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S 000	Initial Comments Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 3001210b) 300.1210d)5 300.3240a	S 000		
S9999	Final Observations Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant 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. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification	S9999		

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Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
b) The facility shall 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 resident care plan. 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
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

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S9999	Continued From page 2 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 These requirements are not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide incontinence care to minimize exposure of skin to moisture; reposition residents who require total staff assist with bed mobility; follow manufacturer's recommendations for use of low air loss mattress; have pressure reducing devices in place, provide nutritional assessment went weight changes or new pressure ulcers are identified, encourage and assist residents at meal time for adequate protein and calorie intake to promote wound healing, provide wound treatments as order by the physician, apply wound medication according to it's intended use and inform the physician of a resident's newly identified pressure ulcer for treatment or a decline status (worsening) of an existing pressure ulcers. In addition, the wound treatment nurses did not demonstrate knowledge for treating wounds according to physician's orders and the Quality Assurance Committee could not demonstrate how the facility is monitoring the compliance with recommendations for pressure ulcer management for residents with in the facility. Further, the facility neglected to follow and implement care plan interventions and	S9999		

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S9999	Continued From page 3 established policies governing the care and treatment for residents, who were identified with a pressure ulcer. These failures apply 12 to 12 residents (R1, R2, R3, R4, R5, R6, R23, R24, R25, R26, R27 and R48) identified with either a pressure ulcer or high risk for the development of a pressure ulcer in the sample of 47 residents. As a result of these failures R1, R2, R3, R4, and R6's existing acquired pressure ulcers increased in size and R4 developed a new pressure ulcer. Findings include: E1(administrator) presented to the surveyor the following policy for pressure ulcer treatment. Facility's undated Skin and Wound Care Protocol statest for "All residents considered at high risk, pressure reducing beds and cushions are implemented regardless of the site of the lesion." The Skin Prevention policy dated 5/14 states "Interventions will be put into place based on risks identified and to include turning and repositioning every 2 hours; level 2 support surfaces; preventive foot care; overlays or wheelchair cushions; incontinent care at least every two hours. In addition, the facility's policy for Change In The Resident's Condition dated 7/08 states "should there be a change in the resident's physical, mental or emotional status, the attending physician should be notified. If the attending physician does not respond within 30 minutes,	S9999		

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contact the medical director.

-R1 was admitted to the facility on 12/6/13. Care plan dated 7/30/14 states R1 has cognitive, physical and communication deficit, incontinent of bowel and bladder, factors that put her at risk for skin breakdown.

On 8/21/14 at approximately 5:20pm, R1 was in bed with a foul body odor. R1 was lying on a quilted pad, wearing a disposable diaper and incontinent of bowel and bladder. R1 was lying on a regular mattress. R1's care plan shows R1 has skin breakdown to her right illiac crest, right hand and left plantar foot. Interventions includes use of low air loss mattress while in bed.

During 8/20/ 8/21 and 8/22/2014, R1 remianed in bed with no low air loss mattress in place. E3 (Wound Treatment Coordinator) was present during these observation and assessed the facility acquired wound on R1's left plantar foot. The wound was measure at 1cm(centimeters) lenght x 1.2cm width. The wound assessment documentation dated 8/18/14 shows this wound has increased in size from 0.8cm x 1.0cm. There was no evidence found to demostrate the physician was notified.

R1's right heel was also noted to have a distinct area of redness. E3 acknowledged the redness and stated the site will be monitored. E3 did notdobtain measurements of this wound.

There was an open wound on R1's Right Illiac Crest which measures 1.8cm x 2.1cm. Wound assessment documentation dated 8/18/14 identifies this wound as a facility acquired skin tear measuring 1.3cm x 1.8cm. E3 also stated R1 should have been provided a low air loss

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S9999	Continued From page 5 mattress. - R2 was admitted to facility with diagnoses of cerebrovascular disease, right side hemiplegia, gastrostomy tube placement, and urinary obstruction. On 8/21/14 at 11:16am, R2 was lying in bed incontinent of stool. E21 (Certified Nurses Aide) was present and stated R2's incontinent brief was last changed at 8:30am (more than 2 hours prior). E11 (wound care nurse- LPN) was also present and performed wound assessment and treatment to R2 ' s left heel wound. This wound showed a measurement of 1.8cm (centimeters) x 2cm. This was a deterioration according to the wound assessment dated 8/18/14 which shows measurement of 1.10cm x 1.10cm. Wound Assessment Report dated 6/27/14 showed R2 acquired an unstageable pressure ulcer to right outer ankle. On 8/14/14, R2 was identified with a stage 2 pressure ulcer on sacrum and a wound behind R2's scrotum that were present on readmission 8/13/14. R2 was noted to have an large area of excoriation behind the scrotum. E11 acknowledged this excoriated and failed to conduct an assessment and stated the redenned area is moisture related. On 8/20/14 at 10:55am, R2 was lying in bed and stated he has not been turned in a long time. R2 also stated he does not know the last time he was transfered out of bed. - On 8/21/14 at approximately 10:15am, R3 was observed in bed lying on her left side, awake, alert with inaudible speech, poor oral hygiene and an odor of feces near R3's bed. R3's care plan dated 6/16/14 states R3 has impaired skin integrity, decreased mobility, incontinent of bowel and bladder and has contractures. On 6/16/14 R3 was assessed with a	S9999		

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deep tissue injury to the sacrum with interventions to include maintaining low air loss mattress to reduce sacral area and perineal care after each incontinent episode. R3 was lying on an adjustable low air loss mattress set at maximum pressure required for residents' weighing 800 - 1000 pounds. Manufacturer's recommendation for use of this mattress states "adjust the support surface pressure using the patient weight buttons on the control panel to the appropriate weight. This facilitates blood circulation and provides maximum body tissue redistribution for treating and prevention pressure ulcers" R3's weight measurement obtained 8/19/14 shows a weight of 90.4 pounds.

