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	146109	A. BUILDING _____ B. WING _____	C 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MENNONITE HOME	**24588 CHURCH STREET CHENOA, IL 61726**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Special Focus Facility Complaint #1664613/IL87733- F157, F221, F225, F226, F312, F314, F323 Complaint #1664712/IL87846-no deficiency	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		9/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/08/2016

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F 157	Continued From page 1	F 157		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to notify the physician of a new pressure ulcer, and failed to notify the physician and power of attorney of an allegation of abuse utilizing a restraint. These failures have the potential to affect two residents (R1 and R5) of 11 reviewed for physician notification in the sample of 11.

Findings Include:

1. R5's undated face sheet documents Diagnoses of Dementia and Alzheimer's.

R5's MDS (Minimum Data Set) dated 7/24/16 documents total assist of two staff is required for bed mobility and transfers.

R5's ID (Interdisciplinary) Notes dated 7/8/16 by E22 LPN (Licensed Practical Nurse) documents, "crack of buttocks continues to be red. Crease open at this time...". There is no documentation in R5's medical record that the physician was notified of the "open crease."

On 8/17/16 at 1:45 pm, Z3 NP (Nurse Practitioner) stated, Z3 couldn't remember exactly when Z3 was notified of the "open crease" but that Z3 "implemented the standing orders for a hydrocolloid dressing at the time (Z3) was notified of the open area."

R5's POS (Physician Order Sheet) dated 8/17/16 documents the order for hydrocolloid dressing was not given until 7/15/16.

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F 157	Continued From page 2 On 8/17/16 at 2:10 pm, E2 DON (Director of Nursing) stated, "when a new wound is found, I expect it to be assessed, the area measured if it is on a pressure point and the Physician to be notified." On 8/17/16 at 2:15 pm, E22 LPN stated, "I don't recall if the physician was notified or not, when (R5's) bottom opened up. It would be documented if I had." The facility Change in Condition Policy dated 6/4/15 documents, "For the purposes of this policy; a change in condition may be considered, but not limited to the following: a noted change in the resident's mental or physical status, a fall, a medication error, a skin tear or bruise, etc. .... 1. Any employee who observes a change in a residents condition will notify the charge nurse on duty. 2. The charge nurse will perform an assessment and notify the physician and family members of any significant change which requires a change in the resident's plan of care. 3. The physician will be notified immediately...." 2. R1's Minimum Data Set dated 7/3/16 documents R1 could not complete a Brief Interview for Mental Status and required staff assessment to determine cognitive status. Staff assessment on this same MDS documents R1 has short term and long term memory problems, inattention, disorganized thinking with moderate cognitive impairment. This same MDS documents R1 is frequently incontinent of bladder and requires extensive assistance of two staff members for transfers, ambulation, hygiene, bathing, bed mobility, and toileting. R1's Interdisciplinary Note dated 8/18/16 (late entry for 8/6/16) documents E9, Certified Nursing	F 157		

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F 157	Continued From page 3	F 157		

Assistant (CNA) arrived at work at 5:00 am on the morning of 8/6/16 and found R1 sitting in a wheelchair with a seat belt restraint applied and was incontinent. This note documents E9 reported the incident to E3, Licensed Practical Nurse (LPN).

The facility's initial report to Department of Public Health dated 8/6/16 documents the reporting of the allegation that R1 was in a wheelchair with a seat belt applied.

On 8/16/16 at 5:15 am and 1:30 pm, E9 stated, "I came into work at 5:00 am and found (R1) in a wheelchair with a seat belt on and buckled."

On 8/18/16 at 12:15 pm E24, CNA, stated, "I worked part of the third shift on 8/6/16. R1 did get up out of bed around 11:30 pm (8/5/16) and I was walking with (R1). (R1) wanted to sit down and the closest chair was a wheelchair, so I sat (R1) in the wheelchair. Then (R1) was bored so we started buckling and unbuckling the seat belt on the chair. (R1) cannot buckle and unbuckle the seat belt by (R1's) self, so I put my hands on his hands and to coach (R1) and told (R1) 'buckle', 'ok, now unbuckle'. I left work at 2:00 am and R1 was still sitting in the same wheelchair by the nurse's station."

