

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/27/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNT OLIVE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365</b>		
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F 309 SS=D	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to routinely observe and assess the gangrenous fingers of 1 of 2 sampled residents (Resident #1) who experienced amputations. Based upon observations, record review, and staff and pharmacy interviews, the facility also delayed the initiation of antibiotic therapy for two days after it was ordered for one of three residents, Resident #8. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 11/22/13, readmitted to the facility on 12/10/13, and expired in the facility on 07/21/14. The resident's documented diagnoses included amputation of fingers on right hand, arterial occlusive disease of the right arm, ulnar (elbow) neuropathy, peripheral neuropathy, diabetes, and end stage renal disease with hemodialysis.</p> <p>At 2:15 PM on 08/26/14 Nurse #2 stated in March and April 2014 Resident #1 had black, hard, dry patches on the fingers of her right hand. She reported both the facility and the dialysis center were aware of the necrosis, but there was some debate back and forth about obtaining</p>	F 309	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F-309</p> <p>1. Resident # 1 is no longer resident in the center.</p> <p>2. The Administrative nurses complete a head to toe skin assessment on residents on 9/12/14 and 9/15/14 to identify any resident that may have skin integrity concerns. Any concerns identified, a physician's order was obtained for treatment as appropriate along with documentation completed in the medical record of the skin integrity concern.</p>	9/24/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/16/2014

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 309	<p>Continued From page 1</p> <p>consultation. According to the nurse, she decided to take action herself, and set up a consult for the resident with a vascular surgeon (on 05/12/04). By that time the nurse explained the necrosis had spread from one finger to three fingers of her right hand.</p> <p>At 3:43 PM on 08/26/14, during a telephone interview, nursing assistant (NA) #1 stated she began to notice dark spots on Resident #1's fingers of the right hand in March 2014. She reported these spots became larger and involved more fingers in April and May 2014.</p> <p>A 04/02/14 neurology consult (referral from dialysis center) documented for the last three months Resident #1 was experiencing bilateral hand weakness and numbness. There were was no documentation of the physical appearance of the resident's hands in the 04/02/14 report. The neurologist confirmed via testing that the resident had ulnar neuropathy.</p> <p>In a 04/11/14 physician progress note Resident #1's nurse practitioner (NP) documented there were ulcerations, eschar, necrotic tissue, and scabbed areas on the fourth and fifth digits of the resident's right hand.</p> <p>At 10:38 AM on 08/27/14 the NP stated 04/11/14 was the first time she was aware of Resident #1 having skin integrity problems to her right hand. She reported these fingers were hard and dry, but presented without odor. According to the NP, Resident #1 had severe arterial disease, smoked cigarettes, and was on dialysis. She commented, depending on whether the damage to the fingers was the result of disease progression or embolism problems, the resident's fingers may</p>	F 309	<p>3. Resident # 8 received Doxycycline twice a day starting 8/20/14 thru 8/27/14.</p> <p>Residents <input type="checkbox"/> physician orders and medication records were audited on 9/2/14, 9/3/14, and 9/11/14 by Nursing Supervisors and Assistant Director of Nursing to identify antibiotic that may have been ordered. The audit included reconciling the physicians order the residents <input type="checkbox"/> medication administration records.</p> <p>Licensed nurses were reeducated on assessment of skin integrity concerns that may be observed which included documentation, notification of physician and obtaining treatment orders as appropriate and follow up monitoring by Staff Development Coordinator (SDC) on 9/11/14 and 9/12/14. The Unit Managers and/or Assistant Director of Nursing (ADN) will complete weekly skin assessments on residents to identify any skin integrity concerns for one month, then monthly for 2 months. The Unit Managers and/or Assistant Director of Nursing will review/audit documentation of residents that have skin integrity concerns weekly for 3 months.</p> <p>Licensed nurses were reeducated on transcription of antibiotic orders, the need for a stop date for any antibiotic and the process to follow if the ordered medication is not in the center. The reeducation was provided by the SDC on 8/27/14, 8/28/14 and 9/8/14. The Unit Manager and/or ADN will audit physician orders for</p>		

