STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD THERMOPOLIS, WY 82443

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 9/5/18 to 9/6/18. The survey was prompted by complaint intakes WY00002608, WY00002633, and WY0002671. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		9/28/18

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

Electronically Signed | 09/27/2018

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F 657	Continued From page 1 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility incident logs, the facility failed to revise the care plan to reflect current status for 7 of 7 sample residents (#6, #17, #34, #35, #44, #45, #46) who were reviewed for care plans. The findings were: 1. Review of progress notes showed resident #35 had the following behaviors: a. On 7/8/18 the nurse attempted to re-direct the resident from entering another resident's room and the resident hit the nurse with a closed fist in the chest. b. On 6/5/18 the resident attempted to stab the nurse with a fork. c. On 6/4/18 the resident placed his/her hand across the nurse's throat. d. On 5/6/18 the resident was noted to have a butter knife at his/her side. Another resident said the resident was waving it at him/her. e. On 5/5/18 the resident swung at the nurse with a closed fist. f. On 4/11/18 the resident twisted the arm of a CNA. Review of the facility's log of reportable incidents showed the resident was the aggressor in resident to resident altercations on 4/6/18, 5/1/18, 5/3/18 and 5/6/18.	F 657	1. Resident #35 care plan was immediately updated to reflect interventions on what to do to prevent and manage behaviors. Resident #44 care plan was immediately updated to address resident to resident altercations. Resident #45 passed away on 9/5/18. Resident #46 passed away on 8/10/18. Resident #6 care plan was immediately updated to reflect that wounds to the resident's forehead and temporal area were addressed. Resident #17 care plan was immediately updated to reflect that wounds to the toes were addressed. Resident #34 care plan was immediately updated to reflect impaired skin was addressed. 2. All residents are expected to have care plans that reflect individualization and that are specific to the resident's skin condition and behavioral health. Facility will audit all resident care plans for individualization and specificity related to wound care and behavioral health. Care plans not in compliance will be immediately modified and updated. Facility will also review care plans post-incident at daily clinical meeting and weekly high risk meeting and make modifications/updates as	

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F 657	Continued From page 2 Review of the resident's care plan (last revised 8/6/18) showed aggressive behavior towards residents and staff was not addressed. The care plan indicated the resident was on psychotropic medications for behavior management, but all the interventions were related to monitoring the psychotropic medications. There lacked interventions on what to do to prevent and manage behaviors. 2. Review of the facility's log of reportable incidents showed resident #44 was the aggressor in resident to resident altercations on 5/1/18, 5/3/18, 7/17/18, 7/24/18, 8/2/18, and 8/13/18. Review of a faxed communication to the physician dated 8/7/18 showed the resident was exhibiting aggressive behavior including hitting residents and throwing things. Review of the care plan showed the problem "potential for behavioral concerns of: verbal and physical aggression, racial slurs, exit seeking, refusing cares, nutrition, hydration, medications and sleep/night time disturbances r/t diagnosis of dementia and metalosis" was included. However, review of the interventions showed the last revision to the interventions was dated 4/10/18. There lacked evidence the facility had updated the care plan to address the resident to resident altercations. 3. Review of a nursing note dated 6/29/18 for resident #45 showed the nurse documented a new wound to the heel. The nurse documented "stage 3 pressure injury that is 3 x 2.5 x 5 mm with dark thick drainage." Review of the 7/20/18 quarterly MDS assessment revealed the resident had one stage 3 pressure ulcer which measured 2 cm x 3 cm x 0.5 cm. Review of the last weekly wound assessment prior to the resident being	F 657	appropriate. 3. Director of Nursing Services educated licensed nurses (including Minimum Data Set Nurse) on care plan individualization and specificity in relation to wound care and behavioral health and how to modify/update care plans in real time on 8/11/18 and 8/12/18. DNS/designee will validate education by reviewing care plan changes at daily clinical meeting and following up with further individual staff education where needed. 4. DNS/designee will randomly audit 10 (ten) care plans for individualization and specificity weekly x 4 weeks and monthly x 2 months. Outliers to be modified immediately. Results will be brought to the facility monthly QAPI for review, recommendations and need for ongoing monitoring.	

