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W 331	Continued From page 21 sitting in a chair at a table in the dining room of the facility. R7 was served a pureed diet. E5 (LPN) was observed to administer crushed medications in R7's plate of food. E5 then left the area and did not stay in the dining room to ensure that R7 consumed her medication that had been placed in her food. R7 was observed to pick at her food and made multiple attempts to open her chocolate candy bar that was sitting on the dining room table. From 5:01 to 5:25 P.M., R7 ate only a small amount of her food. At 5:25 P.M., E6 (Direct Care Staff) removed R7's plate of food from the table. At 5:26 P.M., when E6 was asked how much did R7 consume, he stated, "She ate 0-25% of her meal." The Medication Administration Record dated 12/01/11 identifies that R7 is to receive one tablet of Tums 500 mg (milligrams) and two tablets of Senna 8.6 mg. during the 5:00 P.M. medication administration pass E2 (DON) was interviewed on 12/20/11 at 12:15 P.M. and stated, "Nursing staff should not be mixing medications in the individual's food at meal times. They should be giving the medications in applesauce or pudding. They also should make sure that the person takes and swallows all the medication before walking away from that person."	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230d)1)2)	W9999		

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W9999	Continued From page 22 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	W9999		

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W9999	Continued From page 23 resident. These requirements were not met as evidenced by: Based on observation, interview and record review, after the facility's nursing staff were inserviced on 10/28/11 regarding completing weekly skin checks, documenting wounds and documenting treatment of wounds, nursing staff failed to develop and implement an effective system for pressure ulcer management and/or for maintaining skin integrity for 1 of 1 individual (R4) in the sample of 4 who has history of recurrent pressure ulcers to his left buttock. This failure also affects 1 of 4 indivdiuals (R3) in the sample and 2 of 2 individuals (R5 and R6) outside the sample who are at risk for skin break down. Nursing staff failed to: * Implement policy and procedures for maintaining skin integrity and/or pressure ulcer management; * Complete an initial wound assessment and provide documentation regarding the size and depth of the wound, the stage of the open area, the appearance of the tissue in the wound bed, an assessment for undermining or tunneling of the wound and document the amount of exudates (fluid/drainage) and type if any or the presence of odors; * Notify the physician that R4's pressure ulcer was open and unstageable and the need for referral for wound care treatment for the removal of the eschar;	W9999		

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W9999	Continued From page 24 * Develop procedures within the facility's policy on, "Pressure Ulcer Care" for culturing drainage from the pressure ulcer; * Notify the Occupational Therapist and/or Physical Therapist for re-evaluation for pressure relieving devices and repositioning needs as based on R4's change in condition; * Develop and implement an aggressive, effective individualized treatment plan to promote healing and prevent reoccurrence of pressure ulcers as per the facility's policy; and * Maintain ongoing nursing documentation specific to the status of the pressure ulcer, improvements in the size of the ulcer, the depth of the ulcer, the amount of necrotic tissue, the amount of exudate while the ulcer is healing, the status of the pressure ulcer, if the ulcer has worsened and or if the ulcer has healed. Findings include: After the facility's nursing staff were inserviced on 10/28/11 regarding completing weekly skin checks, documenting wounds and documenting treatment of wounds, nursing staff failed to develop and implement an effective system for pressure ulcer management and/or for maintaining skin integrity. On 12/16/11 at 3:00 P.M. an Immediate Jeopardy was identified to have begun on 12/08/11 when documentation identified that R4 had, "an acquired, unstageable pressure sore to his left buttock with an onset date of 12/08/11." Prior to	W9999		

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this date, R4 had acquired a pressure ulcer to his left buttock with an onset date of 10/24/11. Nursing staff received orders from the physician to measure this area and to document. R4's pressure ulcer was not measured and/or staged by nursing as physician ordered. No aggressive, individualized treatment plan to promote healing and prevent reoccurrence of R4's pressure ulcer was developed by nursing staff after 10/24/11. Nursing staff did not document the ongoing the status of R4's pressure ulcer, whether are not the area had worsened or had healed. On 10/28/11, nursing staff was inserviced on completing skin checks, documenting wounds and documenting treatment of wounds.