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F 309	<p>Continued From page 2</p> <p>have become necrotic anywhere from hours to months ago.</p> <p>In a 04/14/14 physician progress note Resident #1's primary physician documented the tip of the right fourth finger was black, but the skin was intact, and there were two separate blackened areas on the right fifth finger. "She (the resident) feels it is from having her blood sugars tested that her fingers have changed. She notes no prior fistula or shunt to right arm. Her hand is is cool at times."</p> <p>A 04/14/14 physician order requested no finger sticks on the right hand, no blood pressure readings from the right arm, Doppler study on right upper extremity, referral to vascular surgery, and 81 milligrams (mg) of aspirin daily.</p> <p>A 04/15/14 ultrasound report documented Resident #1 had arterial occlusive disease of the right arm.</p> <p>Resident #1's 04/30/14 quarterly minimum data set (MDS) documented her cognition was moderately impaired.</p> <p>During the physical exam on a 05/05/14 follow-up neurology consult the neurologist documented, "Necrotic changes were noted on digits 3 - 5 of right hand."</p> <p>A 05/12/14 vascular surgery consult (referral from nursing home) documented Resident #1 had "necrosis of the entire right third digit (her third finger was necrosed all the way to the base of her hand) and partial fourth and fifth digits." Heart valve studies were completed, and the resident was referred to orthopedics for further evaluation</p>	F 309	<p>antibiotics and reconcile to medication administration record daily for 4 weeks, then weekly for 2 months.</p> <p>Licensed nurses were reeducated on the importance of timely ordering and re-ordering all medications and especially antibiotics on 9/19, 9/20, 9/21, 9/22, and 9/23/2014 by SDC and Administrative Nurses. Nurse completing admission or receiving new medication orders will enter the orders into PCC, print out the requisition and fax to the pharmacy. Re-orders are to be scanned by the charge/medication nurse. Scanned orders are automatically uploaded to the pharmacy for refill. Pharmacy Technician will provide in-service education on 9/23/14 and will leave printed materials containing information on the proper procedure to use for ordering new medications and re-ordering medications. Nurses who missed the training sessions will be required to review the training materials and pass a post test before working another shift. The make-up training will be conducted by the SDC, or Administrative Nurses.</p> <p>4. The Director of Nursing will review the audits of skin assessments, the audit for documentation, the audit regarding antibiotic orders, and the procedures for ordering and refilling medications for any trends and present to the Quality Assurance Committee monthly for 3 months.</p>		

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F 309	<p>Continued From page 3 for digit amputation.</p> <p>In a 05/19/14 physician progress note Resident #1's primary physician documented, "She (the resident) has follow-up with vascular surgery and await further recommendations of whether or not she is a candidate for surgical management. In the meantime, monitor all areas of ischemia and eschar for infection or wet gangrene--currently dry."</p> <p>A 05/22/14 orthopedic consult documented, "...her fingers are mummified and necrotic and this has been going on for a long time." At this time the orthopedist only had information from the resident to evaluate so he scheduled a follow-up appointment.</p> <p>A 05/28/14 orthopedic consult documented, "She is demarcating (developing a more defined zone of inflammatory reaction separating gangrenous tissue from healthy tissue) a little bit more, and I told her that we are going to have to wait until she demarcates further to try to figure out exactly what we are going to do and whether we are going to amputate her fingers."</p> <p>A 06/02/14 follow-up orthopedic consult documented, "Her fingers are demarcating. We are still waiting for the right ring finger to demarcate further."</p> <p>A 06/16/14 follow-up orthopedic consult documented, "____ (name of resident) is demarcating her fingers. She still complains of pain with this. She wants to keep her index finger, but it is as black as her other fingers...We will get notes from ____ (name of vascular surgeon) office, and we will talk to him and see</p>	F 309	4. The Director of Nursing will review the audits of skin assessments, the audit for documentation and the audit regarding antibiotic orders for any trends and present to the Quality Assurance Committee monthly for 3 months.		

