DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING ______ B. WING ______	C 03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(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 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. This REQUIREMENT is not met as evidenced by: Based on record review, staff, family and physician interviews, the facility failed to notify the physician of the development of an unstageable	F 157	The physician of resident #1 was notified by Director of Nursing on March 7, 2014 by telephone of wound and new order	3/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE 03/27/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 pressure ulcer for 1 (Resident #1) of 3 residents reviewed for pressure ulcers. The findings included: Resident #1 was readmitted to the facility on 9/30/13 with medical diagnoses which included traumatic fracture of left hip, dementia, muscle weakness and deep vein thrombosis. The most recent Minimum Data Set (MDS) assessment dated 10/7/13 indicated the resident was severely cognitively impaired. The assessment further indicated the resident required extensive assistance with bed mobility with one person assist. The MDS assessment further indicated the resident was at risk for developing pressure ulcers. The assessment indicated there were no unhealed pressure ulcers at the time of the assessment. The Care Area Assessment (CAA) indicated the problem area was pressure ulcer. The extrinsic risk factor was the resident required staff to move sufficiently to relieve pressure over any one site. The intrinsic risk factors included immobility, altered mental status such as cognitive loss, and incontinence. The CAA further indicated the resident's skin integrity should be monitored and the Medical Doctor (MD) kept aware. The care plan for Resident #1 dated 10/8/13 revealed the resident was at risk for skin breakdown related to incontinence and immobility. The goal stated for the problem was the resident skin would remain intact daily through next review with interventions which included: observe skin daily and report all changes to the nurse promptly, weekly skin assessments by a nurse, monitor labs and report	F 157	received to draw an albumin level. All residents have the potential to be affected by the same alleged deficient practice. An audit was completed March 7,2014 by Director of Nursing to ensure each resident receiving wound treatment has a corresponding M.D. order even if following standing order for wound protocol. No other resident identified to be affected. All license nursing staff reeducated by SDC on informing resident's M.D. of change of condition and or treatment related to wounds. As well as the expectation of accurate documentation on weekly skin checks. Reeducated on appropriate monitoring and treatments of unstageable ulcer. Wounds changes and or treatment are discussed in daily Monday thru Friday and reviewed by weekend supervisor. MD will be notified by telephone and by fax regarding in change of condition and or treatment related to wounds. Fax confirmation will be maintained to verify confirmation was received by MD office. Daily audit to be completed by Director of Nursing and or weekend supervisor weekly times 4, then weekly x4 then monthly times 3. Audits to be completed weekly on skin checks to ensure timely completion to be done by wound care nurse Monday thru Friday. Any identified concern will be addressed immediately and MD notified as indicated.	

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F 157	Continued From page 2 all abnormal findings to MD promptly. A review of the monthly January 2014 physician orders revealed an order for weekly skin check and an order for skin prep to bilateral heels daily. Review of the January 2014 Treatment record revealed the weekly skin checks were initialed for the following dates: 1/15, 1/22 and 1/29/2014. The instructions on the treatment record revealed "weekly skin check nurse initials signify skin is intact without redness exceptions noted on separate form" Review of the facility's "Weekly Skin Check Resident Record Sheet " for January 2014 revealed an entry dated 1/15, 1/21 and 1/29/2014 with an indication of no new areas noted. Review of the February 2014 treatment record revealed the weekly skin check was initialed for 2/19/14. The February 2014 "Weekly Skin Check Resident Record Sheet" revealed an entry on 2/5, 2/12, and 2/19/14 with indications for no new areas noted. Review of the facility's "Treatment Recommendations" undated did not reveal a protocol for unstageable ulcers. There was a treatment recommendation protocol noted to apply skin prep to blister daily for 7 days. Review of a telephone physician order dated 2/21/14 untimed revealed "Discontinue skin prep to bilateral heels- clean unstageable left heel with wound cleanser, apply silvermed and cover, change daily- stress tab with zinc by mouth daily to promote wound healing." Medical record review of the facility's "Treatment/Wound Care Progress Notes" dated 2/21/14 revealed "unstageable left heel, 100% necrotic tissue, necrotic edges are loosely	F 157	The finding from audits will be reported to QAPI monthly with revisions as necessary until otherwise determined by QAPI committee times 4 months.	