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F 657	Continued From page 3 discharged (on 9/1/18) was on 8/22/18. The assessment indicated the pressure ulcer was a stage 2 measuring 1.6 x 1 x 0.3 (no unit of measurement defined). Review of the resident's care plan (last revised 7/18/18) showed "at risk for pressure ulcer both potential and actual" with a goal of "resident will maintain skin integrity." The care plan was not updated to reflect the pressure ulcer to the heel. 4. Review of nursing progress notes for resident #46 showed on 7/2/18 it was documented "Resident has a 3 mm x 4 mm area to the left heel no drainage or redness. In same area as last pressure ulcer." Review of a 7/24/18 physician's progress note showed "pressure ulcer on left heel broke open again." The physician documented "skin ulcer of left heel, limited to breakdown of skin." Review of the care plan (last revised 8/1/18) showed "Potential for skin breakdown related to decreased mobility and poor nutritional intake" with a goal of "Resident will have no skin breakdown or complications such as PU [pressure ulcer]." The care plan had not been updated to reflect the pressure ulcer to the heel. 5. Review of a physician's progress note dated 5/15/18 showed resident #6 had excisions of two growing masses to the forehead and left temporal area. The resident had a history of squamous cell carcinoma. Observation on 9/6/18 at 11 AM revealed the DON applied an Opsite dressing to an area on the forehead and an area near the left eye. Review of the care plan (last revised 8/29/18) showed the wounds to the resident's forehead and temporal area were not addressed. 6. Observation on 9/6/18 at 2:28 PM showed the DON performed wound care on resident #17. The	F 657		

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F 657	Continued From page 4 DON removed the old dressings and applied new dressings (bordered gauze) to the left great toe, left third toe, right second toe and right third toe. The DON stated at that time the resident injured his/her toes in an electric wheelchair incident. Review of progress notes showed the wounds to the toes were mentioned on 7/27/18. Review of the care plan (last revised 9/5/18) showed the wounds to the toes were not addressed. 7. Review of the "Weekly Skin Evaluation" dated 8/5/18 revealed resident #34 had a "non-pressure ulcer" to the coccyx and right buttock. Review of a fax communication to the physician dated 8/4/18 showed the resident had two wounds caused by shearing on the gluteal cleft and the right mid-buttock. Review of the care plan (last revised 3/23/18) showed the resident's impaired skin was not addressed. 8. During an interview on 9/6/18 at 5:15 PM the DON confirmed the care plans had not been updated. She stated the care plan process recently changed and the facility was going to start addressing wounds on the care plans.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		9/28/18