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F 309	<p>Continued From page 4 what we can do at this point. I went ahead and scheduled her surgery."</p> <p>A 06/20/14 2:00 PM nursing home interdisciplinary progress note documented Resident #1 returned from a fishing trip with family with pain and swelling of the right hand. The resident reported she thought this was caused by a fly bite to her hand during the trip.</p> <p>Record review revealed the 06/20/14 interdisciplinary progress note was the first time direct care staff at the nursing home documented on the appearance or assessment of Resident #1's right hand/fingers.</p> <p>A 06/23/14 physician progress note, written by Resident #1's primary physician, documented, "She (the resident) is scheduled for right finger amputations next week. She has had progressive gangrene dry to her right hand, but now has developed increased swelling and drainage to her right hand at the first MCP (metacarpal)...Staff has noted her picking at the dried dead black skin to her fingers." The physician plan documented, "Monitor closely and consider expanding antibiotic if clinically worsens." (This was the last physician progress note completed on Resident #1 until after her amputation).</p> <p>A 06/23/14 physician order started Resident #1 on Doxycycline (antibiotic medication) 100 mg twice daily (BID) x 10 days for wet gangrene of fingers and on Bactroban 2% ointment to affected area x 14 days.</p> <p>On 06/24/14 "Resident has gangrene area on her right hand" was identified as a problem on</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>Resident #1's care plan. Interventions to this problem included "Monitor for any increased s/sx (signs/symptoms) of infection and alert (primary physician) as needed." (The care plan identified a problem with Resident #1's skin integrity on the right hand previously on 04/17/14, but the revision on 06/24/14 wiped out the original electronic problem and interventions).</p> <p>Review of the June and July 2014 medication and treatment administration records revealed Resident #1 received the antibiotic and the ointment as ordered.</p> <p>A 07/07/14 follow-up orthopedic consult documented, "She (the resident) is going to lose her hand, the thumb will probably be the only thing left, and she may even have to go back further with further amputations and she understands that, but she is ready to proceed with this plan because of severe pain."</p> <p>At 3:43 PM on 08/26/14, during a telephone interview, NA #1 stated up until June 2014 the fingers on Resident #1's right hand were black and dry. However, she reported after the fly bite in June 2014 the resident's fingers had a "rotten smell" right up until she left the facility for her amputation. The NA explained the fingers on the right hand were "weepy" after the fly bite.</p> <p>Record review revealed no documentation about the appearance or assessment of the resident's right hand/fingers by nursing home direct care staff after the fly bite on 06/20/14 and before the resident was discharged on 07/11/14 for amputation of the fingers on her right hand.</p> <p>A 07/11/14 hospital operative report documented,</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>"Gangrene of the index, middle, ring and small fingers up to the metacarpophalangeal joints and somewhat beyond on the volar aspect. Some pus was found as there were some areas of wet gangrene....After amputation of these fingers fairly good tissue was seen. There was good bleeding at the open end of the amputations."</p> <p>07/21/14 interdisciplinary progress notes documented Resident #1 expired in the facility.</p> <p>At 5:05 PM on 08/26/14 the director of nursing (DON) stated she expected nursing staff to observe and assess Resident #1's fingers on her right hand daily, starting in March when blackened areas were first noted through discharge for the amputation. She reported this information should have been documented daily in the interdisciplinary progress notes.</p> <p>At 11:42 AM on 08/27/14, during a telephone interview, Resident #1's primary physician stated he referred the resident to the vascular surgeon who would had a better idea about the optimal time to amputate necrotic fingers. He reported as long as the resident's fingers remained dry, the only danger of waiting on the amputation was the loss of viable tissue. However, he commented when the gangrene became wet it became more imperative to amputate because the chance of infection and sepsis was increased. According to the physician, he expected nursing home staff to assess and document on the necrotic fingers weekly, but when the wet gangrene developed he expected the staff to assess and document daily.</p>	F 309			

