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	345144	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

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F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews the facility neglected to provide skin assessments and manage skin treatment of a pressure ulcer identified on admission, and the wound progressed to an unstageable wound with necrosis for 1 of 3 residents (Resident # 2), reviewed for pressure ulcers. The findings included: Resident #2 was admitted on 6/16/2016 with diagnoses of stage 4 chronic kidney disease, Alzheimer ' s dementia and type II diabetes. An admission skin assessment was completed by the admitting nurse on 6/26/2016, which noted a reddened area with possible opening on the coccyx. No measurements or staging were noted on this assessment. A review of the Minimum Data Set (MDS) admission assessment dated 6/29/2016 indicated the presence of a stage 2 pressure ulcer, with granulation tissue, present on admission. A review of the care plan dated 7/6/2016 indicated that Resident #2 had a pressure ulcer. Interventions included turning and positioning, incontinent care, wound care as ordered, supplements as ordered, and weekly wound	F 224	F224 Neglect/Abuse/Miappropriation What measures did the facility put in place for the resident affected: On 7/26/2016 resident #2□s wound was assessed by the MDS Coordinator. On 7/26/2016 a referral was made to the wound doctor by the MDS Coordinator. On 7/28/2016 a wound ulcer flow sheet was completed by the treatment nurse. Resident #2 was seen by wound doctor on 7/28/2016. New treatment orders were received by the wound doctor. On 7/28/2016 the resident RP was made aware of condition of wound and new orders received by the DON. On 7/28/2016 the new orders were transcribed to resident #2□s TAR and initiated. On 7/28/2016 an air mattress was applied to resident bed by . On 7/31/2016 resident #2 had a Foley catheter placed by staff nurse per	8/22/16

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

Electronically Signed | 08/22/2016

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F 224	Continued From page 1 assessments. A review of the treatment record indicated that starting on 7/9/2016 a dressing of hydrocolloid was to be applied every 7 days and as needed, no area was identified for the application and no staging or measurements were indicated. Another treatment was started on 7/9/2016 to apply a tegaderm dressing daily and as needed to a busted blister on the right buttock. Further review of this treatment record indicated a treatment for a stage 4 measuring 4 centimeter (cm) x 3 cm x 1 cm to sacrum with black eschar, to clean with normal saline and cover with a hydrogel dressing starting on 7/22/2016. The previous dressing for hydrocolloid was discontinued at this time. A referral for the wound care physician to evaluate was also noted at this time. Treatments were documented as completed. A review of the nursing notes revealed a care plan wound note dated 7/26/2016 at 12:16 pm, by the MDS nurse, which identified an unstageable pressure ulcer with measurements of 6 cm x 5 cm, unable to determine depth. A description of the wound was circular with thick dark eschar covering the entire wound bed, surrounding tissue was sensitive to the slightest touch, no purulent drainage. The note indicated that a dressing saturated with serous drainage was removed and the resident was placed on the physician board for a wound care referral. On 7/27/2016 at 1:40 pm the wound care nurse was interviewed. She indicated that she has been scheduled on the floor instead of being assigned to wound care. She explained that she has not been assigned to wound care for the last month. She explained that one nurse had been out on leave and another nurse was gone and she had been taking a hall assignment since	F 224	physician order. What measures were put in place for residents having the potential to be affected: On 8/22/16 a 100% skin audit was completed on all residents by the MDS nurse, DON, and/or QI nurse for new skin conditions and/or signs/symptoms of abuse/neglect, skin referrals created, treatment initiated, physician and responsible party are notified with documentation in the clinical record to include Wound Ulcer Flow Sheet, Non-Ulcer Flow sheets and Treatment Record as indicated. . On 8/22/2016 100% of all existing skin conditions were assessed by the MDS nurse and/or DON for worsening with appropriate interventions put in place, and MD/RP notification. On 8/22/2016 wound ulcer flow sheets were completed to include staging, measurements, signs/symptoms of infection, wound description, RP/MD notification and current treatment. On 8/22/2016 100% of resident progress notes were reviewed for the past 30 days by the MDS nurse, DON, and/or the QI nurse for any acute changes to include pressure ulcers have been identified. On 8/22/2016 a 100% audit of all TARs was completed by the MDS nurse, DON, and/or QI nurse to ensure all existing skin conditions have treatments in place. On 8/22/2016 a wound meeting was held with the Treatment nurse, DON, QI nurse, and RD in attendance . Starting 8/22/2016 a staff member or members will be	