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F 684	Continued From page 5 by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to assess, monitor and provide treatment in accordance with physician's orders for 4 of 5 sample residents (#6, #17, #34, #45) with non-pressure-related wounds. The findings were: 1. Review of a physician's progress note dated 5/15/18 showed resident #6 had excisions of two growing masses to the forehead and left temporal area. The resident had a history of squamous cell carcinoma. Observation on 9/6/18 at 11 AM revealed the DON applied an Opsite dressing to an area on the forehead and an area near the left eye. The following concerns were identified: a. Further review of the 5/15/18 progress note showed "...Discussed wound care. Educated patient of signs and symptoms of infection. Remove sutures in 7 days." There lacked specific instructions on wound care. b. During an interview on 9/6/18 at 4:47 PM the DON stated there was no physician's order for wound care. c. Review of the TARs for May through July 2018 showed no mention of wound care. Review of the August 2018 TAR showed "change dressing to left forehead q [every] 3 days." However, the dressing was not specified and there lacked documentation that the dressing had been changed that month. d. Review of progress notes since June 1, 2018 showed documentation of wound care only on the following days: 6/8/18, 7/27/18, 7/30/18, and 8/21/18. e. Review of medical record documentation provided by the facility showed the only documentation of assessment (description,	F 684	1. Resident #6 care plan was immediately updated to reflect specific instructions on wound care, physician order was immediately obtained for wound care, dressing changes were immediately implemented into the Treatment Administration Record and facility immediately began wound monitoring in daily clinical meeting to ensure documentation of wound assessments are up to date. Resident #34 had physician's orders for treatment immediately validated and facility will ensure physician's orders are in place before treatment. Also, Resident #34 immediately had wound documentation implemented into the TAR to reflect timely dressing changes and progress notes are being reviewed and monitored in daily clinical meeting as well as timely weekly skin assessments to reflect proper wound care. Resident #17 immediately had physician orders obtained for treatment, wound care was implemented into the TAR and dressing changes are being validated in the TAR with LN initials. Also for resident #17 progress notes are being reviewed in daily clinical meeting to validate wound care is being documented properly along with timely weekly skin assessments. Resident #45 passed away on 9/5/18. 2. All residents are at risk for wounds/skin breakdown. All residents are expected to have accurate and complete documentation related to skin including individualized care plans, physician orders in place prior to wound treatment, daily	

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F 684	Continued From page 6 measurements) of the wounds since June 1, 2018 was in progress notes dated 6/8/18, 7/27/18 and 7/30/18. There lacked evidence the facility was monitoring the wounds consistently. 2. Review of the "Weekly Skin Evaluation" dated 8/5/18 revealed resident #34 had a "non-pressure ulcer" to the coccyx and right buttock. Review of a fax communication to the physician dated 8/4/18 showed the resident had two wounds caused by shearing on the gluteal cleft and the right mid buttock. The nurse documented the wounds were cleansed, skin prep applied, and a Comfeel dressing was applied to each wound. The nurse requested to continue the dressing change every three days. The following concerns were identified: a. Further review of the fax from 8/4/18 showed the physician didn't respond until 8/14/18 with "noted." There lacked evidence of physician orders for treatment from 8/4/18 until the physician responded on 8/14/18. b. Review of the August 2018 TAR showed "dressing change to buttock Q [every] 3 days" starting 8/14/18. Further review of the TAR showed no documentation the dressing was changed from 8/14/18 through 8/31/18. c. Review of progress notes showed no documentation of wound care. d. Review of the weekly skin evaluations (assessment of wounds) showed an evaluation on 8/19/18. The next evaluation was not until 9/2/18 (two weeks later). 3. Observation on 9/6/18 at 2:28 PM showed the DON performed wound care on resident #17. The DON removed the old dressings and applied new dressings (bordered gauze) to the left great toe,	F 684	review of wound documentation in progress notes, proper and timely treatment documentation in the TAR and timely weekly skin evaluations; all in accordance with the facility's "Skin Integrity" policy. Facility will audit all wound care documentation for accuracy and completion. All outliers will be corrected and/or completed immediately. Facility will ensure that all resident care plans individually and accurately reflect the skin treatment needs of each resident. Wound documentation will be reviewed in daily clinical meeting as well as at the weekly high risk meeting for accuracy and completion, including care plans. 3. On 9/11/18 and 9/12/18 DNS educated LNs on proper wound care including accurate and complete documentation related to skin, individualized care plans, physician orders in place prior to wound treatment, proper validation of wound care in the TAR, daily review of wound documentation in progress notes and timely weekly skin evaluations; all in accordance with facility's "Skin Integrity" policy. LNs will complete wound care education program provided by facility's nursing supply vendor. 4. DNS/designee will randomly audit wound care documentation for completion and accuracy, including individualized care plans, for any wounds in the building weekly x 4 weeks and monthly x 2 months. Outliers to be modified immediately. Results will be brought to the facility monthly QAPI meeting for review and recommendations.	