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F 157	Continued From page 3 separating, drainage noted. Will use silvermed and cover. Added Zinc stresstab to help promote wound healing; also uses profo boot to uplift pressure" noted by Treatment Nurse #1. An interview with Treatment Nurse #1 on 3/4/14 revealed the resident was placed on weekly pressure ulcer log during the week of February 24, 2014. The treatment nurse was unable to provide the specific date. The most recent documentation dated for the week of February 24, 2014 by Treatment Nurse #2 revealed the measurement of the left ankle wound was 2cm x 2 cm, no drainage, wound bed 75% red and 25% black with normal wound edges. The documentation further revealed the unstageable ulcer was acquired in house. Review of the facility's "Report of resident grievance/compliments" undated and untimed revealed a written statement by a family member that indicated "I noticed an awful smell and drainage on a pillow under her left foot. There was a heel protector in place and a sock adhered to her foot with dried drainage. Beneath is an unstageable soon to be III-IV wound that smelled horrible. There was no pressure areas on Resident #1 when she was admitted here and the person who signs her papers should have been notified of this." Review of the "Physical Therapy Plan of Care" dated 2/25/14 revealed "Patient presents with unstageable ulcer on left heel measuring 1.8 X 2.0 X 0.8cm with 100% eschar and foul odor." In an interview on 3/4/14 at 12:38 pm, Treatment Nurse #1 stated she was informed by NA #2 on February 21, 2014 of Resident #1 having a sock stuck to her left foot that was bleeding. She	F 157		

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F 157	Continued From page 4 stated her assessment revealed the area was necrotic with eschar separating from the wound bed with drainage and foul odor. The nurse indicated she initiated a treatment of Silvermed for the wound. She further indicated she did not speak with the attending physician. The nurse stated she faxed a copy of the order for treatment to the attending physician's office. Treatment Nurse #1 was unable to provide a copy of the faxed documentation of notification to the physician or confirmation page. During an interview on 3/4/14 at 1:14 pm, the Physical Therapist (PT) stated she started the wound debridement of the left heel on 2/25/14. She further stated after evaluating the resident's wound, she wrote the order for the evaluation and treatment and informed the nurse which was standard protocol. In a phone interview on 3/5/14 at 11:10 am, the attending physician stated he expected the nurses to notify the physicians anytime a resident developed skin breakdown. He further stated the nurses should notify the physician even if they initiate the wound care protocol. After discussing Resident #1's wound with the physician, he stated he was not aware of the wound. The attending physician further stated he would be coming to the facility to refer to the medical record and discuss but he did not come or call back by the time of exit. During an interview on 3/5/14 at 6:25 pm, the Director of Nursing (DON) stated she expected the treatment nurse to monitor all wounds weekly and document the findings. She further stated she expected the treatment nurse to notify the physician of any changes in the wounds as	F 157		

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F 157	Continued From page 5 indicated. The DON stated she expect the nurse that initially identify a wound to assess the area, notify the responsible party and the physician, and document in the medical record. She stated the nurses normally notify the physician via fax on a change of condition form. The DON was unable to provide a copy of the notification to the physician for resident #1.	F 157		
F 314 SS=D	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 record review, observation and staff interviews, the facility failed to accurately assess and implement effective interventions for an unstageable pressure ulcer for 1 of 3 residents (Resident #1) reviewed for pressure ulcers. Resident #1 was readmitted to the facility on 9/30/13 with medical diagnoses which included traumatic fracture of left hip, dementia, muscle weakness and deep vein thrombosis. The most recent Minimum Data Set (MDS) assessment dated 10/7/13 indicated the resident was severely cognitively impaired. The	F 314	Resident #1 wound was assessed and measured on March 4, 2014 by wound care nurse. Measurements were 1.5 x1.5 cm to an unstageable ulcer to left heel. MD was notified on March 7, 2014 to continue to cleanse left heel ulcer with wound cleanser, pack with idioform and cover change everyday. Resident does sometime refuse soft boot and to be turned and reposition. Refusal of care and treatment has been care planned. All residents have the potential to be affected by the same alleged deficient	3/26/14

