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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)5) 300.1210d)6) 300.1220b)3) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having	S9999		

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S9999	Continued From page 2 pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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	S9999		

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S9999	Continued From page 3 by: A. Based on observation, interview and record review the facility failed to have a system in place to identify, treat, and monitor pressure ulcers. The facility failed to dress a wound, failed to reposition and off load pressure for R9's legs. The facility failed to have a plan to remove hard plastic boots to relieve pressure. The facility failed to obtain treatment orders to treat 2 Stage II wounds for R9's right lower legs which developed into 3 Stage III pressure wounds. The facility failed to check R9's skin daily and failed to perform weekly wound assessments This applies to 1 of 21 residents (R9) reviewed for Pressure Ulcers in a sample of 22. The findings include: 1. R9 ' s Facility Face Sheet shows diagnoses to include: Paraplegia, Bacteremia, Chronic Ulcer, and MRSA (Methicillin-resistant Staphylococcus aureus). R9 ' s Minimum Data Set (MDS) 0f 11/20/14 shows R9 is cognitively intact, and requires extensive staff assistance with repositioning (turning in bed) and bathing. The 11/20/14 MDS shows R9 has a history of stage III pressure ulcers. On 4/9/15 at 10:45 AM, R9 was laying in bed with hard plastic boots to both legs. The boots extended midway up the back of his leg with a layer of padded cloth attached to the boots. On 4/9/15 at 10:45 AM, E4 (Licensed Practical Nurse - LPN) rolled R9 onto his right side. R9 had large gauze dressing in place to his buttocks that had slid up, exposing a large open area to left coccyx. E4 removed R9 ' s dressing and R9 had 5 open, deep wounds to his buttocks. E9 removed the gauze to R9 ' s left lower extremity and a dry abd (gauze) that was stuck to his left	S9999		

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heel wound. R9 had a wound to his left heel and black discolored area to his left lower posterior leg. E4 then removed the gauze to R9 ' s right heel and R9 had a healing wound present.
On 4/9/15 at 11:30 AM, R9 was laying on his back in his bed. E3 raised R9 ' s leg off the bed; R9 had three irregular shaped open wounds with a concave shaped center to the right lower posterior leg. E3 said the wounds do not look like shear wounds " now " and she would classify them as stage II pressure ulcers. E3said this is the first she knew about the third wound to R9 ' s right lower leg. E3 said she did not notify the physician when she assessed the wounds on Monday. E3 said she could not see evidence that the physician had been notified yet, and a treatment order had not been obtained (as of 4/9/15 at 11:30 AM). E3 said R9 ' s physician should have been notified when the wounds were found so a treatment order could be initiated. E9 said she did not know if the wound care center was notified of the new wounds but the nurses should notify them with any changes and new areas.
On 4/10/15 at 9:45 AM, 11:15 AM, and 12:30 PM, R9 was asleep, laying flat on his back. R9 had hard plastic boots to his lower extremities, and his extremities were resting flat on the bed.
On 4/10/15 at 1:30 PM, E4 removed a gauze dressing from R9 ' s left lower extremity above his heel. E4 pointed to a black discolored, irregular shaped area to the right lower extremity and said it is the wound being treated by the wound care center. E4 said she did not know what the treatment order was for the wound.
On 4/7/15 at 2:05 PM, E5 (Registered Nurse- RN) said if the resident goes to the wound care clinic we do not do weekly measurements. E5 said they use the assessment from the wound care clinic and write it on the weekly wound tracking

