STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145969	A. BUILDING _____ B. WING _____	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE NURSING & REHAB CENTER	**8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130**

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F 501	Continued From page 78 to eat in the past month. E35 (Diet Tech) was interviewed on November 16, 2006 and stated that the facility does not write down intakes and therefore if she does not observe a resident, she will ask a nurse aid how a resident is eating. Review of R8's latest care plan was updated on 11/13/06 documentation R8's behavior of R8 refusing care, and not eating. There was no previous documentation prior to 11/13/06 addressing R8's behavior ongoing maladaptive behavior. The facility did not update the care plan that started on May 9, 2006 with interventions to deal with refusal of eating. R8 was admitted to the hospital for a medical evaluation on 11/14/06. Review of hospital record reveals R1 was admitted with diagnosis of Dementia and MRSA of wound heel. The facility failed to act in a timely manner to discharge R8 out to the hospital for weight loss and refusal of treatment and the facility failed to notify the physician of R8's refusal to be hospitalized. Furthermore, the facility failed to monitor and assess R8 for nutritional intake during the period of November 10 to November 13 after R8 had been identified as being at risk for not eating and did not develop care plan interventions to deal with R8's maladaptive behavior. The Dietitian was not notified and the resident continued to refuse an adequate diet and exhibit a significant weight loss of 11% in 5 months.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)1)	F9999		

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F9999	Continued From page 79 300.1210b)2) 300.1210b)3) 300.1210b)4)B) 300.1210b)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following: B) Each resident shall have at least one complete	F9999		

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F9999	Continued From page 80 bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulationns were not met as evidenced by: Based on observations, record review and interviews the facility failed to 1) Identify new pressure ulcers, 2) Treat existing pressure ulcers, 3) Provide appropriate preventive measure to prevent the ulcers and 4) Assess and care plan residents at risk for pressure ulcers. This failure was a systematic failure. Ten (R1, R2, R15, R18, R11, R5, R12, R13, R19, R20) out of 14 sampled residents with pressure sores and 2 outside the sample (R25 and 26) were noted with new pressure ulcers, lack of treatment, lack of assessment or lack of preventative measures. R18, R1, R2, R15, R25, R26, R13, R19, R12, and R20 were noted with new pressure sores during the survey that were unidentified by the facility and without treatment.	F9999		

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F9999	Continued From page 81 R11, R21, and R13 were identified by the facility as being high risk without appropriate monitoring and assessment. Findings include: 1. R18 was admitted to the facility November 1, 2006 for Congestive Heart Failure, Scalp Laceration, Pyelonephritis, and Anemia. The initial nursing assessment dated 11-01-06 indicates that R18 had only a reddened area on the sacrum and left heel. Upon review of the medical record on November 12, 2006, an assessment of the area on the sacrum and/or heel was not measured or assessed, and no orders for treatment or care were noted on the Physician Order Sheet (POS) for skin treatment and or preventative means. The physician's history and physical dated November 4, 2006 does not address any pressure ulcers. The hospital transfer sheet dated November 1, 2006 indicated that R18 had no pressure ulcers when transferred to the facility. A review of the facility's bath sheets for nurse aids indicated that none were present for R18, yet R18 had been identified as being at high risk for pressure sores. The facility utilizes the bath sheets to monitor the residents' skin condition and check for new pressure sores or other skin problems. The treatment book was checked and no treatment record could be located for R18. On November 12, 2006 at 9:07am, R18 was observed in bed with a strong pungent urine odor. E12 (Nurse Aid) stated that she had not given care to R18 yet and would clean her up. R18 was noted to have incontinent pads on her bed that were soaked with urine and brown rings were noted on the bed sheet and pads. R18 was	F9999		

