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F 224 SS=D	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility neglected to provide wound care to existing pressure ulcers to promote healing as evidenced by 2 of 3 residents not receiving daily wound care. (Resident #1 and Resident #3). The findings include: 1. Resident #1 was admitted to the facility on 09/12/16 and had readmission on 01/15/17 following a hospitalization. The resident had diagnosis which included: Peripheral Arterial disease, a previous above the knee amputation of right lower leg, hypertension, atrial fibrillation, anticoagulant therapy, and dementia. The Minimum Data Set assessment completed at time of readmission and dated 01/19/17 indicated that the resident was severely cognitively impaired. Resident #1 required extensive assistance for bed mobility, transferring, dressing, toileting, and personal hygiene. The resident was always incontinent of bowel and bladder functions. Skin assessments performed after readmission and dated 01/16/17 indicated that the resident had developed an unstageable pressure ulcer on sacrum, and deep tissue injury pressure areas on left foot and left heel.	F 224	Preparation of and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This Plan of correction is submitted as the facilities credible allegation of compliance. 1. Dressings were changed for Residents 1& 3 on 2/20/2017 by the ADNS. 2. Each Resident has the potential to be affected by the alleged deficient practice. One hundred percent of residents with wounds were audited by the DNS and wound care nurse for daily documentation on the treatment administration record and that dressings were dated for the date treatment was rendered. The DNS began education for all Licensed nurses, to include agency Licensed Nurses on 2/23/2017. Education was comprehensive training on wound care to include - completing skin audits, proper wound documentation on the TAR & MAR, review of orders and care plans, and the legal obligation of all nurses to	3/20/17

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

Electronically Signed | 03/07/2017

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F 224	Continued From page 1 A record review was conducted and revealed wound care ordered by the Wound Care MD for left heel, left foot, and sacral pressure ulcers to be done daily. Documentation by the Wound Care MD on the form titled Wound Care Specialist Evaluation stated that the wounds on the sacrum, left foot and left heel all had the etiology stated as pressure. The Wound Care MD Wound care for left heel ordered on 01/16/17 was as follows: "Cleanse left heel with Normal Saline apply betadine and wrap with Kerlix daily every day shift." Wound care ordered for left lateral foot on 01/16/17 was as follows: "Cleanse left lateral foot with Normal Saline apply betadine and wrap with Kerlix daily every day shift." The wound care order for the sacrum wound were updated on 2/15/17 and was as follows: "Cleanse sacral wound with Normal Saline apply moistened betadine gauze and cover with dry dressing daily every shift." On 02/20/17 at 11 a.m. resident was observed as incontinence care performed by nursing assistant #1. At that time it was observed that the dressing on the sacral wound was with brown and greyish coloring, was wet, and was loosened from the sacral area of Resident #1. The resident's incontinence brief was wet. Nurse #1 came into the room of Resident #1 and also observed the condition of the wound dressing. Nurse #1 stated that the date of 02/18/17 on the dressing indicated that the dressing had been changed and 02/18/17 and had not been changed on 02/19/17. At 12:20 p.m. on 02/20/17 Nurse # 1 applied a	F 224	follow physician orders so that residents are not subject to neglectful treatment of their wounds. Nurse #3 was asked to not return to the facility due to failure to complete assigned duties as directed by the DNS. Additional counseling of nurses has been conducted per the company policy, as it relates to performance of job duties. All licensed nurses are being required to round with the Treatment nurse as part of an on-going education program related to wounds and treatment thereof, all training will be completed by 3/20/2017. 3. The DNS or Designee will conduct skin audits daily for 2 weeks; For all residents with wounds, charts reviewed during Clinical Start Up, for appropriate wound documentation on TARS to ensure no other residents are affected by alleged deficient practice. The DNS will designate a Unit Manager and/or ADNS to review TARs on the weekends, and validate dressing changes are completed on weekends, to ensure continued substantial compliance. 4. Random audits of all residents with wounds will be conducted by the DNS or Designee 3x weekly for 1 month, then 1x weekly for 3 months by the DNS or Designee to ensure continued compliance. Results of the audits will be reviewed during the QAPI meeting by the ED, to determine if further action is necessary.	

