STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 12/05/2014

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 000	INITIAL COMMENTS IDR 1/26/15 resulted in deleted of F 157 G and reduction of F 280 and F 314 G to D.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update the care plan for a resident with a sacral pressure ulcer to address repetitive head movement, and failed to care plan preventive measures to prevent an ulcer to the back of the head from worsening for 1 of 2 residents care plans reviewed for pressure ulcers (Resident #36). Findings included:	F 280	F280 Right to Participate Planning Care Revise CP Comprehensive Care plans are developed and revised by our qualified persons after each assessment.	12/23/14

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

Electronically Signed | 12/19/2014

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F 280	Continued From page 1 Resident #36 was admitted into the facility on 8/11/14. Diagnoses included General Muscle Weakness, Encephalopathy (disease that affect brain functioning) and Pressure Ulcer to the sacrum. The admission Minimum Data Set (MDS) completed on 8/18/14 indicated short and long term memory problems. Decision making was severely impaired and there was no rejection of care listed. Extensive care of two persons' physical assist was required with bed mobility and transfers. No pressure ulcer was indicated to the head; however at risk for pressure ulcer development was indicated. The Care Area Assessment (a tool used for identifying care problems) completed on 8/18/14 specified Resident #36 required staff assistance with all transfers, turning and repositioning due to at risk for pressure ulcers. The resident also required the staff assistance to move sufficiently, to relieve pressure over any one site and with all transfers, turning and repositioning. No pressure ulcer to the head, or repetitive movement was indicated. A review of the care plan dated 8/21/14 indicated as a problem impaired thought process with short and long term memory loss, difficult in making needs known and self care deficit related to decline in condition and decreased mobility. The care plan in part read "Provide incontinence care timely and ensure skin clean and dry, measure wound at least once a week - record appearance, amount and odor of any drainage and report decline in wound status to the physician when available, administer treatment as ordered by the physician and document, and use pillows, air mattress, other supportive devices to assist with positioning and avoid restrictive clothing."	F 280	Corrective Action for those residents found to have been affected. Resident #36 continued to be treated for his head ulcer and has since healed. Corrective Action for those residents found to have been affected. Any resident that develops a skin condition can be subject to this alleged deficient practice. All other residents with skin conditions had their care plan evaluated by the DON and/ or Nurse Managers. No other residents were found to be affected by this alleged deficient practice. Measures put into place or systemic changes made The MDS/ Care plan nurse responsible for not updating the care plan correctly has been reeducated on proper protocol for updating a plan of care for any resident who develops any type of skin condition. Ultimately the responsibility lies with the MDS/ Care plan nurse to update the plan of care, although the DON, ADON, and Nurse Mangers have been reeducated to reflect changes on the care plan as necessary. Monitor A monitoring tool titled Change in Condition has been instituted and used in our clinical ops meeting to determine if care plans have been appropriately	

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F 280	Continued From page 2 A review of the nurse's note dated 10/14/14 indicated while performing incontinence care, the Nursing Assistant (NA) while the resident was turned on his side, noticed an opened area to the back of Resident #36's head. The area was documented as opened, with drainage, measured 3.5 cm (centimeter) in diameter, cleaned with normal saline, a sponge dressing applied and the treatment nurse (Nurse #2) notified. The quarterly MDS completed on 11/11/14 indicated no problems with mental status. Extensive assistance of two persons' physical assist was required with bed mobility and transfers. Rejection of care was indicated as occurred 1 to 3 days. A stage 2 pressure ulcer was listed dated 10/14/14, described with granulation tissue-pink or red tissue with shiny, moist and granular appearance. Ulcer care and treatment included: pressure reducing device for chair/bed, turn/reposition, nutrition/hydration, pressure ulcer care, application of dressings and apply ointments/medications. The care plan updated on 11/18/14 indicated to continue with the current care plan - referring to the previous care plan dated 8/21/14. Approaches for care for pressure ulcer directed to "Measure wound at least once a week, record appearance, report any decline in wound status to physician, administer treatments as ordered by physician and document, use pillows, air mattress and other supportive devices to assist with positioning." The care plan did not specifically indicate a pressure ulcer to the back of the head, measures or interventions to address the repetitive head movements. On 12/3/14 at 10:50 am, in an interview, the Director of Nursing (DON) stated "Resident #36	F 280	updated for new concerns. The DON and/or Unit Managers are reviewing any changes in skin condition on a daily basis in our morning clinical ops meeting and in our weekly wound care focus group. The Monitoring tool will be reviewed again during this weekly focus group. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the DON with the responsibility of follow through with any changes or follow-ups from committee.	