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F9999	Continued From page 82 noted with open areas on her mid back that were reddened and with slight blood area, and a DuoDerm patch was noted in the middle of the area with no date or time. In addition a Stage I area was noted on the right back leg area. Later at 10:30am, R18 was getting a shower and sustained a skin tear. While observing the area, R18 was noted with a blackened blister area on the right bunion area, and the surrounding area was noted to be bright red and inflamed. During this observation, surveyor questioned E10 (Treatment Nurse) and E11 (Treatment Nurse) about the wound to R18's back area. Both nurses denied applying a treatment and or noting an area on R18's back. E10 and E11 both observed the bunion wound and noted the blister and reddened area. R18 was then placed back to bed at 2:45pm and surveyor, E10, and E11 returned to observe the resident's back area. The DuoDerm dressing was noted to be imbedded in the skin and the area around the dressing was raw and bleeding. The resident was noted to cry out in pain when E11 attempted to remove dressing. E11 stopped and medicated R18 for pain and returned fifteen minutes later to remove the dressing. E11 had to soak the dressing in saline and even with pain medication, R18 was noted to cry out when the dressing was removed. The area was noted to be red and raw with bright red blood and layers of skin missing. Again both E11 and E10 denied knowledge of the wound. R11 stated that she would call the physician and obtain treatment orders. On November 12, 2006, surveyor noted that R18 had been referred to Z1 (Physician Assistant/Wound Specialist). Z1 was interviewed on November 12 at 11:30am about R18. Z1 stated that she was not aware of the wound on	F9999		

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F9999	Continued From page 83	F9999		

the bunion. Z1 stated that the wounds on R18's back were the result of "Shearing" or "burn like" from pulling when moving R18. Z1 stated that R18 needed an air mattress and a two person transfer due to her delicate skin. Z1 stated she did not know about the bunion but would look at the area to make recommendations. Finally, an order for wound treatments were obtained for all areas of wound and an assessment was done by the nursing staff.

The facility failed to identify a new pressure ulcer, failed to obtain a physician's order for a wound treatment, failed to provide preventative measures to prevent pressure ulcers and failed to keep the resident dry and clean to prevent skin irritation. This failure resulted in R18 sustaining new pressure ulcers and suffering pain and discomfort that was preventable.

2. R1 was admitted to facility on 7/12//06 with diagnosis of Respiratory Failure, Congestive Heart Failure and Dementia. Review of R1's initial nurses notes revealed R1 had no pressure ulcers at time of admission on 7/12/06. Review of R1's Braden Scale of 9/27/06 assessed R1 as mild risk for pressure ulcers. On 11/11/06 during initial tour surveyor observed R1 lying in bed. R1 is alert to verbal stimuli and just cries and moans. Surveyor observed R1 lying on a mattress that was approximately 8" shorter than the bed frame.

Review of R1's record revealed R1 had developed multiple areas of breakdowns to the left flank, right outer heel, right lateral heel,left lateral heel and groin area in August 2006. There were no assessments or reassessments with measurements in the treatment book or chart. Review of R1's treatment records revealed

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F9999	Continued From page 84 treatments were discontinued to the pressure areas due to healing: - right outer heel-no date discontinued -left flank-healed 9/7/06 -right lateral heel discontinued 9/28/06 -left ankle heel -healed 9/28/06 Review of wound assessment record dated 10/26/06 revealed R1 was found to have a stage II blood filled blister measuring 1.2 x 1.4 centimeter. Review of Physician's Order Sheet revealed an order to cleanse with normal saline or wound cleanser, pat dry, wipe with sure prep, and cover with dry dressing every daily/prn until healed. Review of R1's October 2006 treatment record lacked documentation that R1 received treatments on 10/28-10/29-10/30. Review of R1's November treatment record lacked documentation that R1 received treatment to the right lateral heel. On 11/12/06, surveyor requested E37(LPN) to do a skin check on R1. Surveyor observed large darkened area to the right lateral heel. There was no dressing in place. A further skin check revealed an open area to R1's sacral area. Surveyor asked E37 to stage the open area. E37 identified it as a Stage II. Surveyor prompted E37 to have wound care nurse reassess R1 and provide the information to the surveyor. There is no documentation that R1's physician was notified of the right ankle area not being treated or an order for R1's new sacral pressure ulcer. On 11/13/06, facility provided new wound assessments for R1's right heel wound. The wound assessment for R1's right lateral heel ulcer revealed the wound had significantly increased in size from 1.2 centimeters x 1.4 centimeters on 10/26/04 to and an unstageable Stage IV measuring 1.7 cm. x 1.8	F9999		