R3's foam boots were observed on the window ledge to which E21 (Nurse) stated R3 requires off-loading of the heels and should be wearing the boots at all times. R3 was noted to be incontinent of bladder and bowel and the perineum was observed to be red and excoriated. E11 (nurse) and E23 (Certified Nurses Aid) changed R3's disposable diaper and quilted pad by pulling these items under R3 exposing R3's skin to friction. R3 was left on her left side.

On 8/21/14 at approximately 4:15pm R3 was found to be incontinent of both bowel and bladder and sacral dressing soiled. R3's buttocks and perineum was again noted to be red and excoriated to which E3 stated R3 has dermatitis as a result of incontinence. R3's deep tissue injury identified on 6/16/14 was now a Stage IV pressure ulcer. Based on new measurements obtained at the time of observation, R3's wound has further deteriorated over 7 days.

- R4's face sheet states R4 is an seventy six year (76) old resident admitted to the facility on

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S9999	Continued From page 7 12/27/2009, with diagnosis which includes depressive disorder, multiple sclerosis, pressure ulcer. On 8/20/2014 at approximately 10:15 am, R4 was observed laying on a regular mattress, with a deflated air loss mattress under the regular mattress. In addition, R4's heel protectors were noted on the floor under R4's bed. There was no off-loading of R4's heels. Based on direct observation from 10:15am through 1:00pm, R4 remained on his left side without turning and repositioning from nursing staff. On 8/20/2014 at approximately 1:10 pm E18 (CNA)) was asked to assess R4 for incontinence. R4 was incontinent of urine and stool. R4's incontinent brief was overly saturated with urine and dried stool. E18 was asked how often should R4 be repositioned. E18 stated all residents should be turned and repositioned every two hours. E18 was also asked why was R4 laying on a regular mattress with deflated air mattress underneath the regular mattress. E18 stated," I have no idea. " On 8/21/2014 at 9:45 am, R4 was observed still laying on a regular mattress on his right side. It was also noted there was no off loading of R4s heels. E3 (Wound Treatment coordinator) was present and stated R4 should have an air mattress. On 8/21/2014 at approximately 12:00 pm, during wound care observations, R4 was incontinent of stool. R4 has a urinary catheter which was covered with dried stool. In addition R4 was observed laying on right side. Wound assessment reports shows R4 has wounds to left heel, right medial foot. right trochanter and sacrum, all acquired in the facility R4's care plan dated 7/10 2014 states R4'S Braden score reflects 12, to be turned every two hours, kept clean and dry, off loading of heels,	S9999		

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and apply pressure reduction or low air loss mattress therapy and pressure relieving cushion when up in wheel chair.
-On 8/21/14 at 9:40am R6 was observed in bed, incontinent of bowel. R6's diagnoses includes cerebrovascular disease, aphasia, right side hemiplegia, chronic respiratory failure, dysphagia, gastrostomy tube placement, and tracheostomy. R6 also has an acquired a stage 2 sacral pressure ulcer and an acquired right heel deep tissue injury. R6 has limited bed mobility and is incontinent of bowel and bladder.
R6 also has an acquired a stage 2 sacral pressure ulcer and an acquired right heel deep tissue injury. R6 has limited bed mobility and is incontinent of bowel and bladder.
-According to R5's closed record, R5 was admitted to facility on 4/22/2014. R5 is a 58 year old diagnosed with End Stage Renal Disease, Hypertension, Type II Diabetes Mellitus, and Angina Pectoris.
The facility's weekly wound assessment report dated 5/12/14 denotes R5 acquired a " superficial sacrum wound, due to moisture associated skin damage ." On 5/12/2014, the wound was measured at 7.50 centimeters x 1.50 width.
The facility's weekly wound report dated 7/21/2014 denotes, R5 acquired a " buttock wound " which is classified as a full thickness, and related the wound development due to incontinence. On 7/21/2014 the wound was measured at 8.00 centimeters x 5.50 width.
The facility's weekly wound report dated 7/25/2014 denotes, R5's buttock wound measured 6.00 centimeters x 7.50 width x 4.00 depth. The wound report further detailed that the wound had a foul odor with a large amount of exudates. Z2(wound physician) referred R5 to a surgeon for debridement.
R5 was admitted to local hospital due to the

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infected buttock wound and under the supervision of an infectious disease physician.
The facility documented the wound as facility acquired. There were no documented clinical records that addressed the onset and progression of this wound. In addition, there were no daily skin assessments provided by the facility.
A review of R5's care plan dated 4/24/24 states R5's Braden scale was 13, which put R5 at moderate risk for skin breakdown. Care plan further stated that, R5 required assistance to turn and reposition every two hours. The facility did not provide a care plan for R5's buttock wound nor a wound prevention protocol.
A review of R5's hospital medical records denotes, R5 presented to the hospital on 7/25/2014, febrile, and 2-3 centimeter severe sacral decubitus ulcer that look like there was communication between the skin and the rectum, with drainage that look and smelled liked feces. R5 was also diagnosed with leukocytosis. R 5 underwent debridement down to the bone and was fully admitted to the local hospital. On 7/26 /2014, R 5 was full admitted to local hospital due to the infected buttock wound, R5 was placed under the supervision of an infectious disease physician.