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F 224	Continued From page 2 then. When asked who is responsible for wound care she explained that the nurses on the halls are supposed to do their own resident ' s wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms. On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2 ' s room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen. On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that. She indicated that she would do the dressings as scheduled on evenings but no one has ever told her that she needed to do measurements. On 7/27/2016 at 4:29 pm the nurse supervisor for	F 224	assigned to complete resident treatments daily as ordered. What systems were put in place to prevent the deficient practice from reoccurring: On 8/12/2016 a 100% in-service for all staff including contract staff was initiated by the administrator related abuse/neglect including signs and symptoms and will be completed by 8/22/2016. On 8/22/2016 an in-service was initiated by the DON to all RN□s and LPN□s related to failure to report skin abnormalities to the physician and delaying treatment for resident can be a form of neglect and will be 100% completed by 8/22/2016. On 8/19/2016 an in-service for all RN□s and LPN□s was initiated by the DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, MD/RP notifications, and skin referrals will be 100% complete by 8/22/2016. On 8/19/2016 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by 8/22/2016. On 8/19/2016 an in-service for all CNA□s and medication aides by the	

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F 224	Continued From page 3 evenings was interviewed. She explained that evenings are responsible for the odd number room dressing changes. When asked about wound assessments and measurements, she indicated that the wound nurse would do those and that the nurses on the hall would not be responsible for wound measurements. On 7/28/2016 at 10:09 am wound assessment and care was observed with the consulting wound care physician and the wound care nurse. The resident was seated in an upright position in bed with her knees raised. The physician instructed the wound care nurse to make sure she was never raised higher than 30 degrees due to the pressure that position would put on her back. He also recommended an air mattress to relieve some of the pressure while in bed. The resident was lowered and turned to her side. The dressing was removed. A strong foul odor was noted. The physician explained that the smell was from necrotic tissue. He tapped the eschar and noted that it was firm and thick. He explained that it needed debriding. Measurements were completed by the physician and noted to be 7 cm x 5 cm x 1 cm, estimated depth due to eschar. The physician explained that it would probably be stage IV after debridement. Debridement was attempted by the physician with a large amount of black substance removed from the wound bed. The physician explained that he was not able to get it all today so he would come back next Thursday to do the rest. On 7/28/2016 at 11:12 am the wound care nurse was observed applying the dressing to Resident #2 ' s sacral wound. She noted that urine was leaking when the resident was moved. She explained that she may benefit from a urinary catheter. She applied the recommended	F 224	DON related to notification to nurse of new skin condition observed and dressings being off or saturated and will be 100% complete by 8/22/2016. On 8/22/2016 the treatment was in-serviced by the DON related to completing treatments as ordered, TARS, skin referrals , completion of wound ulcer flowsheets and flowsheet of non-ulcer skin sheets (how to complete and must be completed every 7 days), notification of MD and RP of new areas and worsening of areas. On 8/16/2016 the director of nursing, nursing supervisors, and all on-call nurses were in-serviced by the administrator that a staff member or members must be assigned to complete treatments daily as ordered. No staff will be allowed to work after 8/22/2016 until in-services are completed. All new hires will receive in-services during new employee orientation. How the facility will monitor systems put in place: On 8/19/2016 the MDS nurse, QI nurse, and/or the DON began auditing 100% of resident progress notes for any acute changes to include new or worsening of skin conditions using the 24 hour report sheets. On 8/19/2016 the MDS nurse, DON, and/or QI nurse began auditing 100% of the TARS, wound ulcer flow sheets, flow sheets of non-ulcer conditions and skin referrals for completion and accuracy using the 24 hour report sheets. A The Treatment nurse, or RN nurses will conduct a skin	