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F9999	Continued From page 85 cm. with serosanguinous drainage with yellow slough 10% and 90 % black wound color. On 11/15/06 surveyor again requested the wound assessment of R1's sacral pressure ulcer. E19 (wound consultant) stated she was not aware of R1 having a sacral ulcer. E19 then assessed R1's sacral wound on 11/15/06 as a reopened Stage II measuring .7cm. length x .6 cm. x <.1 cm in depth. An order was obtained to cleanse sacral ulcer and apply Hydrocolloid every 3 days and as necessary until healed. The order for the treatment was obtained 3 days after the surveyor and E37 identified the wound. 3. R2 has a diagnosis that includes Diabetes Mellitus, Asthma, Chronic Obstructive Disease. Review of facility weekly bath and skin report revealed that on 11/9/06 R2 received a bath. There was no assessment of R2's skin on the bath sheet. On 11/12/06 surveyor asked E2 (wound care nurse) if R2 had any history of any sacral ulcers. E9 stated "I don't think so." Surveyor asked to do a skin check on R2, and observed an opened area to R2's sacral area. E9 measured the area at 1.9 (length) x .9 (width) < .1 cm in depth. An order was obtained the cleanse the sacral area with normal saline or wound cleanser, pat dry and apply hydrogel cover with dry dressing every day and prn until healed. Review of R2's admit/readmission assessment form reveals R2 was readmitted to the facility with a Stage 2 to the sacral area. No other wounds were identified. New wound assessments dated 11/15/06 for R2 provided by facility, revealed R2 was found to have acquired new areas to the right lateral area, Stage 2, measuring .6 cm length x .3 cm. width, and described as a blood filled blister. R2 also	F9999		

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F9999	Continued From page 86 acquired a stage I measuring 2.8 cm x 3.9 cm. to the left hip area. Treatments orders were obtained on 11/15/06. Review of R2's October 2006 treatment record lacked documentation that R2 received the following ordered treatments on the following dates: Site right heel, left heel-cleanse with sure prep and cover with dry dressing daily on 10/7, 10/8, 10/10, 10/12, 10/13, 10/16, 10/17, 10/18, 10/21, 10/22, 10/24, 10/25, 10/28, 10/29, 10/31. Right leg cleanse with normal saline and apply bacitracin and leave open to area on 10/7, 10/8, 10/10, 10/12, 10/13, 10/16, 10/17, 10/18, 10/21, 10/23, 10/24, 10/26, 10/28, 10/29. Surveyor was unable to find assessments for the above wounds in the treatment book or medical record. R2's care plan of starting date 10/4/06 requires facility to measure wounds weekly and record measurements on the "Wound Assessment Form." 4. R15 was observed on 11/11/06 sitting in special wheelchair in the hallway. Surveyor observed R26's left foot to have a dressing on it and observed the foot dependent on the floor. Review of R15's record revealed R15 was admitted to facility on 4/25/06 with diagnosis End Stage Renal Disease and Pulmonary Disease. R15 receives dialysis 3 times a week. Review of R15's Braden Scale dated 9/27/06 assessed R15 as mild risk for pressure ulcers. R15's quarterly Minimum Data Set dated 9/28/06 revealed R15 had no pressure ulcers. Review of weekly bath	F9999		

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F9999	Continued From page 87 and skin sheet lacked documentation that R15 had any showers or baths in November 2006. On 11/12/06 at 12:30 PM surveyor asked E9 (LPN) to observe R15's left foot wound. R15 was in his room at the time and was alert and orientated and his left foot was dependent on the floor. Surveyor asked R15 how long he has had the wounds on his toes. He stated, it's from them banging my foot against the wheel chair and it hurts like hell. Surveyor observed E9 remove R15's dressing from the left toe areas. The surveyor observed the following wound areas: right posterior toe, darkened area and open blister to anterior 5th left toe, left 4th lateral toe reddened, blister to 2nd toe left. Review of R15's wound care assessment dated 11/10/06 revealed the following: Left 5th toe Stage 2 measuring 1.5 cm. x 2.1 cm depth< .1 Left 4th lateral toe Stage 2-measuring 2.6 cm. x 1.1 cm. Left 2nd toe Stage 2-measuring 1.9 x 1.2 blister. Review of facility wound treatment record lacked documentation that R15 received previously ordered treatments to the left 4th toe for saline and apply Bacitracin daily and leave open to air on 11/1, 11/3, 11/5, 11/7, 11/9. An order for the the left lateral 5th toe was obtained on 11/8/06, and lacked documentation on the treatment record that R15 received the treatments form 11/8-11/12. Surveyor asked R15 if he receives his treatments everyday, and he stated no. Surveyor asked R15 if any other areas hurt him, and R15 stated "my butt hurts like hell." E10 was present at that time	F9999		