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clean dressing to the sacral wound of Resident# 1. The wound appeared dark pink in color and bled easily when cleansed by Nurse #1. At that time it was observed that the resident had a dressing on the left foot which covered most of the foot and the heel. The date written on the foot dressing was 02/18/17. Nurse # 1 stated that the date of 02/18/17 written on the dressing indicated that the dressing had been changed on 02/18/17 and had not been changed on 02/19/17. The dressing on the left foot was not removed by the nurse at that time. Nurse #1 stated that the resident was being transported to an appointment out of the facility and the wound would be observed at the appointment. The dressing on the left foot was dry and intact. The dressing had a brown colored dry circle about one inch in diameter over the heel area.

A telephone interview was conducted on 02/20/17 at 5:20 p.m. with Nurse # 3 who had worked as week-end supervisor and treatment nurse on 02/18/17 and 02/19/17. It was stated by Nurse #3 that all of the wound treatments had not been completed prior to leaving the facility at the end of shift. Nurse # 3 also stated that the method used by the facility to document wound care completed was to sign and initial the dressing and to make the Treatment Administration Record (TAR) with check mark and initials on the appropriate date. The date of 02/19/17 was blank.

2. Resident #3 was admitted to the facility on 02/20/17 and readmitted on 7/15/16 following a hospitalization with diagnosis which included: Multiple Myeloma, arthritis, hypertension, diabetes, and dementia. The Minimum Data Set

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(MDS) quarter assessment dated 01/24/17 indicated the resident required extensive assistance with bed mobility, transfers, dressing and personal hygiene and was severely impaired cognitively. The resident was incontinent of bowel and bladder functions. The MDS dated 01/24/17 indicated that Resident # 3 had a Stage 4 pressure ulcer on the sacral area.

A record review revealed that wound care order was updated on 02/15/17 for the sacral pressure ulcer. The wound care was as follows: "Cleanse sacrum with Normal Saline apply Dakin's solution and cover with dry dressing daily every day shift." A record review revealed a Treatment Administration Record (TAR) for wound care. The Chart Codes at the bottom of the page on the TAR indicated that a check mark equaled administered care. The dates of 02/18/17 and 02/19/17 were blank on the TAR for Resident #3 for the sacral wound care.

On 02/20/17 at 5:00 p.m. the dressing on the sacra area of Resident 33 was observed while accompanied by Nurse #4. The dressing was loosened from the sacral wound area and was wet and greyish in color. The dressing had the date 02/17/17 written on it. The color of the wound was dark pink and there was no observed drainage. Nurse #4 stated that the date of 02/17/17 indicated the dressing had been changed on 02/17/17 and had not been changed on 02/18/17 and 02/19/17.

A telephone interview was conducted on 02/20/17 at 5:20 p.m. with Nurse #3 who worked at RN

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F 224	Continued From page 4 supervisor and treatment nurse on 02/18/17 and 02/19/17. It was stated by Nurse #3 that all of the wound care had not been completed prior to leaving at the end of shift. Nurse #3 also stated that the method of documentation of completed wound care was to initial and check the Treatment Administration Record (TAR) on the appropriate date. The areas of the TAR for the sacral wound care for Resident #3 were blank for 02/18/17 and 02/19/17. Nurse #3 stated that areas without the initials and check mark indicated wound care had not been done. An interview was conducted with the DON on 02/20/17 at 5:30 p.m. The DON stated that it was the expectation that the RN supervisor would make sure that treatments would be administered as ordered. A telephone interview with the Wound Care MD was attempted, but the MD did not return a call prior to the end of the survey.	F 224		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		3/20/17

