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Interview with E1, Adm., on 9/26/07 at 2:40pm indicates that name badges for all staff is a policy of the facility and is enforced. E1 stated the policy is new within the past month.

F9999 FINAL OBSERVATIONS — F9999

LICENSURE VIOLATIONS

300.1210a)
300.1210b)2)
300.1210b)3)
300.1210b)5)
300.1220b)2)
300.1220b)3)
300.1220b)8)
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:
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

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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.
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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as

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indicated by the resident's condition. The plan shall be reviewed at least every three months.
8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure there is an effective system in place to identify pressures sores; to monitor pressure sores; to provide treatment for pressure sores; and to provide pressure sore prevention for 10 residents (R1, R2, R3, R4, R6, R7, R9, R10, R11 and R12) of 15 in house sampled residents and 9 residents (R25, R29, R34, R35, R36, R37, and R39) off the sample. This systemic failure resulted in harm to R2 who was admitted to the facility with pressure sores in January 2005 and continued to have a chronic stage 4 pressure sore on her sacrum as of September 2007. This failure resulted in harm to R1 who acquired an in house stage 2 pressure sore to the coccyx on 1-11-06 measuring 2 cm x 1 cm x <.1 cm depth. R1 continued to have a chronic pressure sore which was identified as

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stage 3 pressure sore as of September 2007. R1 and R2's pressure sores have not healed due to facility failure to accurately assess pressure sores; implement plans of care to aid in healing pressure sores; and to provide treatment to the pressure sores as ordered by the Physician. The facility failed to follow Manufacturer's Policy and procedures for Wound VAC on R2 and R12 and failed to follow their own Policy and procedures for wound VAC dressings. The facility failed to follow their Policies and Procedures for Aseptic techniques for dressing change on R1, R2, and R12. R12's surgical wound increased in size within 1 week of being admitted to the facility. R9 developed an avoidable stage 3 pressure sore while in the facility.

Findings include:

1. R2's Hospital Records of 1-05 show that R2 was admitted from home with 2 pressure sores on her right and left buttock at the sacral area. These wounds were debrided and R2 was admitted to the facility on 1-19-05 with the pressure sores.

Facility Pressure Ulcer Progress Report shows admission with two pressure sores on left and right gluteal at a stage 4. Note of 5-2-05 states now are one large area. There are no measurements documented as to the size of the pressure sore.

A Wound Consultant report of 10-24-06 shows that the age of the sacrum wound was 03-05 and that Wound Consultant began care on 8-12-06. The report identifies the wound as a stage 4 measuring 4.5 x 4.5 x 1.5 cm depth with tunneling and undermining.

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R2 was observed on 9-16-07 during tour of facility at 4:25PM to be lying in bed, with the head of the bed elevated. E26, Certified Nurse Aide (CNA), stated they were going to get R2 up for the evening meal. Skin check with E26 and E3, Licensed Practical Nurse, present showed R2 to have a Urinary Catheter that was connected to a leg bag. R2's catheter was leaking and R2 was lying on a wet bed pad that had dried dark brown ring of urine at the edges. This was confirmed by E26 and E3.

R2 had a wound vac attached to her sacrum area. The wound vac was set at 75 mmHg. R2 was observed to have dark brown scabbed areas under her left upper back thigh/gluteal fold. E3 confirmed the areas on the back upper thigh and said they must be from lying on her catheter tubing. (E3 later that evening stated she had called the doctor and got an order for a dressing to the pressure sores on the gluteal fold.) R2 was cleaned and transferred to her wheel chair. R2 was observed throughout the evening of 9-16-07 from 4:35PM to 7:10PM (2 hours and 35 minutes) to be up in her wheel chair without being repositioned.

R2 was observed on 9-17-07 at 7:25AM to be already up in her wheel chair and being taken to the Dining Room by staff. R2 wound vac was off. At 7:45AM, E30, CNA, was observed to come into the Dining Room and plug in R2's wound vac but the vac was off and remained off while R2 ate her breakfast meal. R2 was taken to her room after breakfast and was observed at 8:43AM to be sitting in her room in her wheelchair. The wound vac was unplugged and off. R2 remained in her room in her wheelchair with the wound vac

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unplugged and off until 9:50AM. At that time E19, LPN/Wound Nurse, was informed that wound vac was unplugged and off. E19 confirmed that wound vac was off and plugged in the vac and the vac was on at 75 mmHg. When E19 was informed that the Treatment Administration Record (TAR) documented that the vac was to be at 100 mmHG, not 75 mmHG, E19 stated that the vac must have been set at 75 mmHg the night before as she just plugged in the vac and turned it on and it automatically went to 75 mmHg.

At 10:00AM, E19 checked the Physician Order Sheet (POS) which showed an order for 100 mmHg wound vac setting to be on continuous. At 10:10AM R2 was transferred to bed and the wound vac was set at 100 mmHg. (R2 had been up in the wheel chair for 2 hours and 45 minutes without being repositioned and the wound vac had been off 2 hours and 35 minutes.) The wound vac was checked at 10:12AM and E19 was informed that the vac alarm was off and the vac was set on mute and was not functioning. E19 asked if she should turn on the alarm and stated the vac must have a leak. E25, LPN, came into the room and adjusted the vac tubing and the vac started to work. At 4:35PM, R2's wound vac was observed to be set at 125 mmHg (not at 100 mmHg as ordered by the Physician). E1, Administrator and E2, Director of Nursing, were informed of concerns at Daily Status Meeting on 9-17-07. On 9-18-07 E19 stated that the facility called the company for a new wound vacuum and until it came in they were treat R2's pressure ulcer with a wet to dry dressing.