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F 684	Continued From page 7 left third toe, right second toe and right third toe. The DON stated at that time the resident injured his/her toes in an electric wheelchair incident. The following concerns were identified: a. Review of progress notes showed the wounds to the toes were mentioned on 7/27/18. However, review of physician orders showed an order for wound care was not received until 8/15/18. During an interview on 9/6/18 at 4:47 PM the DON stated she was unable to find an order for treatment prior to the 8/15/18 order. b. Review of the July 2018 TAR showed wound care was not addressed. Review of the August 2018 TAR showed "dressing changes to bilateral foot and lower legs..." was included; however, there lacked any documentation to show dressing changes were actually completed (there was an "X" in every box instead of nurses' initials). c. Review of progress notes showed the only documentation of wound care was dated 7/27/18. d. Review of medical record documentation provided by the facility showed the only documentation which showed an assessment of the wounds was dated 7/27/18. 4. Review of a physician's progress note dated 4/18/18 showed resident #45 had a stage 2 non-pressure ulcer and a skin tear to the right lower leg. The physician wrote an order on 4/18/18 for "unna boot to RLE [right lower extremity] toes to knee." The order instructed staff to change the unna boot every 72 hours. Review of a physician's progress note dated 5/2/18 showed the resident had a non-pressure ulcer to the right lower leg which was being treated with an unna boot. The physician documented "continue with current wound care and Unna boots until fully resolved." Review of a	F 684		

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F 684	Continued From page 8 verbal physician's order dated 6/11/18 showed "apply Unna Boot to Right Lower Leg wound as needed, every 72 hours as needed." The following concerns were identified: a. Review of the May 2018 through July 2018 TARs showed "wound care to R [right] lower leg- continue until wounds healed... one time a day for skin" was added to the TAR starting 5/2/18. However, there lacked evidence the physician ordered wound care one time a day on 5/2/18. The physician's progress note on 5/2/18 indicated the current wound care and the Unna boot should be continued (which had been changed every 72 hours up until that point). The physician's order on 6/11/18 to change the Unna Boot every 72 hours was not transcribed onto the June or July TARs. b. Review of the TARs for May 2018 through July 2018 showed sporadic documentation for "wound care to R lower leg- continue until wounds healed...one time a day for skin." Nursing staff initialed that the daily wound care was done on 11 days in May, 7 days in June, and 5 days in July. c. During an interview on 9/6/18 at 4:47 PM the DON stated the order was transcribed wrong on the TAR in May 2018. She stated the TAR should have indicated that the unna boot was to be changed every 72 hours. The DON confirmed inconsistent documentation on the TARs regarding treatment for the lower leg wound. d. On 8/2/18 the physician wrote another order to continue the 3 day dressing change to the right lower extremity. However, review of the August TAR showed only two days (8/15, 8/30) were documented for wound care. e. Review of medical record documentation provided by the facility showed the last documentation of an assessment of the wound (description, measurements) was dated 8/2/18.	F 684		

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F 684	Continued From page 9 The resident was discharged on 9/1/18. 5. During an interview on 9/6/18 at 2:40 PM the DON stated she had identified problems with the facility's wound care process. She confirmed the problems with lack of documentation of assessments of wounds and treatment of wounds. She stated nursing staff were not documenting wound care consistently on the TARs and the weekly wound care evaluation forms did not have a place to document wound care performed. She stated she was in the process of improving the wound care system and was going to be doing some staff education and audits. On 9/6/18 at 4:47 PM the DON stated she had no further documentation to provide for residents #6, #17, #34, or #45 and confirmed the problems identified with each resident related to wound care. 6. Review of the facility's policy "Skin Integrity" (updated March 2018) showed "...7. For skin impairment identified with admission (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc), the LN [licensed nurse] completes the following: a. Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation. b. Notifies the Physician and obtain a Treatment Order if needed, document on the Treatment Administration Record (TAR) after implemented....8. If skin impairment is noted after admission (in addition to above steps), the LN: a. Initiates Alert Charting. b. Completes (and documents notifications to the physician and Resident representative. c. Completes Braden Scale and evaluates current interventions for	F 684		