During initial observation of R1 on 8/20/14 at approximately 11:45am, R1 was in bed, awake and non-verbal. Z3 (Family) was present and stated she's visiting with R1 today because she received a call from the facility regarding development of sores on R1's back side which is draining and infected.

Pressure sore risk assessment dated 8/18/14 shows R1 at high risk for pressure sore development with a risk score of 12, related to

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completely limited sensory perception, limited bed mobility, bedfast and very moist skin. R1 required 2 persons physical assist with bed mobility.

-On 8/21/14 at approximately 5:20pm, R1 was in bed with a foul body odor. E3 (Wound Care Coordinator) was present, preparing to conduct wound assessment. R1 was lying on a regular mattress, not an low air loss mattress. R1 was soiled with urine and feces. E25 (Certified Nurses Aid) was present and provided incontinent care for R1. R1 was wearing foam padded boots and when removed by E3, a pressure sore was observed on the left plantar foot. There was no dressing in place to which E3 stated "it must have fallen off." E3 assessed this wound as a Stage 2. There was minimal drainage noted at the wound site. The wound was measured at 1cm x 1.2cm. Wound assessment documentation dated 8/18/14 shows this wound was initially assessed on 8/18/14 with measurements of 0.8cm x 1.0cm. The assessment identified this wound as a facility acquired skin tear.

R1's right heel was noted to have a distinct area of redness. This site was assessed to be healed on 7/14/14 and treatment orders were discontinued. E3 acknowledged the redness and stated the site will be monitored. E3 stated that "the redness is non-blanchable which is not a concern." E2 (Director of Nursing) was unable to provide pressure sore staging guidelines upon request. The National Pressure Ulcer Advisory Panel's (NPUAP) literature on non-blanchable skin states this would be classified as a Stage I pressure ulcer.

There was an open wound on R1's Right Iliac Crest which measures 1.8cm x 2.1cm. Wound assessment documentation dated 8/18/14

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identifies this wound as a facility acquired skin tear measuring 1.3cm x 1.8cm. R1 is not listed on the facility's wound report dated 8/21/14.

-Z2 (Wound Physician) stated on 8/22/14 at 11:35am she has never assessed R1 and was not aware that R1 has wounds. R1 was added to her referral list today (8/22/14) and she (Z2) plans to assess R1 today if time permits. Z2 stated she depends on staff to inform her of which residents are to be evaluated.

-E26 (Registered dietitian) stated on 8/22/14 at approximately 10:45am that she assessed R1 nutritional status today in response to new Stage 2 wound on right Illiac Crest and R1 protein intake needed to be increased promote healing of newly acquired wounds. E26 stated prior to today she did not recognize the need for additional protein intake for R1.

2. R2 was admitted to facility with diagnoses of cerebrovascular disease, right side hemiplegia, gastrostomy tube placement, and urinary obstruction.
-Wound Assessment Report dated 6/19/14 shows the facility identified R2 with a stage 2 pressure ulcer to left heel was present on admission. Another report dated 6/27/14 shows R2 acquired an unstageable pressure ulcer to right outer ankle. On 8/14/14, R2 was identified with a stage 2 pressure ulcer on sacrum and a moisture associated skin damage behind R2's scrotum that were present on re-admission 8/13/14.
-On 8/21/14 at 11:16am, E11 (wound care nurse) performed wound care to R2's wounds and E21 CNA (Certified Nurse Aide/ CNA) assisted with positioning R2. R2 was incontinent of stool. E21 stated R2's was last checked and incontinence care provided at 8:30am. Facility's skin protection

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policy states residents are to be checked for incontinence at least every two hours.
R2's the left heel pressure ulcer measurement was 1.8cm(centimeters) length x 2cm width. Review of Wound Assessment Details Report dated 8/18/14 indicates wound measurement was 1.10cm x 1.10cm which indicates a deterioration of wound.
E11 stated R2's right outer ankle dressing was not due to be changed today. Review of physician orders dated 8/15/14 indicates dressing is to be changed every three days and as needed. Review of the TAR (Treatment Administration Record), indicates right outer ankle dressing was last changed on 8/16/14, 5 days prior.
It was noted by surveyor that R2's sacral wound dressing had brown discoloration and was not securely attached to R2's skin. E11 stated the sacral wound was not due to be treated today because it was just changed. Review of physician orders dated 8/15/14 indicates sacral dressing is to be changed every three days and as needed. R2's treatment administration record (TAR) indicated the sacral dressing was last changed on 8/16/14, 5 days prior. Treatment to this site was not done according to physician's order.
According to E11, the excoriated area behind R2's scrotum is moisture related. Measurements were not obtained for this area prior to applying vasolex ointment. Review of physician orders dated 8/13/14 states vasolex ointment is to be applied daily. Review of TAR indicates R2 did not receive this treatment on 8/19/14.
-On 8/20/14 at 10:55am, R2 was lying in bed and stated it has been mush more that two hours since he has been repositioned. R2 also stated he does not know the last time he was transferred out of bed.