In an interview with E13, Physical Therapist, on 9-24-07 at 9:50AM, E13 stated she last measured R2's pressure sore on 9-14-07. E13 stated that

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R2's pressure sore was a stage 4 and had undermining. E13 stated she has had education on assessment of pressure sores and continuing education on pressure sore assessment. E13 stated she assessed R2 as having undermining on 9-14-07. E13 stated that the undermining would not have healed out within one week.

A review of the PHYSICAL THERAPY WOUND WEEKLY TREATMENT SUMMARY: FOR SACRAL PRESSURE SORE for R2 indicated that on 6-6, 8-15, 8-23, and 9-14-07 R2 was assessed as having a Stage 4 pressure sore with undermining, and measurements on 6-6-07 were 8 x 4 cm with 2 cm depth with no tunneling and with undermining at 3 cm at 12:00, 2.75 cm at 2:00 and 4 cm at 11:00 with 20% slough to 9-14-07 measuring 5 cm x 5 cm x 3 cm depth, tunneling not assessed, and 3cm of undermining at 10:00 and 3:00. On 6-14-07 it was staged at a 3.

On 9-17-07 at 12:32PM, E3 and E24 (LPN's) were observed to measure R2's pressure sore. E24 did the treatment with E3 assisting. E24 removed the wound vac drain canister (which was 1/3 full) and discarded the canister. The wound vac dressing was removed and the wound was elongated in shape slightly larger than a golf ball in width and with depth. The wound had a foul odor. E24 placed the wound dressing supplies and scissors directly on R2's bed. No clean field was set up for the dressing change. E24 stated that there is "tunneling in here" and "shelving" around the edge of the wound; and measured the wound to be 8 cm x 11 cm with 6 cm of tunneling at 11:00. E24 stated shelving was 2.5 cm at 12:00, 4 cm at 2:00 and 5 cm at 8:00. E24 stated that the pressure sore was a stage 4 with some

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necrotic tissue. E3 agreed that the wound was a stage 4. Both E3 and E24 stated they had not done R2's dressing change since she was recently changed to the wound vac. They said R2 did have a wound vac in the past and she responded well to the treatment. E3 was observed to cut white foam for the wound packing with scissors that laid directly on R2's mattress. E3 had been wearing the same gloves while she was positioning R2 as E24 removed the wound vac dressing and feces from R2's rectal area. E3 placed the white foam in the "shelving" areas around the wound bed. (This is where undermining was observed.) The same scissors were used to cut the gray foam that was placed in the wound bed.

On the morning of 9-18-07 the facility provided a new Pressure Sore Log dated 9-17-07 identifying R2 as having a stage 4 pressure sore on the sacrum measuring 5 x 6 cm x 3 cm depth with odor and drainage. These measurements were not the same as the measurements E3 and E24 obtained the day before. In an interview on 9/18/07 E3 and E24 stated the treatment nurse told them she did not need the measurements from the previous day.

On 9-19-07 at 1:00PM, R2's Treatment Administration Record was reviewed with E19. They were the same measurements that were on the Pressure Sore Log. At 2:50PM, E19 and E2 were shown a copy of Physical Therapy evaluation of R2's wound that showed undermining of R2's pressure sore. E19 stated she did not assess R2 for undermining or tunneling.

On the morning of 9-22-07 the facility provided an

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assessment dated 9-21-07 by Z7, Wound Consultant Nurse. The wound is documented to be a chronic pressure sore on the Sacrum at a stage 3 measuring 3.0 cm x 5.0 cm with a depth of 2.0 cm. with rolled edges. There is no undermining identified on the assessment. The Wound Consultant documented the rolled edges were agitated with a curette to enhance healing. Recommendations were to use gray foam at 125 mmHG continuous wound vac with education on wound care and pressure relief.

R2 was observed through out the survey to have her head of bed elevated when she was in bed. R2 has a Physician order to keep head of bed elevated at 30 degrees. Interview with E2 on 9-19-07 stated that she had never considered that keeping R2's head of bed elevated may contribute to lack of healing or increased pressure on the sacrum.

Physician Note of 7-30-07 states R2 has a sacral open wound with increased brownish drainage, has increased in size and is tunneling. Note states, "Have wound nurse measure wound." Will benefit from Vac due to size of wound.

During interview with E19 on 9-18-07 at 4:10PM, E19 stated she had been hired to work as a nurse on the floor and then was told she would be the Treatment Nurse. E19 said she worked as the Treatment Nurse for a couple of days and then back as a floor nurse E19 stated she did not do the current pressure sore measurements on R2 that were on the 9-17-07 Pressure Sore Log.