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F 280	Continued From page 3	F 280		

pressure ulcer to the back of his head was acquired in the facility." She indicated the resident had a history of constantly moving his head from one side to the other. She added the facility had attempted a Geri chair, Brodachair and currently an air mattress to allow freedom of the head from a surface; however the resident constantly continued to move his head from side to side when in the bed and Geri chair. She added the resident was resistant with being turned and repositioned every two hours by the staff. The DON indicated the care plan did not reflect the resident constantly turning and repositioning his head while in the bed and the Geri chair, nor, Resident #36 removal of the dressings from the back of his head himself; however she expected the care plan to reflect such.

On 12/3/14 at 3:06 pm, in an interview, the DON, accompanied by the MDS nurse stated she (DON) did not expect Resident #36 to go two weeks without a skin assessment being completed. She stated a skin assessment should have been completed on 9/30 and 10/7/14. She elaborated because the treatment nurse was on leave from 12/1 - 12/3/14, the skin assessment still should have been completed on 12/1/14 however the record did not reflect such. The MDS nurse indicated she became aware of the stage II pressure ulcer to the back of the head on 10/14/14. She also stated she was aware the resident constantly turned and repositioned his head from side to side while in the bed and Geri chair. The MDS nurse indicated she did not care plan specifically; related to the stage II pressure ulcer to the back of the resident's head or the constant turning of his head from side to side while in the bed and Geri chair. She concluded she completed a generic care plan for pressure

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F 280	Continued From page 4 ulcers.	F 280		
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, observations, staff and physician interviews, the facility failed to complete weekly skin assessments and closely monitor the progress of a worsening pressure ulcer and also failed to put interventions in place to relieve pressure for 1 of 2 residents reviewed for pressure ulcers (Resident #36). Findings included: Resident #36 was admitted into the facility on 8/11/14. Diagnoses included General Muscle Weakness, Encephalopathy (disease that affect brain functioning) and Pressure Ulcer to the sacrum. The admission Minimum Data Set (MDS) completed on 8/18/14 indicated short and long term memory problems. Decision making was severely impaired and there was no rejection of care listed. Extensive care of two persons' physical assist was required with bed mobility and transfers. No pressure ulcer was indicated to the head; however at risk for pressure ulcer	F 314	F314 Treatment/SVCS to Prevent/Heal Pressure Sores Based on the comprehensive assessment of a resident, the facility does ensure that a resident who enters the facility without pressure sores does not develop pressure sores. Corrective Action for those residents found to have been affected Resident that was found #36 continued to be treated for his head ulcer and has since healed. Corrective Action for those having the potential to be affected.	12/23/14