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sheet. E5 said if the resident does not go to the wound care clinic they do a weekly wound measurement and assessment that goes on the back of the TAR (Treatment Administration Record).
On 4/8/15 at 9:30 AM, E4 said they use the wound care clinic assessment for the weekly wound assessment on the TAR. E4 said the wound care center stopped sending a description of the wound and complete wound assessment for the last month so they don ' t always have one to use.
On 4/9/15 at 11:30 AM, E3 (Administrator) said " he [R9] told me he had two new areas when I worked Monday night (4/7/15). E3 said she completed his dressing changes in the early morning of 4/7. E3 said E10 (LPN) told her she found the wounds on Sunday (4/5/15) but did not document an assessment. E3 said when she first saw the wounds to the back of R9 ' s legs they looked like two skin tears or " shearing " .
On 4/9/15 at 12:10PM, and 3:15 PM, Z2 (Medical Director) said a resident with a known or existing pressure ulcer should have a daily skin check completed. A resident who is at high risk for skin breakdown should be checked 2-3 times per week. The primary physician, wound care clinic or surgeon should be notified with any new pressure ulcers. Z2 said the facility should be doing weekly monitoring of wounds separate from the wound care clinic.
On 4/9/15 at 3:50 PM, R9 said that on the previous Wednesday (4/1/15) or Thursday night (4/2/15) he did not get treatments put on the wounds to his coccyx and heals. R9 said he got in an argument with the night nurse earlier in the shift. R9 said he took a shower around 2:00 AM, and E9 (Certified Nurse Assistant- CNA) helped him into bed after the shower. R9 said he did not have any dressings on his wounds and the CNA

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told the nurse he needed the dressings put back on after the shower. R9 said he was lying on his back and fell asleep for about 45 minutes, woke up, and put the call light back on. R9 said he fell asleep again and did not wake up for about 11/2 hours and then put the call light back on again. R9 said he asked " four times " for the new dressings to be put on after his shower. R9 said the nurse (E10 - Licensed Practical Nurse -LPN) told him " she wasn ' t going to do the dressing because of the way I talked to her and she would pass it on to the next shift " . R9 said he woke up around 9:30 AM, and still did not have a dressing on (71/2 hours later). R9 said " I was laying flat on my back " because I didn ' t have a dressing on my bottom and then on his right side. R9 said the dressing was not applied until 10:00 AM. R9 said he knows that ' s how he got the new breakdown to his right lower leg. He said he lay on his back for so long waiting for the new dressings to be applied after his shower. R9 said he told E3 (administrator) on Monday night (4/6/15) that the sores " were all the way up the back of my leg " . R9 said E9 (CNA) checked his skin when he had his shower on Wednesday night (4/1/15) and there was " not one wound " to the back of his right leg. R9 said the CNA noticed blood on his sheet on Friday night (4/3/15) and that is when the first open area was found to the back of his right leg. R9 said the wound to his heel does not bleed so he knew the blood on his sheet was from a new wound.
On 4/9/15 at 4:35 PM, E10 (Licensed Practical Nurse - LPN) said she works night shift and cared for R9 during the past week and part of the weekend (facility schedule shows E10 worked on 4/1/15 to 4/2/15). E10 said she had a busy shift and was unable to complete the treatment to R9 ' s wounds. E10 said R9 did take a shower and did put his call light on for the new dressing to be

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applied but she was unable to do it and passed it on to the day shift nurse.
On 4/10/15 at 8:45 AM, E3 (Administrator -RN) said there is no evidence the facility notified the wound care clinic of R9 ' s wounds to his right lower extremity. E3 said daily skin checks should be completed on a resident who is high risk for skin breakdown. and if a new skin concern is noted, it should be filled out on the new skin concern form. The Director of Nursing (DON) is notified, and the physician should be notified. E3 said a weekly measurement should be completed and a weekly assessment on the back of the Treatment Administration Record (TAR). E3 said all wounds should be assessed as individual wounds and have their own weekly assessment and treatment intervention. E3 said healing cannot be determined if the wounds are not assessed individually. E3 said the facility has not had a DON since March 2, 2015, and the policy is for all wounds (including pressure ulcers) to be reported to the DON. E3 said the DON is responsible for monitoring wounds and there is no nurse assigned to monitor the wounds in the absence of the DON.
On 4/10/15 at 8:55AM, Z1 (Wound Care Physician), and Z3 (Clinical Coordinator-RN Wound Care Clinic) said the facility should be doing weekly internal monitoring and assessments of all wounds, not relying on the wound care center documentation. Z1 and Z3 said pressure wounds to R9 ' s lower extremities could be prevented with proper offloading and pressure relieving interventions while he is in the bed and in the wheelchair. Z1 and Z3 said the facility should be notifying the wound care clinic with any changes and any declines. Z1 and Z3 said the Stage III pressure ulcer to R9 ' s posterior left lower extremity was not a recurring wound and was a new wound as of 3/13/15.