Interview with E2 on 9-20-07 at 9:12AM reflected that Pressure Sore measurements could be found in the wound care book. She stated R2's

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measurements are done by Physical Therapy and could be found in the Physical Therapy Notes. E19 has a Pressure Sore Book, and assessments can be found on the Pressure Sore Log, and these are the only place measurements are kept.

On 9-20-07 at 10:00AM, E19 stated she had been employed at the facility for 2 weeks. She started on 9-5-07. She helped E2 with the 9-7-07 Pressure Sore Log and that information is also kept in the Wound Book. On 9-7-07, R2's Pressure Sore was documented on the Pressure Sore Log as being a stage 3 on the sacrum measuring 5 x 6 cm x 3 cm depth and no undermining measurements. E19 stated these measurements came from the PT (Physical Therapy) Weekly Wound Summary of 9-5-07. Record review of the PT report shows that R2 had a stage 4 pressure sore on sacral area measuring 5 x 6 cm with 3 cm depth and 3 cm undermining at 10:00. E19 confirmed that PT had identified a stage 4 Pressure Sore, not a stage 3 as is documented on the facility Pressure Sore Log, and that PT identified undermining with 25% necrosis surrounding wound. E19 confirmed the discrepancy. E19 stated on the 9-14-07 Pressure Sore Log identifies a Stage 3 to sacrum. E19 stated she knew it was a stage 4, she checked the wrong box that identified the sore as a Stage 3. E19 stated she did R2's pressure sore measurements on 9-18-07 when her wound vac was off and these measurements are on the Pressure Sore Log that was incorrectly dated 9-17-07. E19 stated she documented a stage 4 to R2's sacrum that measured 5 x 6 x 3 cm. she did not measure for tunneling or undermining. E19 stated she should have but did not know how. E2 was going to show her how but had not. (This conflicts with E19's statement on 9-18-07 at

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4:10PM, that she did not do the measurements that were recorded on the Pressure Sore Log of 9-17-07.)

Interview with Z1, R2's Physician/ Facility Medical Director, on 9-20-07 at 11:45AM, Z1 stated R2 was admitted from the hospital after debridement of the pressure sore on her sacrum. They had used the wound vac in the past and the pressure sore was mostly healed but has now returned. Z1 stated there is a problem with staffing. There are a lot of new staff. The facility needs continuous training of staff. Z1 stated there are concerns that staff know how to manage the vac. Z1 stated that it is a concern that R2's vac was not running for over 2/1/2 hours and lack of repositioning.

Interview with E9, LPN, on 9-24-07 at 9:40AM reflected that E9 had changed R2's vac dressing at 6:30AM. E9 stated she used the white foam where there was undermining in the wound and then packed the wound bed with a piece of gray foam.

An interview with Z5 and Z6 (wound vacuum nurse consultants), on 9-24-07 at 11:10AM., reflected that they were at the facility to do staff training on the wound vac. Both stated that rolled edges is a sign that there is a lack of healing on a pressure sore. R2 having rolled edges would indicate that the healing is at a stalled state and the wound is chronic. Staff would need to assess as to causal factors such as offloading (turning and repositioning), nutritional intake, and if staff are using the vac properly. Z5 and Z6 stated that having R2's head of bed elevated at 30 degrees all the time poses a significant increase of pressure sores and decreased healing. R2 needs to be repositioned often, the wound vac

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does not relieve pressure.

R2's Minimum Data Set of 5-26-07 and 8-23-07 identify R2 as having a stage 4 pressure sore. MDS's states that R2 has severely impaired cognition; has no behaviors; and is totally dependent on 2 staff for transfer, bed mobility and hygiene. R2 has a urinary catheter and is incontinent of bowel.

A review of R2's Interim Care Plan that is not dated indicates: Wound to sacral area left and right sides with goal that area will be healed by next evaluation and treatment of negative pressure dressing at 70 continuous.

R2's Care Plan dated 6-7-06 indicates the most current review was done on 8-26-07. The care plan indicates that R2 requires total care with all Activities of Daily Living and reflects R2's care should include: Turn and reposition from side to side per MD order. Care Plan note of 6-7-07 states, "Impaired skin integrity- stage 4 pressure ulcer. Location: Center coccyx - Resident was originally admitted 01/05 with pressure ulcer and was then hospitalized on 03/05 and returned to the facility with a dx (diagnosis) of aspiration pneumonia and is at risk for further skin breakdown - family refused g-tube." Note of 8-31-06 states that R2 is being seen by wound consultant and continues to have a stage 4 decubitus on coccyx and that wound is slowly healing. Note of 10-6-06 states sacral area is now stage 3. There are no other notes on the Care Plan describing the pressure sore. Care Plan approaches include, in part, assess pressure sore's size depth and color every week. Assess skin daily paying special attention to bony prominence. Cleans and dress the ulcer per

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physician order. Do not lay resident directly on pressure sore. Urinary Catheter due to impaired skin integrity. Low air loss mattress. Note of approaches of 8-8-07 state Wound Vac as ordered