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F 314	Continued From page 5 development was indicated. The Care Area Assessment (a tool used for identifying care problems) completed on 8/18/14 specified Resident #36 required staff assistance with all transfers, turning and repositioning due to at risk for pressure ulcers. The resident also required the staff assistance to move sufficiently, to relieve pressure over any one site and with all transfers, turning and repositioning. No pressure ulcer to the head, or repetitive movement was indicated. The Braden scale (an assessment tool used for predicting pressure ulcer risk) completed on 8/11/14 scored a 13; indicative of moderate risk. A review of the nurses notes documented on "8/14/14 involuntary movement", "8/15/14 attempted (Resident #36) to help with positioning in bed by grabbing the headboard and pulling himself up when being pulled up in bed", "8/18/14 difficultly to keep resident positioned due to involuntary movement" and "8/19/14 grabbed head board and pulled self up in bed when staff indicated they were going to do it." A review of the care plan dated 8/21/14 indicated as a problem impaired thought process with short and long term memory loss, difficult in making needs known and self care deficit related to decline in condition and decreased mobility. The care plan in part read "Provide incontinence care timely and ensure skin clean and dry, measure wound at least once a week - record appearance, amount and odor of any drainage and report decline in wound status to the physician when available, administer treatment as ordered by the physician and document, and use pillows, air mattress, other supportive devices to assist with positioning and avoid restrictive clothing."	F 314	Any resident that develops a skin condition can be subject to this alleged deficient practice. All other residents with skin conditions had their treatment and monitoring records reviewed by the DON and/ or Nurse Managers at the time of survey. No other residents were found to be affected by this alleged deficient practice. On 12/23/14 a 100% head to toe skin audit has been completed on each resident with written assessments updated as necessary. Measures put into place or systemic changes made All licensed staff has been reeducated on treatment and monitoring of skin conditions between 12/18/14-12/22/14. For instance if the wound gets worse, if it develops eschar or exudate, or does not have any improvement in two weeks. The monitoring tool is labeled Change in Condition. New licensed staff will be educated regarding treatment and monitoring documentation during the orientation period. Monitor A monitoring tool titled Change in Condition has been instituted and used in our clinical ops meeting to determine if treatment and monitoring records have been appropriately reviewed and updated. The DON and/or Unit Managers are	

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F 314	Continued From page 6 A review of nurse's notes dated 8/25/14 read "Unable to keep abrasion/skin tear to back of head with a dressing on it related to continuous movement of head." A review of the weekly skin assessment record dated 9/2, 9/9, 9/16, 9/23/14, revealed the skin assessments were signed as completed. No pressure ulcer or changes in skin condition to the back (posterior) of Resident #36's head was indicated. The skin assessment records dated 9/30 and 10/7/14 were not signed as completed. A review of the daily staffing nursing assignment sheet dated 10/7/14 for the 400 hall read "400 hall do own treatments." Nurse #1 was the primary nurse for this day. A review of the nurse's note dated 10/14/14 indicated while performing incontinence care, the Nursing Assistant (NA) while the resident was turned on his side, noticed an opened area to the back of Resident #36's head. The area was documented as opened, with drainage, measured 3.5 cm (centimeter) in diameter, cleaned with normal saline, a sponge dressing applied and the treatment nurse (Nurse #2) notified. A review of the wound/skin record completed by Nurse #2 revealed a stage II pressure ulcer to the back of the head was identified on 10/14/14 that measured 1.5 cm (centimeter) length x 2 cm width, no odor, red wound bed with normal brown surrounding skin color and brown edges with hydrocolloid every three days. A review of the weekly skin assessment record completed on	F 314	reviewing treatment and monitoring records on a daily basis in our morning clinical ops meeting and in our weekly wound care focus group. Monitoring tool will be reviewed again during this weekly focus group. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the DON with the responsibility of follow through with any changes or follow-ups from committee.	

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F 314	Continued From page 7 10/14/14 by Nurse #2 was initialed as completed A review of the physician order dated 10/14/14 read "Clean stage II to back of head with normal saline. Pat dry, apply hydrocolloid (a wafer type that contains gel forming agents, that provide a moist healing environment, autolytic debridement and insulation) dressing every 3 days and as needed until resolved." Autolytic debridement refers to the body's own enzymes and moisture to provide rehydration, soften and eventually liquefy hard eschar (dry or dark scab or falling away of dead skin) and slough (indicative of tissue damage). A review of the nurses' notes indicated on "10/27/14 received treatment to Stage II area to back of head, area is without hair due to constant movement from resident, wound bed 0.8 cm x 0.9 cm with Hydrocolloid dressing applied", "11/4/14 received treatment to posterior head and Hydrocolloid dressing applied, wound bed pink with surrounding pink skin where hair has been rubbed away, wound measures 1.5 cm x 2.0 cm which is an increase since last measured", "11/5/14 Resident #36 continues to rub head against Geri chair and causing worsening of wound on his occipital (head) lobe, nursing will do a referral to occupational therapy for possibilities of positioning device, have occipital wound due to constant rubbing his head against back of Geri chair when up in chair", "11/6/14 responsible party notified of use of Broda chair starting today for one week trial to promote improved positioning while out of bed and of stage II to back of head and ongoing treatment", "11/7/14 constantly turns head side to side", "11/10/14 treatment received to stage II with Hydrocolloid dressing but resident is constantly moving and rubs the dressing off his	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 12/05/2014

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F 314	Continued From page 8	F 314		

head after a little while, wound bed is dark pink surrounded by light pink colored skin, size of wound has not changed since last measured."