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On 4/10/15 at 9:50 am, E3 said R9 has an order for multipodus boots from the wound care center. E3 said the boots should be worn anytime he [R9] is up and they (staff) leave the boots on when he is in bed. On 4/10/15 at 11:00 AM, E3 said the staff put R9 ' s boots on and take them off. E3 said she did not know if the boots should come on and off when he is in bed. E3 said " I can tell you the only times I see them come off is with treatments and bathing " . E3 said there should be scheduled times to remove the boots and the facility " should have clarified the original order from the wound care clinic to determine when the braces should be on and when they should be removed " .

On 4/10/15 at 10:15 AM, E4 said when a new wound is identified the nurse should assess the wound to include measurements, description of wound, odor, etc. E4 said the assessment is documented in the nurse notes and on the " new wound " form. E4 said the physician should be notified and treatment orders obtained.

On 4/10/15 at 10:15 AM, E4 (LPN) said the "We don ' t normally send paperwork with the resident to the wound care clinic." E4 stated, "We were going off the wound care paperwork for our assessments." E4 said she did not notify the wound care clinic of the new wounds to R9 ' s right posterior leg.

On 4/10/15 at 11:00 AM, E3 said R9 repositions himself but does need help getting his legs repositioned. E3 said the staff should be encouraging him to reposition but alert and oriented residents do no usually need reminders. E3 said she is not aware that R9 is on a turning schedule. E3 said " we put residents on turning schedules when they are not able to turn themselves and require us to it for them " (R9 ' s diagnosis included Paraplegia).

On 4/10/15 at 2:10 PM, E2 (Nurse Consultant)

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said " from 3/13/15 until now they [facility nurses] have been dressing it [wound to R9 ' s left lower leg] with an ABD [abdominal pad] and kerlix [gauze wrap] " . E2 said they were not sure what treatment was ordered for the left lower extremity and they would call the wound care clinic and clarify the treatment. E2 said " from what I understand that is what he came back from the wound care clinic with " and they just continued it. E2 said the nurses should clarify the treatment ordered when a new wound is treated.

On 4/10/15 at 2:10 PM, E12 (CNA) said R9 wears boot all the time even when he is in bed. E12 said " he [R9] will put pillows under his feet " and " we [CNAs] do not do any offloading of pressure " for R9.

On 4/10/15 at 3:00 PM, E11 (CNA) said R9 is not on a repositioning schedule. E11 said R9 " says he turns himself " . E11 said they do not go in every 2 hours to prompt him to turn and reposition during the night. E11 also stated, she cared for R9 on Thursday (the night he did not get his new dressings put on). E11 said R9 went to bed around 2:30 AM, and she let the nurse know that he was ready for his wound treatments. E11 said R9 was holding down the light and calling constantly for the nurse to do his treatment. E11 said R9 was lying on his back in his room and asked repeatedly for the nurse to do his treatment. E11 said the dressing was not done to R9 ' s wounds and was passed onto the day shift to complete.

R9 ' s Pressure Ulcer Care Plan shows an intervention dated 9/3/14 of " pressure reduction boots when up in wheelchair, float heels when in bed " . The pressure ulcer care plan shows " Assess for cause of pressure ulcer. Observe for pressure cause, friction, and contributing factors " dated 9/3/14. The care plan also shows on 9/3/14 " Assist resident to turn and reposition