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F 309	Continued From page 7  2. A review of the Admission Assessment dated 07/25/2014 revealed Resident #8 was re-admitted to the facility on 07/18/2014 with diagnoses which included, but were not limited to, anemia, heart failure, hypertension, and Parkinson's disease.  An observation of medication administration for Resident #8 was made on 08/26/2014 at 9:15 AM. Upon observation, the medication nurse, Nurse #1, discovered that the resident's Doxycycline was not available in the medication cart. After Nurse #1 administered the other medications that Resident #8 was scheduled to receive, she went to the nurse's station to make a request for a Doxycycline dose from the facility's local back-up pharmacy. Nurse #1 explained that a facility staff member would need to pick up the order from the pharmacy.  A review of the August 2014 Medication Administration Record (MAR) revealed Resident #8 was to receive the following: "Doxycycline Hyclate Tablet 100 milligram, give 1 tablet by mouth two times a day for L (left) toe infection. Start Date- 08/19/2014." (Doxycycline Hydrate is an antibiotic for the treatment of bacterial infections.) The Doxycycline Hyclate was initialed as given twice per day on 08/21/2014, 08/22/2014, 08/23/2014, 08/24/2014, and 08/25/2014. The MAR also indicated that the resident was to continue the antibiotic twice per day through 08/26/2014, for a total of 12 doses.	F 309			



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F 309	<p>Continued From page 8</p> <p>A review of the handwritten physician's orders for Resident #8 revealed an order dated 08/19/2014 for Doxycycline 100 milligrams by mouth twice per day for seven days. The order was signed by the Nurse Practitioner on 08/19/2014.</p> <p>In an interview with Nurse #1 on 08/26/2014 at 10:00 AM, she stated that the Doxycycline was to be given twice per day for 7 days starting 08/19/2014, and she did not know why the medication was not started until 08/21/2014. She stated that the MAR reflected that the Doxycycline was to be administered only through 08/26/2014, which was a total of only 6 days.</p> <p>An interview was conducted with Nurse #2 on 08/26/2014 at 10:30 AM. During the interview, she stated that she was the nurse who read the physician's order for Doxycycline on 08/19/2014 and created a MAR to reflect administration for the antibiotic. She also stated she did not know why the Doxycycline therapy was not initiated the same day, 08/19/2014, and that the MAR should have reflected that the antibiotic was to be given for 7 days, twice per day, instead of 6 days twice per day. She explained that she reported to the nurse who was coming in for the following shift that the Doxycycline had been ordered, and that she would probably need to get the first dose from the back up medication kit in the facility. Nurse #1 further stated that she did not know why the Doxycycline was not administered to Resident #8 on 08/19/2014 or 08/20/2014.</p> <p>In an interview with the facility's Nurse Practitioner on 08/26/2014 at 11:00 AM, she stated that she wrote the order for Doxycycline for Resident #8 on 08/19/2014, and that she</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>expected for the antibiotic to be started the same day, or at least the next day, depending on the time the order was written on 08/19/2014. She reiterated that if an infection was present for the resident, the antibiotic therapy initiation should not have been delayed until 2 days after it was ordered. In addition, she stated that the MAR did not reflect the correct number of days or doses the Doxycycline was to be administered, and that she expected for the resident to receive 14 doses, not 10 or 12 doses. She also stated that Doxycycline was not a medication that would be kept in the back up kit in the facility.</p> <p>An interview was conducted with the Director of Nursing (DON) on 08/27/2014 at 5:30 PM. During the interview, the DON stated that she would expect for the Doxycycline to be started on the same day as it was ordered, or at least the next day if the order was made late in the day. The DON also stated that Doxycycline was never kept in the back up medication kit in the facility.</p> <p>In a telephone interview with the pharmacy representative on 08/27/2014 at 1:00 PM, she stated that the new order for Doxycycline was faxed to the pharmacy on 08/20/2014, and that the pharmacy dispensed 10 doses on 08/20/2014 in the evening. She explained there was no start or stop date included with the order, and no duration for the Doxycycline Hyclate to be administered, so the pharmacy could only dispense 10 doses until clarification of the order could be made. The representative also stated that if a medication could not be dispensed immediately after it was ordered, then the order would be provided by the local back-up pharmacy for the facility. In addition, she stated that it is the responsibility of the facility to provide start</p>	F 309			