The quarterly MDS completed on 11/11/14 Resident #36 was indicated with no problems with mental status. Extensive assistance of two persons' physical assist was required with bed mobility and transfers. Rejection of care was indicated as occurred 1 to 3 days. A stage 2 pressure ulcer was listed dated 10/14/14, described with granulation tissue-pink or red tissue with shiny, moist and granular appearance. Ulcer care and treatment included: pressure reducing device for chair/bed, turn/reposition, nutrition/hydration, pressure ulcer care, application of dressings and apply ointments/medications. The care plan updated on 11/18/14 indicated to continue with the current care plan - referring to the previous care plan dated 8/21/14. Approaches for care for pressure ulcer directed to "Measure wound at least once a week, record appearance, report any decline in wound status to physician, administer treatments as ordered by physician and document, use pillows, air mattress and other supportive devices to assist with positioning." The care plan did not specifically indicate a pressure ulcer to the back of the head.

A review of the nurse's notes documented "11/20/14 treatment to posterior head area measured 1.5 cm x 2 cm no bleeding or drainage, Hydrocolloid dressing applied to head - head is elevated off chair to reduce friction."

A review of the wound/skin record completed on 11/24/14 by the treatment nurse (Nurse #2) documented a stage II 1.5 cm x 1.8 cm with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 12/05/2014

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F 314	Continued From page 9	F 314		

odor, red wound bed and pink surrounding tissue with continued hydrocolloid dressing, as the plan of care. The facility was unable to provide a skin assessment for Resident #36 completed for 12/1/14.

On 12/3/14 at 10:15 am, in an interview, Nurse #3 indicated Resident #36 could move his upper body independently but could not move his lower body.

On 12/3/14 at 10:20 am, during an observation, Resident #36 was observed in the bed positioned on his back with his head on the pillow, looking up at the ceiling and the head of bed was at elevated 75 degrees. The resident was not observed turning his head from side to side while in the bed. The resident was lying on an air mattress.

On 12/3/14 at 10:30 am, during an observation, Nurse #3 asked Resident #36 to lift his head from the pillow, to relieve pressure. The resident opened his eyes, attempted to lift his head from the pillow but did not completely lift his head off the pillow. He required the assistance of NA #2 to lift and hold his head, while Nurses #3 provided care to the pressure ulcer on the back of his head. The area was observed to be blackened in the center of the wound bed with surrounding pink skin tissue. The edges of the blackened matter were embedded into the wound completely. As Nurse #3 cleansed the wound, the blackened matter continued in the center of the pressure ulcer fixed to the wound. No odor or drainage was observed.

On 12/3/14 at 10:50 am, in an interview, the Director of Nursing (DON) stated "Resident #36 pressure ulcer to the back of his head was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 10	F 314		

acquired in the facility." She indicated the resident has a history of constantly moving his head from one side to the other. She added the facility had attempted a Geri chair, Brodachair and currently an air mattress to allow freedom of the head from a surface; however the resident constantly continued to move his head from side to side when in the bed and Geri chair. She added the resident was resistant with being turned and repositioned every two hours by the staff. The DON indicated the care plan did not reflect the resident constantly turning and repositioning his head while in the bed and the Geri chair, nor, Resident #36 removal of the dressings from the back of his head himself; however she expected the care plan to reflect such.

On 12/3/14 at 12:23 pm, in an interview, Nurse #3 stated residents' skin assessments are completed weekly according to the skin assessment record, where one documents the completed skin assessment. She added new admission residents were completed by the primary floor nurse and the treatment nurse was responsible for completing weekly skin assessments and treatments. Nurse #3 concluded in the absence of the treatment nurse, the primary floor nurse was responsible for completing the skin assessment and any needed treatment.