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every 2 hours and prn [as needed] or per reposition schedule -see plan of care.
The wound care clinic 1/8/15 documentation shows an order " needs heel lift boot please " .
The wound care clinic documentation dated 3/13/15 shows R9 had a Stage III Pressure Ulcer to the Left Lower Extremity with the date acquired as 3/13/15. This assessment shows the wound is not recurrent and measured 2.0x0.5x0.2cm.
R9's TAR, Nurses' Notes and Weekly wound tracking documents has no record of a facility assessment of the wound to R9 ' s left lower extremity before or after it was identified at the wound care clinic.
The TAR for R9 dated March 2015 shows a treatment order to " cleanse buttocks coccyx with Dakins 0.5% then apply xeroform gauze/ABD to all open areas, and right and left heels - change every day and as needed " The March TAR shows the treatment was not completed on March 3, 4, 8, 10, 11, 12, 21, 22, 26,30 and 31, 2015 (11 out of 31 days). R9 ' s 3/1/15 TAR does not have any interventions for daily skin checks and does not have a treatment intervention for the Stage III pressure ulcer to R9 ' s left lower extremity identified on 3/13/15. The April TAR did not have an intervention for wound treatment to R9 ' s new wounds to the right lower extremity as of 4/8/15.
On 4/7/15, R9 ' s weekly wound assessment shows two wounds to " right leg lower- shearing wound 5cm x 3cm and right leg above the other wound- shearing wound - 3.3cm x 1.7 cm " . R9 ' s weekly wound assessment dated 4/13/15 (6 days later) shows the two shear wounds had declined to three stage III pressure ulcers to his posterior right lower extremity. The 4/13/ 15 assessment shows a right lower extremity pressure ulcer measuring 3.0cm x 2.0cm, a stage III pressure ulcer to the right middle extremity

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measuring 2.6cm x 2 cm, and a stage III to the right lower extremity measuring 2.8cm x 2 cm. No treatment was ordered for the two shear wounds identified on 4/7/15. The physician was notified of the wounds on 4/9/15, after the third pressure ulcer was identified.
Upon request, the facility was unable to provide an assessment of any of R9 ' s gluteus, coccyx, or heel wounds for the month of March. The only facility assessment completed in February was on 2/9/15 which included an assessment of the left heel, gluteus, and coccyx. The facility had no assessment of the new wound to R9 ' s left lower extremity that was identified at the wound care clinic. As of April 9, 2014, no facility assessment of the wounds to R9 ' s buttocks or heels were available.
The facility policy for Decubitus Care/Pressure Areas revised on 5/2007 states: Newly Acquired Skin Conditions ... will be assessed and documented on the Treatment Administration Record ... Document size, stage, site depth, drainage, color, odor and treatment ....Notify the physician for treatment orders
...Documentation of the pressure area must occur upon identification and at least once each week on the treatment record. The assessment must include: Characteristics (size, shape , depth, color, presence of granulation tissue, necrotic tissue), and treatments and the response to treatment ....Re-evaluate the treatment for response at least every 2 - 4 weeks, If no improvement, contact the physician for a new treatment order ....Initiate problem on care plan.
The (undated) facility policy for Preventative Skin Care states, " Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every 2 hours. Special mattresses and or chair cushions will be used on any resident identified as being at

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S9999	Continued From page 12 high risk for potential skin breakdown. " (B) B. Based on observation, interview and record review the facility failed to ensure residents with new pressure ulcers were identified and assessed. The facility failed to notify the physician, obtain wound treatment orders and failed to monitor and evaluate wound healing. The facility failed to ensure residents at risk for skin breakdown were assessed, failed to identify contributing risk factors, and failed to implement specific pressure relieving interventions. This applies to 6 of 21 residents (R1, R3, R4, R17, R18, R20) reviewed for pressure in the sample of 22. The findings include: 1. On 4/7/15 at 2:30 PM, R17 was transferred with assistance from E6 (Certified Nursing Assistant- CNA) into his bed for incontinence care. R17 was involuntary of stool and urine. R17 stated, " I had to go to the bathroom when I came back from lunch, but they didn ' t get to me in time " . E6 stated R17 does use the bathroom at times. " He usually lets me know " . E6 removed the soiled brief. R17 had an occlusive dressing with a wound vacuum on his right upper gluteus area, and 2 open wounds over the right and left ischial areas and 1 open wound on the scrotum. The underside of the occlusive dressing over the gluteal area was soiled with stool. E7 (Registered Nurse - RN) replaced the wound vacuum dressing. A large deep wound (approximately 4 inch x 3.5 inch with 1 inch depth) had necrotic (grey colored) tissue in the proximal side of the wound. The open areas on	S9999		