R2 has an order for a pureed diet with super cereal in the morning, med pass 120 cc three times a day, Arginade 1 package with liquid a day and Nectar thickened liquids. Nutritional Note of 9-6-07 states that R2 takes in 100% at meals. Laboratory tests of 3-15-07 show Total Protein within normal limits at 5/7 gm/dl and albumin at 3.0 with normal levels (3.2 -5.5 gm/dl). E25, LPN, stated on 9-25-07 at 10:40AM that R2's most current weight was 140.2 lbs. There is nothing in R2 medical record that would indicate that R2's pressure sores are not healing due to nutritional status

WOUND VAC THERAPY CLINICAL GUIDELINES OF July 2007 show:
Page 3. Accurately record the number of foam pieces used in the patient's chart and on a readily visualized place on the drape.
Monitor continuously and check and respond to alarms. (R2 was observed on 9-17-07 to have her wound vac off for 2 hours and 35 minutes.)
Page 17. The decision to use clean versus sterile/aseptic technique is dependent upon wound pathophysiology, physician/clinician preference, and institutional protocol.
Page 22. WARNING: Never leave a vac dressing in place without active vac therapy for more than 2 hours. If therapy is off for more than 2 hours, remove the old dressing and irrigate the wound. Either apply a new vac dressing from an unopened sterile package and restart vac therapy; or apply an alternative dressing at the

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direction of the treating clinician.

2. R1 has an order of 9-4-07 for PT to treat decubitus ulcer on sacral area 3-5-times a week, HVPC for sacral wound. R1 has a treatment order for hydrogel (line wound bed) cover with coversite twice a day. R1 has an order for Zinc Sulfate 220 mg dly and Vitamin C 500mg twice a day

The facility Weekly Wound and Skin Care Log of 1-13-06 identifies R1 as having stage 2 pressure sores that were acquired in the facility on 1-11-06 one is on the center of the coccyx measuring 2 x 1 x < .1 cm, and another stage 2 pressure sore on right coccyx measuring .5 x .5 x <.1 cm depth.

PHYSICAL THERAPY WOUND WEEKLY TREATMENT SUMMARY of R1's pressure sore on the sacrum reflects: 7-10-07 identifies stage 3 measuring 2 cm x 1 cm x .75 cm with no tunneling or undermining or necrosis; 8-15-07 identifies a stage 3 measuring 2 cm x 4 cm with 1 cm depth and undermining surrounding wound; 9-8-07 identifies a stage 3 measuring 2 cm x 1 cm x 1 cm depth with no undermining or necrosis.

R1 was observed on 9-16-07 at 4:15PM to be lying in bed on her back. R1 stated she was in pain. R1 was observed to remain on her back until 7:00PM when staff brought in her dinner tray and began to feed R1 her dinner meal. At 6:55PM, R1 stated they forgot her food and if they don't hurry up she wouldn't be able to eat.

R1 was observed on 9-17-07 from 8:10AM to 10:40AM to be up in a wheel chair without being repositioned (2 hours and 30 minutes). At 10:40AM, R1 was observed to have a bandage

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that was dated 9-16-07 that had bunched up above her pressure sore on the sacrum. The pressure sore had brown tissue and R1's buttocks were deep creased and red

At 10:45AM, E3, LPN, was informed that R1's dressing was off. E24, LPN, was present and stated she would do the treatment but R1 needed pain medication first. E24 stated to come back in 1/2 hour to observe the treatment.

At 11:15AM, E24 stated R1 still did not have pain medication and stated she needed the medication 1 hour prior to the dressing change. E24 stated to come back around 12:30PM. At 12:30PM, R1 was in the dining room eating noon meal. R1 was observed to remain up in her wheel chair until 1:45PM. At 2:20PM R1 was in bed and stated, " The sore on my bottom hurts." At 3:17PM, R1 was observed to still have no treatment to her pressure sore and was lying on a wet sheet. E28, CNA, confirmed the sheet was wet saying R1's urinary catheter must be leaking and confirmed the treatment was not on the pressure sore. At 4:00PM, E24, LPN, stated that she was waiting for R1 to get a shower before doing the treatment to her pressure sore. At 4:20PM R1 was in the shower room. At 4:35PM, E24 began to gather supplies to do the treatment. E24 stated the treatment order was vague and she was not sure what she needed. At 4:45PM, E3, LPN came and assisted and found supplies for R1's treatment to her sacrum. At 4:50PM, E24 was observed to do the treatment to R1's sacrum with E3 assisting. E24 did not set up a clean field for the pressure sore supplies and laid the supplies directly on R1's mattress. E24 stated the pressure sore looked much worse. E24 stated there was necrotic tissue and the

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pressure sore needed debridement E3 confirmed the pressure sore had declined. Both E3 and E24 stated that the last time they saw the pressure sore it was superficial with no depth and was approximately .5 cm in diameter. E24 stated the pressure sore is now a stage 4 with necrotic tissue and measured the pressure sore as being 5 cm x 6 cm with a 5 cm depth.

Note written on 9-17-07 with E2's signature that was found in R1's TAR states, Tx. (Treatment) Sacrum area wound bed noted to be necrotic, no drainage. MD notified and waiting for reply.

On 9-19-07 at 1:00PM, E19 brought her treatment book in to review with new measurements dated 9-17-07. These were documented on the Pressure Sore Log. E19 was told there was a concern that her measurements were much different from measurements obtained by E3 and E24 on 9-17-07. E19 stated the measurements she had were measurements she and E2 measured together.

