STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345457	A. BUILDING _____ B. WING _____	C 11/16/2012

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BELAIRE HEALTH CARE CENTER	2065 LYON STREET GASTONIA, NC 28052

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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 observations, record reviews, and interviews with staff, family, and physician, the	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How the corrective action will be accomplished for the resident(s) affected. F.157 Resident #193 was sent to emergency for evaluation. The DON performed and investigation into bruise of unknown origin of resident # 76 once notified of the bruise by the surveyor. The nurses involved were immediately educated on notification of MD, RP and DON of any change in condition and bruises of unknown origin	

DHSR NH L&C Black Mountain WRO
Received
DEC 20 2012
by: SKH

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

12-19-12

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.

Original signature 12-12-12 mb

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F 157	Continued From page 1 facility failed to notify the physician and/or family of a resident with an elevated axillary (A) temperature of 103.8 degrees Fahrenheit (F) (Resident #193) and a resident with a facial bruise (Resident #76) for 2 of 5 sampled residents reviewed for notification of change. The findings include: 1.The facility standing physician order form, date unknown, read the following in part: "Give Tylenol for temperature above 101 degrees F orally or 102 degrees F rectally for 3 days. Call physician if temperature is greater than 101 degrees F." Resident #193 was re-admitted on 07/26/12. Cumulative diagnoses included hypertension, aspiration pneumonia, diabetes, coronary artery disease, chronic kidney disease and hyperlipidemia. A quarterly Minimum Data Set (MDS) dated 09/19/12 indicated Resident #193 had no speech, was unable to understand and had long and short- term memory impairment. The MDS also indicated Resident # 193 was dependent on staff for all activities of daily living (ADL) and required tracheostomy care. A plan of care dated 07/26/12 revealed the resident had a potential for altered respiratory status related to a history of respiratory failure. The goal was for vital signs to remain stable with an intervention to keep the physician informed of any changes. A review of a nurse's note dated 10/04/12 documented a late entry for 10/03/12, 3:00 PM to 11:00 PM shift and revealed Resident #193's	F 157	How corrective action will be accomplished for those residents with the potential to be affected by the same practice. F. 157 the staff development coordinator initiated education to all nurses on 11/15/12 on reporting of bruises of unknown origin, change of condition, MD and RP notification. 'The education will be completed by 11/27/12. All certified nursing assistants will be educated on the reporting of any change in condition. This education will be completed by 11/27/12. The DON and SDC will audit all nurses' notes and shift report to include all in house residents for any change of condition, MD and RP notification. The audit will be completed by12/31/12. The MD and RP will be notified of any unreported changes in condition as found in the audits.	

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F 157	Continued From page 2 tracheostomy was suctioned four times that shift and noted a moderate amount of yellowish thin secretions with foul odor. The physician was notified. A nurse's note dated 10/04/12 documented a late entry for 11:00 PM to 7:00 AM shift and revealed Resident #193 with an increased temperature of 103.8 degrees F (A). Tylenol was given and effective at 1:00AM with a rechecked temperature of 102.6 degrees F (A) and this was reported to 1st shift. Further review of the nurse's note revealed the resident was suctioned five times throughout the night, sputum was yellowish/white and thick with a foul odor. A nurse's note dated 10/04/12 at 4:33PM documented Resident #193 with a temperature of 102 degrees F during the morning medication administration Tylenol was given, the family informed the resident was spiking a temperature and the physician was contacted due to the change in condition. The note further indicated a chest x-ray, labs, sputum culture and antibiotics were ordered by the physician. The antibiotics were administered and roughly 10 minutes after administration the resident's respiration increased significantly to 50 breathes per minute and the physician was contacted immediately and gave an order to send the resident to the hospital for evaluation. The resident left the facility via emergency medical services at roughly 10AM. A review of the hospital Emergency Department report dated 10/04/12 indicated the chief complaint as hypoxia and respiratory distress. The diagnostic impression noted acute respiratory failure and pneumonia.	F 157	Measures in place to ensure practices will not occur. F. 157 The SDC, Unit Manager or designee will audit change of condition using the facility preexisting shift report and nursing notes daily Monday thru Friday for a period of three months then weekly for three quarters. The Unit Manager, SDC or Unit Manager will audit the shift report and nurses notes on Monday mornings to identify any changes in condition, MD and RP notification that occurred on the previous weekend. The Staff development coordinator or Unit Manager will educate all nurses and certified nursing assistants in monthly meetings of change in condition, RP and MD notification monthly times three months then quarterly times three. The staff development coordinator will ensure all annual education and new hire education of change in condition and MD and RP notification is performed. The SDC will re educate all licensed nurses to review shift report every shift for notification of changes in condition, MD and RP notification. The education will be completed by 12/30/12.	