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the ischium on the right and left buttocks were approximately 2.5 x 3 inches on each side with a 1 inch deep red border. The new wounds were tender to touch during incontinence care. The opening on the scrotum was 1 - 1.5 cm in diameter. E7 stated she had not seen the new wounds before because she has been working on the other wing.

R17 ' s wheelchair cushion was 1 ½ inches of soft foam and had a black covering. The center of the cushion was thinner than the edges. R17 stated, " I spend the day in my chair. I get up at 5:30 AM and go to bed around 8:30 PM. " R17 stated he does not have a routine of lying down during the day.

On 4/7/15 at 1:30 PM, E4 (Licensed Practical Nurse - LPN) stated she noticed R17 ' s bottom was a deep red color on 4/3/15 but the skin was not open. " It was just red, I thought it was from sitting and where his briefs sit. " E4 stated she did not assess the skin condition or change any interventions to relieve pressure from sitting for R17. E4 stated she changed the wound vacuum dressing this morning.

The treatment record for R17 for the month of April 2015 shows on 4/6/15, 2 new open areas on the buttocks were identified. Measurements for the Right side were 3.5 cm x 4.3 cm x < 0.1 cm, and the Left side measurements were 4.8 cm x 3.6 cm x < 0.1 cm. Scrotal redness was noted, no was opening recorded.

The nurses ' notes on 4/6/15 at 12 PM stated the CNA reported open areas on the buttocks. The physician and wound clinic were not notified of the new openings on the buttocks. The nurses ' notes and treatment record notes on 4/7/15 and 4/8/15 did not have any assessment of the new open area on R17 ' s scrotum. The physician and wound clinic were not notified of the 3rd new pressure ulcer. No initial assessment of the

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scrotal wound was documented.
The Physician Order sheet (POS) for R17 dated April 2015 does not show a treatment order for the new scrotal wound. R17 ' s diagnosis list includes Sacral Decubitus Ulcer, and Post Cerebral Vascular Accident. MDS (Minimum Data Set) of 1/15/2015 shows R17 has a BIMS (Brief Interview for Mental Status) score of 15 (Cognitively intact). The MDS shows R17 is non-ambulatory, self propels in a wheelchair and requires assistance with toileting and bathing. The MDS shows R17 is at risk for pressure ulcers and had 1 unhealed ulcer, Stage III, measuring 1.7 cm x 0.8 cm x 0.2 cm. The wound clinic notes dated 3/27/15 shows R17 has a Stage IV pressure ulcer of the right gluteus measuring 9.9 cm x 10.5 cm x 5 cm. The wound contains 67 - 100 % necrotic tissue and the tendon and muscle are involved. The care plan for R17 shows the goals for pressure ulcer care were last evaluated on 1/22/15.
On 4/9/15 at 10:15 AM, E3 (Administrator) stated pressure relieving cushions should be 3 - 5 inches thick. E3 stated they have an ample supply of thick cushions. E3 stated the thin cushions should be disposed of.
The facility policy for Decubitus Care/Pressure Areas revised on 5/2007 states: Newly Acquired Skin Conditions ... will be assessed and documented on the Treatment Administration Record ... Document size, stage, site depth, drainage, color, odor and treatment ....Notify the physician for treatment orders ...Documentation of the pressure area must occur upon identification and at least once each week on the treatment record. The assessment must include: Characteristics (size, shape , depth, color, presence of granulation tissue, necrotic tissue), and treatments and the response to treatment ....Re-evaluate the treatment for