On 8/17/16 at 12:30 pm by phone interview, Z1, R1's spouse, stated, "None of the staff notified me when this situation happened with (R1). One of the nurses came to me privately this past weekend (8/13/16 or 8/14/16) to inform me about what happened."

On 8/17/16 at 2:30 pm by phone interview, Z4, Primary Care Physician for R1, stated, "No one

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F 157	Continued From page 4 from the nursing home told me about the situation with (R1) and the seat belt. The first I heard of it was when (Z1) called and left a message at my office, either 8/14/16 or 8/15/16."	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess for the use of a restraint, and failed to obtain consent for the use of a restraint. These failures have the potential to effect one resident (R1) on the sample of eleven. Findings include: R1's Minimum Data Set dated 7/3/16 documents R1 could not complete a Brief Interview for Mental Status and required staff assessment to determine cognitive status. Staff assessment documents R1 has short term and long term memory problems, inattention, disorganized thinking with moderate cognitive impairment. This same MDS documents R1 is frequently incontinent of bladder and requires extensive assistance of two staff members for transfers, ambulation, hygiene, bathing, bed mobility, and toileting. R1's Interdisciplinary Note dated 8/18/16 (late entry for 8/6/16) documents E9, Certified Nursing	F 221		9/8/16

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F 221	Continued From page 5	F 221		

Assistant (CNA) arrived at work at 5:00 am on the morning of 8/6/16 and found R1 sitting in a wheelchair with a seat belt restraint applied and was incontinent of bowel and bladder. This note documents E9 reported the incident to E3, Licensed Practical Nurse (LPN).

The facility's initial report to Department of Public Health dated 8/6/16 documents the reporting of the allegation that R1 was in a wheelchair with a seat belt applied.

On 8/16/16 at 5:15 am and 1:30 pm, E9 stated, "I came into work at 5:00 am and found (R1) in a wheelchair with a seat belt on and buckled. (R1) was incontinent of bladder, but not bowel. (R1's) (incontinent brief) was soaking wet, dripping wet. The wheelchair belongs to another resident (R12) which (R12's) family purchased to use when they take (R12) outside. (R12's) wheelchair is supposed to kept behind the door in (R12's) room."

R1's electronic and paper medical record did not contain an assessment for the use of a restraint, nor documentation for any less restrictive measures attempted prior to the use of the seat belt, nor a consent for the use of a restraint.

On 8/19/16 at 10:40 am, E1, Administrator, stated, "As administrator, I operate a restraint-free facility."

On 8/17/16 at 2:30 pm by phone interview, Z4, Primary Care Physician for R1, stated, "We are supposed to be a restraint-free facility."

On 8/16/16 at 12:18 pm, E3, Licensed Practical Nurse (LPN), stated, "We are a no-restraint

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F 221	Continued From page 6 facility."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		9/8/16

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F 225	Continued From page 7	F 225		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to identify and investigate an injury of unknown origin and failed to report the injury of unknown origin as well as an allegation of abuse to the State Survey and Certification Agency (Illinois Department of Public Health). These failures affect two of eight residents (R2, R7) reviewed for abuse/neglect in a sample of 11.

Findings include:

1. The facility's Electronic Medical Record documents R7 has diagnoses of Dementia, Depression, Anxiety, and Heart Failure.

The Nurses Note dated 8/7/16 documents R7 was found with a 1 cm x 1 cm bruise noted to the left side of her forehead.

On 8/17/16 observation confirmed a light brown bruise on the left of R7's forehead.

On 8/17/16 at 1:10 PM, E3 Licensed Practical Nurse (LPN) stated she observed R7's bruise on 8/7/16 and staff and family were not able to conclude how the bruise occurred. E3 stated she did not complete an incident report concerning the bruise.

On 8/17/16 at 2:54 PM, E2 Director of Nurses (DON) stated she would have expected E3 LPN to investigate the origin of R7's bruise herself and if no conclusion could be found, then make an

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incident report and notify herself (DON). E2 confirmed that no incident report was written.

