1/28/16, showed directions for treatments every 5 days for the "denudement to the buttocks." The following concerns were identified: a. Review of the January and February 2016 treatment records showed no documentation to confirm the resident received the physician-ordered treatments. b. The facility was unable to provide documented weekly skin assessments of the reddened area after the 1/28/16 assessment. c. Review of the pressure ulcer logs for	F 224		

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F 224	Continued From page 9 February 2016 showed this resident had not been included in the monitoring logs. d. Observation on 2/10/16 at 7:45 PM with the unit manager revealed the area on the buttocks that was documented as starting to breakdown on the 1/28/16 had deteriorated to a stage II pressure ulcer. This area was observed to be a nickle-sized open, red, and moist area surrounded by a 2 centimeter area of redness. e. During the observation, the unit manager revealed staff had not reported the pressure ulcer to her.	F 224		
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 observation, medical record review, policy and procedure review and staff interview, the facility failed to ensure residents having pressure ulcers received necessary treatment and services to promote healing and prevent new ulcers from developing for 2 of 5 sample residents (#97, #108) with pressure wounds. This failure resulted in actual harm to resident #108. The findings were:	F 314	F314 TREATMENT AND SERVICE TO PREVENT / HEAL PRESSURE ULCERS It is the practice of the facility to strive to ensure that based on comprehensive assessment of a resident, that a resident who enters the facility without a pressure sore does not develop pressure sores unless the resident'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 pressure sores from developing.	3/15/16 ~~3/10/2016~~ 3/9/2016

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3/7/16

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F 314	Continued From page 10 1. Review of the 11/20/15 annual MDS assessment showed resident #108 had diagnoses that included diabetes mellitus, hypertension and non-Alzheimer's dementia. The resident required the extensive assistance of 1 person for ADLs including bed mobility, transfers, dressing, and personal hygiene. Further review showed the resident was deemed to be at risk for developing pressure ulcers, but did not have unhealed pressure ulcers at the time of the assessment. Review of the CAA for pressure ulcers revealed the resident did not "...present with any pressure ulcers, but [s/he] does have an arterial ulcer on [his/her] right malleolus [ankle]..." The following concerns were identified: a. Review of the 11/8/15 head to toe skin check showed the resident had a pressure wound located on the left outer ankle. The was no other assessment of the wound, such as measurements, stage, or wound characteristics included. The section entitled "Further description of skin issues" showed "pressure sore on L [left] heel, dressing was changed and it appears to be healing." Review of the medical record showed no further information on a left ankle or heel wound, such as the date of onset, initial assessment, physician notification or physician orders, and date of resolution was available. b. Review of the 12/7/15 head to toe skin check showed the resident had an existing wound to the right ankle. Further review of the medical record showed no additional head to toe skin checks were completed between 12/7/15 and 1/28/16. c. Interview with the administrator and corporate nurse on 1/10/16 at 2:20 PM revealed the facility had recently become aware the new electronic charting system was not notifying nursing staff when head-to-toe skin checks were	F 314	CORRECTIVE ACTION Resident #108 was discharged from the facility on 1/28/2016 to hospice. The wound on resident #97's left buttock was healed on 2/18/2016. A head to toe skin check was completed on 3/2/2016 by licensed nurse and confirms resident #97 is free from skin breakdown at this time. IDENTIFICATION OF OTHERS Facility residents had head to toe skin checks completed between 2/09/2016 to 2/15/2016 to identify any skin concerns. Documentation was completed on any identified wounds and appropriate interventions put into place. An additional audit will be completed by date of compliance to verify that head to toe skin checks are completed and wound documentation and assessments are completed. Follow up will be completed as needed. SYSTEMIC CHANGES The nursing staff was be educated on skin management policies, including weekly wound evaluation and documentation on weekly pressure ulcer record and weekly non pressure ulcer record, obtaining physician orders and	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016
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OMB NO. 0938-0391