After 10/28/11, R4 was found to have a acquired a pressure ulcer to his left buttock with an onset date of 12/08/11. Nursing staff did not stage this area, nor notify the physician that R4's pressure ulcer was open and unstageable. Nursing staff did not contact the physician for a referral to a wound care specialist for treatment and for removal of the eschar. The Occupational and/or Physical Therapist were not contacted to re-evaluate R4 for pressure relieving devices and/or repositioning needs. Nursing staff did not develop and implement an aggressive, individualized treatment plan as per the facility's policy after R4 acquired a pressure ulcer to his left buttock with an onset date of 12/08/11. E1 (Administrator) and E2 (Director of Nursing/DON) were notified of the Immediate Jeopardy on 12/16/11 at 4:05 P.M.

The facility's undated policy and procedures for, "Pressure Ulcer Care" states, "When a pressure area is identified, an aggressive treatment

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W9999	Continued From page 26 program will be instituted and closely monitored to promote healing. Definition: Pressure Area: Areas of skin, redness or broken skin related to: Staging to be used for depth identification: Stage I: Nonblanchable erythema or intact skin; no broken skin; Stage II: Broken skin, an abrasion, blister or shallow crater; Stage II: Broken skin, Affects full thickness and presents as deep crater; Stage IV: Broken skin, muscle and/or bone exposed. IMPORTANT NOTE: Any area covered with eschar so that the wound is not visible can not be staged until eschar is removed and adequate visual assessment is possible. PROCEDURE: 1. When the Charge Nurse is aware of skin breakdown, whether in house or upon a resident's admission, area is assessed and initial treatment started per physician orders. 2. Make entry in Nurse's Notes that pressure ulcer was identified and refer to Pressure Ulcer Report. 3. Initiate a treatment sheet and start the Pressure Ulcer Report. This policy goes on to state that documentation of the decubitus should include the characteristics, (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue) treatment and response and prevention techniques.	W9999		

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1) The Physician's Order sheet dated 12/01/11 states that R4 is a 56 year old male who requires a custom tilt wheelchair with belted hip support, hip profile cushion, padded foot box and lock, rear arch up custom curved back system for his wheelchair.

The Norton Plus Pressure Ulcer Scale dated 12/03/11 identifies that R4 has a total score of 5 which places him at a high risk for developing pressure ulcers.

R4's Individual Program Plan (IPP) dated 08/12/11 includes a Comprehensive Care plan dated 08/12/10 which identifies that he has potential for skin breakdown due to immobility and history. This plan states that a long term goal has been developed to prevent skin breakdown. There are three approaches identified within this plan that includes completing daily skin assessments on R4, repositioning him every two hours and having him use a pressure release mattress when in bed.

In the Additions and Deletions of Information sheet contained within R4's (IPP of 08/12/11), nursing staff documented, "10/24/11 Keep res (resident) off L (left) buttock. Measure area and document. Clean with H2O (water) and antibacterial soap, TAO (Topical Antibiotic Ointment) BID (twice daily). Call if worsens." R4's Nurse's Notes for 10/24/11 duplicates the same information that nursing documented in his IPP on 10/24/11.

R4's Treatment Record for 10/01 - 10/31/11 identifies that nursing staff applied TAO to his left buttock twice daily from 10/25 -10/31/11. The

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back side of the Treatment Record for the month of October, 2011 is totally blank. The back of the Treatment Record is where nursing staff are to describe the initial treatment provided and identify the width, length, depth, and staging of the pressure ulcer. Nursing staff are also to document if there is drainage and/or an odor present and a description of R4's open area and surrounding skin.

The Nurse's Notes from 10/25/11 - 10/30/11 identifies that R4 had no signs of symptoms of infection to his left buttock as a result of the pressure ulcer. No documentation is noted within these notes regarding characteristics and/or changes of the open area, response to treatment, if the area had worsened and/or when the area was healed.

E3 (Director of Nursing/DON) was interviewed on 12/16/11 at 10:10 A.M. and was asked to find where nursing measured and documented R4's 10/24/11 open area as physician ordered. E3 looked in R4's IPP, Nursing Notes and his Treatment Record and stated, "I can't find where nursing documented this information." When E3 was asked where R4's measurements and documentation should be located, she stated, "On the back of the Treatment Record and in his (R4's) Nurse's Notes. E3 was asked if R4's wound was cultured and stated, "No, the facility's current policy does not address culturing wounds. I know there is nothing documented showing that the nurses staged and/or notified the physician to culture the drainage of R4's pressure ulcer on or after 10/24/11. We (the facility) did recognize there was a problem with nursing documentation after 10/24/11 and inserviced nursing staff on

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documentation and documenting pressure ulcers on 10/28/11."