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F 157	Continued From page 3 During an interview with Nurse #2 on 11/16/12 at 10:35 AM, the Nurse revealed on 10/04/12 he received report that Resident #193 had spiked a temperature early that morning on third shift. Nurse # 2 explained he notified the physician of Resident # 193's temperature being 102 degrees F and received orders from the physician. He further explained Resident #193's medical condition would suggest the physician should be notified for any change in status. He added that typically for a temperature above 100.5 degrees F he would notify the physician. During a telephone interview with Nurse #8 on 11/16/12 at 11:42 AM, the Nurse explained she cared for Resident #193 on 10/04/12 during the 11:00 PM to 7:00 AM shift and the resident had an elevated temperature in the early morning hours as well as some labored respirations. Nurse #2 revealed she did not notify the physician of Resident # 193's temperature of 103.8 degrees F or the labored respirations. She stated since the temperature had decreased to 102 degrees F with the administration of Tylenol and the labored respirations did not appear any different from Resident #193's baseline, she did not think she needed to notify the physician. Nurse# 2 added she did report the elevated temperature to the oncoming nurse. Nurse # 2 further stated she typically notified the physician for temperatures above 100.4 degrees F and should have notified the physician of Resident #193's change in condition. Interview with the physician on 11/16/12 at 2:11 PM revealed he typically was notified of temperatures of 101 degrees F and above and	F 157	How the facility plans to monitor and ensure correction is achieved and sustained. The DON or Unit Manager will present all education to QA monthly time three then quarterly times three to show compliance with education	

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F 157	Continued From page 4 would have expected the nurse to have notified him of a temperature of 103.8 degrees F when Resident #193 was also displaying changes in respiration and sputum secretions. The physician further added he did not feel the delay in notification would have changed the outcome for Resident #193. Interview with the Director of Nursing (DON) on 11/16/12 at 3:45PM revealed she expected the nurses to notify the physician of any change in condition when it was identified. The DON further added she would have expected Nurse #2 to have notified the physician immediately of Resident #193's temperature of 103.8 degrees F. 2. Resident #76 was admitted to the facility on 05/08/12 and readmitted on 08/02/12 with diagnoses that included dementia. The Minimum Data Set (MDS) dated 10/23/12 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident was dependant on staff for activities of daily living (ADL) and had impaired use of her upper extremities. Review of Resident #76's medical record revealed a document titled "Nursing Fax Communication Form" dated 11/12/12 completed by Nurse #1 that specified Resident #76 had a bruise of unknown origin. The document also noted a request for Nurse #2 to contact the family. On 11/13/12 at 3:00 PM Resident #76 was	F 157		

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F 157	Continued From page 5 observed in bed and noted to have a greenish bruise approximately the size of a nickel on the bridge of her nose. On 11/13/12 at 3:30 PM Resident #76's family member was interviewed and reported she was concerned about the bruise on the resident ' s nose. She stated that she visited often and noticed the bruise herself and had not been notified by the facility regarding the bruise or how it happened. When did the family member notice the bruise? On 11/15/12 at 12:50 PM Nurse #1 was interviewed and reported she was trained to notify the physician and the family when a change occurred in a resident's condition. She stated that a bruise of unknown origin was considered a change in condition and required physician and family notification. Nurse #1 reported that on 11/12/12 early in the morning she was notified by the nurse aide that Resident #76 had a bruise on the bridge of her nose. She stated that she assessed the resident and completed the "Nursing Fax Communication Form" to notify the physician of the bruise. Nurse #1 added that because of the early hour the bruise was found and because it was not an emergency she did not notify the family. Nurse #1 stated she left a note for Nurse #2 to contact the family. She stated she assumed Nurse #2 contacted the family but had not followed-up to make sure the family was notified about the bruise. On 11/15/12 at 1:20 PM Nurse #2 was interviewed and reported he had not contacted Resident #76's family regarding her bruise and was unaware he was supposed to. Nurse #2	F 157		