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response at least every 2 - 4 weeks, If no improvement, contact the physician for a new treatment order ....Initiate problem on care plan.
The (undated) facility policy for Preventative Skin Care states, " Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every 2 hours. Special mattresses and or chair cushions will be used on any resident identified as being at high risk for potential skin breakdown. "
2. R20 ' s facility face sheet shows diagnoses to include: Multiple Sclerosis and urinary incontinence.
The MDS of 11/20/14 shows R20 is non-ambulatory and requires extensive assistance from staff with transfers, repositioning in bed, dressing, eating, hygiene, and bathing.
a) R20 ' s wound care clinic documentation dated 12/19/14 shows a " healed pressure injury to coccyx " .
On 4/7/15 at 1:50 PM, E12 (CNA) helped position R20 on her left side. R20 had a large open wound to her left buttocks. E12 put her hand on R20 ' s buttock and pulled her buttock open. R20 had an open slit from the top of her coccyx down to her rectum. E12 said the open area to R20 ' s coccyx is new but the nurse knows. R20 had a guaze dressing to the left side of her buttock. E12 removed the dressing and R20 had an irregular shaped open area to the left side of the buttock.
b) On 4/8/15 at 10:45 AM, E4 (LPN) looked at the open area to R20 ' s coccyx and said she was not aware R20 had an open area to her coccyx. E4 said if a CNA is aware a resident has an open area, the CNA should report it immediately to the nurse. E4 looked at R20 ' s TAR (Treatment Administration Record) and did not find an assessment of the open area to R20 ' s coccyx (that was witnessed one day prior by E12). E4 said it should have had an assessment

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completed. E4 said R20 had a history of this wound to her coccyx and it was last healed on 12/19/14 according to the wound care clinic documentation.
On 4/8/15 at 11:25 AM, E5 (Registered Nurse - RN) stated, " I did her treatment yesterday and it was not reported to me that her coccyx was open " . E5 said, " I told them they need to pull from under her when repositioning " and they should not pull her from the top because they tend " to split her " . E5 said when a wound is found it should have an assessment, treatment, and documentation of the wound on the TAR. E5 said she did not know that R20 ' s coccyx reopened.
On 4/9/15 at 8:55AM, E12 said she was told that R20 had the wound to her coccyx and it was from " people pulling on her butt when they turn her over " . E12 said she told E5 when she left the room (on 4/7/15) and E5 told her she was going to put cream on it. E12 said the nurse told her to not pull on R20 ' s bottom when she repositions her.
The pressure ulcer care plan dated 12/26/13 shows E20 did not have any interventions in place to prevent her coccyx from reopening. E12 was aware of R20 ' s coccyx wound on 4/7/15 and an assessment was not completed until 4/8/15. The 4/8/15 nurse note assessment shows " this nurse was informed of an open area on coccyx ...area measure 8.0cmx0.7cmx0.2cm ... "
On 4/8/15 at 10:00 AM, R20 was lying in bed with socks on. R20 did not have heel protectors on. E6 and E13 (CNAs) said the heel protectors " are supposed to be on when she is in bed " .
The March 2015 TAR for R20 shows " Moon boots/heel protectors on while in bed at all times " dated 6/11/13.
On 4/8/15 at 10:45 AM, E4 took the sock off of R20 ' s right foot. R20 had a scab on the bottom