2. The facility's Electronic Medical Record documents R2 has diagnoses of Dementia, Depression, Insomnia, Anxiety, Epilepsy, Incontinence, and Alzheimer's Disease.

The Nurse's Note dated 8/8/16 documents R2 reported the night shift staff the night prior were rough with her and banged her knee against the wall. R2 also reported that she believed the same staff hit her roommate (R3) causing her to cry out in pain.

The Initial Abuse Investigation concerning R2's allegation that the night staff were rough with her is dated 8/10/16. This report was sent to the State Survey and Certification Agency (Illinois Department of Public Health) on 8/10/16.

On 8/17/16 at 3:22 PM, E1 Administrator stated on 8/8/16 she focused her investigation on the R3's injury and failed to report R2's injury and allegation of abuse to the State Survey and Certification Agency (Illinois Department of Public Health) until 8/10/16.

The facility's Abuse Prevention Policy dated 1/2/15 documents, "The Administrator and Director of Nursing or their designee will initiate an investigation immediately and in cases involving Meadows residents, the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the Illinois Department of Public Health", and "The following information should be reported to the Administrator and the Director of Nursing or their designee: In the event of suspicious bruising, the nursing staff is

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F 225	Continued From page 9 responsible for reporting the appearance of bruises, lacerations, or other abnormalities as they occur. The Director of Nursing or Unit Coordinator is responsible for determining the source of these abnormalities".	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to operationalize their Abuse Prevention Policy by not investigating an injury of unknown origin and by not reporting the injury of unknown origin as well as an allegation of abuse to the State Survey and Certification Agency (Illinois Department of Public Health). These failures affect two of eight residents (R2, R7) reviewed for abuse/neglect in a sample of 11. Findings include: The facility's Abuse Prevention Policy dated 1/2/15 documents, "The Administrator and Director of Nursing or their designee will initiate an investigation immediately and in cases involving Meadows residents, the Preliminary Investigation will be faxed immediately and not to exceed within 24 hours to the Illinois Department of Public Health", and "The following information should be reported to the Administrator and the	F 226		9/8/16

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F 226	Continued From page 10	F 226		

Director of Nursing or their designee: In the event of suspicious bruising, the nursing staff is responsible for reporting the appearance of bruises, lacerations, or other abnormalities as they occur. The Director of Nursing or Unit Coordinator is responsible for determining the source of these abnormalities".

1. The facility's Electronic Medical Record documents R7 has diagnoses of Dementia, Depression, Anxiety, and Heart Failure.

The Nurses Note dated 8/7/16 documents R7 was found with a 1 cm x 1 cm bruise noted to the left side of her forehead.

On 8/17/16 observation confirmed a light brown bruise on the left of R7's forehead.

On 8/17/16 at 1:10 PM, E3 Licensed Practical Nurse LPN stated she observed R7's bruise on 8/7/16 and staff and family were not able to conclude how the bruise occurred. E3 stated she did not complete an incident report concerning the bruise.

On 8/17/16 at 2:54 PM, E2 Director of Nurses DON stated she would have expected E3 LPN to investigate the origin of R7's bruise herself and if no conclusion could be found, then make an incident report and notify herself (DON). E2 confirmed that no incident report was written.

2. The facility's Electronic Medical Record documents R2 has diagnoses of Dementia, Depression, Insomnia, Anxiety, Epilepsy, Incontinence, and Alzheimer's Disease.

The Nurses Note dated 8/8/16 documents R2

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F 226	Continued From page 11 reported the night shift the night prior were rough with her and banged her knee against the wall. R2 also reported that she believed the same staff hit her roommate (R3) causing her to cry out in pain. The Initial Abuse Investigation concerning R2's allegation that the night staff were rough with her is dated 8/10/16. This report was sent to the State Survey and Certification Agency (Illinois Department of Public Health) on 8/10/16. On 8/17/16 at 3:22 PM, E1 Administrator stated on 8/8/16 she focused her investigation on the R3's injury and failed to report R2's injury and allegation of abuse to the State Survey and Certification Agency (Illinois Department of Public Health) until 8/10/16.	F 226		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide incontinence care for two residents (R1 and R2) on the sample of eleven, and fourteen residents (R13 through R26) on the supplemental sample. Findings include:	F 312		9/8/16

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F 312	Continued From page 12	F 312		

On 8/17/16 at 3:22 pm, E1, Administrator, stated "Neighborhood one is our full-on dementia unit."