On 9-19-07 at 2:45PM, E2 stated she did not measure R2's pressure sore with E19. E2 stated she did assist with the filling out the report (Pressure Sore Log) but did not do measurements. E2 stated she had never even seen R1's pressure sore on the coccyx.

On 9-20-07, at 3:15PM, E2, E41, Corporate Nurse, E24, E19 and E42, Registered Nurse, were in R1's room assessing the pressure sore on her sacrum. E24 stated that the pressure sore had brown necrotic tissue on 9-17-07 but did not at this time. E24 measured the pressure sore as 3 cm x 2 cm with 4 cm depth and stated it was a stage 4. E2 was asked what stage she thought

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the pressure sore was and she stated she agreed that it was a stage 4.

At 3:30PM, E2 stated she disagreed with the way E24 did the pressure sore measurements. She uses the diameter and not the linear edge of the assessment tool. E2 stated she thought that using the linear edge would give a more accurate reading. E2 was questioned about the depth of the pressure sore and E2 stated she disagreed with the depth measurement. E2 stated she did not not re-measure the pressure sore. E24 was informed of the concern of the accuracy of the measurements. E24 was requested by the surveyor to show how she measured the depth of R1's pressure sore and E24 showed she would put a Q tip into the depth of the wound and compare the depth to the diameter measurement. E24 placed the Q tip on the measuring instrument and showed how she got the depth of the pressure sore. This demonstration showed E24 was assessing twice the depth of the pressure sore.

On 9-22-07 at 10:30AM, E2 asked for pressure sore measurements that were assessed by E24 on 9-17-07. According to E2, on 9-18-07, the facility had implemented a Weekly Pressure Ulcer Healing Record (after they were informed of concerns of pressure sore assessment and treatment) to be kept in the TAR. Copy of the record for R2 showed an unstageable pressure sore on the sacrum, black/ brown in color with E2's signature. There was no date or measurements on the assessment.

On 9-20-07, E2 stated they were getting orders and making arrangements to have a wound nurse

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consultation to see R1.

Interview with Z2, R1's Physician, on 9-20-07 at 2:50PM, Z2 stated he looked at R1's pressure sore and it was 1 cm x 1 cm with rolled edges. Z2 stated he had gone back to his notes and in May the pressure sore was only pin point. Z2 confirmed decline.

On 9-21-07 at 3:35PM, Z8, Wound Consultant, stated R1's pressure sore no longer had necrotic tissue. It did have a tan area that could be infection. Z8 assessed R1's sacral pressure sore on 9-21-07 and documented the pressure sore is a chronic stage 3 pressure sore on the sacrum. Assessment identifies the pressure sore as being a stage 3, measuring 1 cm x 1 cm with .2 cm depth. Wound bed is red and dusky with scant exudate. Assessment states R1 soiled with fecal incontinence. Will change treatment to poly sporin powder and santyl dry dressing daily and as needed. With goal to debride, granulate and heal.

R1's MDS of 1-26-07 and 7-23-07 show R1 had mild cognitive impairment. R1 is totally dependent on staff for transfer and requires extensive assistance of 2 for bed mobility. MDS's identify a stage 3 pressure sore. MDS of 7-23-07 shows R1 is 5'7" tall and weighs 148lbs.

R1's Care Plan of 8-2-06 shows next review will be 10-26-06, and has a note written 10-12-06 that R1 had a stage 3 sacral ulcer. Note of 10-27-06 states stage 4 area to sacrum increase related to enzymatic debridement. Care Plan approaches include, in part, turn and reposition at least every 2 hours, special mattress to bed and wheel chair, encourage R1 to follow repositioning schedule

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every 2 hours and to be up for meals, observe for breakthrough pain.

R1's Lab tests of 8-21-07 show Total Protein is within normal limits at 5.6 gm/dl (normal 5.5 -8.3 gm/dl) and Albumin in near normal at 3.1 gm/dl (normal 3.2 -5.5 gm/dl). Iron is 45 (normal 39 - 150 UG/DL). Laboratory Tests of 9-24-07 show Total Protein at 5.9 and Pre Albumin at 15.4 (normal 20 -40 mg/dl). (As of 9-26-07, there is no assessment of these labs.) MDS of 7-23-07 documents that R1 is 5'6" tall and weighed 148 lbs. Dietitian Assessment of 2-20-05 states that R1's Ideal Body Weight is 122 lbs - 148 lbs. Dietitian Note of 9-24-07 states R1 is on a pureed low concentrated sweet diet with 2 TBSP of milk powder to AM hot cereal, Arginaid twice a day for wound healing on coccyx, Megace, Multiple Vitamin and Vitamin. Meal intake records show R1 eats 100% at breakfast and lunch. Dinner is not documentated. Recommendation to fill out food intake records. September weight is 150.8 lbs. Weight stable in the past 3 months.