On 12/3/14 at 3:06 pm, in an interview, the DON, accompanied by the MDS nurse stated she (DON) did not expect Resident #36 to go two weeks without a skin assessment being completed. She stated a skin assessment should have been completed on 9/30 and 10/7/14. She elaborated because the treatment nurse was on leave from 12/1 - 12/3/14, the skin assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 11	F 314		

still should have been completed on 12/1/14 however the record did not reflect such. The MDS nurse indicated she became aware of the stage II pressure ulcer to the back of the head on 10/14/14. She also stated she was aware the resident constantly turned and repositioned his head from side to side while in the bed and Geri chair. The MDS nurse indicated she did not care plan specifically; related to the stage II pressure ulcer to the back of the resident's head or the constant turning of his head from side to side while in the bed and Geri chair. She concluded she completed a generic care plan for pressure ulcers.

A review of the wound/skin record assessment completed by the DON on 12/4/14 revealed the pressure ulcer to the back of the head worsened which read "Response to treatment: deteriorated, stage: unstageable, 1.2 cm length x 1.5 cm width, wound bed: minimal eschar, with surrounding skin color pink."

A review of the nurse's note dated 12/4/14 completed by the DON in part read "Reassessed wound on resident's occipital (head) area, an area of dark eschar was noted in the middle of wound bed. Physician to be notified for change in treatment orders. Resident continue with constant moving of his head from side to side causing frequent dislodging of dressings. Nursing staff to replace dressing if it is noted to come off."

A review of the physician orders received on 12/4/14 to the DON read "Discontinued all previous treatments to wound on posterior head - clean with normal saline then start Santyl (a wound debriding agent) ointment to area with eschar on wound bed daily (posterior head),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 12 cover with sterile dressing. Stop Santyl application once eschar has come off. Reassess daily." On 12/4/14 at 9:11 am, in an interview, the treatment nurse (Nurse #2) stated she was responsible for doing skin assessments and wound measurements for all residents. She stated because the Hydrocolloid dressing would come off the back of Resident #36's head continuously and the resident would also pull it off; she questioned if the treatment was working due to the resident would move his head back and forth on the pillow while in bed, causing the Hydrocolloid not to stay on. She stated she discussed the concern with the DON and ways were discussed such as roll a sheet up and put behind his neck to elevate his head off of the pillow/Geri chair; however she did not consult with the physician for further guidance. Nurse #2 did not indicate how long she questioned if the treatment was working or why she did not consult with the physician for further guidance. She added prior to the development of the pressure ulcer, she did not have knowledge the resident constantly turned his head back and forth while in the bed and Geri chair. The treatment nurse stated she last saw the pressure ulcer to the back of his head on 11/24/14, per her wound assessment and she documented it was healing as evidence by pink tissue and no odor. She indicated she had not seen the pressure ulcer again until 12/4/14, because she was on a leave of absence from 12/1 - 12/3/14. She stated in her absence, the unit manager or the DON were responsible for completing the skin measurements, per past instructions received from the DON.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 13	F 314		

On 12/4/14 at 10:00 am, in an observation, accompanied by the DON and the treatment nurse, revealed a pressure ulcer to the back of Resident #36's head, with blackened matter embedded into the center of the wound bed and surrounding wound tissue pink.

On 12/4/14 at 10:10 am, in an interview, the DON stated the pressure ulcer to the back of the head was unstageable and she expected the physician to have been notified on 12/3/14 when Nurse #3 assessed a change in the physical description from pink to darken. She stated the wound measurement was not obtained because she instructed the nursing staff the treatment nurse is expected to do them, however the treatment nurse was out on leave of absence from 12/1 to 12/3/14, and the measurements should have been obtained on 12/2/14 by her (DON), to ensure consistency and prevent discrepancies in measurement, in the absence of the treatment nurse.

On 12/4/14 at 10:29 am, in an interview, accompanied by the DON, Nurse #4 who was assigned to do skin assessment/treatment on 10/7/14, acknowledged she was responsible for the skin assessments/treatments of residents, however she was not responsible for Resident #36. Nurse #4 revealed she wrote on the staff assignment sheet "400 hall nurse to do own treatment." The staffing schedule revealed Nurse #4 communicated "400 hall do own treatment."