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F 314	Continued From page 6 assessment further indicated the resident required extensive assistance with bed mobility with one person assist. The MDS assessment further indicated the resident was at risk for developing pressure ulcers. The assessment indicated there were no unhealed pressure ulcers at the time of the assessment. The Care Area Assessment (CAA) dated 10/7/13 indicated the problem area was pressure ulcer. The extrinsic risk factor was the resident required staff to move sufficiently to relieve pressure over any one site. The intrinsic risk factors included immobility, altered mental status such as cognitive loss, and incontinence. The CAA further indicated the resident ' s skin integrity should be monitored and the Medical Doctor (MD) kept aware. The care plan for Resident #1 dated 10/8/13 revealed the resident was at risk for skin breakdown related to incontinence and immobility. The goal stated for the problem was the resident skin would remain intact daily through next review with interventions which included: observe skin daily and report all changes to the nurse promptly, weekly skin assessments by a nurse, monitor labs and report all abnormal findings to MD promptly. A review of the medical record revealed a telephone physician order dated 11/25/13 for a soft boot to the left heel while in bed. Review of the monthly January 2014 physician orders revealed an order for weekly skin check and an order for skin prep to bilateral heels daily. Review of the January 2014 Treatment record revealed the weekly skin checks were initialed for the following dates: 1/15, 1/22 and 1/29/2014. The instructions on the treatment record revealed	F 314	practice. 100% skin check on all current skilled residents was completed on March 6, 2014 by Director of Nursing and wound care nurse. No other residents were identified to have unstageable ulcers. Skin risk reviews will be completed for all residents on admission with current interventions reviewed and new orders obtained for additional appropriate interventions added as necessary. Residents to have skin risk assessments completed timely as per protocol. Residents to have weekly body checks weekly by licensed nurse. C.N.A.s to evaluate each resident's skin when bathed and document their findings on body check form. The licensed nurse will review, co-sign body check forms, and notify MD of skin changes for new orders. Resident skin isses to be addressed in weekly review meetings with new orders obtained for treatment as necessary. Administrative Nurses to review weekly checks and follow up with any new skin integrity concerns with MD for treatment. Admnistrative nurses to review new orders daily for any new treatment orders and check for correct implementation of order. All licensed nurses were inserviced by Staff Development Coordinator on 3/12/14 on the following: 1. Admission Body Checks 2. Weekly Skin Checks 3. Braden Scale protocol 4. C.N.A. Body Check sheets 5. Wound Care Formulary for appropriate treatment 6. Notification of MD of new orders and	

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F 314	Continued From page 7 "weekly skin check nurse initials signify skin is intact without redness exceptions noted on separate form" Review of the facility's "Weekly Skin Check Resident Record Sheet" for January 2014 revealed an entry dated 1/15, 1/21 and 1/29/2014 with an indication of no new areas noted. Review of the February 2014 treatment record revealed the weekly skin check was initialed for 2/19/14. The February 2014 "Weekly Skin Check Resident Record Sheet" revealed an entry on 2/5, 2/12, and 2/19/14 with indications for no new areas noted. Review of the facility 's "Treatment Recommendations" undated did not reveal a protocol for unstageable ulcers. There was a treatment recommendation protocol noted to apply skin prep to blister daily for 7 days. Review of a telephone physician order dated 2/21/14 untimed revealed "Discontinue skin prep to bilateral heels- clean unstageable left heel with wound cleanser, apply silvermed and cover, change daily- stress tab with zinc by mouth daily to promote wound healing." Medical record review of the facility's "Treatment/Wound Care Progress Notes" dated 2/21/14 revealed "unstageable left heel, 100% necrotic tissue, necrotic edges are loosely separating, drainage noted. Will use silvermed and cover. Added Zinc stresstab to help promote wound healing; also uses proof boot to uplift pressure" noted by Treatment Nurse #1. An interview with Treatment Nurse #1 on 3/4/14 at 12:38 pm revealed the resident was placed on weekly pressure ulcer log during the week of February 24, 2014. The treatment nurse was	F 314	change of condition of wound 7. Appropriate documentation on TAR of treatment administered. Staff Development and Weekend Supervisor to observe resident care practices on daily compliance rounds(incontinence care, nutrition, hydration, turning and repositioning) with concerns followed up by Nursing Administration. Administrative Nurses to check daily for new admissions to ensure that admission body checks are completed timely. Observations and audits to be reviewed by Director of Nursing with findings reported to the QAPI Committee monthly x 3 with revisions as necessary until otherwise determined by QAPI Committee. Findings of audits and observations will be reported to QAPI monthly times 4 with revisions as necessary until otherwise determined by QAPI Committee.	