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F 314	Continued From page 5 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to provide treatment to existing Pressure Ulcers to promote healing as evidenced by 2 of 3 residents not having daily wound care as ordered. (Resident #1 and Resident #3). The findings include: 1. Resident #1 was admitted to the facility on 9/12/16 and was readmitted 1/15/17 following hospitalization. The resident had diagnosis which included: Peripheral Arterial disease, a previous above the knee amputation of right lower leg, hypertension, atrial fibrillation, anticoagulant therapy, and dementia. The Minimum Data Set assessment completed at time of readmission and dated 1/19/17 indicated the resident was severely cognitively impaired. Resident #1 required extensive assistance for bed mobility, transferring, dressing, toileting and personal hygiene. The resident was always incontinent of bowel and bladder functions. Skin assessment performed on 1/16/17 indicated that the resident had developed an unstageable Pressure Ulcer on sacrum, and deep tissue injury pressure areas on left foot and left heel.	F 314	Preparation of and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This Plan of Correction is submitted as the facilities credible allegation of compliance. 1. Dressings were changed for Residents 1 & 3 on 2/20/2017. 2. Each Resident has the potential to be affected by the alleged deficient practice. One hundred percent of residents with wounds were audited by the DNS and wound care nurse for daily documentation on the treatment administration record and that dressings were dated for the date treatment was rendered. The DNS began education for all Licensed nurses, to include agency Licensed Nurses on 2/23/2017. Education was comprehensive training on wound care to include - completing skin audits, proper wound documentation on the TAR & MAR, review of orders and care plans, and the legal obligation of all nurses to follow physician	

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F 314	Continued From page 6 A record review was conducted and revealed wound care ordered for left heel, left foot, and sacrum pressure ulcers. Wound care for left heel ordered on 1/16/17 as "cleanse left heel with Normal Saline apply betadine and wrap with Kerlix daily every day shift". Wound care ordered for left lateral foot on 1/16/17 as "cleanse left lateral foot with normal Saline apply betadine and wrap with Kerlix daily every day shift." Wound care order for sacrum wound updated on 2/15/17 as "cleanse sacral wound with normal saline apply moistened betadine gauze and cover with dry dressing daily every day shift." for left lateral foot on 1/16/17 as "cleanse left lateral foot with normal Saline apply betadine and wrap with Kerlix daily every day shift." Wound care order for sacrum wound updated on 2/15/17 as "cleanse sacral wound with normal saline apply moistened betadine gauze and cover with dry dressing daily every day shift." On 2/20/17 at 11 a.m. nursing assistant #1 was observed as incontinence care was provided for Resident #1. It was observed that the dressing on the sacral wound was with brown and greyish coloring, was wet and loosened from the wound on sacral area of Resident # 1. The resident's incontinence brief was wet. Nurse # 1 observed the condition of the wound dressing and stated that the date written on the dressing was 2/18/17. Nurse #1 said that the date of 2/18/17 on the dressing indicated that the dressing had not been changed on 2/19/17. At 12:20 p.m. on 2/20/17 Nurse #1 applied a clean dressing to the sacral wound of Resident #1. The wound appeared dark pink in color and	F 314	orders so that residents are not subject to neglectful treatment of their wounds. As part of ongoing education for nurses related to wound protocol, all nurses will be making rounds with the treatment nurse. All education will be completed by 3/20/2017. 3. Physicians orders and Care Plans were reviewed by the DNS, daily for two weeks, for all residents with wounds. Orders and care Plans updated as appropriate. Unit Managers, DNS, ADNS and the Field Service Clinical Support for the company, conducted a 100% skin sweep on Feb 1 & 2, 2017, as part of a QA measure. The DNS will designate a Unit Manager and/or ADNS to review TARs on the weekends, and validate dressing changes are completed on weekends, to ensure continued substantial compliance. Dressing Change Competency Checklist will be used by the Treatment Nurse to determine if additional training is needed on a continual basis. 4. Random audits of all residents with wounds will be conducted by the DNS or Designee 3x weekly for 1 month, then 1x weekly for 3 months by the DNS or Designee to ensure continued compliance. Results of the audits will be reviewed during the QAPI meeting by the ED, to determine if further action is necessary.	