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F9999	Continued From page 88 and asked R15 why she didn't tell him. Surveyor requested to do a skin check on R15's bottom and observed an open area to R15's sacral area. A wound assessment for R15 was completed and the wound was measured 1 x 1 and <.1 in depth, Stage II. An order for treatment was obtained on 11/12/06. R15 was asked if he was having any severe pain, and R15 responded "yes." E9 stated R15 receives Morphine Sulfate 2 mg twice a day, but also has an order for Hydrocodone/Ibuprofen 7.5 1 tablet every 4 hours and Acetaminophen. Review of Medication Administration Record revealed R15 did not receive either prn medication 5. R25 was observed on 11/13/06 in his room in his wheel chair. R25 has a dressing to his right heel. R25 was asked by surveyor if he receives his treatments every day and R25 responded not all the time. Review of R25's Braden Scale assesses R25 as a 21(low risk for pressure ulcers). There were no current wound assessment records in the treatment book. The last assessment was dated 7/28/05. R25's October 2006 treatment record lacked documentation that R25 received the ordered treatment on the following dates: 10/8, 10/10, 10/12, 10/15, 10/25, 10/28, 10/29. The treatment included cleanse right lateral foot malleolus with normal saline, apply Eadem ointment to outer skin and fill area with hydrogel and apply dressing daily. Review of R25's weekly bath/skin checked lacked documentation that R25 had a weekly skin check.	F9999		

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F9999	Continued From page 89 Review of 4th floor bath/skin checks on 11/11/06 revealed R16 was found to redness to the buttock area. Record reviews revealed no follow up by staff on the reddened buttocks. Surveyor requested to do a skin check with staff and observed R16's buttock very reddened. This was confirmed by a bath/skin check done on 11/13/06. An order for Baza Creme was obtained on 11/13/06. 6. Review of R26's Braden Scale dated 7/26/06 assessed R26 as a mild risk for pressure sores. E11 was asked by surveyor to do a skin check . R26 was observed to have very reddened areas to the scrotum and buttocks. There was no creme residue to R2's scrotal area or buttocks. Review of POD revealed an order to apply Hydrocortisone creme to genital area till healed. E11 was asked who applies the creme and E11 stated the CNA. E38 stated that R26 did not have any creme in his drawer to put on. 7. During initial tour on 11/11/06 at 9:45 AM, R13 was observed up in wheelchair in the Dining Room. On the second day 11/12/06 at 8:00 AM, R13 was again observed in the dining room eating breakfast while up in a wheelchair. R13 continued to be up in the wheelchair and was moved to the activity area at 10:00 AM. Again R13 continued to be up in a wheelchair as noted at 12:30 PM eating in the dining room. During the meal observation, R13 complained about pain on her bottom stating that she has been up on the chair since 6:00 AM. At 3:00 PM, R13 was still noted in the chair and surveyor requested staff to check buttocks area as she was still complaining of pain. E31, CNA (Certified Nursing Assistant) taking care of R13 indicated that he had checked R13 while working	F9999		

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	145969	A. BUILDING _____ B. WING _____	11/16/2006

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F9999	Continued From page 90	F9999		

the night shift (11:00 PM to 7:00 AM) and indicated that R13 did not have any sore. E32, (Nurse) with surveyor checked on R13's back after putting R13 in bed. R13 was observed with four open areas on the right buttock measuring 0.9 cm by 1.5 cm and 0.5 cm by 0.4 cm on the upper buttock and 0.3 cm by 0.4 cm and 1.2 cm by 1.8 cm on the lower buttocks. The left lower buttock has also open areas measuring 0.3 cm by 1.1 cm. Both buttocks are reddened and excoriated around the open sores.

Also noted were dressing to left and right heel with yellow drainage noted seeping through her socks. The dressings were dated 11/09/06. The wounds were checked and the left heel was stage II measuring 3.5 cm by 0.6 cm. The right heel was stage II measuring 1.5 cm by 2 cm. There were no order for treatment of these pressure sores. These sores were shown to E32 (Nurse) and she was notified that there was no order for these sores. A follow up on the next day 11/13/06, R13 continued to have no orders for treatment and documentation indicated the buttocks sores still were not treated.

R13's initial skin assessment for risk of pressure sore is left blank. R13's care plan calls for pressure reducing device on the mattress and wheelchair. The mattress being used for R13 shows regular mattress. The facility's skin assessment for R13 is derived from what the staff document on the weekly bath and shower sheet. Review of R13's weekly bath and skin report for October and November 2006 does not show any documentation that R13 was given a bath or skin check was done.