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F 157	Continued From page 6 stated he had not seen a note to communicate to him to contact Resident #76's family. On 11/16/12 at 3:30 PM the Director of Nursing (DON) was interviewed and stated she expected the family to be contacted regarding Resident #76's bruise.	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	How the corrective action will be accomplished for the resident(s) affected. F.278 Resident # 91 MDS assessment was assessed and verified as a Stage 2 on admission by DON. Resident # 149 Skin assessment and wound was verified by DON. The assessments were corrected on the MDS. How corrective action will be accomplished for those residents with the potential to be affected by the same practice.F.278 The DON, SDC or designee will audit all charts of residents with pressure ulcers and wounds to ensure documentation is accurate. The DON will audit all MDS assessments of in house residents with pressure ulcers to ensure MDS is correct Audits initiated on 11/19/12. Completion date 12/20/12. The Staff development coordinator will educate all nurses on wound and pressure ulcer monitoring and documentation. Completion date is 12/18/12.	

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F 278	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to indicate the presence of a Stage 2 pressure ulcer and a surgical wound on a comprehensive assessment for 2 of 4 sampled residents whose comprehensive assessments were reviewed for pressure ulcers (Residents #91 and #134). The findings are: Example #1 Resident #91 was admitted to the facility on 07/06/12. Diagnoses included dementia and cerebral vascular accident. An admission Minimum Data Set (MDS) dated 07/13/12 indicated Resident #91 was at risk for pressure ulcer development and required staff assistance for all activities of daily living (ADL). The MDS did not indicate the presence of any pressure ulcers. Review of Resident # 91's medical record revealed an ulcer and wound record dated 07/06/12 which indicated a Stage 2 pressure ulcer to the coccyx with an onset date of 07/06/12. A review of the skin risk/ weekly assessment sheet dated 07/06/12 indicated Resident #91 had a Stage 2 pressure ulcer to the sacral/coccyx area. A plan of care dated 07/09/12 documented a potential for skin breakdown due to decreased mobility and indicated an intervention of weekly skin assessment. A quarterly MDS dated 09/30/12 indicated	F 278	Measures in place to ensure practices will not occur. F. 278 The DON, Unit Mangers, Staff development coordinator or designee will audit all new admission skin assessments and wound records daily to identify any wounds or pressure ulcers and to verify appropriate treatments are in place Monday through Friday for 3 months then weekly for 3 quarters. The DON, Unit Manager or designee will meet with MDS weekly for 3 months then quarterly thereafter on skin assessments and pressure ulcer records to ensure communication and accuracy of section M. The DON, Unit Manager and SDC will have a weekly meeting to review wounds, pressure ulcers and treatments and skin assessments to ensure appropriate treatment and healing of areas. How the facility plans to monitor and ensure correction is achieved and sustained. F.278. The results of all audits will be presented in QA &A committee monthly times 3 months then quarterly times 3	

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F 278	Continued From page 8 Resident #91 had one Stage 2 pressure ulcer which was present on admission. A plan of care dated 10/09/12 documented a problem of presence of pressure ulcer/ skin breakdown with potential for further breakdown, Stage 2 to sacrum. During an interview with MDS Nurse #6 on 11/16/12 at 9:20AM, MDS Nurse #6 explained the Nurse Manager was responsible for the completion of the skin section of the MDS. MDS Nurse #6 further explained the MDS department was responsible for the completion of the MDS and would at times verify the skin section by reviewing the treatment orders, treatment administration record and weekly skin sheets in order to verify the accuracy of the pressure ulcer assessment. During an interview with MDS Nurse #7 on 11/16/12 at 9:25AM, MDS Nurse #7 explained she had completed Resident #91's admission assessment however the skin section was completed by the Nurse Manager. The MDS nurse added she typically checked the treatment administration record (TAR) and the ulcer and wound record to verify the information entered by the Nurse Manger. Nurse #7 further explained she would not have been able to verify the section for accuracy because the treatment record did not reflect the treatment of a Stage 2 pressure area during that time period and she did not recall checking the ulcer and wound record. MDS Nurse #7 further acknowledged Resident #91's 07/13/12 MDS should have been noted a Stage 2 pressure area since it was present on admission.	F 278		