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F 309	Continued From page 10 dates, stop dates, and duration of antibiotic therapy to the pharmacy when a new order was placed. She added that a request was made for 2 doses of Doxycycline Hyclate on 08/26/2014 and for 2 doses on 08/27/2014, and that these orders were filled by the facility's local back up pharmacy. Also, the representative stated the pharmacy had provided training for the facility regarding protocol for ordering new medications for residents and that refresher training could be provided by request at any time.	F 309			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to make changes in the treatment of a pressure ulcer as recommended by the wound clinic and signed off on by the primary physician team, and failed to assess a pressure ulcer weekly per facility protocol for 1 of 3 sampled residents (Resident #1) with pressure ulcers. Findings included:  A 11/22/13 hospital discharge summary documented, "...she (Resident #1) has a known	F 314	F 314  1. Resident #1 is no longer in the center 2. The Administrative nurses complete a head to toe skin assessment on resident on 9/12/14 and 9/15/14 to identify any resident that may have skin integrity concerns. Any concerns identified, a physician's order was obtain for treatment as appropriate along with documentation completed in the medical record of the skin integrity concern. Unit	9/24/14	

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F 314	<p>Continued From page 11</p> <p>history of decubitus ulcer with underlying osteomyelitis of the sacral bone in the past. She was completely noncompliant with her antibiotics...."</p> <p>Resident #1 was admitted to the facility on 11/22/13, readmitted to the facility on 12/10/13, and expired in the facility on 07/21/14. The resident's documented diagnoses included sacral pressure ulcer, peripheral neuropathy, diabetes, and end stage renal disease with hemodialysis.</p> <p>A 11/22/13 admission nursing assessment documented Resident #1 had a stage II pressure ulcer on her sacrum, and there was pain associated with this wound.</p> <p>A 11/22/13 interdisciplinary progress note documented, "Wound round completed, sacral stage II wound assessed. Area was present on admission, measures 3.5 x 1.3 x 0.3 cm (centimeters). Wound bed is greater than (symbol used) 50 epithelial tissue with macerated wound edges, surrounding tissue healthy. Minimal amount of serosanguineous drainage with no odor. Pt. (patient) does not complain of (symbol used) pain. Will start daily dressing changes with Maxorb as per protocol. Has wound clinic appointment 12/03/13.</p> <p>A 11/26/13 physician progress note documented Resident #1 had "sacral wound with infection, stage IV."</p> <p>Resident #1's 11/29/13 admission minimum data set (MDS) documented her cognition was intact, and she had a stage II pressure ulcer.</p> <p>Record review revealed Resident #1 was</p>	F 314	<p>Managers reviewed weekly documentation of residents with skin integrity concerns on 9/19/14. Medical record audit of consultant reports was completed on 8/27/14, 8/28/14, and 9/4/14 by Director of Nursing, Assistant Director of Nursing, and Unit Managers to identify any treatment orders written by consultant physicians.</p> <p>3. Licensed Nurses were educated on reviewing consultant physician consult form for orders upon return to the center and writing orders that may be sent back with the resident. The education was presented by the SDC on 8/27/14 and 8/28/14. The Wound Champion was educated on weekly assessment documentation by the Director of Nurses on 9/9/14. The Unit Managers and/or Assistant Director of Nursing (ADN) will complete weekly skin assessments on residents to identify any skin integrity concerns for one month, then monthly for 2 months. The Director of Nurses will audit the weekly documentation of skin integrity concerns weekly for three months. The Unit managers will audit the returning consultant form weekly for any orders that may have been recommended and reconcile with the physician orders.</p> <p>4. The Director of Nurses will review the audit for the weekly skin integrity documentation and the audit of consultant reports for trends and present to Quality Assurance Committee monthly for 3 months.</p>		