On 8/17/16 at 10:06 am, E5, Licensed Practical Nurse, stated, "I gave written warnings to two Certified Nursing Assistants (CNA's) (E10 and E11) on 8/5/16 because I came in around 5:00 am that morning and (R1) was soaked up to (R1's) armpits, and there were fifteen residents who were soaked and needed to have complete bed linen changes."

The typed and signed report from E5 dated 8/5/16 documents at 5:00 am, E5 came in to work and found R1 up ambulating without any supervision. This report documents R1 was soaked up to R1's armpits and had experienced a bowel movement. E5 documents (E5) asked a minimum of four times for 2 CNA's (E10 and E11) to assist R1 but neither CNA responded. This report from E5 continued to document that 15 additional residents (R2, and R13 through R26) were completely soaked (from urinary incontinence) and required complete bed linen changes.

The facility's Bathroom Sheet dated 8/5/16 documents R1, R2, R13, and R26 had not received hygiene care at all during the night, and R14, R16, R18, R19, R20, R21, R23, R24, and R25 had received hygiene care only once during the night.

The facility's undated List of Incontinent Residents documents R1, R2, and R13 through R26 are incontinent of bowel and/or bladder.

The facility's Resident Roster Matrix form 802 also documents R1, R2, and R13 through R26

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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) COMPLETION DATE
F 312	Continued From page 13 are incontinent.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assess a new pressure ulcer and do weekly measurements, implement skin breakdown and nutritional interventions, reposition a resident according to Physician Standing Orders, and provide wound care treatment as ordered by the physician for one of three residents (R5) reviewed for pressure ulcers in the sample of 11. This resulted in R5 developing three unstageable pressure ulcers. Findings Include: R5's undated face sheet documents Diagnoses of Dementia and Alzheimer's. R5's MDS (Minimum Data Set) dated 7/24/16 documents R5 has moderately impaired cognition, and is totally dependent on two staff for bed mobility and transfers.	F 314		9/8/16

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F 314	Continued From page 14 R5's Skin Risk Assessments dated 7/4/16, 7/11/16, 7/18/16, and 8/1/16 all document "high risk" for skin breakdown. R5's Care Plan dated 7/24/16 documents, at risk for skin breakdown due to decreased mobility and incontinence. Currently has an open area on left buttocks measuring 1.0 (length) x 0.4 cm (width) and on right buttocks measuring 0.8 x 0.8 cm. This Care plan, updated on 8/15/16, documents, "all ulcer areas diagnosed as Kennedy Ulcer (total area measuring 4 (length) x 2.5 (width) x 0.5 cm (depth)). The care plan interventions document, "please check my skin twice daily...my skin is fragile. 8/1/16 (skin tear) Geri-chair padding placed to cushion chair for skin protection...8/10/16 reposition me frequently during the day and evening, 2cal TID (three times a day) 90cc (cubic centimeters)...8/11/16 Arginaid daily for wound healing." R5's ID (Interdisciplinary) Notes dated 7/8/16 by E22 LPN (Licensed Practical Nurse) documents, "crack of buttocks continues to be red. Crease open at this time..". There is no documentation in R5's medical record that describes the size, or characteristics of the wound until 7/15/16. The Skin Evaluation Record for R5 on 7/15/16 by E5 LPN documents, "small 1.0 cm (centimeter) x (by) 0.4 cm open area to left inner buttock near coccyx. Pink dry area surrounding." There is no other measurements of this wound until 8/2/16. The following wound measurements that are documented in R5's medical record, in the ID Notes document the following:	F 314		