On 12/4/14 at 11:32 am, in an interview, the unit manager stated she became aware of the pressure ulcer to the back of Resident #36's head on 10/14/14. She stated in the absence of the treatment nurse, the unit manager or the DON is

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	345534	A. BUILDING _____ B. WING _____	C 12/05/2014

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F 314	Continued From page 14	F 314		

responsible for completing skin assessments and wound measurements. She indicated in absence of the treatment nurse on 12/1 to 12/3/14, she did not complete a skin assessment or measurement, nor was she aware there was a change in the status of the pressure ulcer. She added if she had been made aware there was a change in the pressure ulcer, she would have obtained measurements and notified the physician for any new orders or guidance.

On 12/4/14 at 12:42 pm, in an interview, NA #3 who worked on 9/30/14 from 11pm - 7am, stated she recalled giving the resident a bed bath, however did not recall observing any skin concerns.

On 12/4/14 at 1:17 pm, in an interview, NA #4 who worked on 9/30/14 from 3pm - 11pm, stated she did not recall observing any opened skin areas while providing care.

On 12/4/14 at 2:25 pm, in an interview, NA #5 who worked on 10/7/14 from 3pm - 11pm indicate she did not observe any opened skin areas while providing care.

On 12/4/14 at 2:33 pm, in an interview, NA #1 who worked on 10/7/14 from 11pm - 7am stated while providing incontinence care, when she turned and repositioned Resident #36, she observed an open skin area to the back of his head with blood at the site. She stated prior to her observation of the opened area to the back of the head, the resident would not keep a pillow under his head and would rub his head against the sheet of the bed continually when in the bed and in the Geri chair. She stated she did not report this to a nurse because she assumed, the

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F 314	Continued From page 15	F 314		

nursing staff was aware the resident would continually rubbed his head against the bed sheet and Geri chair, and would not keep the pillow under his head. NA #1 concluded she notified the nurse on duty related to the opened area, however did not recall the name of the nurse. NA #1 did not indicate if there was a dressing was in place.

A review of the nurse's note for 10/7/14 did not reveal a nursing entry related to NA # 1' s report. Nurse #7 who worked on 10/7/14 from 11pm - 7am was unable to be interviewed.

On 12/4/14 at 2:50 pm, in an interview, the MDS nurse stated she was aware Resident #36 moved his head from side to side, including general involuntary movements. She stated she did not update the care plan to specifically address interventions to maintain his head from developing a pressure ulcer. She stated she developed the care plan to reflect general interventions for at risk for pressure ulcer preventions. She concluded she was aware the resident would not keep the pillow under his head and moved his head constantly from side to side while in the bed and in the Geri chair.

On 12/4/14 at 4:15 pm, during a pressure ulcer observation, accompanied by the DON she assessed the pressure ulcer to the back of the head as "Black in the center of the wound bed, with surrounding pink tissue."

On 12/4/14 at 4:30 pm, in an interview, Nurse #3 who worked on 9/30/14 from 7am - 7pm, stated she did not recall doing the skin assessment for Resident #36 scheduled on 9/30/14, nor did she receive any reports from the NAs of any skin

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F 314	Continued From page 16 concerns. She further indicated while providing care to the back of the resident's head on 12/3/14, she observed the area (back of head) blackened in the center of the pressure ulcer. She indicated she did not notify the physician because she did not think there was a change in the pressure ulcer. On 12/4/14 at 4:34 pm, in an interview, the physician stated he expected to be notified by the nursing facility within 24-48 hours for chronic concerns and acute concerns immediately to ensure if there was a change or worsening in the resident's condition, medical guidance was provided related to care and treatment. On 12/5/1/4 at 1:52 pm, in an interview, Nurse #1 who worked on 10/7/14 from 7am - 7pm stated she was aware on 10/7/14 the treatment nurse (Nurse #4) did not complete the skin assessment or treatments as documented on the staffing assignment sheet for the 400 hall. Nurse #1 acknowledged she was supposed to do Resident #36's skin assessment. She concluded if she did not sign the treatment record, then the skin assessment was not completed.	F 314		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		12/23/14