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F 278	Continued From page 9 During an interview with the Director of Nursing (DON) on 11/16/12 at 9:45AM, the DON explained the Nurse Manger who was responsible for the completion of the skin section of Resident # 91's admission assessment was no longer employed at the facility. The DON further explained the admission MDS should have indicated the Stage 2 pressure ulcer since it was present on admission and she would have expected the MDS to have been accurately coded. 2. Resident #149 was admitted to the skilled nursing facility on 10/05/12 with diagnoses of stage 3 pressure ulcer and diabetes. A review of the hospital discharge summary dated 09/26/12 revealed Resident #149 had received treatment for a non-healing surgical wound on the right hip while hospitalized. The discharge summary included a discharge diagnosis of right ischial osteomyelitis with right hip abscess secondary to staph aureus. A review of the admission Minimum Data Set (MDS) dated 10/12/12 revealed Resident #149 was cognitively intact and required limited assistance with ambulation, toileting, transfers, dressing and bathing. Section M (skin conditions) of the MDS noted a Stage III pressure ulcer of right buttock. There was no indication of a surgical wound. An observation of wound care for Resident #149 was completed on 11/15/12 at 2:00 PM. Nurse #3 irrigated the wound on the right hip with normal saline, packed with calcium alginate and covered	F 278		

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F 278	Continued From page 10 with a dry dressing using clean technique. An interview with Nurse #3 on 11/15/12 at 2:15 PM revealed that she did not know that Resident #149 had a non-healing surgical wound of the right hip. An interview with Resident #149 on 11/15/12 at 2:25 PM revealed that he had an open wound on his right hip from an abscess that was opened by a surgeon. Resident #149 stated that the wound just won't heal. Resident #149 stated that the wound that the nursing home staff are packing is the same wound that was opened by the surgeon to treat the abscess. An interview with the Director of Nursing (DON) on 11/15/12 at 2:30 PM revealed that she was not aware that the wound on Resident #149's hip was a surgical wound. The DON also stated that she had not observed the wound since the resident was admitted on 10/5/12. The DON confirmed that she entered the wound assessment information into the MDS in the absence of a unit manager. She also confirmed that the information she entered into the M section of the MDS is obtained from the admission assessment that was completed by the nursing staff. An interview with MDS Nurse #6 on 11/16/12 at 9:00 AM revealed the DON entered the skin assessment for Resident #149 into section M of the admission MDS. She stated the MDS staff were not responsible for checking the accuracy of the information in section M after it is entered into the MDS. MDS Nurse #6 stated there was no communication between the MDS staff and nursing staff related to ulcer or wound changes.	F 278		

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F 278	Continued From page 11 An interview with Nurse #7 on 11/16/12 at 9:15 AM revealed that she cared for Resident #149 approximately 2 weeks ago. She stated that after reading the resident ' s medical record, she realized the resident's wound was a surgical wound. Nurse #7 stated she should have modified the MDS and started a new Ulcer and Wound Record to reflect that the wound was a surgical wound and not a pressure ulcer. She stated that she failed to communicate to the DON or other nursing staff that Resident #149 ' s wound was a surgical wound. An interview with Nurse #4 on 11/16/12 at 1:34 PM revealed that she completed the admission wound assessment for Resident #149 on 10/5/12. Nurse #4 confirmed that she assessed the wound as a Stage III pressure ulcer. She stated she did not know the wound was a non-healing surgical wound. An interview with the DON at 3:35 PM stated that she entered Resident #149 ' s wound information into section M of the MDS using the admission assessment completed by Nurse #4. The DON confirmed she had not visualized the wound herself. The DON also confirmed that Nurse #7 should have modified section M of the MDS and started a new Ulcer and Wound Record when she realized the wound was surgical and not a pressure ulcer.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	How the corrective action will be accomplished for the resident(s) affected. F.309 The DON and SDC will audit all residents for bowel movements. Completion date 12/15/12. The DON immediately educated nurse # 3 on the policy and procedure for elimination and constipation prevention. Resident was immediately assessed for bowel movement by charge nurse. The MD was notified. Resident was found to have had a documented BM within 3 days.	