On 9-17-07, R1's Treatment Administration Record, TAR, was copied showing documentation of treatment to R1's pressure sore on the sacrum. The TAR showed there were blanks (no initials that treatment was done) on the 6AM to 2PM shift on 9-12-07 and 9-14-07. There was a blank on 9-16-07 for the 2PM to 10PM shift. On 9-18-07, R1's TAR had been altered with initials added to the TAR on 2PM to 10PM shift on 9-16-07. E2 stated they were E3's initials. Interview with E3 on 9-18-07 at 3:45PM, E3 was asked if it was her initials on the TAR on 9-16-07 on the 2PM to 10PM shift. E3 looked at the TAR and said "No. I didn't write that." E3 stated it looked like her

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initials, but it's different. E24 was present and stated the initials documented looked different than E3's.

On 9-19-07, the TAR was observed to have the initials of AA documented as doing R1's treatment on the 2PM to 10PM shift on 9-17-07. (E3 was observed to do the treatment and these were not her initials.) Interview with E2, on 9-19-07, reflected that the initials look like AA and she did not know who's initials they were. Interview with E3 on 9-19-7 at 9:45AM, E3 said she worked the evening of 9-17-07 and was training another nurse whose initials were not AA. E3 stated she doesn't know any nurse at the facility with initials AA. E3 confirmed that E24 did the treatment on 9-17-07 at around 5:00PM and stated that R1 did not require another treatment to the pressure sore on her sacrum that evening. E3 stated she should know because she would have been the nurse to do the treatment if needed.
Copies were obtained of the TAR's showing the discrepancies.

3. During tour of the facility with E18, LPN, R9 was observed on 9-16-07 at 4:07PM to be in bed. E26, CNA, stated they were getting her up for the supper meal. R9 was observed to be incontinent of urine with a 3 foot in diameter urine stain on the the bed pad, that had a dark brown edge where urine was drying. E26 confirmed that the urine was drying. R9 started to urinate again and also had been incontinent of bowel. R9 had a dressing on her coccyx that was dated 9-16-07 and coming off the pressure sore. E26 was observed to remove the dressing. E26 failed to wash R9's buttocks and back of thighs that had been soiled with urine and failed to clean feces from the upper thigh/lower buttock area. R9 was

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transferred by mechanical lift to her wheel chair and taken to her evening meal. (R9 was still up in her wheel chair at last observation at 7:25PM. R9 was up in wheel chair for over 3 hours with no treatment on pressure sore and not being repositioned.

R9 was observed on the morning of 9-17-07 to already be up when observation started at 7:25AM and remained up in the wheel chair until 10:15AM (2 hours and 50 minutes) when E19, LPN, was informed of concern that R9 had been up for extended time without being repositioned. R9 was transferred to bed by mechanical lift by E30 and E31, CNA's. R9's incontinent brief was wet with urine and R9 did not have a dressing on her pressure sore. There was no dressing in the incontinent brief, in the bed or around/under the bed.

R9 POS of September 2007 shows an order to cleanse coccyx with normal saline and pack with wound gel cover with dry dressing twice daily. R9 has an order for a pureed regular diet with nectar thick liquid and a multiple vitamin and ascorbic acid daily. R9 has an order of 9-17-07 for daily skin checks.

R9's MDS of 9-9-07 identifies R9 as beng cognitively impaired; totally dependent on staff for transfer and hygiene and requiring extensive assistance for bed mobility, eating, bathing and toilet use; incontinent of bowel and frequently incontinent of urine.

R9's most current Care Plan that was provided by the facility on 9-18-07 shows goal date of 9-14-07. Care Plan is dated 12-20-26 and identifies R9 as being at high risk for pressure

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ulcers. Care Plan approaches include, in part, turn and position every 2 hours, incontinent care as needed, treatment as ordered.

Interview with E19 on 9-20-07 at 11:00AM, E19 stated that R9 developed an in house pressure sore on 5-10-07 and was a stage 2. E19 stated on 9-14-07 R9's pressure sore was a stage 3 measuring 0.5 x 2.4cm with no depth. E19 stated the measurement on 9-17-07 showed a decline. The pressure sore was measured at 1 x .4 cm with .2 cm depth and was a stage 3. (The Pressure Sore Log shows Stage 2 and Stage 3 was marked. E19 stated she marked the stage 2 and E2 must have marked the stage 3.)

R9's Weekly Pressure Ulcer Healing Record that facility implemented during the Survey showed that R9 had a stage 3 pressure sore on the coccyx. There are no measurements of the pressure sore and the form is not dated or signed.

4. Review of the Admission sheet for R12 identifies her to be a 66 year old female admitted to the facility on 9/13/07 with diagnoses of morbid obesity, hypertension, rectal carcinoma with resection, and abdominal wound. The clinical record indicates she is alert and interviewable and dependent on staff for all activities of daily living (ADL's). R12 has a colostomy and a urinary catheter. The admitting orders from the hospital indicate R12 had debridement of the perianal wound and the abdominal wound with closure on 7/27/07. The hospital record indicates original discharge was to occur on 9/10/07 and reflected an order for "W (wet) to D (dry) DRSG (dressings) q (every) shift until transfer while vac off." The INTERIM CARE PLAN identifies R12

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as being at high risk for pressure ulcers, having a special mattress. An addition dated 9/18/07 identifies that R12 had wound VACs on but does not indicate R12's extensive wounds with needed supervision for dressing placement. The INTERIM CARE PLAN also identifies R12 as being interviewable. The facility neglected to adequately document R12's wounds on admission, neglected to use aseptic technique during a dressing change, neglected to monitor physician ordered treatment for compliance, and neglected to provide nursing services to promote healing, prevent infection and prevent wound deterioration of R12's abdominal and perianal wounds. The facility neglected to follow their policy/procedure for wound care.

