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F 315	Continued From page 9 indwelling catheter. Additionally, there is a care plan for Urinary/Bowel incontinence initiated 11/5/11 which does not mention an indwelling catheter. Review of R3's physician order sheets from R3's 10/24/11 re-admission contain no orders for catheter or for catheter care. Review of R3's TARs (treatment administration records) reflects no documentation of catheter care or monitoring of the catheter. Nursing notes for R3 from 10/26/11 through 12/2/11 reflect no mention of R3's indwelling catheter. The first mention of R3's catheter is in a nursing note dated 12/3/11, at 10:50 am, which indicates the catheter was draining clear yellow urine. On 12/4/11, at 10:00 pm, another note again indicates the catheter was draining well. A nursing note from 12/5/11 at 10:00 pm reflects that the catheter was draining amber-colored urine. This note indicates catheter care was rendered, but does not state specifically what was done. There is no mention of R3's catheter care or any assessment of R3's catheter/urine from admission 10/24/11 to the first note in December on 12/2/11. This information was presented to E1 (Interim Administrator) and Z1 (Clinical Services) at daily status meeting at 4:30 pm on 2/14/12. No further documentation was presented for review regarding the catheter care for R3.	F 315		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a)	F9999		

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F9999	Continued From page 10 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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	F9999		

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F9999	Continued From page 11 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following: A. Based on record review and interview, the facility failed to take into account major risk factors present for 1 resident (R3) in determining the overall risk of developing pressure ulcers out of 7 residents reviewed for pressure ulcers. The facility also failed to follow its' protocol for assessment and monitoring the skin of R3 who was deemed at low risk for pressure ulcer development. These failures resulted in R3 being assessed as low risk for development of pressure ulcers rather than at high or moderate risk. R3 was treated with a lower level of interventions and monitoring of skin by less skilled staff than if at high risk.. These failures to accurately assess and monitor R3's skin integrity resulted in R3 developing deep tissue injuries to bilateral heels 2 weeks after admission to the facility. Findings include: R3 is an 80 year old female admitted to the facility on 8/22/11. R3's initial admission assessment, dated 8/22/11, assesses R3 to be at low risk for Pressure ulcer development based on a Braden score of 16 (low risk 15-18). This same admission assessment indicates that R3 has an altered mental status, requires assistance for bed mobility and toileting, has slightly limited sensory perception, slightly limited activity and mobility, occasional moist skin and has a potential problem with friction and sheer due to her	F9999		

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requirement for assistance with bed mobility and feeble independent movement. This 8/22/11 assessment indicates that R3's skin was intact upon admission. R3 was noted to have 2 bruises on admission. R3's diagnoses include hepatic encephalopathy, altered mental status, difficulty in walking, liver cirrhosis, alzheimer's disease, diabetes mellitus. R3's care plan for functional mobility imitated on 8/23/11 reflects that R3 was unable to move independently. R3's cognitive loss care plan, initiated 8/27/11 reflects that R3 has decreased orientation and safety awareness, as well as short term memory impairment secondary to alzheimer's disease. R3 has a care plan initiated 8/29/11 for altered nutrition, secondary to R3 receiving a therapeutic diet due to her diabetes and potential for fluid shifts secondary to noted edema. R3 required a modified diet per speech therapy according to this care plan.

Page 4 of the facility's Skin Practice Guide states, "If a patient is at low or moderate risk and other major risk factors are present, e.g., advanced age, poor dietary or protein intake, diastolic pressure below 60, hemodynamically unstable, advance to the next level of risk." R3 had advanced age, liver cirrhosis, impaired mental status, impaired mobility, occasional incontinence, diabetes mellitus, and altered nutrition, but was still assessed at low risk..

On 2/16/11 at 11:45 am, E1 (Interim Administrator) stated that a resident at low risk, with no skin alteration, will have skin checks done twice a week, documented on shower sheets..According to the facility's Skin Practice Guide, page 12 states that these routine skin

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observations are conducted by nursing assistants during the resident's bath or shower, with the CNA(certified nursing assistant) submitting results to the nurse. Residents at high risk or very high risk will have skin checks weekly by a licensed nurse, documented in the TAR (treatment administration record).