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-On 8/22/14 at 11:50am, E4 (Certified Nurses Aid-CNA)stated music is played over the intercom to indicate when it is time to turn residents.
On 8/22/14 at 12:30pm, E5 (Nurse) stated she has a reference card attached to her name badge noting times residents are to be turned and music is played over intercom to notify staff to turn residents. E5 also stated she last heard music between 10:00am and 10:30am, more than two hours prior. E5 stated R2 was transferred to current room in July, 2014, and has been on bedrest since then. E5 said at that time, the wound team instructed nursing staff not to get R2 out of bed until further notice.
-Review of physician orders for July and August 2014 does not include an order for bedrest for R2. Review of weekly Wound Assessment Details Reports for July and August do not note any recommendations for R2 to be on bedrest due to wounds.
E26's (Registered Dietitian) dietary notes dated 8/19/14 states R2's tube feeding is adequate to promote wound healing and weight gain. On 8/22/14 at approximately 11:45am, E26 stated she re-assessed R2 and recommended increasing R2's protein intake based on wound healing concerns.

3. On 8/20/14 at 10:15am, R3 was observed in bed lying on her left side, awake, alert with inaudible speech, poor oral hygiene and an odor of feces near R3's bed. E21 (Nurse) was present and stated that R3 has a history of Cerebro-vascular Accident (CVA), is aphasic and has contractures in all four extremities. E21 also stated that R3 is totally dependent on staff for all activities of daily living (ADL's) including toileting and bed mobility, and requires hourly monitoring by staff and has a pressure sore. R3 was lying on an adjustable low air loss mattress at maximum

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pressure distribution at a setting of 800 - 1000 pounds. R3 weighs 90 pounds.
R3's foam boots were observed on the window ledge to which E21 stated that R3 requires off-loading of the heels and should be wearing the boots at all times while in bed. E21 proceeded to check R3 for incontinence and noted R3 was incontinent of bladder and bowel.

E21 asked E22 (Certified Nurses' Aid - CNA) and E23 (CNA) to provide incontinent care for R3.

At approximately 10:40am, while receiving incontinent care, R3 was noted to have a dressing on the sacrum which was soiled with urine and feces. R3's perineum was observed to be red and excoriated. E11 (Wound Treatment Nurse) was present in R3's room to perform wound treatment. E11 removed R3's sacral wound dressing to reveal a Stage 4 ulcer with gauze packing, copious amount of sero-sanguineous drainage and a foul odor. R3's wound was not clearly visible because there was very poor lighting near R3's bed. E11 was observed to apply Santyl to healthy tissue surrounding the wound and bactroban using a wooden spatula. E11 then used several dry gauze pads to pack the Stage 4 wound. E11 stated R3 has large amount of drainage and she (E11) decided it best to use the gauze packing. E11 could not recall if the application of the gauze packing is part of the physician's treatment order.

R3's Physician's Order Sheet (POS) dated 8/2/14 shows a wound treatment order which includes "Santyl with Bactroban, cover with dry dressing, change daily and prn (as needed)." There was no order for use of packing to the wound.

Upon completion of wound treatment, E11 and

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E23 changed R3's disposable incontinent brief and quilted pad by pulling these items under R3 exposing R3's skin to possible friction. R3 was left on her left side.

-On 8/21/14 at 4:15pm E3 (Wound Treatment Coordinator) was observed performing wound assessment and treatment for R3. R3 was again found to be incontinent of both bowel and bladder and dressing soiled. R3's buttocks and perineum was again noted to be red and excoriated to which E3 stated R3 has dermatitis as a result of incontinence. R3's gauze packing was noted to be saturated and there was large amount of necrotic tissue and slough in the wound bed. The perimeter of the wound was red. E3 attempted to obtain wound measurements in poor lighting. Surveyor illuminated the wound site using a flash light to provide better view of the wound. E3 obtained measurements of 6.5cm (centimeters) X 9.0cm X 2.5cm with 3.0cm - 3.5cm undermining. R3's previous wound measurements dated 8/13/14 shows measurements of 7.5cm x 7.7cm x 3.0cm. E3 applied a large amount of Santyl mixed with Bactroban preparation filling the wound cavity, applied gauze packing to the wound, dispersing Santyl to the healthy surrounding tissue and covered the wound with an abdominal pad. E3 then applied barrier cream to the excoriated areas of buttocks and perineum stating the CNAs will be monitoring the redness.

-On 8/20/14 and 8/21/14, R3's adjustable low air flow mattress was observed to be at a setting of 800 - 1000 pounds. Manufacturer's recommendation for use of this mattress states "adjust the support surface pressure using the patient weight buttons on the control panel to the appropriate weight. This facilitates blood circulation and provides maximum body tissue

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redistribution for treating and prevention pressure ulcers" The recommendations also state it is recommended to limit bed linens to one sheet in order to maximize the system's performance. R3's weight measurement obtained 8/19/14 shows a weight of 90.4 pounds.

-R3's Care Plan dated 6/16/14 stated: R3 was admitted on 6/14/14 with deep tissue injury to the sacrum. Interventions included daily skin treatment, reduce sacral pressure, maintain low air loss mattress while in bed to prevent further deterioration. Care Plan 6/30/14 states R3 is at high risk for impairment of skin integrity due to contractures and decreased mobility. The care plan does not address R3 needs for total assist with bed mobility, need for frequent turning and repositioning and incontinent care.

-During an interview with Z2 (Wound Physician) on 8/22/14 at approximately 11:35am, Z2 stated R3 was recently treated with antibiotics for an infection at the pressure ulcer site. Z2 stated she was not made aware of R3's further deteriorating wound. Z2 also stated that Santyl is used for debriding wounds and should not be applied to R3's healthy skin and R3's wound requires a wet gauze packing, not a dry packing.