A. On 9/12/07, a hospital note identifies R12's perianal wound as measuring "10cm length x 6cm wide x 3 cm depth c (with) 2cm undermining at 12 o'clock - visible bone - 95% red c granulation" The record indicates the wound had 5% slough - no erythema and no odor. Measurements documented on 9/12/07 also indicates R12's abdominal wound "tunnels up 12 cm @ (at) 7 cm wide - visible base red - no erythema No odor.." Review of the facility's admission orders, R12 was to have a wound vac placed on the perianal wound with readings at 100mmg, change on M-W-F (Monday, Wednesday,Friday). The orders indicate a wet to dry dressing can be used until the vac arrived.

On 9/17/07 at 12:55pm, R12 stated she had been here since Thursday (4 days prior) and had not had any care in terms of washing her off and/or changing her gown. She stated the facility had not received the wound vac yet and the nurses had been changing her dressings 1-2 times daily

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since her arrival. At 2:45pm, R12 was observed to be on her back and laying on a turn sheet which was soaked with drainage which was visible while she was on her back. The edges of the drainage was yellow/brown with streaks of red and had dried to an inch of the edge of the drainage circumference. R12 was given pain medication just prior to cleansing her wound. E24, LPN (Licensed Practical Nurse) rolled R12 to her left side. R12's coccyx wound was gaping open with the packing laying on the sheet under her. The drainage on the turn sheet extended from her mid scapula's to her knees. The perianal wound was approximately the size of a soft ball with visible bone noted. Gauze packing was laying loose in the bed with one side of an ABD dressing being attached. E14 rolled the drainage soiled turn sheet under her and replaced it with a clean sheet but did not wash her hands, change her gloves or cleanse the mattress that was visibly wet with drainage. E14 set her supplies on top of the overbed table along with R12's water pitcher and personal items. No clean field was set. E14 then soaked gauze with normal saline and wiped the open wound. Measurement were done at that time. She then changed her gloves but again, did not wash her hands before placing new gloves on and packing the wound with saline soaked gauze. The wound area was covered with 2 ABD dressings and taped in place. Lighting was poor and E14/E3, LPN's stated it was not conducive to doing treatments.

R12 was noted to have an additional open areas on her upper right posterior thigh which measured 11.5cm in length and .1cm in width with no depth. The area was pale pink and skin was intact. This area was not identified by the facility before this

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time. R12 also had two areas observed on her upper left thigh which measured 1) 2.2cm long x 2cm wide and 2) 2cm x 3cm at it's widest. The nurses did not record any measurements as they were taken

According to the treatment sheets, R12's wound dressing was changed twice daily from admission 9/13/07 through 9/17/07. However, there is no documentation as to the measurements and or dressing changes done on an "as needed basis." The nurses notes neglected to reflect any description of the wound and/or drainage although it was observed to be a copious amount. On 9/17/07, the treatment nurse (E19) was asked for measurements and gave the surveyor a small sticky note which read "coccyx-buttock 16 x 11 x 9" that she got off the top of her desk. There is no indication there was any drainage and/or undermining or tunneling at the time these measurements were obtained. E19 stated she had yet to get the measurements on the chart even though she had done them on 9/14/07, three days prior. E19 was asked about the vac and when it was going to be in, and stated they had called the company and ordered it on 9/14/07. On 9/17/07, E2, DON, implemented daily skin checks to be done on R12.

Interview with Z4 and Z5, nurses with KCI (Wound Vac), stated on 9/24/07 at 11:15am that a wound vac should be in within 24 hours and could not discuss with us as to why the vac was not sent although payment is one of the reasons why it would not have been. Both indicated they were called again at 7:49am on 9/17/07 and the vac was sent out. The facility received it the evening of 9/17/07.

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On 9/18/07 at 8:40am, E2 stated R12's vac came in "last night" and was placed that morning. E2 was asked why the vac was not placed the night before, and stated the nurses did not know what the settings were. However, review of the orders from the hospital showed the settings recorded on the transfer sheets which the nurses would have had from admission. E2 then described R12 as having a "bed full of drainage" again when she went in to put the vac on. There is no documentation that R12's physician was notified of the copious amount of drainage or the lack of the VAC.