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3/7/16

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F 314	Continued From page 11 due to be completed, and because of this, head-to-toe skin checks had not been done. d. Review of the 1/1/16, timed 5:37 PM, progress note showed: "Physician Order Note - Left hip/flank DTI [deep tissue injury] - Cleanse area with vashe [wound cleanser], pat dry with gauze, apply sure prep to area and place hydrocolloid. Change Q [every] 5 days and prn...Dressing in place, current measurements to area of erythema [redness] 2.4 cm x [by] 1.8 cm x UTD [unable to determine]. No open area, center of erythema with DTI [deep tissue injury] purple in color." Further review of progress notes showed no additional information on this wound, such as additional assessments. e. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 1 occasion between 1/3/16 and 1/21/16. f. Review of the January TAR showed the treatment order for the left hip wound changed on 1/23/16 to the following: "Left Hip DTI- Cleanse area with vashe, pat dry with gauze, apply sure prep to area, barrier cream to wound edges, tenderwet to wound bed, secure with large foam. one time a day..." g. Further review of the January TAR showed the physician-ordered dressing change was documented as completed on 3 days between 1/23/16 and 1/28/16. h. Review of the 1/1/16, timed 5:35 PM, progress note showed: "Physician Order Note - Left knee Abrasion - Cleanse with VASHE, pat dry with gauze, apply sure prep to peri wound, calazime cream to wound margins, hydrogel gauze fold to fit wound bed and secure with border foam. Change Q day... Dressing in place and no s/sx of infection. Current measurements 1.8 cm x 1 cm x UTD blood tinged scab to area,	F 314	timely and accurate completion of head to toe skin checks by the Director of Nursing or designee on 2/18/16. Treatment sheets in electronic medical record have been amended to include weekly head to toe skin checks. Treatment sheets will be amended to include daily monitoring of pressure ulcers and monitoring each ulcer for status of dressing and surrounding skin and pain associated with wound. During morning clinical meeting the facility will continue to review the PCC dashboard, 24 hour report for any changes in skin condition, any new wound treatment orders, assigned head to toes skin checks for timely completion and new admissions for any skin concerns. Corrective actions will be taken as needed for any identified concerns. The Director of Nursing or designee will continue to conduct wound rounds weekly and review / complete wound evaluation and documentation. A designated nurse will assist with wound rounds weekly for consistency and will complete rounds in absence of Director of Nursing for consistency.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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3/7/16

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F 314	Continued From page 12 erythema to edges, non tender." Further review of progress notes showed no additional information on this wound, such as additional assessments of the wound. i. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 7 days between 1/2/16 and 1/21/16 (20 days). j. Review of the 1/22/16, timed 12:35 AM, showed: "Left knee Abrasion - Cleanse with VASHE, pat dry with gauze, apply sure prep to peri wound, calazime cream to wound margins, colagen fold to fit wound bed and secure with border foam. Change Q day, one time a day..." The reason for the change in wound care orders was shown as "..Upon wound assessment, need new tx [treatment]." k. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 3 days between 1/23/16 and 1/28/16. The resident was discharged from the facility on 1/28/16 l. Review of the 1/23/16, timed at 5:38 PM, phone order showed: "Left Ischium - Cleanse with Vashe, pat dry with gauze, apply sure prep to peri wound, calcium alginate to wound bed, secure with border foam, change Q day..." m. Review of the January TAR showed the physician-ordered dressing change was documented as completed on 2 days between 1/23/16 and 1/28/16. n. Review of wound logs provided by the facility on 2/8/16 at 1:30 PM showed the following: i. The weekly non-pressure ulcer QA & A [Quality Assessment and Assurance] log dated 1/13/16 showed the resident had three wounds: a left knee wound that measured 2.6 cm x 1.2 cm, an ankle wound (not identified as either right or	F 314	The Director of Nursing or designee will audit current wounds weekly for 3 months. The audit will include evaluation and staging/classification and measurement of wound and documentation, appropriate treatment orders and completion of head to toe skin checks. Corrective actions will be taken as needed. MONITORING The Director of Nursing or designee will track and trend the wound audits monthly for any trends / patterns for 3 months. The audit results will be reported to the Quality Assurance Performance Improvement Committee (QAPI). The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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