On 2/16/11 at 2:30 pm, E1 stated that she has not located any skin/shower sheets for R3 from her admission on 8/22/11 up to the date of 9/6/11, when her heel wounds were discovered. Review of R3's medical record including TARs reflects no evidence of ongoing skin assessment/monitoring from her admission of 8/22/11 through 9/6/11, when bilateral heel wounds were noted..

On 1/26/12 at 11:00 am, E3 (wound coordinator) stated that high risk residents are care-planned as such, and get interventions including a low air loss mattress and protective boots, even if they have no breakdown. Residents at high risk will be repositioned every 2 hours. For low risk residents, those residents get repositioned every 4 hours, or as needed. They make sure the low risk residents have wheel chair cushions and barrier ointment applied. According to E3, residents at moderate risk are considered at high risk, and they will still get a low air loss mattress and protective boots unless they refuse. They may use pillows in place of the boots for comfort. E3 also stated that all of their mattresses are pressure-relieving, but there are special mattresses that are pressure-reducing, which are only used when certain criteria are met.

Wound care notes for R3 dated 9/6/11 (untimed) reflect that a DTI (deep tissue injury) was noted to

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F9999	Continued From page 14 R3's right heel measuring 2cm by 2cm, and another to the left heel, measuring 2.5 by .5 cm. The skin was described as intact, with edema noted of the lower legs. This note also reflects that protective boots were applied and a low air loss mattress was ordered. R3's Physician's Order Sheet for telephone orders dated 9/7/11 reflects treatment orders obtained and orders for daily skin checks, air mattress and protective boots to be on at all times when in bed. On 1/26/11 at 12:20 pm, E3 stated that a deep tissue injury, along with a pressure ulcer is due to pressure. It is a purplish discoloration of the skin over a bony prominence but with intact skin, so you can't tell what's going on underneath. A DTI may or may not open up. R3's initial skin care plan for skin was initiated 8/22/11, and indicates that R3 is at risk for altered skin integrity related to limited mobility; it does not address all of her other risk factors, such as impaired circulation secondary to diabetes mellitis. The interventions are vague and generic interventions that would be used for any resident: ie, encourage and assist as needed for repositioning frequently. It does not specify how frequently or how this is to be measured or monitored. Encourage consumption of all foods high in protein and encourage fluids. It does not indicate how this will be measured/monitored. Use pillows/positioning devices as needed. Again, it does not indicate how this will be measured and monitored, or how frequently this is to be done. Barrier cream to peri area as needed; this is vague and generic and does not state when specifically barrier cream is to be used. Observe skin condition with ADL (activities of daily	F9999		

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living)care daily and report abnormalities. This leaves checking of R3's skin to CNAs rather than to licensed nursing staff.

This information regarding a resident at low risk for developing pressure ulcers actually developing a DTI in the facility was discussed with E3 on 1/26/11 at 12:50 pm. E3 was unable to give any explanation as to why R3 developed these DTIs. This same information was presented to the facility management (E1, E2-DON, Z1- Clinical Services; Z2-Regional Director) during the daily status meeting on 1/26/12 at 4:30 pm.
Pressure ulcer development was discussed in subsequent daily status meetings on 2/14/12 and 2/15/12 at 4:30 pm. No facility staff ever provided an explanation of why R3 developed DTIs while in the facility. No documentation was provided or found in the medical record indicating that these DTIs were unavoidable.

B. Based on record review and interview, the facility failed to perform skin checks/implement interventions as ordered for 2 residents (R8, R4) at risk for pressure ulcer development out of 7 residents reviewed for pressure ulcers. The facility also failed to maintain accurate assessment records relating to admission assessment of wounds for 2 resident (R8, R7) out of 7 residents sampled for pressure ulcers.