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bled easily when cleansed by the Nurse. At that time it was observed that the resident had a dressing on the left foot which covered most of the foot and the heel. The date written on the dressing on the foot was 2/18/17. Nurse # 1 stated that the date 2/18/17 written on the dressing indicated that the dressing had not been changed on 2/19/17. The dressing was not removed by the Nurse at that time. The Nurse was getting the resident ready for an appointment outside of the facility to a Wound MD. The dressing was dry and intact. The dressing had a brown dry circle about one inch in diameter over the heel area.

A telephone interview was conducted on 2/20/17 at 5: 20 p.m. with Nurse #3 who worked as week-end supervisor. Nurse # 3 was responsible for wound care, also. It was stated by Nurse # 3 she had not been able to complete all treatments before the end of her shift on the week-end of 2/18/17 and 2/19/17. It was stated by Nurse # 3 that the method used to document wound care completion was to sign and initial the dressing and to mark the TAR. Nurse #3 stated that areas without initials and the check mark indicated wound care not done.

2. Resident #3 was admitted to the facility on 2/20/14 and readmitted following hospitalization on 7/14/16 with diagnosis which included: Multiple Myeloma, arthritis, hypertension, diabetes, and dementia. The Minimum Data Set quarterly assessment dated 1/24/17 stated the resident required extensive assistance with bed mobility, transfers, dressing and personal hygiene and was severely impaired cognitively. The resident was

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incontinent of bowel and bladder functions. The Minimum Data Set assessment dated 1/24/17 indicated that Resident #3 had a stage 4 pressure ulcer on the sacral area.

A record review revealed that wound care order for the sacral pressure ulcer were updated 2/15/17. The care ordered as "cleanse sacrum with Normal saline apply Dakin's solution and cover with dry dressing daily every day shift."

A record review revealed a Treatment Administration Record (TAR) for wound care. The Chart Codes at the bottom of the page on the TAR indicated that a check mark equaled administered. The dates of 2/18/17 and 2/19/17 were blank on the TAR in the area of sacral wound care.

On 2/20/17 at 5:00 p.m. the dressing on the sacral area of Resident # 3 was observed in the presence of Nurse #4. The dressing was loosened from the wound area and was wet and greyish in color. It was observed that the date of 2/17/17 had been written on the dressing. The wound color was dark pink and there was no drainage observed. Nurse # 4 stated that the date of 2/17/17 on the dressing indicated that the dressing had not been changed on 2/18/17 or 2/19/17.

A record review revealed that wound care order for the sacral pressure ulcer were updated 2/15/17. The care ordered as "cleanse sacrum with Normal saline apply Dakin's solution and cover with dry dressing daily every day shift."

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A record review revealed a Treatment Administration Record (TAR) for wound care. The Chart Codes at the bottom of the page on the TAR indicated that a check mark equaled administered. The dates of 2/18/17 and 2/19/17 were blank on the TAR in the area of sacral wound care.

A telephone interview was conducted on 2/20/17 at 5: 20 p.m. with Nurse #3 who worked as week-end supervisor. Nurse # 3 was responsible for wound care, also. It was stated by Nurse # 3 she had not been able to complete all treatments before the end of her shift on the week-end of 2/18/17 and 2/19/17. It was stated by Nurse # 3 that the method used to document wound care completion was to sign and initial the dressing and to mark the TAR. Nurse #3 stated that areas without initials and the check mark indicated wound care not done.

An interview was conducted with the DON on 2/20/17 at 5:30 p.m. The DON stated that it was the expectation that the RN supervisor would make sure that treatments would be administered as ordered.