4. R4 is an seventy six year (76) old resident admitted to the facility on 12/27/2009 with intact skin, diagnosis of hypertension, cerebrovascular disease, diabetes mellitus, depressive disorder, multiple sclerosis, gastronomy tube.
Braden scale: 15 or 16 = low risk, 13 or 14 = moderate risk, 12 or 15 = high risk
-On 8/20/2014, at 10:15 am, R4 was observed laying on a regular mattress, with a deflated air mattress under the regular mattress. In addition, R4's heel protectors were noted on the floor

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under R4's bed. There was no off-loading of R4's heels during this same observation. R4 was observed from 10:15 am through 1:00 pm, during 15 minute intervals while she remained in the room. The staff did not enter R4's room to provide turning, repositioning and toileting.
-On 8/20/2014 at 1:10 pm, E18 (CNA) was asked to assess R4 for incontinence. R4 was incontinent of stool which appeared dry. R4 has a urinary catheter. R4's disposable brief was overly saturated with urine. E18 was asked how often should R4 be repositioned. E18 stated all residents should be turned and repositioned every two hours. E18 was also asked why was R4 laying on a regular mattress with a deflated air mattress underneath the regular mattress. E18 stated " I have no idea."
-On 8/21/2014 at 9:45 am, R4 was observed still laying on a regular mattress with the deflated air mattress underneath the regular mattress. R4 was observed laying on right side-. It was also noted there was no off loading of R4's heels. E3 (Wound Treatment coordinator) was present and stated R4 should have an air mattress.
-On 8/21/2014 at approximately 12:00 pm 1: 30 pm , during initial wound treatment observations, R4 was incontinent of stool which covered the urinary catheter, and sacral wound. E3 (Wound care coordinator) and E11 (Wound Treatment nurse) provided incontinence care and then proceeded with dressing changes for R4. The wounds were noted as follows:
R4's Sacrum healing Stage 3 with measurements at 1.5cm centimeters length x 1.5 width, exudates was noted on old dressing. The facility's wound assessment report dated 8/18/2014, classified wound as a pressure ulcer. Measurements on 8/18/2014 reflect 1.50 cm length x 1.00 width, and a 0.20 depth. The facility's wound assessment report denotes the pressure ulcer

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was facility acquired.
R4's right trochanter (hip), Stage 3 healing wound. There were no measurements obtained. The facility's wound report dated 8/18/2014, classify the wound as a pressure ulcer. The facility's wound report denotes the pressure ulcer was facility acquired.
R4's left lateral foot- Stage 2 pressure ulcer showed measurements of 1.0cm length x 1.5cm width. The dressing was saturated with blood. The facility's treatment record dated 8/18/2014, did not document the fact that there was a left lateral foot pressure ulcer. E3 cleansed this wound with normal saline and applied santyl to the wound and covered the wound with a dry dressing. The physician's orders were reviewed, there were no orders to treat the left lateral foot pressure ulcer. E3 and E11 could not contest to the development of the left lateral foot pressure ulcer. E3 and E11 could not confirm if Z2 (wound care physician) was aware of the left lateral foot pressure ulcer. Wound report dated 8/20/14 stated this pressure ulcer was facility acquired.
R4's left heel pressure ulcer shows measurements of 5.5cm length x 4.4cm (width) x 0.3cm (depth) - Stage 3. Left heel pressure ulcer with measurements of 1.5 cm length x 1.5 cm width. The facility's wound report dated 8/18/2014, classifies the wound as a pressure related ulcers. Measurements on 8/18/2014 reflect 3.50 cm length x 5.30 cm width. The facility's wound assessment report denotes that the Left heel pressure ulcer was facility acquired.
R4's right medial foot pressure ulcer measures of 2.6 cm length x 2.8 width, with a depth of 0.3 cm- Stage 2- Beefy red appearance. The facility's wound report dated 8/18/2014, classify the wound as a pressure ulcer. Measurements on 8/18/2014 reflect 3.0 cm length x 2.50 width, and 0.20 cm depth. The facilities wound assessment report

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denotes the pressure ulcer was facility acquired.
R4's care plan dated 4/17/13 denotes R4 has limited ability to move upper and lower extremities through full range of motion related to weakness. Pressure risk score reflects 12, showing high risk for developing pressure ulcers. Care plan denotes R4 to be turned every two hours, kept clean and dry, off loading of heels, and apply pressure reduction or low air loss mattress therapy and pressure relieving cushion when up in wheel chair.
-On 8/20/2014 and 8/21/2014, at approximately 12:45 pm, R4's lunch (mechanical soft diet) tray was sitting on his bedside table. R4 did not receive assistance with his lunch meal. At least 90% of R4's lunch meal was not consumed. E27 (CNA) was present during this observation and was asked if R4 required assistance with meals. E27 stated "he feeds himself."
-E26's (registered dietician) progress notes dated 8/20/14 denotes R4 requires assistance with meals. E26 (Registered Dietitian) stated on 8/22/14 at 11:45am residents with pressure sores require a higher intake of calories and protein in their diet to promote wound healing. On 8/22/14 at approximately 10:45am, E26 stated she assesses R4's nutritional status on a monthly basis. E26 stated at the time of her 8/20/14 assessment, there were no updated wound report for R4 and she (E26) based her recommendations on wound report of 8/13/14. E26 also stated she was not made aware of R4's recent weight loss. Over what time period was this weight loss?
R4 care plan dated 7/10 2014 denotes R4 has the potential for alteration in nutrition related to chewing difficulty requires encouragement and assistance with meals to ensure proper nutritional intake. R4's weight tracking record denotes R4 has lost a total of 10 pounds in one month (7.5%).