1. R8 was re-admitted to the facility on 10/25/11 with a Braden score of 14, indicating R8 was at moderate risk for developing pressure ulcers. The Patient Admission/Re-admission screen dated 10/25/11 which is the Admission Nursing Assessment and contains R8's Braden score,

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F9999	Continued From page 16 indicates the following findings under the skin section: a black, round area on R8's posterior left thigh; long toenails bilaterally, upper back with scratches, multiple puncture sites, multiple bumps and scratches and left abdomen discoloration. There is no documentation in this admission assessment of any breakdown on R8's buttocks/sacral area. Admission Nursing note dated 10/25/11 at 7:50 pm reflects that R8 was re-admitted from the hospital and that fall precautions were in place. This admission note makes no mention of any skin breakdown/open areas on R8's skin.. Wound care notes from 10/26/11 (untimed) indicates R8 re-admitted and seen by wound care. This note written 10/26/11 describes a Stage 2 pressure ulcer to R8's coccyx measuring 1 by 1 cm with no drainage. R8's POS (physician order sheet) for telephone orders reflects the following wound care orders dated 10/26/11; clean coccyx with normal sterile saline; apply mepilex dressing 2 times a week (Monday and Friday); daily skin checks, and air mattress. On 2/14/12 at 3:15 pm, E3 (wound coordinator), after reviewing the wound note of 10/26/11, stated that she believed R8 was re-admitted from the hospital with this Stage 2 wound. E3 explained that the admission nurse does the first assessment, and that is a staff nurse who is not to stage any wound or make any diagnosis: that nurse is just to document what she sees. Within 24 hours, a new admission is seen by someone from the wound care team , who is able to stage wounds and confirm appropriate treatment orders. She reviewed the admission nursing	F9999		

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F9999	Continued From page 17 assessment containing the Braden score and agreed that this assessment and picture depicting skin alteration did not document a Stage 2 wound on R8's coccyx. She also agreed this wound was not mentioned in the nursing admission note. E3 reviewed the hospital transfer form and notes that their description of R8's sacrum is that R8 had blanchable redness on the sacrum. November TAR (Treatment Administration Record) reflects skin checks not done daily; specifically, skin checks not documented as being done on 11/5/11, 11/6/11, 11/11/11. 11/12/11 and 11/16/11 (R8 was transferred to the hospital on 11/17/11). This same TAR also reflects that R8's dressing change was not done on the days ordered between 11/8/11 to 11/13/11. This TAR shows a dressing change on Monday, 11/7/11, and Sunday, 11/13/11, with 6 days in between dressing changes. R8's POS of 10/26/11 orders daily skin checks. E3 reviewed R8's November 2011 TAR and on 2/14/11 at 3:15 pm, agreed that some skin checks were missed. She also stated that while R8's dressing change was performed twice in the week between 11/8 and 11/13, she agreed that the dressing change did not occur on Monday and Friday as ordered, which would only allow 4 days in between dressing change, rather than 5. 2 R4 was admitted to the facility on 9/23/11 with an admission Braden score of 14, indicating that R4 was at moderate risk for pressure ulcer development per her 9/23/11 admission nursing assessment. This same assessment documents that R4 was admitted with redness of the coccyx. Initial wound care note dated 9/25/11 also states	F9999		

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that R4 was admitted with a healed Stage 2 ulcer on her buttocks This note reflects that R4 is at risk for skin breakdown due to skin integrity, and documents that daily skin checks were ordered. Telephone order sheets dated 9/25/11 confirm the order for daily skin checks.

November 2011 TAR for R4 reflects that daily skin checks for November were not done as ordered; specifically, skin checks were not conducted on 11/5, 11/6, 11/10, 11/13, 11/14, 11/17, 11/19 and 11/24.

3. R7's re-admission assessment dated 10/24/11 reflects a Braden score of 12, indicating R7 was at high risk for pressure ulcer development. R7's re-admission assessment also reflects that R7 had a skin tear on his coccyx measuring 1 cm by .5 cm. A wound care note dated 10/25/11 (untimed) reflects a stage 2 pressure ulcer to the sacrum measuring 2 cm by 2 cm. On 2/14/12 at 3:15 pm, E3 stated she believed the Stage 2 was the same area the admission nurse referred to as a skin tear. E3 stated that the admission nurse is not to stage a wound or make a diagnosis, but only to describe what she sees. Review of POS for R7 does not reflect any treatment orders obtained for R7 for the sacral wound until 10/25/11.

B