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F 314	Continued From page 15 8/2/16 by E3 LPN - "treatment completed per physician order to left buttocks near coccyx 1.0 x 0.4 cm. Surrounding area red and dry." 8/10/16 by E22 LPN - "treatment done to area on coccyx. Open area measured 2 cm x 3 cm. Surrounding skin red and excoriated measuring 6 cm. Area very painful...". 8/15/16 by E3 LPN - "measurement to buttocks wound..coccyx 4cm x 2.5 cm x 0.5 cm, 8.8 cm x 6.2 cm total redness to area. 1 cm x 1 cm open area to right buttocks, 0.8 cm x 0.8 cm open area to left buttocks. (Z3 NP) seen and new treatment ordered to entire area... POA (Power of Attorney) updated on change of wound and possibility of this being a Kennedy Ulcer and the fact that these wounds deteriorate quickly." R5's Physician Orders dated 8/17/16 document the following orders: 7/15/16 {first wound treatment order}- Hydrocolloid to left inner buttocks, change every three days. 8/15/16 {current wound treatment order} - cleanse sacral wound. Skin prep to peri wound, calcium alginate to Decubitus, cover with dressing every day and PRN (as needed). R5's Dietary Assessment dated 7/21/16 by Z5 RD (Registered Dietician) documents, "..open area in gluteal fold (1 x 0.4 cm)..intake fair to good...Goals:..maintain skin integrity. Refer to RD PRN." There were no nutritional interventions recommendations documented. On 8/18/16 at 9:30 am, Z5 RD stated, "when I did (R5's) assessment, I was told that (R5) had a shearing on (R5's) bottom. I was not told that it	F 314		

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was actually open. If I would have been notified that it was a stage II, or actually open, I would have made recommendations. The same type of recommendations that was implemented by the physician on 8/10/16; Arginaid, zinc, vitamin c, and medpass. Maybe not all of them but at least the zinc, vitamin c, and medpass. I am at the facility at least once a month. If a new wound is found or if a wound is not healing, I would prefer to be contacted so recommendations could be made before that month time."

On 8/17/16 at 10:50 am, E3 and E5 both LPN's completed R5's ordered dressing change while R5 was lying in low bed with a regular mattress. Upon removal of the incontinence brief, there was no dressing on R5 or in R5's brief. E3 and E5 confirmed that R5 did not have a dressing on covering R5's wounds and E3 stated, "I don't know how long it {dressing} has been off, nobody told me that (R5) didn't have one {dressing} on." R5 had been incontinent of stool. E3 and E5 provided incontinent care. Once resident was clean, E3 was asked to describe and show R5's pressure ulcer. R5 has 3 pressure ulcers: one on the coccyx that is covered in gray slough, and one on each buttock that is covered in yellow slough. All three of these wounds were within a large triangle shaped red area extending from above the coccyx down to the middle of R5's bilateral buttocks. E3 stated while pointing to the coccyx area, without the aid of a scaled measure instrument, "this is approximately 4.5 x 3 cm and would be considered unstageable because you can't see what is under there." E3 then pointed to bilateral buttocks and stated, "these are both approximately 2 x 2 cm, and would also be unstageable." E3 stated, "the entire area here {while pointing to the reddened area} is

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approximately 9 x 6 or 7 cm. E3 stated, "we just started getting (R5) up for meals only because there were times (R5) would be up in the chair for three to four hours at a time, and these wounds have gotten much worse just since Monday {2 days prior}."

On 8/17/16 at 11:15 am, E13 CNA (Certified Nursing Assistant) transferred R5 from the bed into a reclining geriatric chair that had a foam overlay. R5 was in the reclining geriatric chair at 11:43 am, 12:30 pm, 1:00 pm and 1:25 pm.