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	345457	A. BUILDING _____ B. WING _____	C 11/16/2012

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F 309	Continued From page 12 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to implement a bowel protocol for 1 of 10 sampled residents reviewed for bowel movement frequency. (Resident #41). The findings are: The facility's protocol for constipation dated 09/01/11 specified in part residents would be monitored for regular bowel elimination as evidenced by a bowel movement at least every 3 days. Resident #41 was admitted to the facility with diagnoses including history of dementia with psychosis and constipation. The most recent Minimum Data Set dated 10/01/12 indicated Resident #41 was severely cognitively impaired and required extensive assistance of staff for all care. A review of Resident #41's Medication Administration Record (MAR) for the period of 09/01/12 through 09/30/12 revealed a physician's order dated 03/14/12. The order specified a laxative was to be given twice daily due to a diagnosis of constipation. A review of Resident #41's bowel elimination record revealed no bowel movement documented	F 309	How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Staff development coordinator educated all licensed nurses of the nursing policy and procedure for elimination and constipation prevention. Completion date is 11/28/2012. All nursing assistants will be educated on the policy and procedure for elimination and constipation prevention. Completion date is 12/12/12. The licensed nurses will run a bowel movement report every shift and document any interventions into the nurse's notes. The certified nursing assistants will ensure that documentation is accurate in the ADL record. The DON, Unit Manager, Staff development coordinator or designee will review the bowel movement record daily Monday through Friday for 3 months to ensure that interventions are in place. The DON or SDC will audit all in house residents to ensure bowel movements within 3 days. The residents affected will be assessed for bowel movements. The MD and RP will be notified of any resident without a bowel movement with in 3 days. The audit will be completed by 12/20/2012.	

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F 309	Continued From page 13 any shift from 09/16/12 through 09/20/12 (5 days) and 09/23/12 through 09/27/12 (5 days). A review of Resident #41's MAR for the month of September 2012 revealed no other medication related to bowel evacuation was administered other than the laxative ordered to be given twice daily. An interview with Nurse #3 was conducted on 11/16/12 at 2:50 PM. Nurse #3 stated if a resident had no bowel movement for 3 days, on the morning or night of the third day staff would initiate the standing order for Milk of Magnesia. Nurse #3 said medication given to a resident for a bowel movement should be documented on the MAR. After reviewing Resident #41's September bowel elimination record and MAR, Nurse #3 confirmed the resident had gone over 3 days without a bowel movement for 2 periods of time and was not given anything other than her routine laxative. An interview with the Director of Nursing (DON) on 11/16/12 at 3:30 PM revealed the unit manager ran a daily bowel report containing names of residents who had not had a bowel movement in 3 days. On weekends the nurses ran the report themselves. The DON stated she expected the nurses to initiate standing orders for any resident who appeared on the report and notify the physician of the need for any additional medications to address constipation. The DON added she expected this protocol to be followed for Resident #41.	F 309	Measures in place to ensure practices will not occur. F. 309 The Unit Managers, Staff development coordinator, DON or designee will audit the Bowel movement record daily for three months then weekly times 3 quarters. The Staff development coordinator or Unit Managers will educate the licensed nurses and certified nursing assistants monthly times 3 then quarterly thereafter in monthly staff meetings. How the facility plans to monitor and ensure correction is achieved and sustained. F. 309. The DON or Unit Manager will present audits and education to QA& A monthly time 3 months then quarterly times 3	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 14 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 observations, staff interviews and clinical record review, the facility failed to provide treatment for a Stage 2 pressure ulcer identified on admission for 1 of 4 sampled residents reviewed for pressure ulcers (Resident #91). The findings include; Resident #91 was admitted to the facility on 07/06/12. Diagnoses included dementia and cerebral vascular accident. An admission Minimum Data Set (MDS) dated 07/13/12 indicated Resident #91 had cognitive impairment, required extensive assistance with activities of daily living (ADL) and was at risk for pressure ulcer development. The MDS did not indicate the presence of any pressure ulcers. A plan of care dated 07/09/12 documented a potential for skin breakdown due to decreased mobility and indicated an intervention of weekly skin assessment. A quarterly MDS dated 09/30/12 indicated Resident #91 had one Stage 2 pressure ulcer which was present on admission. A plan of care	F 314	How the corrective action will be accomplished for the resident(s) affected. F. 314 Resident # 91 pressure ulcers and pressure ulcer records were reviewed by DON for accuracy and treatments How corrective action will be accomplished for those residents with the potential to be affected by the same practice. F.314 The staff development coordinator and DON will audit all charts of residents with pressure ulcers and wounds to ensure accurate documentation and treatment. Audits initiated on 11/19/12. Completion date 12/20/12. The Staff development coordinator will educate all nurses on wound and pressure ulcer monitoring, documentation and treatment per policy and procedure. Completion date is 12/18/12.	