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F 314	Continued From page 8 unable to provide the specific date. The most recent documentation dated for the week of February 24, 2014 by Treatment Nurse #2 revealed the measurement of the left ankle wound was 2 centimeters (cm) x 2 (cm) with no drainage, wound bed 75% red and 25% black with normal wound edges. The documentation further revealed the unstageable ulcer was acquired in house. Review of the "Physical Therapy Plan of Care" dated 2/25/14 revealed "Patient presents with unstageable ulcer on left heel measuring 1.8 (cm) X 2.0 (cm) X 0.8 (cm) with 100% eschar and foul odor." Review of a telephone physician's order dated 2/25/14 indicated "Physical Therapy (PT) evaluation and treat for wound care" noted by Nurse #2. A second telephone physician order dated 2/25/14 indicated "PT clarification: Patient to receive skilled physical therapy 5 times a week for 12 weeks for selective debridement, electrical stimulation, therapeutic activities, Treatment diagnosis pressure ulcer heel" noted by Nurse #2. Review of the "Physical Therapy Daily Treatment Note" dated 2/27/14 revealed "Consulted with treatment nurse in reference to packing wound due to undermining present and wound contraction noted already. Recommend packing to prevent closing wound with cavity." An observation of wound care for Resident #1 by PT on 3/5/14 at 1:30 pm revealed a half dollar sized open area to the center of the left heel. There was a minimal amount of yellow slough noted. Debridement was performed by the physical therapist. The area was cleansed with	F 314		

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F 314	Continued From page 9 wound cleanser, packed with iodoform gauze and covered with a non adherent dressing and tape. In an interview on 3/4/14 at 12:38 pm, Treatment Nurse #1 stated she was informed by NA #2 on February 21, 2014 of Resident #1 having a sock stuck to her left foot that was bleeding. She stated her assessment revealed the area was necrotic with eschar separating from the wound bed with drainage and foul odor. The treatment nurse further indicated she initiated a treatment of Silvermed to the wound on 2/21/14. She further indicated she was aware of resident's left heel being black for some undetermined amount of time. Treatment Nurse #1 stated dark black meant necrotic. She stated initially the area started as a bubbly blister. There was no documentation as to the status of the wound in the medical record. She further stated the area was unstageable because she could not see what was underneath. Treatment Nurse #1 stated she did not include unstageable ulcers on the weekly report for monitoring if skin prep was being applied. She further indicated it was the responsibility of the hall nurses to document on any area that was receiving skin prep. After reviewing the medical record, she stated did not see any documentation concerning the wound on the left heel except the entry made by her on 2/21/14. During an interview on 3/4/14 at 1:14 pm, the Physical Therapist (PT) stated she started the wound debridement of the left heel on 2/25/14. PT stated she was asked to look at the wound by Treatment Nurse #1. On 3/4/14 at 2:32 pm during an interview, Nurse #1 stated the hall nurses are responsible for	F 314		

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F 314	Continued From page 10 documenting on skin tears. She further indicated the treatment nurse was responsible for documenting on the pressure areas. In an interview on 3/4/14 at 2:47 pm, NA#1 stated the resident's sock was stuck to her foot on Tuesday, February 19th when she was getting her ready for a shower. She further stated Resident #1's left heel had a foul odor to it at that time. She stated she reported the findings to a nurse but could not recall what nurse she told. NA#1 further added when she come to work in the mornings, the resident would not have a soft boot on because she refused it. An interview on 3/4/14 at 3:18 pm with NA #2 revealed she noticed the sock was stuck to the resident's left foot on 2/21/14. On 3/4/14 at 3:59 pm in an interview, Nurse #2 stated she just noted the orders for PT for Resident #1. She further stated the hall nurses are responsible for applying the creams, powders, and skin assessments on the treatment book. Nurse #2 stated the treatment nurse was responsible for monitoring and documenting on the wounds. During an interview on 3/4/14 at 4:32 pm, Nurse #3 stated she completed the skin assessments on January 22nd and 29th, 2014. She further indicated she recalled the resident ' s left heel was inflamed and red. The nurse stated she did not notify the physician because she thought the treatment nurse "was handling all of that. "She further stated "we now have to reposition the resident every two hours since the family requested it." She further stated the turning and repositioning had been implemented since the	F 314		

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F 314	Continued From page 11	F 314		

family complained about the sore on the resident's left heel.