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F 684	Continued From page 10 necessary revision. d. Implements new interventions as needed. Documents on the resident's care plan and Care Directive..." In addition, "...10. Wounds are evaluated weekly by Center clinicians. Arterial, Pressure, Stasis, Venous Ulcers, significant surgical wounds, and burns are evaluated, measured, and findings documented in the medical record...11. Significant abrasions and bruises are evaluated weekly by the LN (excoriations, rashes, skin tears, etc) and documented in the medical record."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedures, the facility failed to assess, monitor, and provide treatment in accordance with physician's orders for 2 of 2 sample residents (#45, #46) with pressure ulcers. The findings were:	F 686	1. Resident #45 passed away on 9/5/18. Resident #46 passed away on 8/10/18. 2. All residents are at risk for wounds/skin breakdown. All residents are expected to have accurate and complete documentation related to skin including individualized care plans, physician orders	9/28/18

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(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 686	Continued From page 11 1. Review of the 6/26/18 Braden Scale (for predicting pressure ulcer risk) showed resident #45 was at moderate risk for pressure ulcers. Review of a nursing note dated 6/29/18 showed an Unna boot was removed from the resident's leg (resident had a non-pressure ulcer to right lower leg). The nurse documented a new wound to the heel. The nurse documented "stage 3 pressure injury that is 3 x 2.5 x 5 mm with dark thick drainage. The wound bed is hard to determine if it has eschar. The wound was cleansed with cleaner silvasorb was placed for debridement and a dermalyvn was placed. A boot was placed on resident to off load the heel." Review of the 7/20/18 quarterly MDS assessment revealed the resident had one stage 3 pressure ulcer which measured 2 cm x 3 cm x 0.5 cm. The assessment indicated the pressure ulcer was not present on admission. The following concerns were identified: a. Review of the June 2018 TAR showed a weekly skin assessment was documented on 6/5/18, and then not again until 6/26/18 (three weeks later). Review of the associated weekly skin assessment note in the progress notes dated 6/26/18 showed "Weekly skin check presents no new skin issues. Unna boot to R [right] leg remains." During an interview on 9/6/18 at 4:47 PM the DON stated "it really did show up that quick" when discovered on 6/29/18. b. Review of physician orders showed an order dated 8/2/18 for every 3 days dressing change to the right heel. There lacked evidence of a physician's order for wound care prior to the 8/2/18 order. On 9/6/18 at 4:47 PM the DON stated there was not an order for wound care prior to the 8/2/18 order. c. Review of the August 2018 TAR showed wound care to the right heel every three days was	F 686	in place prior to wound treatment, daily review of wound documentation in progress notes, proper and timely treatment documentation in the TAR and timely weekly skin evaluations; all in accordance with the facility's "Skin Integrity" policy. Facility will audit all wound care documentation for accuracy and completion. All outliers will be corrected and/or completed immediately. Facility will ensure that all resident care plans individually and accurately reflect the skin treatment needs of each resident. Wound documentation will be reviewed in daily clinical meeting as well as at the weekly high risk meeting for accuracy and completion, including care plans. 3. On 9/11/18 and 9/12/18 DNS educated LNs on proper wound care including accurate and complete documentation related to skin, individualized care plans, physician orders in place prior to wound treatment, proper validation of wound care in the TAR, daily review of wound documentation in progress notes and timely weekly skin evaluations; all in accordance with the facility's "Skin Integrity" policy. LNs will complete wound care education program provided by facility's nursing supply vendor. 4. DNS/designee will randomly audit wound care documentation for completion and accuracy, including individualized care plans, for any wounds in the building weekly x 4 weeks and monthly x 2 months. Outliers to be modified immediately. Results will be brought to the facility QAPI meeting monthly for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 09/06/2018