8. R19 was observed at 11/13/06 at 8:00 AM in

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	145969	A. BUILDING _____ B. WING _____	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE NURSING & REHAB CENTER	**8200 WEST ROOSEVELT ROAD FOREST PARK, IL 60130**

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F9999	Continued From page 91	F9999		

bed eating breakfast on her back. At 11:30 AM follow up with E2 DON (Director of Nursing) and E9 LPN (Treatment Nurse), R19 was observed soaked with loose bowel movement from her waist to lower thigh. Bowel Movement were also noted on the inner thighs and behind the knees. R19 has three incontinent pads stacked on top of each other. All these pads were soaked and saturated with Bowel Movement. After cleaning the Bowel Movement from R19's thigh, 2 blisters were noted on the right posterior thigh measuring 0.6 cm by 0.5 cm, 0.2 cm by 0.3 cm and left buttock has three blisters all measuring 0.1 cm by 0.1 cm. Right heel stage I measuring 0.5 cm by 0.5 cm. Buttocks and peri-area were all excoriated. Review of documentation show these sores were not identified and no treatment provided. On 11/13/06 at 11:30 AM, Z5 (family member) was noted at bedside. Z5 indicated that he came in at 8:30 AM and until now 11:30 AM R19 was not changed or repositioned.

9. On 11/12/06 at 13:30 AM, R12 was checked with E22 (Nurse). R12 was noted with a stage II on her left posterior thigh measuring 3.1 cm by 0.5 scm and reddened bottom. There was no dressing applied to this open pressure sore. Record also indicate there was no order for this open sore nor was it assessed by the staff.

Weekly bath and skin report on 11/08/06 has documented that R12 already had a peeling blister identified but no treatment or assessment followed after this discovery.

10. On 11/12/06 at 11:15 AM, R20 was observed with E9 (Treatment Nurse) with a blackened scab on the right lateral ankle that is reddened around the site. R20 complained of

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F9999	Continued From page 92 pain on the site during observation. There is no treatment observed and no order for treatment on the chart. The facility has not documented this sore. 11. R11 has numerous pressure ulcers (Stage III and Stage IV) and a low albumen and a tube feeding. R11 had a weight of 94.8 pounds and the last nutritional note in the record, dated September 29, 2006 did not address the wounds. The nutritional needs for these large pressure ulcers was not addressed until prompted by the survey team. In addition, because of her pressure ulcers and risk for developing additional pressure ulcers, R11 should have had a "resident bath a skin report" done during the twice weekly shower sheets. The shower sheets for R11 were noted to be empty indicating that R11 had not been monitored for additional pressure sore development. 12. R21 was readmitted to the facility on a tube feeding after treatment in the hospital for debridement of a pressure ulcer. R21 returned to the facility on November 6, 2006 and was not evaluated until November 14, 2006. Furthermore, the facility did not weigh this resident upon readmission to determine if the resident's nutritional needs were met. In addition since R21 has numerous pressure ulcers that developed in the facility, R21 was placed on skin monitoring. Upon review of R21's "bath and shower record" on November 14, 2006, it was noted that R21's skin check sheet was empty. R21 is at risk for new pressure ulcers based on mobility and present skin issues. 13. R5 is considered by the facility to be at risk for pressure sore development based on her	F9999		

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F9999	Continued From page 93	F9999		

mobility issues and obesity. R5 was being treated for skin issues during the survey, yet R5's bath and skin report was not complete. Only one entry was present for October of 2006 and one entry for November of 2006. The sheet was reviewed on November 14, 2006.

14. E8 (Medical Director) was interviewed by phone on November 1, 2006 at 1:30 PM. E8 stated that as part of skin care and protocol that the nurse aids were the first line of defense in identifying skin issues and that skin break down needed to be identified and reported to ensure treatment. E8 stated that the daily checks and shower sheets were an important component of identifying pressure ulcers.

A review of the facility's policy states: "It is the policy of this facility that pressure and other ulcers will be assessed and measured at least every seven days by a licensed nurse and recorded on the facility approved Wound Assessment Form. The ulcer assessment will be completed at the time of admission/readmission and will be updated quarterly or as needed." "Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. At the earliest sign of a pressure ulcer or other skin problem, the resident, legal representative and attending physician will be notified." In addition, the facility policy states that all ulcers showing evidence of change the physician shall also be notified along with other interested parties. All changes and new ulcers should be documented within the medical record and the resident's plan of care should be updated to reflect any changes in the