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F 425	Continued From page 17 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews, the facility failed to have medication readily available Labetalol (prescribed for hypertension), Nystatin (prescribed for Oral Thrush) to be administered as ordered for 2 of 8 residents medications reviewed (Resident #202, #27). Findings included: 1. Resident #202 was admitted into the facility on 9/17/13. Diagnoses included Hypertension. A review of the physician orders for December 2014 read "Labetalol 200 mg take two tablets by mouth every six hours for hypertension (6:00 am, 12:00 noon, 6:00 pm, 12:00 midnight)." A review of the Medication Administration Record (MAR) revealed Labetalol 200 mg two tabs was signed as administered on 12/2/14 at 12:00 noon and 12/2/14 at 6:00 pm. On 12/3/14 at 1:49 pm, in an interview, Nurse #5 who worked on 12/2/14 from 7am-7pm stated she did not administer Labetholol 200 mg two tablets	F 425	F425 Pharmaceutical SVC- Accurate Procedures, RPH The facility provides routine and emergency drugs and biologicals to its residents, or obtains them under an agreement described in o483.75 (h) of this part. Corrective Action for those residents found to have been affected. Resident #202 is receiving medication as ordered and continues to do so. Resident #27 received ordered medication until planned discharge to home. Corrective Action for those having the potential to be affected. All residents that receive medication have the potential to be affected by the same alleged deficient practice. An audit was	

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F 425	Continued From page 18 at 12:00 noon or 6:00 pm because the medication was not available on the medication cart. She stated she should have circled the medication on the MAR to signify not administered. She stated she reported the concern to the Director of Nursing (DON). On 12/4/14 at 3:08 pm, in an interview, the Pharmacist stated the request to refill the medication was not received until 12/1 and was refilled on 12/2/12. He stated expectation is the facility not wait until medications are almost depleted prior to reordering. He concluded the facility is expected to pull the reorder sticker upon noticing the supply of mediation is getting low and fax to the pharmacy, to ensure medication arrives before completely exhausted. On 12/4/14 at 4:00 pm, in an interview, the DON stated she expected the reorder sticker to have been pulled prior to the medications being exhausted and the meds to be available and administered as ordered. 2. Resident #27 was admitted into the facility on 11/5/14. Diagnoses included Oral Thrush. A review of the December 2014 physician orders read "Nystatin 5 milliliters (ml) by mouth four times daily for two weeks, end 12/5/14 for Oral Thrush at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm." A review of the MAR Nystatin 5 ml on 12/2/14 was signed as administered at 8:00 am, 12:00pm, and 4:00 pm by Nurse #5. On 12/3/14 at 1:49 pm, in an interview, Nurse #5 stated she did not administer Nystatin 5 ml on	F 425	done by the DON and the Unit Managers at the time of the survey, and no other resident was identified as having unavailable medications. Measures put into place or systemic changes made The individual nurse responsible for this deficient practice has received individual reeducation in medication administration. All licensed nurses have received reeducation in medication administration during 12/18/14-12/22/14. A focus group has been held consisting of Nurse Managers and Pharmacist to determine if any other issues could contribute to this alleged deficient practice. New staff nurses will receive medication administration education during orientation. Monitor The DON and/or Nurse Managers will perform daily audits of MARs for two weeks, looking for medications that may not be available. Random MAR audits for four weeks. Monthly random MAR audits for three months. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the DON with the responsibility of follow through with any changes or follow-ups from committee.	

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F 425	Continued From page 19 12/2/14 at 8:00 am, 12:00 noon or 4:00 pm because the medication was not available on the medication cart. She stated she reported the concern to the DON. On 12/4/14 at 3:08 pm, in an interview, the Pharmacist stated the last refill was on 11/20/14 and was a 15 day supply. He stated expectation is the facility not wait until medications is almost depleted prior to reordering. He concluded the facility is expected to pull the reorder sticker upon noticing the supply of mediation is getting low and fax to the pharmacy, to ensure medication arrives before completely exhausted. On 12/4/14 at 4:00 pm, in an interview, the DON stated she expected the reorder sticker to have been pulled prior to the medications being exhausted and the meds to be available and administered as ordered.	F 425		