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5. Closed record review denotes R5 was admitted to facility on 4/22/2014. R5 is a 58 year old diagnosed with End Stage Renal Disease, Hypertension, Type II Diabetes Mellitus, and Angina Pectoris.
-The facility's weekly wound assessment report dated 5/12/14 denotes R5 acquired a " superficial sacrum wound, due to moisture associated skin damage". On 5/12/2014, the wound was measured at 7.50 cm length x 1.50 cm width.
The facility's weekly wound report dated 7/21/2014 denotes, R5 acquired a " buttock wound. " The facility classified the wound as full thickness, and related the wound to incontinence. On 7/21/2014 the wound was measured at 8.00 centimeters x 5.50 width. There were no documented clinical records that addressed the onset and progression of this wound. In addition, there were no daily skin assessments provided by the facility upon request.
-The facility's weekly wound report dated 7/25/2014 denotes, R5's buttock wound measured 6.00 cm length x 7.50 cm width x 4.00 cm depth. The wound report further detailed that the wound had a foul odor with a large amount of exudates. Z2(wound physician) referred R5 to a surgeon for debridement.
-R5's care plan dated 4/24/24 states R5's Braden scale was 13, which put R5 at moderate risk for skin breakdown. Care plan further stated that, R5 required assistance to turn and reposition every two hours. The facility did not provide a care plan for R5's buttock wound nor a wound prevention protocol.
-R5's hospital medical records denotes, R5 presented to the hospital on 7/25/2014, febrile, and with a 2-3 centimeter severe sacral pressure ulcer that look like there was communication between the skin and the rectum, with drainage

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that look and smelled liked feces. R5 was also diagnosed with leukocytosis. R5 underwent debridement down to the bone and was fully admitted to the local hospital. On 7/26 /2014, R5 was admitted to local hospital due to the infected buttock wound, R5 was placed under the supervision of an infectious disease physician.

6. R6 was admitted to the facility on 8/7/14 with diagnoses of cerebrovascular disease, aphasia, right side hemiplegia, chronic respiratory failure, dysphagia, gastrostomy tube placement, tracheostomy.
R6's Weekly wound report dated 8/17/14 indicates the facility identified R6 with an acquired Stage 2 sacral pressure ulcer (10 days after admission). This report dated 8/18/14 showed R6 also acquired a right heel deep tissue injury (11 days after admission). R6's pressure sore risk assessment dated 8/8/14 shows R6 scored at "12" which signifies high risk for developing pressure sore. Facility's Skin Prevention policy dated 5/14 states "skin checks will be completed daily for at risk residents." After several requests for skin check documentation for R6, none was provided.
-On 8/21/14 at 9:40am R6 was observed in bed, incontinent of bowel. E3 was present to perform wound care with E9 (Nurse) assisting with positioning of R6. A sacral dressing was noted to not be securely attached to R6's skin. E3 removed the sacral dressing and there was feces present in wound. Wound measurement obtained as 5cm length x 4.2cm width. Wound Assessment Details Report dated 8/17/14 indicates wound measurement was 4.5cm length x 2cm width.
R6's right heel dressing was removed and wound measured 2.4cm length x 3.4cm width. Wound Assessment Details Report dated 8/18/14

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indicates wound measurement was 2cm length x 3.3cm width. E3 was observed to apply skin preparation solution to entire wound and surrounding tissue.
On 8/21/14 at 11:23am, E11 stated skin prep is applied to surrounding tissue; it goes on the outside of wound not on the wound.

7. On 8/20/2014 from 10:00 am to 12:40 pm every fifteen interval observations were made while residents were in the dining room area. During this time period, R23, R24, R25, R26, and R27 were not turned, repositioned, or assessed for incontinence while in this area. These residents remained in their wheel chairs over this time period and all require staff assist for mobility and toileting and at risk for skin breakdown.
E18 (CNA) was monitoring the dinning room and was asked what was the facility's policy regarding turning and repositioning residents who are compromised, and unable to independently turn and reposition themselves in bed, or when up in a chair. E18 stated "we're suppose to check them every two hours and before lunch." E18 was also asked who was responsible for assessing the residents' for incontinence when the residents are in the dining room area. E18 stated, when a CNA monitors the dining room, they are responsible for checking the residents' for incontinence.
According to E18; R23, R24, R25, R26, and R27 had not been assessed for incontinence since 9:00 am (more than 3 hours prior).

-R23 care plan dated 8/7/14 shows diagnosis of Dementia, hypertension, epilepsy. R23 cannot independently perform activities of daily living. R23 was noted to be sitting in a reclining chair and wearing an incontinent brief due to incontinence. Care plan denotes R23 is incontinent of bowel and bladder related to

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decreased mobility. Intervention denotes assessment for incontinence every two hours, provide total assistance when necessary, check skin daily, and to keep skin clean and dry. 8/20/14 at 12:50 pm E18 was asked to escort R23 to their assigned room to assess for incontinence. R23's diaper was saturated with urine.
During this same observation Z5 (family member) was present and stated "my sister is always soaking wet; this happens all the time." R23's care plan dated shows R23 is at risk for impaired skin integrity. Braden score reflects 14 which puts R23 at moderate risk for developing pressure ulcers.