On 8/17/16 at 1:45 pm, Z3 NP (Nurse Practitioner) stated R5's wound "looks like a Kenney Ulcer to me due to the irregular shape and the fact it developed so quickly. It has doubled in size in the last couple weeks." Z3 stated, Z3 couldn't remember exactly when Z3 was notified of the "open crease" but that Z3 "implemented the standing orders for a Hydrocolloid at the time (Z3) was notified of the open area. If (R5) would have been on a special air mattress, repositioned more timely and given supplements sooner, maybe these wounds would not have deteriorated so quickly. I have only seen the wound twice and one of those times, there was no dressing on the wound." Z3 also stated that Z3 really didn't think about starting any supplements sooner, to help with wound healing, because R5 did not have a big weight loss.

On 8/17/16 at 2:00 pm, R5 was lying in bed, with a therapeutic alternating pressure air mattress. At this time, E13 CNA stated, "they just put this new mattress on (R5's) bed when (R5) was up for lunch. I laid (R5) down at 1:30 pm {2 hours and 15 minutes after being gotten up}."

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On 8/17/16 at 2:10 pm, E2 DON (Director of Nursing) stated, "when a new wound is found, I expect it to be assessed, the area measured if it is on a pressure point and the Physician to be notified. We have standing orders for skin care that should be followed. If the open area is over a bony prominence, then it would be at least a stage II. (R5) had been on a general pressure reducing mattress until today." E2 did not produce documentation on the "general pressure reducing mattress" to show if it was categorized for a stage II - unstageable pressure ulcer. E2 confirmed that R5 has been in a reclining geriatric chair for about a month and stated, "I don't remember if there was any type of pressure relieving cushion in it before we place the foam overlay {on 8/1/16}."

On 8/18/16 at 9:15 am, Z3 NP stated, "I called (R5's) pressure ulcer a Kennedy Ulcer based off of what I was told by the facility. I did not do my own investigation into what caused it. I had never even heard of a Kennedy Ulcer until a few months ago, I guess I need to do some research and educate myself as to what differentiates it from a regular pressure ulcer." Z3 confirmed that if the interventions that were discussed on 8/17/16 (air mattress/repositioning/nutritional supplements) were in place, "the wound might not have gotten to this point." Z3 also stated that Z2 Physician is not aware of the wound as Z2 has been on vacation for the last two weeks.

On 8/18/16 at 2:40 pm, Z2 Physician stated, "you are not going to heal an end of life ulcer but basic pressure relieving measures like repositioning and giving optimum nutrition would give a chance for a pressure ulcer to heal."

On 8/18/16 at 4:25 pm, Z2 stated, "I did look at

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(R5's) wounds and (R5) does have a big area affected, that is getting worse. All areas are definitely pressure related, the one on the coccyx is unstageable and the two smaller ones {on bilateral buttock} you can't see the wound bed but they do not appear to be too deep. I cannot say if they are Kennedy Ulcers or not without monitoring them for a while. It does not help that with (R5's) dementia and curling up {in fetal position}, it puts that area out there for pressure, that is why a alternating air mattress would be beneficial. It would relieve some pressure since (R5) isn't able to move by (R5's self)."

The facility Pressure Ulcer Policy dated 7/28/15 documents, "In addition to ongoing assessment of the skin, the facility will implement measures to protect the resident's skin integrity and to prevent skin breakdown...any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Typically the goal is one of promoting healing and preventing infection unless a resident's preferences and medical condition necessitate palliative care as the primary focus...Stages of Pressure Ulcers: Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough...Unable to Stage (UTS) - if a wound is covered with necrotic tissue or eschar and the wound bed can not be visualized, the stage of the wound may be documented as UTS...Ongoing Wound Assessment: 1) A system for weekly (or more frequently) wound assessment has been established..3) Comprehensive Wound Assessment should include at least the following parameters: a) location of wound which may provide information related to the etiology of the wound..b) length, width, and depth

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F 314	Continued From page 20 measurements recorded in centimeters c) direction and length of tunneling and undermining d) appearance of the wound base e) drainage amount and characteristics including color, consistency and odor." The facility undated Physician Standing Orders documents, "Stage II pressure ulcers: turn and position frequently, cushion in chairs, Cleanse area- apply Hydrocolloid and change every three days or PRN, monitor measurements weekly in ID/Skin Notes, Dietician consult upon discovery, notify MD and Dietician if no improvement in two weeks."	F 314		