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F 224	Continued From page 4 dressing of Santyl to the wound bed with calcium alginate over that and covered with a dry dressing. After the wound care, on 7/28/2016 at 11:33 am the wound care nurse was interviewed. She indicated that she does not see the wounds like she would like. She explained that she has not been assigned to be the wound care nurse because they do not have enough nurses scheduled. She said, " They schedule me to take a hall and I can ' t do two things at once. " She explained that the nurses rely on the direct care staff to report changes to them. She indicated that most nurses try to do a good job with dressings but they are assigned 40 plus residents at times. When asked if the lack of wound assessments had impacted the wound for Resident #2, she indicated that it had, explaining further that the interventions that were identified today could have been implemented earlier. She indicated that when Resident #2 came to the facility her wound was small. As a wound care nurse, she indicated that she had been trained to assess wounds for changes and identify interventions. She explained that her priority would have been to change treatments per protocol, ask for wound care referrals, change her positioning, and possible ask for a catheter to keep the urine from soaking the wound. She explained she would have been aware of these interventions and communicated them to the physician to put them into place. Staffing for June and July were reviewed. Beginning in June, the wound care nurse was not assigned to wound treatments about half of the time. In July the wound care nurse was assigned to wound care only 4 days. On 7/28/2016 at 3:42 pm the Director of Nursing was interviewed. She explained that for the last	F 224	audit of 10% of the residents and observations for any acute change in condition 2x a week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month using the Chart Audit Tool to ensure any new or worsening skin abnormalities to include pressure ulcers have been identified, skin referrals created, treatment initiated, physician and responsible party are notified with documentation in the clinical record to include Wound Ulcer Flow Sheet, Non-Ulcer Flow sheets and Treatment Record as indicated. Any concerns will be addressed immediately by the treatment nurse or RN nurse with an assessment of the skin abnormality, initiation of treatment, creation of a Skin Referral, notification of the physician and responsible party, and documentation of findings in the clinical record to include Wound Ulcer Flow Sheet, Non-Ulcer Flow Sheet, and Treatment Record. All audits will be completed 2x a week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. On 8/22/2016 a wound meeting was held with the Treatment nurse, DON, QI nurse, and dietary manager in attendance using the wound QI tool . The meeting will continue to be held weekly x 12 weeks then monthly.	

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F 224	Continued From page 5 three weeks the wound care nurse was not assigned to wound care. One week she was on vacation and for two weeks she was assigned to take a hall. She explained that it was necessary. She staffed the floor with the wound care nurse so the halls would be covered and expected the floor nurses to do their own wound care. She indicated that would include assessing wounds.	F 224		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and physician interview, the facility failed to follow the care plan and skin protocol by not providing wound assessments and overseeing treatment of a pressure ulcer, which progressed to an unstageable pressure ulcer with eschar, for 1 of 3 residents (Resident #2) reviewed for pressure ulcers. The findings included: The undated skin care protocol interventions included that the skin should be inspected and appropriate personnel notified of abnormal changes. The protocol indicated skin inspections could be done by Nurse Aides and licensed personnel during daily care and by treatment nurses. The skin care protocol stated, " Patients are to be thoroughly assessed prior to selecting a wound dressing. " The following treatments were	F 282	F Tag 282 Care Planning What measures did the facility put in place for the resident affected: On 8/9/2016 resident #2□s care plan was reviewed by the MDS Nurse to ensure skin impairment to the sacrum was included in the focus. What measures were put in place for residents having the potential to be affected: On 8/22/16 the MDS Nurses completed a 100% audit of resident□s with pressure ulcers care plans to ensure accuracy including staging and interventions. All care plans were updated as necessary.	8/22/16