The Inservice Education Program Attendance Sheet entitled, "Skin Checks, Documentation of wounds and Treatment of wounds dated 10/28/11 identifies that eight nurses were in attendance at this inservice (E4, E5, E10 - E15) training.

R4's Nurse's Notes for 11/01/11 - 11/30/11 does not identify that nursing staff completed R4's weekly skin assessments for the month as per the facility's policy. No documentation regarding weekly skin assessments which include characteristics, (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue) treatment and response to this treatment and prevention techniques. One entry is noted on 11/20/11 identifying that he had scratched his inner buttock area and that the area was red. No further entries are noted for the month regarding R4's skin condition and if his pressure ulcer (with an onset date of 10/24/11) had worsened and/or when the area was healed.

The weekly Skin Assessments completed by nursing for R4 from 11/01/11 - 11/30/11 does not identify that nursing staff completed R4's weekly skin assessments for the month as per the facility's policy. This assessment identifies that only two entries were made by nursing for the entire month. Nursing documented that R4 was assessed on 11/07 and assessed on another undated date. The 11/07 entry identifies that a check mark has been made by nursing between normal and decubitus, however there is no description of any abnormality. The undated

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entry identifies a check mark also has been made by nursing between normal and decubitus, however there is no description of any abnormality. There are no further entries on the front and/or back of R4's Skin Assessment sheet for 11/01/11 - 11/30/11.

The Treatment Record for the month of November 2011 identifies that weekly skin checks were completed by nursing staff on 11/07, 11/14 and 11/21/11. R4's nursing notes corresponding with the dates of 11/14 and 11/21 do not identify that weekly skin checks were done on these dates.

Forty one days after the facility inserviced nursing staff on skin checks, documentation of wounds and treatment of wounds, R4 was discovered to have a pressure ulcer to his left buttock area with an observed onset date of 12/08/11.

R4's daily Skin Assessments sheets for the A.M. and P.M. for 12/01/11 - 12/09/11 were reviewed. Direct care staff's documentation on this assessment for 12/08/11 A.M. identifies that R4 has an open area on his right buttock. . On 12/08/11 for the P.M., this assessment states that R4 had a scratch to his scrotum. No open area to his buttock(s) was identified on this form. On 12/09/11, staff documented that R4 had an open area to his left buttock on both the A.M. and P.M. skin assessment sheets.

The Nurse's Notes for R4 for 12/08/11 at 1 A.M. states, "This nurse (E17 Licensed Practical Nurse/LPN) came to hall to give resident his scheduled feeding when E16 CHT (Certified

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Habilitation Technician) asked if I (E17) was aware about res. (resident's R4's) open area. Upon examining it, this nurse saw a small partially open area with red, hardened skin et (and) serosanguinous drainage in moderate amount. Will call Dr (doctor) in A.M. for Tx (treatment) order. Cleansed with sterile water et applied D/D (dry dressing) for time being."

R4's Physician's Order for December 2011 identifies that orders were received on 12/09/11 to:

1. Cleanse area to left buttocks. Apply Aquacel to site, cover with adhesive dressing et (and) check twice daily for drainage. Change dressing when exudate reaches border or every three days.
2. Zinc 220 mg (milligrams) daily for fourteen days
3. Vitamin C 500 mg. twice daily
4.Arginade one packet twice daily mix with water (180 cc (cubic centimeters) flush)
5. Multivitamin daily
6. Augmentin 875 twice daily for ten days.

R4 was observed on 12/09/11 at 3:45 P.M. with E4 (LPN) in bed in his bedroom. A mattress pad t was positioned directly under him and was soiled pink from the drainage from R4's open area. R4's open area was located from the medial portion of his buttock to the inner left portion of his buttock. A dry, scabbed area was within the center of the open area and roughly measured the size of a quarter. The skin around this scab was red and raw and was roughly the size of a baseball. The surrounding skin around the raw area was red. E4 (LPN) stated, "No, not yet" when asked if R4's open area had been staged

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by nursing. She (E4) stated, "I'm going to call E3 (Director of Nursing/DON) to come over and help me stage it." When E4 was asked where the skin assessments were located, she stated, "Staff document each shift on the daily Skin Assessment sheets and nursing documents on the weekly Skin Assessment sheets." When E4 was asked where nursing documents their weekly skin assessments and treatments, she stated, "In the Treatment book."