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of her right foot.
c) R20 ' s nurse note dated 3/28/15 shows " upon assessment blister noted to bottom of right foot-slightly open measuring 1.9x0.3x0cm " . R20 ' s TAR assessment dated 3/28/15 shows a stage II pressure ulcer and " blister to bottom of right foot ... " As of 4/9/15, no weekly assessments were done of the stage II pressure ulcer to R20 ' s right foot.
As of 4/9/15, the care plan did not show any new interventions to prevent further blisters from developing on R20 ' s feet. R20 is non-ambulatory and does not wear shoes. There was no assessment to identify the cause of the blister to R20 ' s foot.
On 4/9/15 at 10:30 AM, E3 said she was not sure what caused the blister to R20 ' s foot and there is no assessment of how the blister occurred. E3 said an investigation should be done with any new wound to determine what caused it and interventions should be implemented to prevent it from happening again. E3 said the pressure ulcer care plan should identify specific pressure ulcers with interventions to prevent recurrence. E3 said the blister was probably caused from " rubbing or friction " . E3 said R20 should also have interventions to prevent the area on her coccyx from re-opening. E3 said there were no interventions identified on R20 ' s care plan to prevent her coccyx from re-opening. E3 said R20 had a skin check on the evening shift of 4/7/15. E3 said the open area to R20 ' s coccyx should have been found during the daily skin check completed on 4/7/15.
The March 2015 TAR for R20 shows an order for " skin check daily 2-10pm " . The TAR shows skin checks were not completed on March 4, 9, 10, 11, 12, 14, 18, 2015.
b. R20 ' s Wound Clinic documentation shows dated 3/27/15 shows a stage III pressure ulcer to

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R20s left upper leg-posterior measuring 2.2cm x1cm x 0.1cm. The first complete weekly facility assessment in March for R20 ' s left upper leg-posterior wound was not documented until 3/23/15 (3 weekly assessments missing).
On 4/8/15 at 10:00 AM, E2 (Corporate Staff) said the nurses do not have to reassess a wound weekly if the resident went to to the wound care clinic. E2 said the weekly wound sheet is used for a skin condition that is being monitored. E2 said the nurses should be measuring and monitoring weekly. E2 said the nurses should be tracking wounds on the wound tracking sheet even if seen by a physician. E2 said new wounds should be assessed and measured and the doctor should be notified when they are identified. E2 said there should be interventions in place to prevent worsening of wounds or new areas from forming.
3. The Minimum Data Set of 11/14/14 shows R18 has a BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact).
On 4/7/15 at 10:30 AM, R18 was in a wheelchair in her room returning from the bathroom. R18 stated, " I have a wound between the cheeks of my buttocks. " R18 stated she has been going to the wound clinic for several months to treat a large decubitus ulcer which is healing and now has a new problem. A slit shaped opening was observed in the natal cleft of R18 ' s buttocks. R18 ' s wheelchair had a 1 inch thick foam cushion in the seat of the chair. R18 commented, " It ' s not too comfortable. The wound clinic told me I was supposed to get a new cushion but I haven ' t got it yet " . Upon leaving the room with E4 (LPN), she stated she was not aware of the order to get a new cushion.
The wound clinic visit records for R18 dated 3/13/15 state R18 developed 2 new onset Stage II pressure ulcers on the Midline,inferior coccyx,

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and the Midline superior coccyx. The measurements were 3.0 x 0.1 x 0.1 and 1.0 x 0.1 x 0.1 respectively. The wound clinic note showed R18 has a Stage III pressure ulcer of the coccyx acquired on 5/1/14.
The wound clinic order sheet dated 1/30/15 for R18 under Interventions shows " Needs cushion " . The care plan for R18 reviewed on 1/29/15 states to off load pressure to areas of concern, sacral area.
The facility treatment record dated 3/18/15 states, " Open area " . No additional assessment including the location, size, wound description, or measurements of the open area was documented.
On 4/7/15 at 2:05 PM, E4 stated, " Wound measurements are done by the wound clinic. We check the skin for any new areas or changes. "
4. On 4/8/15 at 11:35 AM, R3 was sitting in a large wheelchair. R3 was in a slouched position in the chair. E7 and E8 (CNAs) transferred R3 from the wheelchair to her bed to change her incontinence brief. The skin over R3 ' s buttocks was bright red and peeling. E7 stated the buttocks have been red for some time.
R3 ' s wheelchair had a thin 1 inch thick foam cushion with a black cover. R3 stated her bottom is sore and described the cushion as " not much " and stated " I don ' t know why it doesn ' t heal up. "
The care plan for R3 dated 1/28/13 states R3 requires assistance for bed mobility, and she has a diagnosis of Multiple Sclerosis. The care plan states R3 is non - ambulatory with left hand contractures. The care plan interventions dated 5/1/14 show to continue use of barrier cream to R3 ' s buttocks as needed. Use of a chair cushion was initiated on 12/12/14.
The Minimum Data Set of 2/6/15 shows R3 has 1 unhealed pressure ulcer, Stage III measures 1.7