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F 686	Continued From page 12 listed starting 8/3/18. However, further review showed wound care was only documented on 8/15 and 8/30. Review of progress notes showed no further evidence wound care was provided. d. The last weekly wound assessment prior to the resident being discharged (on 9/1/18) was on 8/22/18. The assessment indicated the pressure ulcer was a stage 2 measuring "1.6 x 1 x 0.3." 2. Review of the 5/14/18 Braden Scale showed resident #46 was at moderate risk for pressure ulcers. Review of a physician's progress note dated 5/2/18 showed the resident was seen for wound follow-up. The resident had a decubitus ulcer of the left heel which was a stage 3. According to nursing notes, on 5/30/18 the wound to the left heel was "scabbed over...resident will still wear protective boot when sitting in [his/her] chair." The following concerns were identified: a. Review of the June 2018 TAR showed "Continue wound care and continue to wear heel protectors continuously one time a day" was still on the TAR even though the last documentation of the resident's wound was on 5/30/18. It was unclear from documentation if the resident still had a wound in June. Regardless, there was only documentation for that intervention on 6/9, 6/10, 6/12, 6/26, and 6/30. b. Further review of the June 2018 TAR showed "wound, left heel, expose wound, cleanse et cover with border gauze daily." Again, there lacked any documentation in June 2018 that the resident had a wound to the left heel. Regardless, the only documentation for that intervention was 6/9, 6/10, 6/12, 6/26, and 6/30. c. Review of the June 2018 TAR showed "weekly skin assessment on Thursday. Head to toe..." However, there lacked documentation of any weekly skin assessments. Review of nursing	F 686		

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F 686	Continued From page 13 notes showed skin notes dated 6/5/18, 6/6/18, 6/7/18 and 6/13/18. There lacked evidence of weekly skin checks since 6/13/18. d. Review of nursing progress notes showed on 7/2/18 it was documented "Resident has a 3 mm x 4 mm area to the left heel no drainage or redness. In same area as last pressure ulcer. Skin broken but level to the skin margins. Covered with an UNNA boot and off loading boot placed for resident to wear all the time." e. Review of the July 2018 TAR showed "Unna boot to left lower leg to be changed Q [every] week in the morning every Monday for pressure ulcer." However, there lacked documentation the Unna boot was changed on 7/30/18 as scheduled. f. Review of medical record documentation provided by the facility showed an assessment of the wound (type, description, size) was only documented 7/2, 7/18, and 7/27. The resident was discharged on 8/7/18. g. Review of a 7/24/18 physician's progress note showed "pressure ulcer on left heel broke open again." The physician documented "skin ulcer of left heel, limited to breakdown of skin." 3. During an interview on 9/6/18 at 2:40 PM the DON stated she had identified some issues with the wound care process. She agreed that it was hard to track the progression of pressure ulcers due to sporadic documentation of assessments of the wounds. She stated nursing staff were not good about documenting when wounds were healed, and also did not consistently document skin assessments and treatments on the TARs. She stated she was planning on education for nursing staff and was planning on doing some audits.	F 686		

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F 686	Continued From page 14 4. Review of the facility's policy "Skin Integrity" (updated March 2018) showed "...7. For skin impairment identified with admission (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc), the LN [licensed nurse] completes the following: a. Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation. b. Notifies the Physician and obtain a Treatment Order if needed, document on the Treatment Administration Record (TAR) after implemented....8. If skin impairment is noted after admission (in addition to above steps), the LN: a. Initiates Alert Charting. b. Completes (and documents notifications to the physician and Resident representative. c. Completes Braden Scale and evaluates current interventions for necessary revision. d. Implements new interventions as needed. Documents on the resident's care plan and Care Directive..." In addition, "...10. Wounds are evaluated weekly by Center clinicians. Arterial, Pressure, Stasis, Venous Ulcers, significant surgical wounds, and burns are evaluated, measured, and findings documented in the medical record...11. Significant abrasions and bruises are evaluated weekly by the LN (excoriations, rashes, skin tears, etc) and documented in the medical record."	F 686		