The Treatment Book which contains the Treatment Record for the month of December 2011 identifies an order for nursing staff to cleanse, apply Aquacel and an adhesive dressing to R4's open area. This record also identifies that nursing is to check R4's open area twice daily for drainage and change his dressing if the exudate reaches the border. Nursing staff documented that checks were completed twice daily on 12/09, 12/10 and 12/11/11. Documentation for 12/12, 12/13, 12/14 and 12/15/11 does not identify that R4's dressing was checked twice daily for drainage and/or if the exudate reached the border of the dressing as the physician ordered.

The back side of the Treatment Record dated for the month of December 2011 is blank. Nursing staff did not document R4's initial treatment which was ordered by the physician on 12/09/11. No entries are noted by nursing regarding the width, length, depth, stage and/or comments regarding odors and/or drainage from R4's pressure ulcer.

E3 (Director of Nursing/DON) was interviewed on 12/16/11 at 10:10 A.M. and stated, "Nursing staff are to document treatments on the Treatment Record." When E3 was shown R4's blank

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Treatment Record for December 2011, she stated, "Nursing should have documented and staged R4's pressure ulcer. The nurses have been trained to document and stage open areas." When E3 (DON) was asked why nursing staff had not staged R4's pressure ulcer upon discovery of the area on 12/08/11, she stated, "I'm not sure." E3 stated that she had staged R4's area and left the conference room to retrieve this report. E3 returned with an undated Skin Integrity Report which states that R4 has an acquired, unstageable pressure sore to his left buttock with an onset date of 12/08/11. This report states that the eschar/slough was 75-100%, that there was no odor and there was a scant amount of serosanguineous drainage from the site. This report states that R4's pressure ulcer was measured at 2 cm x 2 cm x 0 cm. A pressure relieving mattress is listed on this report as a pressure relieving device. When E3 was asked if the physician had been notified regarding nursing staff's inability to stage R4's pressure ulcer, she stated, "No, but we plan to call him (the physician) for a referral for wound care treatment."

R4's Nursing Notes for December 2011 does not identify that the Occupational Therapist and/or the Physical Therapist was contacted upon discovery of R4's pressure area. In review of R4's Occupational Therapy Evaluation dated 08/04/11 and R4's Physical Therapy Evaluation dated 08/12/11, these evaluations do not address his repositioning needs and/or his need for pressure relieving devices. Additionally, R4's Nursing Notes do not identify ongoing documentation specific to the status of his pressure ulcer, improvements in the size of the ulcer, the depth

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W9999	Continued From page 34 of the ulcer, the amount of necrotic tissue, the amount of exudate while the ulcer is healing, the status of the pressure ulcer, if the ulcer has worsened and/or when the ulcer healed. The IPP dated 08/12/11 does not include an aggressive treatment program has been developed and initiated after 10/24/11 to address R4's recurrent pressure ulcer to his left buttock area . In the Additions and Deletions of Information regarding R4's (IPP) dated 10/24/11, no further entries were made since this date. No aggressive treatment program plan has been developed and included within R4's IPP to address the pressure ulcer that was documented by nursing staff on 12/08/11 as per the facility's policy. R4's ulcer was not staged until 12/17/11 and was staged as a 3 after debridement by the nurse practioner (Z2). 2) The Physician's Order sheet dated 12/01/11 states that R3 is a 64 year old female with diagnoses of Osteopenia and Kyphosis Cervical Tordosis. R3 has orders for a custom wheelchair with a pelvic positioning belt and custom molded seating to support abnormal posture and decrease risk of skin breakdown. It is also noted, that R3 has orders to ambulate with a gait belt with hand held assist of two staff to any destination at tolerated. In reviewing the daily Skin Assessment forms for R3 from 12/01/11 to 12/17/11, these forms identify that she has no reddened areas, skin tears, bruises and or open areas when assessed by direct care staff after her morning shower.	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G022	A. BUILDING _____ B. WING _____	01/17/2012