In an interview on 3/5/14 at 6:35 am, Nurse #4 stated the resident refused to be turned and that she just liked to be left alone. The nurse stated they now have to make sure the resident is turned since the area on her foot got bad. She further stated she has started documenting in the medical record now if the resident refused to be turned or was combative.

An interview on 3/5/14 at 6:40 am with Nurse #5 revealed she completed the skin assessments for resident #1 on February 19, 2014. She further stated she recalled the resident's left heel was necrotic. The nurse further described necrotic as soft, black in color with skin intact. She stated she went to check to see if a treatment was in place and it was. Nurse #5 stated if a treatment was already in progress, then the nurses did not document about it. She stated the nurses only document if the area was a new finding and they start the treatment.

On 3/5/14 at 6:47 am in an interview, NA #3 stated the resident did not like to be turned. She further stated she thought it was the resident's right to not be turned. The NA further indicated everyone knew the resident would refuse to turn. She stated if the resident refused to be turn now, they have to notify the nurse so she can document in the chart. NA #3 further indicated the resident had a soft boot on her left foot last night when she came in and it was the first time she had seen the boot on the resident.

During an interview on 3/5/14 at 8:43 am, Treatment Nurse # 2 stated when she applied the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING ______ B. WING ______	C 03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(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 314	Continued From page 12 skin prep to the resident's left heel on January 8, 2014, the heel was necrotic. She further stated necrotic meant dead tissue. The treatment nurse stated she did not notify the physician because there was a treatment for skin prep already in place. She further stated the treatment nurse would not document on an area that was necrotic until the area was open or if there was some kind of problem with it. Treatment Nurse #2 stated she did the measurements on the resident's wound during the week of February 24, 2014 but could not recall what date. In an interview on 3/5/14 at 9:22 am, Nurse #6 stated when she applied the skin prep to Resident #1's left heel on January 1, 2014 she noticed a quarter sized area with a discolored, soft center. She further stated she seen the area again on February 6, 2014 and it was still discolored. Nurse #6 stated she did not document her findings because she thought the treatment nurse did all of the wound documentation and there was a treatment already in place. She further stated a treatment should be changed after a certain amount of time if there is no improvement in the wound and the doctor should be notified. On 3/5/14 at 10:08 am during a phone interview, Nurse #7 stated she recalled the area to Resident's #1 left heel on February 8, 2014 was dark, black eschar tissue. She stated it was the size of two quarters put together. The nurse further stated the area was an unstageable pressure ulcer that was not open. She stated she did not document on the area because it was already being treated. Nurse #7 stated there was no need to notify the doctor because they were putting skin prep on the area.	F 314		

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F 314	Continued From page 13	F 314		

In a phone interview on 3/5/14 at 11:10 am, the attending physician stated he expected the nurses to notify the physicians anytime a resident developed skin breakdown. He further stated the nurses should notify the physician even if they initiate the wound care protocol. After discussing Resident #1's wound with the physician, he stated he was not aware of the wound. The attending physician further stated he would be coming to the facility to refer to the medical record and discuss but he did not come or call back by the time of exit.

On 3/5/14 at 3:10 pm during an interview, Nurse #8 stated she completed the skin assessments on 2/5/14 and 2/12/14. She further stated she recalled a darkened area to the left heel on those dates. She stated she did not document on the area because there was a treatment already in progress and the treatment nurse usually did the documentation on the wounds. Nurse #8 further indicated she did not call the physician because the area was being treated.

A phone interview on 3/5/14 at 4:05 pm with Nurse #9 revealed she was notified by NA #2 of a sock being stuck to Resident #1's left heel. She stated she recalled doing a skin assessment on February 19, 2014 but she did not document it. She further stated the assessment revealed a hard darkened area to the left heel. She stated she did not notify the physician because the area was being treated with skin prep.

During an interview on 3/5/14 at 6:25 pm, the Director of Nursing (DON) stated she expected the treatment nurse to monitor the wounds weekly and document. She further stated she

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F 314	Continued From page 14 expected the treatment nurse to notify the physician of any changes in the wounds as indicated. The DON stated she expect the nurse that initially identify a wound to assess the area, notify the responsible party and the physician, and document in the medical record. She stated the nurses normally notify the physician via fax on a change of condition form. The DON was unable to provide a copy of the notification to the physician for Resident #1.	F 314		