8. 8/20/14 at 12:57 pm, E18 was asked to escort R24 to the assigned room. R24 is prescribed a wheel chair. R24's incontinent brief was saturated with urine. R24 is diagnosed with glaucoma, senile dementia, depressive disorder, and degeneration of interferer disc. Care plan dated 7/21/2014, denotes R24 is incontinent of bowel and bladder and is unable to inform staff of need to void. Interventions reflect turning and repositioning every two hours, assess for incontinence every two hours, skin checks daily and R24 to be kept clean and dry. R24 is at risk for impaired skin integrity. Braden score reflects 12 which puts R24 at high risk for developing a pressure ulcer.

9. R25 is diagnosed with Osteoporosis, Osteopathic, Gout, heart failure, Chronic Airway obstruction, and hypertension. R25 is prescribed a wheel chair. Care plan dated 4/22/2014, denotes R25 is incontinent of bowel and bladder and is unable to inform staff of need to void. Interventions reflect turning and repositioning every two hours, assess for incontinence every

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24	S9999		

two hours, skin checks daily and R25 to be kept clean and dry. R25 is at risk for impaired skin integrity. Braden score reflects 19.
8/20/14 at 1:10 pm, E18 (CNA) was asked to escort R25 to the assigned room. R25's incontinent brief was saturated with urine.

10. R26 is diagnosed with Paralysis, hypertension, dementia with behavioral disturbance. R26's care plan dated 8/25/2014, denotes R26 is incontinent of bowel and bladder and is unable to inform staff of need to void. Interventions reflect turning and repositioning every two hours, assess for incontinence every two hours, skin checks daily, and R26 to be kept clean and dry. R26 is at high risk for impaired skin integrity. Braden score reflects 17.
8/20/14 at approximately 1:30 pm E18 was asked to escort R26 to the assigned room. R26's incontinent brief to be saturated with urine.

11. R27 is diagnosed with Hypertension, muscle weakness, senile dementia, osteoporosis, constipation, and chronic airway obstruction. Care plan dated 5/28/2014, denotes R27 is incontinent of bowel and bladder and is unable to inform staff of need to void. Interventions reflect turning and repositioning every two hours, assess for incontinence every two hours, skin checks daily, and R27 to be kept clean and dry. R27 is at high risk for impaired skin integrity. Braden score reflects 11.
8/20/14 at 1:30 pm E18 was asked to escort R27 to the assigned room. R27's incontinent brief to be saturated with urine.

12. R48 ' s closed record review of R48 ' s wound assessments shows R48 was admitted to the

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	IL6002265	A. BUILDING: _____ B. WING _____	C 09/26/2014

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facility on 4/10/14 pressure sores to the left ear (Stage 2), right ear (Deep tissue injury), right shoulder (unstagable), left below knee amputation (BKA) stump (unstagable), right BKA stump (unstagable), sacrum (Stage 4), right ischial tuberosity (Stage 3). On 4/18/14 a new unstagable right elbow wound was identified. The right BKA stump wound increased in size on 5/8/14. There was gradual deterioration of this wound from unstagable to Stage 4, the left BKA stump wound from unstagable to Stage 3 and sacral wound which increased in size. R48 received ultra sound therapy to the sacral wound and required the use of a wound vacuum. There was documented on 6/21/14 regarding odor to the wound.
Nursing notes dated 6/27/14 states R48 developed a change in condition and sent out to the hospital for evaluation. Emergency room notes states R48 ' s wounds were mal-odorous and R48 required antibiotic regimen.
E34 (Wound treatment Nurse) stated on 9/25/14 she provided wound treatments for R48 throughout her stay in the facility. E34 ' s most recent skin assessment and wound treatment was conducted on 6/27/14, the day of R48 ' s discharge. Regarding her assessments of R48 ' s wounds E34 stated she never noted any foul odor to the wounds. E34 went on to say that R48 was receiving " mist therapy " by physical therapy department to the wounds which was done prior to her assessments. E34 stated may be the reason why she did not detect any odors because the mist therapy washed out the wound. E34 admitted to not assessing R48 ' s right ear wound on 6/9/14; not identifying the left Ischium wound as facility acquired and documented it was present on admission; did not identify the specific location of a " posterior knee " wound and did not identify a Stage 2 wound to R48 ' s left upper

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back which was noted in the emergency room records.
13. On 8/22/14 at approximately 11:35am, Z2 (Wound physician) stated the timely turning and repositioning of residents, minimizing skin exposure to moisture, utilizing pressure relieving measures and providing adequate nutritional intake are necessary factors to prevent development of and worsening of pressure sores. Z2 further stated that she has been working at the facility for approximately one month and is present in the facility 2 days each week. Nursing personnel provides a list of the residents to be seen during the wound rounds. Wound assessments are performed upon nursing recommendation. Z2 stated that she is available by phone and expects nursing personnel to contact her if there are signs of new skin breakdown or deterioration of wounds. There has been no reports of newly acquired nor deterioration of wounds from facility staff. Z2 went on to say that she had no knowledge of the high prevalence of facility acquired wounds and stated she has no opinion of the amount of acquired pressure in the facility because she is new and has not yet identified an interdisciplinary wound management team.