On 9/20/07, R12 was seen by Z1, Physician who writes that she removed the vac dressing at the time of her visit. The physician writes "pt (patient) admitted c (with) above sores from hospital was already on VAC wound drsgs." The physician's notes fail to reflect that she knew R12 had gone without the VAC for 4 days. On 9/21/07 at 8:32am, R12's wound vac was "off" and unplugged. It remained off until 10:00am when E24, LPN, was notified. E24 went to the room and R12's coccyx wound was observed to have the vac dressing off of the right side and R12 was laying in a copious amount of wound drainage that again extended from her shoulders to her mid thighs. The drainage edges were noted to have started to dry. E24, LPN, stated she did not know who shut the vac off but later stated the canister was completely full when she replaced the vac dressing and canister and thought perhaps the vac was shut off when the alarm let them know the canister was full. The facility neglected to ensure that R12's physician's orders for the wound VAC were followed. In addition, the area on R12's upper left thigh was noted to be much larger, open, beefy red and actively

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bleeding at this time. There is no order for this area dated 9/17/07 when the area was first identified/observed by the facility. On 9/20/07, the facility obtained an order for R12 to be seen by a Wound Specialist. Review of the treatment sheet fails to reflect that the wound vac dressing had been replaced after Z1, physician removed it. However, interview on 9/24/07 with two nurses, E9 and E25, LPN's, stated they redid R12's wound vac dressing following Z1's visit although they did not document it. Review of the nurses notes also fails to indicate the dressing had been changed.

On 9/21/07, a Wound Specialist assessed R12's sacrum wound to measure 15cm long x 9cm wide x 7 cm deep. This measurement shows much deterioration in the wound bed since her admission to the facility 8 days before. The assessments states "brown discoloration areas appear to be from radiation burn..." However, there was no brown discoloration of the wound identified on either of the previous assessments done earlier in the week by the facility and none observed on 9/17/07. The Wound Specialist also measured the upper posterior thigh and it measured 2.6cm long x 7cm wide with <0.2 cm depth, showing significant decline in just 4 days. The Wound nurse identified these areas as "abrasions" with scant exudate and open. There is no investigation as to how these "lacerations" occurred. Observation throughout the survey showed R12 to be on her back with the head of the bed elevated. Interview with R12 indicates the staff did not turn her or encourage her to turn side to side but left her in bed. The left side was not observed by the Wound Specialist although it was identified on 9/17/07 and measured.

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The facility neglected to address R12's sacrum wound in a timely manner, neglected to consistently implement treatment orders, neglected to use aseptic technique when doing dressing changes to promote wound healing and neglected to accurately document treatments when done.

Interview with KCI nurses (wound vac providers) on 9/24/07 indicates the alarm would sound before the canister was full and that the whole canister is changed at that time.

B. R12's abdominal wound was measured on 9/12/07. It measured 7cm wide with up to 12cm tunneling. The note further states the base was red, no erythema and no odor. The note indicates there is tunneling of 8cm.

Review of the post-it note from 9/14/07 indicates the facility measured it as #1 - 9 x 10 x 6 and #2 as 1 x 1 x 7. Again, there is no description of the wound base and the presence or lack of drainage. There is no indication the wound had any tunneling. Interview with E19 who did the measurements on 9/14/07 asked if the smaller area above the large area was noted. She was unaware that this area tunneled to the larger area.

On 9/17/07, R12 was observed have no wound vac on and was observed to have wet and dried yellow/pink drainage on her hospital gown. R12 had multiple scabbed areas from her surgery on the left side of her mid abdomen and one open area to the right of the suture line. E24 set the wound supplies on the bed and donned gloves. E24 then cleansed the area with normal saline, then changed her gloves but did not wash her

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hands before putting on a clean pair of gloves E24 measured the abdominal wound's tunneling but did not measure the width and length. Measurements of the tunneling were: 1 o'clock 3 inches, 2.5in. at 12, 4.5in at 2 and 1in at 5

On 9/21/07, the Wound Specialist assessed and measured the abdominal wound to be 4/5cm long x 8cm wide x 7cm deep. Tunneling was documented as 9cm at 12, 11cm at 1, 9cm at 2, 6cm 11, 5.5cm at 10 and 5cm at 9. Notes recorded at the time identified the wound as having moderate to copious amounts serosanguinous drainage. These measurements also show significant deterioration of R12's abdominal wound since her admission 1 week before.

The facility neglected to timely implement orders for the wound vac, neglected to accurately and consistently measure and monitor R12's wound, neglected to use aseptic technique when dressing the wounds, and neglected to follow the facility policy on wound care.

On 9/23/07, the DON approached the survey team and requested the measurements taken during the treatment on 9/17/07 as the nurses doing it did not record it. Those measurements were provided. On a statement provided on 9/24/07, these measurements were recorded as "inaccurate."

C. On 9/24/07, a policy on wound management was requested from the facility and a copy of the PRESSURE ULCERS/SKIN BREAKDOWN - CLINICAL PROTOCOL was provided. Under "DRESSINGS, DRY/CLEAN," the policy identifies the steps as being: 1. adjust beside stand to

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waist level, clean bedside stand and establish a clean field. The facility failed to do this during both treatments. #8 states put on clean gloves. Loosen tape and remove soiled dressing and 9. pull glove over dressing and discard into plastic or biohazard bag. The facility failed to do this. 10. Wash and dry your hands thoroughly. The nurse doing the treatment did not wash her hands throughout the treatment. Documentation section of the policy indicates the following information will be recorded in the resident's medical record - date and time the dressing was changed, wound appearance - including wound bed, edges, presence of drainage, name and title of individual doing the treatment, type of dressing used and wound care given, all assessment data (color, size, drainage, etc) obtained by inspecting the wound, how the resident tolerated the treatment and any problems or complaints during the treatment. The facility failed to follow this portion of the policy also.

(A)