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3/7/16 QA

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F 314	Continued From page 13 left) that measured 1.4 cm x 0.7 cm, and a right hip wound that measured 1.5 cm x 1.5 cm. No other information about the wounds, such as the type of wound, the depth of the wound, and presence of odor or drainage was included. ii. The weekly pressure ulcer QA & A log dated "week of 1/20/16" showed the resident had three wounds: an ankle wound (not identified as either right or left) that measured "1.5 cm," a right knee wound that measured 2 cm x 1.5 cm, and a right hip wound that measured 4 cm x 1.5 cm. No other information about the wounds, such as the actual date the wound was assessed, the stage of the wound, depth, odor, or drainage was included. iii. The weekly non-pressure ulcer QA & A log dated "wk [week] of 1/29/16" showed the resident had three wounds: a left hip deep tissue injury attributed to trauma that measured 4 cm x 6.4 cm x UTD, had no odor, and did have drainage; a left ischial pressure ulcer that measured 3.2 cm x 1.1 cm x UTD, had no odor, and did have drainage; and a left knee wound attributed to trauma that measured 2 cm x 1.5 cm x UTD, had no odor, and did have drainage. Further review of the medical record failed to show a date of onset, or any assessment regarding a left ischial pressure ulcer. iv. The weekly non-pressure ulcer QA & A log dated "wk of 2/1" showed the resident had three wounds: an ankle wound (not identified as either right or left) that measured "1.5 cm," a right knee wound that measured 2 cm x 1.5 cm, and a right hip wound that measured 4 cm x 1.5 cm. No other information about the wounds, such as the actual date the wound was assessed, the depth of the wound, odor, or drainage was included. Review of progress notes showed the resident was discharged from the facility on 1/28/16 and	F 314		

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

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3/7/16 AV

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F 314	Continued From page 14 was not in the facility the week of 2/1/16. o. The facility provided updated copies of the wound logs on 2/8/16 at 3:35 PM, 2/9/16 at 8:30 AM, and 2/9/16 at 5 PM to clarify which resident wounds were pressure ulcers, which were non-pressure wounds, and whether wounds were actually located on the right or left. Interview with the corporate nurse on 2/8/16 at 3:35 PM confirmed the resident had wounds on the left hip, left knee, right malleolus and left ischium, and did not have open wounds on the right hip or right knee. p. Interview with the corporate nurse on 2/8/16 at 3:35 PM revealed both pressure and non-pressure wounds were being documented on forms the facility had on hand, because they were no longer ordering the forms. According to the corporate nurse, the facility was phasing out the weekly pressure and non-pressure wound logs as they had changed to electronic charting. q. Review of all skin and wound assessments contained in the electronic charting failed to show any documentation of the left hip, left knee, or left ishial wounds. r. Review of progress notes showed a "Skin/Wound Note" dated 1/23/16 and timed 5:25 PM. The note revealed the resident had a noted decrease in consumption, non-healing wounds, and increased pain. After conversations with the resident's family members and physician the resident was referred for hospice care. s. Review of the hospice agency initial nursing assessment dated 1/24/16 and timed 1:50 PM showed the resident had wounds in the following locations: left hip, left sacral, right hip and buttocks, left knee and right ankle. Further review of the assessment showed "Wounds unable to be seen as SNF [skilled nursing facility] staff are too busy at this time to do wound care	F 314		

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

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3/7/16

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F 314	Continued From page 15 dressing change on Pt [patient]. Will follow up on wounds with comprehensive assessment. Reported by [facility LPN] Pt (L) [left] hip wound is eschar, (L) sacral is a deep ulcer, (R) [right] hip and buttocks are intact but reddened that is blanching, also (L) knee is down to the bone, and (R) ankle pressure ulcer is healing well. Pt is having daily dressing changes." t. Review of the hospice agency wound assessment and intervention record dated 1/26/16 and timed 2 PM showed the resident had the following wounds: i. A left hip wound that was unstageable, had a moderate amount of purulent drainage, and a foul odor. ii. A left knee wound that was unstageable and had a foul odor. iii. A left buttock wound that was unstageable, had a moderate amount of purulent drainage and a foul odor. iv. A second left hip stage I wound. v. "Left hip reddened, foam dressing applied, right hip had foam dressing on it, not removed. [Facility] nurse reports only redness and no open area on right hip, right malleolus reddened, healing wound, did not not (sic) any skin breakdown to shoulders or back." u. Review of the progress note dated 1/29/16 and timed 6:12 AM showed the resident had been discharged from the facility and admitted to an inpatient hospice facility on 1/28/16. v. Interview with the corporate nurse on 2/8/16 at 3:35 PM revealed the facility DON was in the process of delegating wound care responsibilities to other nursing staff. She further revealed there was not a consistent person doing wound measurements, and there was not a consistent schedule for completing wound assessments.	F 314		