E1 (Administrator) stated during an interview on 8/22/14 at approximately 11:30am that she is new to the facility (less than 1 month) and is not knowledgeable about the facility's quality of care concerns. E1 stated that the Quality Assurance committee identified wound management as an area of concern in the facility. The Committee also identified a concern regarding staff's failure to implement recommendations to improve wound management. The Committee also recommended the use of "Shake, Rattle and Roll" music to be played over the intercom to indicate

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and remind staff to reposition residents. The Committee, in June 2014, decided that the facility's wound care team will work with the new wound physician to ensure that all are on the same page for documentation and care/treatment routines. The Committee has focus on the development of heel wounds and staff will monitoring the compliance with off-loading of residents' heels.

During observation, on 8/20/14, 8/21/14, 8/22/14 the music for repositioning residents could be heard over the intercom approximately 1-2 times during 8 hour period. The facility's Turning and Repositioning Program policy dated 11/03 does not specify the frequency for turning and repositioning and does not address the use of musical cues for staff.

Nursing in-service log shows wound care and prevention inservice was conducted on 5/12/14. Three of four wound treatment nurses attended the inservice. E2 (Director of Nursing) was asked on 8/21/14 at approximately 4:30pm to provide survey team with the educational tools used during the inservice. E2 stated she is new to the facility (less than 2 weeks) and does not know what educational tools were used. E2 also stated she is not able to locate a wound management and treatment policy in the facility.

Facility's undated Skin and Wound Care Protocol states "All residents considered at high risk, pressure reducing beds and cushions are implemented regardless of the site of the lesion." The Protocol also states Comprehensive skin assessment done on all admissions and re-admissions and to be documented on the Skin Risk Assessment tool. This has not be implemented for which sample " The protocol

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S9999	Continued From page 28 states dressings are to be "changed when they become soiled or wet." This policy has not been consistently followed for all sampled residents. The skin Prevention policy dated 5/14 states "skin checks will be completed daily for at risk residents and twice weekly for other residents." The policy goes on to state that Interventions will be put into place based on risks identified and to include turning and repositioning every 2 hours; level 2 support surfaces; preventive foot care; overlays or wheelchair cushions; incontinent care at least every two hours who were affected?; encourage resident mobility; dietitian review for protein, calorie, fluids and weight monitoring; prevention of friction and shear and these interventions are to be reviewed and updated quarterly and with significant change of condition. (A)	S9999		

Imposed POC

F 224:

It is the policy of Symphony of Crestwood not to neglect residents.

Corrective measures for identified residents:

R1 was immediately given a low air loss mattress. R2 is no longer in the facility; but at the time of the survey was immediately changed and repositioned. R3's mattress was immediately adjusted to the correct weight and his foam boots applied. E11 and E24 were inserviced on turning to prevent friction. R4 was immediately placed on an inflated mattress, incontinence care provided, turned and her heel boots applied. R6 preventative care plan was reviewed. R5 is no longer at the facility.

Identification of other resident's potentially affected:

All other residents at high risk for pressure ulcers were reviewed to ensure they have their preventative measures in place.

Corrective Measures:

An inservice was completed for nurses and aides on skin/wound prevention.

QI Tools:

A random sample of 5 residents per floor per week will be reviewed to ensure that the pressure ulcer prevention devices are in place and that residents are being changed timely.

Completion: 10-27-14 accepted

Imposed POC

F 314

It is the practice of the facility that a resident who enters the facility without pressure sores does not develop pressure sores unless the individuals condition demonstrates that they were unavoidable and a resident having a pressure ulcer receives the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing

Corrective Measures Identified Residents

1. R1's pressure ulcers are healed. Prevention measures are in place per the plan of care. Z2 was informed of R1's wounds and followed the resident until healed. The RD has assessed R1 and continues to follow as indicated.
2. R2 no longer resides in the facility.
3. R3's low air loss mattress was adjusted per resident's weight and offloading boots are in place. The wound care staff use a head lamp for additional lighting with providing wound care. R3's treatment is applied as ordered. The care plan has been updated to reflect preventive skin care interventions. Z2 has been made aware of the wound status and continues to follow.
4. R4 has a low air loss bed in place and offloading boots in place. The resident is turned & repositioned per the plan of care. The RD has reviewed and assessed the resident and continues to follow. The RD is communicated with weekly re: residents with pressure ulcers and weight loss.
5. R5 was a closed record review and does not reside in facility.
6. R6's pressure ulcers are now healed. R6 skin checks are completed per the plan of care.
7. R23 is repositioned, turned and checked for incontinence per their individualized plan of care.
8. R24 is repositioned, turned and checked for incontinence per their individualized plan of care.
9. R25 is repositioned, turned and checked for incontinence per their individualized plan of care.
10. R26 is repositioned, turned and checked for incontinence per their individualized plan of care.
11. R27 is repositioned, turned and checked for incontinence per their individualized plan of care.
12. R48 was a closed record review and does not reside at the facility.
13. Z2 is communicated weekly on residents who have acquired pressure ulcers. Z2 has been trained on the facility wound system and has access to all reports

Identification of other residents potentially

1. Residents had a head to toe skin assessment completed by licensed staff. Any findings were followed up on as indicated.
2. Resident with current pressure ulcers were reviewed by LN to ensure individualized interventions were in place and the care plans have been updated.
3. Residents with skin impairments were reviewed for accuracy of wound identification
4. Residents with pressure ulcers were reviewed for signs of deterioration based on PUSH scores with follow-up as indicated
5. The RD Reviewed all residents with pressure ulcers and documented in the medical record
6. Residents triggering high risk were reviewed to ensure appropriate interventions in place for skin prevention.
7. Wound nurses have been competencied on the performance of wound treatments