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x 2.2 x 0.1 cm. The BIMS score for R3 was 11 (moderate cognitive impairment).
5. On 4/7/15 at 12:15 PM, R1 was lying in bed, turned onto her right side. She had a scoop shape mattress with an air flow mattress topper. A large foam wedge was used to position R1 on her side. R1 ' s hands were in a closed hand position. A wound dressing was intact over the coccyx area. E4 (LPN) stated, " We check the wound (coccyx) every day. The wounds are measured and a narrative is done weekly. " The nurse will evaluate the wound and contact the physician for changes in the orders if needed. "
The MDS (minimum data set) of 3/19/15 shows R1 was assessed to have a significant change. R1 is totally dependent on staff for bed mobility, transfer, dressing, personal hygiene and bathing. The assessment shows R1 has 1 Stage IV unhealed pressure ulcer. R1 ' s risk for skin breakdown assessment on 3/15/15 shows she is at high risk.
The facility skin report shows on 4/9/15, R1 has a blister on the first digit measuring 2.0 x 1.5 cm, and a second blister on the thumb 3.0 x 1.5 cm.
On 4/10/15 at 2:05 PM, E3 (Admin - RN) stated the blisters on R1 ' s fingers are caused by a positioning problem. A hand support will be used.
6. R4 ' s Facility face sheet shows diagnoses to include: Neurogenic Bladder, Paraplegia, Pressure Ulcer Stage III, and Open wound of the buttock.
R4 ' s MDS shows R4 requires extensive staff assistance with transfers, dressing, hygiene, and repositioning.
On 4/7/15 at 12:55PM, E12 (CNA) positioned R4 on her left side. R4 had dressing to her left ischium. E12 removed the gauze and R4 had an open with a red wound bed.
R4 ' s first facility weekly wound assessment in

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March was not until 3/16/15. Upon request the facility did not provide evidence of any completed wound assessments in February, 2015.
7. The facility roster matrix dated 4/7/15 showed 8 residents with pressure. Review of the facility skin check audit completed on 4/10/15 show 13 additional residents (R21, R22, R23, R24, R25, R26, R27, R28, R29, R30. R31, R32, R33) have skin concerns.

R16's skin audit dated 4/9/15 shows stage II pressure ulcer to right inner buttock measuring 3.0x 1.0cm.
A stage II pressure ulcer to the left inner buttock measuring 3.3cm x 2.3cm.
A stage II pressure ucler to coccyx measuring 5cm x 1.0cm.

R24 's skin audit dated 4/9/15 shows a stage I pressure ulcer to the right heel measuring 2cmx 2cm and a stage II pressure ulcer to the natal cleft measuring 2cmx 0.2cm.

R23's skin audit dated 4/9/15 shows a stage II to the right elbow measuring 0.7cm x 0.5cm and a stage II pressure ulcer to the right great toe measuring 0.3cm x 0.3cm.

R25's skin audit dated 4/9/15 shows "5th digit has sore 0.65 x 0.2 cm.

R27's skin audit dated 4/9/15 shows a stage II pressure ulcer to the coccyx measuring 1.5cm x 1.0cm.

R29's skin audit dated 4/9/15 shows a stage II pressure ulcer to the left little toe measuring 1.5x 1.0cm.

R31's skin audit dated 4/13/15 shows a stage II to

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S9999	Continued From page 22 the coccyx measuring 1.8cm x 1cm x 0.1cm. The same audit shows a stage II pressure ulcer to the left buttocks measuring 1.9cm x 1.6cm x 0.1. R33's skin audit dated 4/9/15 shows stage II blister to the left anterior foot measuring 1.5cm x 1.2cm. R3's skin audit dated 4/9/15 showss a stage II pressure ulcer on the left buttock measuring 0.5cm x 0.7cm. (B)	S9999		