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

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FORM APPROVED
OMB NO. 0938-0391

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3/7/16

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F 314	Continued From page 16 w. Interview with the DON, ADON and corporate nurse on 2/10/16 beginning at 12:10 PM revealed that, as the facility had been transitioning to an electronic medical records system, the DON had delegated some wound duties to the ADON and the unit manager. The DON stated nursing documentation had "been an issue" at the facility. It was confirmed wound assessments were supposed to be completed on a weekly basis, and were to include all relevant assessment of the wound such as the site of the wound, type of wound, measurements of the wound including depth, wound odor, and presence of drainage. x. Interview with the DON, ADON, and corporate nurse on 2/10/16 beginning at 3 PM revealed the unit manager had been completing wound assessments for residents located on the secure unit, and the DON further stated that she was not aware of the deteriorating state of the resident's wounds the last week the resident had been in the facility. y. Interview with the unit manager on 2/10/16 at 8:30 PM revealed she had been on vacation beginning on 1/22/16. She did not know who took over wound rounds while she was on vacation. z. Review of the facility's policy and procedure entitled, "Skin Management" last revised August 2012, showed the following: i. "7. Wounds are tracked as acquired (developed in-house or admitted with) and are assessed and documented on the Weekly Pressure Ulcer Record..." ii. "8. The Licensed Nurse will document daily monitoring of all pressure ulcers on the Treatment Administration Record (TAR)." iii. "9. A Physician's Order will be written to monitor each ulcer and documentation on the TAR will reflect the status of the dressing,	F 314		

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

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

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3/7/16 QV

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F 314	Continued From page 17 surrounding skin color and skin and pain associated with the wound." iv. "16. Skin assessments: a. 'Weekly Skin Check' will be transcribed onto the Treatment Record including the day and shift on which the check will be conducted....c. Skin assessment findings will be documented weekly on the Head to Toe Skin Check form. Note: Alterations or change(s) in skin integrity, any break in the resident's skin including skin tear, bruises, abrasions, ulcers, rash, surgical wounds etc. are to be recorded on the Head to Toe Skin Check form." v. "18. Pressure ulcers are measured and staged weekly in accordance with the Practice Guidelines." 2. Review of the 12/21/15 quarterly MDS assessment showed resident #97 required assistance with ADLs and did not have pressure ulcers. Review of the resident's care plan, revised 12/22/15, showed the resident had potential skin issues related to possible breakdown from incontinence, wheelchair mobility, oxygen tubing, and thin skin/bruising easily. Further review showed interventions for this problem included skin cheeks weekly per facility protocol, document findings, and notify the physician of changes in wound or emerging wounds. Review of the 12/22/15 pressure ulcer risk assessment showed the resident had a high risk for developing pressure ulcers. Review of the 1/28/16 weekly head to toe skin assessment showed "left buttocks reddened and skin starting to break, hydrocolloid dressing put on to prevent further breaking of skin." Review of the physician's order, dated 1/28/16, showed directions for treatments every 5 days for the "denudement to the buttocks." The following	F 314		

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

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FORM APPROVED
OMB NO. 0938-0391

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3/7/16

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F 314	Continued From page 18 concerns were identified: a. Review of the January and February 2016 treatment records showed no documentation to confirm the resident received the physician-ordered treatments. b. The facility was unable to provide documented weekly skin assessments of the reddened area after the 1/28/16 assessment. c. Review of the pressure ulcer logs for February 2016 showed this resident had not been included in the monitoring logs. d. Observation on 2/10/16 at 7:45 PM with the unit manager revealed the area on the buttocks that was documented as starting to breakdown on the 1/28/16 had deteriorated to a stage II pressure ulcer. This area was observed to be a nickle-sized open, red, and moist area surrounded by a 2 centimeter area of redness. e. During the observation, the unit manager revealed staff had not reported the pressure ulcer to her.	F 314		