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W9999	Continued From page 35 On 12/08/11, R3 was observed at the offsite day training program from 8:50 A.M. to 11:05 A.M. During this two hour and fifteen minute observation, R3 was not transferred from her wheelchair. When Z1 (Day Training Coordinator) was interviewed on 12/08/11 at 11:00 A.M. she stated, "No, she is never transferred to a regular chair " when asked if R3 is transferred from her wheelchair to another chair or repositioning device. Z1 stated, "R3 is not transferred from her wheelchair unless she is being toileted. She has a tilt in space wheelchair and we change her position by tilting her chair." R3's Nurse's Notes dated 12/17/11 at 4:20 P.M. states, "Skin assessment completed. Observed 0.5 cm scratch to L (left) buttock. Also observed 1 x 0.75 x 0 superficial Stage 2 to R buttock. Slough spot 0.4 x 0.3 in center of area. Surrounding tissue intact. No drainage. Notified Z2 (Nurse Practitioner) of areas. No tx (treatment) order at this time. Will look at areas 12/18/11. T and P (turn and position) q (every) 2 hours. Will monitor for s/s (signs and symptoms) of infection..." R3's Norton Plus Pressure Ulcer Scale dated 10/15/11 identifies that she has a total score of 11 which places her at moderate risk of break down. The Individual Program Plan (IPP) dated 03/04/11 states that R3 has a "Problem/Need" of moderate risk for skin breakdown related to incontinence. Her goal is to be free of skin breakdown. Approaches for this goal state, "1. Wash with soap and water and pat dry after each incident of incontinence.	W9999		

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W9999	Continued From page 36	W9999		

2. Notify physician of any breakdown and obtain treatment.
3. Weekly skin assessment."

No further documentation is contained within this plan identifying R3's need for repositioning out of her wheelchair when she is at the facility and attending the off site day training program.

R3's Physical and Occupational Therapy assessments dated 03/01/11 do not identify preventative measures addressing her repositioning needs and/or pressure relieving devices.

R3 was observed on 12/20/11 at 3:32 P.M. in the bathroom adjoining her bedroom with E7 and E8 (Direct Care staff) in attendance. E7 stated that R3's open area was located on her right lower buttock. When staff (E7 and E8) transferred R3 from the toilet, her buttock skin drooped down whereby covering the open area. After R3 was transferred to her bed by E7 and E8, she was observed to have a roughly 2 cm. (centimeter) x 2 cm. pressure area on her right buttock cheek. A yellow scab was located in the center of this area and depth could not be determined. The skin surrounding this scabbed area was red and raw. On the left buttock cheek, R3 had a 1-2 cm .open area which looked like a skin tear.

The Treatment Record for December 2011 identifies that orders were received on 12/18/11 for nursing staff to apply Aquacel to R3's right pressure ulcer and apply Calmoseptine lotion round the site daily. A dry dressing is to be applied daily to the area. On the back of this Treatment Record, E2 (DON) documented, "Skin

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W9999	Continued From page 37 check completed. Observed 1 x 0.75 x 0. Superficial Stage 2 are to right buttock. 0.4 x 0.3 slough spot in center of area. Surrounding tissue clear/intact. No drainage. 0.5 scratch on L (left) buttock. No redness. No drainage." E2 (DON) was interviewed on 12/20/11 at 3:40 P.M. and stated, "R3's open area has been staged as a two." When E2 was asked if R3's Pressure Ulcer Assessment dated 10/15/11 had been reviewed and revised to reflect the change in her skin condition, she stated, "No." When E2 was asked if an aggressive treatment program plan has been developed to address the current status of R3's pressure ulcer as per the facility's policy, she stated, "No, but we are in the process of updating R3's, R5's and R6's plan of care for pressure ulcer management including repositioning. The Occupational Therapist is scheduled to reassess R3, R4, R5 and R6 who are at risk for skin break down. The Nurse Practitioner (Z2) is now doing our wound care treatments." When E3 (DON) was asked on 12/16/11 at 12:40 P.M. if nursing staff had implemented the facility's policy and procedures for maintaining skin integrity and/or pressure ulcer management for R3, R4, R5 and R6 prior to the surveyor's entrance to the facility, she stated, "No." (B)	W9999		