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F 314	Continued From page 15 dated 10/09/12 documented a problem of presence of pressure ulcer/ skin breakdown with potential for further breakdown, Stage 2 to sacrum. A review of the skin risk/weekly assessment sheet dated 07/06/12 revealed recorded under the section titled: week 1 a Stage 2 pressure area to the sacral/coccyx area. The skin risk/ weekly assessments next review was dated 07/18/12 and indicated a Stage 2 to the sacral/coccyx area. An ulcer and wound record dated 07/06/12 indicated a Stage 2 coccyx ulcer with no measurements and described the ulcer as epithelial with an intact peri-wound and current treatment of extra protective cream (EPC). The next recorded documentation noted on the ulcer and wound record was dated 07/27/12 and indicated a Stage 2 sacral/coccyx ulcer with an onset date of 07/06/12 which measured 1x1centimeters (cm) and described the ulcer as epithelial with a redden peri-wound, no drainage and a current treatment of EPC twice daily. An ulcer and wound record dated 07/31/12 indicated a Stage 2 sacral/coccyx ulcer with an onset date of 07/06/12 which measured 7.5x5.5 cm and described the ulcer as opened, red and inflamed with drainage and a current treatment of a hydrocellular dressing every 3 days and as needed. Review of the Treatment Administration Record (TAR) for the month of July 2012 revealed an order for EPC cream to be applied to sacral Stage 2 twice daily with a start date of 07/27/12. The TAR indicated no treatment for the sacral	F 314	Measures in place to ensure practices will not occur. F. 314 The DON, Unit Manager, Staff development coordinator or designee will audit all new admission skin assessments and wound and pressure ulcer records daily Monday through Friday for 3 months then weekly for 3 quarters. The Don, Unit Managers and staff development coordinator will meet weekly to review wound and pressure ulcers to ensure pressure ulcer and wound management weekly times 3 months, then every 2 weeks times 3 quarters. How the facility plans to monitor and ensure correction is achieved and sustained. F.314 The Unit Manager or designee will present audits to QA&A monthly time 3 months then quarterly time 3	

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F 314	Continued From page 16 ulcer from admission until 07/27/12. A physician order dated 07/31/12 indicated to apply a hydrocellular dressing to the coccyx area stage 2, every 3 days and as needed until healed. An observation of Resident #91's sacral wound was made on 11/15/12 at 2:25 PM. The observation revealed the sacral ulcer to extend from the sacrum downward toward the left and right buttocks. The area was intact and pink in color with no signs of odor, slough or drainage. An interview with Nurse #3 on 11/15/12 at 2:48 PM revealed Resident # 91 had been transferred to her unit from the other side of the building with a pressure ulcer to the sacrum. Nurse # 3 stated when Resident #91 initially arrived from the other unit the sacral pressure ulcer was opened. Interview with Nurse #5 on 11/15/12 at 3:33 PM revealed the area to Resident #91's sacrum was initially a raised discolored area and the area eventually opened and a dressing had to be applied. Nurse #5 stated she never applied EPC to the area but did apply a dressing once it had opened. A follow-up interview with the DON on 11/16/12 at 3:45 PM revealed she would have expected the nurse manager to have initiated treatment according to the wound protocol upon Resident #91's admission by implementing an order for the EPC. The DON also stated she was not sure why the nurse manager failed to initiate treatment for the sacral ulcer.	F 314		