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F 314	<p>Continued From page 12 hospitalized from 12/07/13 until 12/10/13.</p> <p>A 12/17/13 physician progress note documented Resident #1 had "sacral wound with infection, stage IV."</p> <p>The facility did not assess the resident's wound after 11/22/13 until 12/18/13. On 12/18/13 the sacral pressure ulcer remained a stage II wound measuring 3.0 x 0.5 x less than 0.1 cm.</p> <p>Record review revealed Resident #1's first wound clinic appointment was 12/27/13. Comparison between wound clinic recommendations and treatment administration records (TARs) revealed the facility followed wound clinic recommendations until 01/24/14 when Resident #1's physician assistant (PA) ordered the sacral wound treatment of Maxorb Ag with border gauze daily versus the clinic recommendation of Aquacel Ag with zinc oxide in the periwound, xtrasorb foam dressing, and tape or tegaderm every two days.</p> <p>Record review revealed members of Resident #1's primary physician team signed off on wound clinic recommendations made on 02/07/14, 03/12/14, 03/26/14, and 04/16/14, but the facility did not provide the recommended wound treatments. The facility continued to provide Maxorb Ag with border gauze daily through 04/30/14. The wound clinic's treatment recommendations were for Iodosorb gel with xtrasorb foam dressing every three days on 02/07/14, zinc oxide/Aquacel Ag/xtrasorb/tegaderm or medipane every three days on 03/12/14, Prisma or Promagran/zinc oxide/foam/tape or tegaderm every three days on 03/26/14, and skin prep and sensicare to the</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>periwound/Prisma or Promagran to the wound bed/xtrasorb foam dressing every three days on 04/16/14.</p> <p>Review of the Skin Integrity Reports revealed Resident #1's sacral pressure ulcer was not assessed between 04/10/14 and 05/02/14.</p> <p>Resident #1's 04/30/14 quarterly MDS documented her cognition was moderately impaired, and she had a stage II pressure ulcer.</p> <p>On 05/01/14 the facility began to follow the treatment recommendations made by the wound clinic on 04/16/14 and 04/30/14 for skin prep and sensicare to the periwound/Prisma or Promagran to the wound bed/xtrasorb foam dressing every three days.</p> <p>On 05/05/14 "Resident has actual skin breakdown related to incontinence, vascular disease, limited mobility, refuses incontinent care at times; resident has a pressure ulcer on her sacrum" was identified as a problem on the resident's care plan. Interventions to this problem included "Provide wound treatment as ordered", "Weekly skin assessment by licensed nurse", and "Weekly wound assessment to include measurements and description of wound status."</p> <p>Resident #1's Skin Integrity Report documented on 05/16/14 her sacral wound had declined to a stage III pressure ulcer measuring 1.8 x 1.5 x 0.3 cm with 75% epithelial tissue and 25% slough in the wound bed.</p> <p>Review of the Skin Integrity Reports revealed Resident #1's sacral pressure ulcer was not assessed between 05/22/14 and 06/20/14.</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>05/28/14 and 06/11/14 the wound clinic recommended continuing its 04/16/14 and 04/30/14 recommendations for the treatment of the resident's sacral pressure ulcer, but recommended changing the frequency of the treatment. These recommendations were signed off on by Resident #1's primary physician team. "Change dressing every other day or as needed for excessive drainage.</p> <p>Review of Resident #1's May and June 2014 TARs revealed the facility continue to change the dressing to the sacral pressure ulcer every three days.</p> <p>A 06/23/14 physician progress note documented, "...remaining (sacral) wound is small. May d/c (discontinue) wound clinic and continue current care and monitoring with staff."</p> <p>Resident #1's Skin Integrity Report documented on 07/09/14 the resident had a stage II sacral pressure ulcer measuring 1.0 x 0.6 x 0.2 cm with greater than 75% granulation tissue in the wound bed.</p> <p>Record review revealed no further assessments of the resident's sacral pressure ulcer until she expired in the facility on 07/21/14.</p> <p>At 4:12 PM on 08/26/14 the director of nursing (DON) stated per facility protocol pressure ulcers were to be measure and assessed weekly. She also reported when members of the primary physician team signed off on consult recommendations, the facility was supposed to follow them. The DON commented she could not explain why the facility did not follow wound</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>clinic recommendations for treatment of Resident #1's sacral pressure ulcer from 02/07/14 through 04/16/14 and recommendations for the change in frequency to treatments made on 05/28/14 and 06/11/14. The DON stated these recommendations should have been followed by the facility since all of them were signed off on by the resident's primary physician team.</p> <p>At 4:20 PM on 08/26/14 Unit Manager #1 stated wounds were to be measured and assessed weekly. She reported this was important to capture any decline in the wounds quickly and react by possibly changing treatments/frequencies and increasing nutrition interventions to promote healing. She explained she was the only unit manager in the facility for a long period of time, and she did the best she could, but was not always able to assess wounds/pressure ulcers weekly per facility protocol. According to this unit manager, when members of the primary physician team signed off on consult recommendations, the facility was supposed to follow them.</p>	F 314			