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F 282	Continued From page 6 included by wound staging: 1. Stage 2 (Partial thickness skin loss) - If wound has small to moderate amount of drainage apply a hydrocolloid and change every seven days and as needed. 2. Stage 3 (Full thickness tissue loss) and Stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle) - Apply a hydrogel to all wound surfaces. Cover with secondary dressing of choice. Frequency of dressing changes per the discretion of the Treatment Nurse. 3. Stage 3 or 4 wounds with necrosis - Santyl dressing recommended for debridement. Resident #2 was admitted on 6/16/2016. The admission assessment indicated the presence of a reddened are with a possible opening on the coccyx. There was no measurements or wound staging provided on this assessment. A review of the Minimum Data Set (MDS) admission assessment dated 6/29/2016 indicated the presence of a stage 2 pressure ulcer, with granulation tissue, present on admission. A review of the care plan dated 7/6/2016 revealed that weekly wound assessments and treatments as ordered by physician or per protocol to sacrum were listed as interventions. There were no other revisions to this care plan as the condition of the pressure wound progressed to an unstageable wound. The care plan did refer to the skin care protocol which defined interventions at different wound stages. A review of the treatment record showed that hydrocolloid dressings were applied beginning 7/9/2016, with no reference to wound size or staging, and ordered to be changed every seven days or as needed. Other than the Standing Orders signed at admission, that included wound care protocol, there were no new or different physician orders	F 282	On 8/22/16 a 100% audit of residents with skin impairments care plan were audited to ensure interventions were being followed, to include the wound care protocol and weekly assessments were completed by 8/22/16. What systems were put in place to prevent the deficient practice from reoccurring: On 8/18/16 the DON in-serviced the MDS Nurses related to pressure ulcers being included in resident□s plan of care. On 8/18/16 an in-service for all RN□s and LPN□s was initiated by DON related to completing resident treatments as ordered, staging of wounds, interventions, and MD/RP notification, and the wound care protocol including Stage 2 (Partial thickness skin loss) □ If wound has small to moderate amount of drainage apply a hydrocolloid and change every seven days and as needed. Stage 3 (Full thickness tissue loss) and Stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle) - Apply a hydrogel to all wound surfaces. Cover with secondary dressing of choice. Frequency of dressing changes per the discretion of the Treatment Nurse. Stage 3 or 4 wounds with necrosis -Santyl dressing recommended for debridement. On 8/18/16 an in-service for all RN□s and LPN□s was initiated by DON related to wound ulcer flow sheets and flow sheet of non-ulcer skin sheets. In servicing will be 100 % complete by 8/22/16. No staff will be allowed to work a shift after 8/22/16	

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F 282	Continued From page 7 for the treatment of Resident #2 pressure ulcer until 7/22/2016. On 7/22/2016 a change in the treatment was noted with a wound assessment documented on the treatment record of Stage 4 with black eschar and measurements of 4 cm x 3 cm x 1 cm. A hydrogel dressing was implemented at this time to be changed every three days or as needed. A review of the nursing notes indicated that there was no wound assessments between the admission assessment and the assessment noted on the treatment record on 7/22/2016. There were no indications that nursing staff were monitoring the skin for changes as outlined in the wound care protocol and the care plan. From the initiation of treatment on 7/9/2016, until the notation on the treatment record on 7/22/2016 there were no measurements documenting the progression of this wound from a stage 2 pressure ulcer to a stage 4. The Treatment Administration Record indicated there were no adjustments made to the treatment of the pressure ulcer as defined in the wound care protocol. On 7/27/2016 at 1:40 pm, the wound care nurse was interviewed. She indicated that she was scheduled on the floor instead of being assigned to wound care for the last month. When asked who was responsible for wound care she explained that the nurses on the halls were responsible for wound care for their residents. On 7/27/2016 at 4:15 pm, the nurse caring for Resident #2 was interviewed. She indicated that she did the dressings as scheduled on evenings but no one had ever told her that she needed to do measurements. On 7/27/2016 at 4:29 pm, the nurse supervisor for evenings was interviewed. When asked about wound assessments and measurements, she	F 282	until all in-services have been completed. All new hires will receive in-services during new employee orientation. On 8/22/16 a wound meeting was held with the RD,DON,QI, Treatment Nurse in attendance and will continue to be held weekly x 12 weeks then monthly x 3. How the facility will monitor systems put in place: All resident□s with pressure ulcers care plan, intervention, and weekly assessments will be audited using the wound QI tool during each facility wound meeting. A wound meeting was held on 8/22/16 with the RD,QI,DON, Treatment nurse in attendance and will continue to be held weekly x 12 weeks then monthly x 3. The monthly QI committee will review the results of the Wound QI audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 282	Continued From page 8 indicated that the wound nurse would do those and that the nurses on the hall would not be responsible for wound measurements. On 7/28/2016 at 10:09 am, wound assessment and care was observed with the consulting wound care physician and the wound care nurse. The physician explained that it needed debriding. Measurements were completed by the physician and noted to be 7 cm x 5 cm x 1 cm, estimated depth due to eschar. He indicated that it was unstageable, but would probably be a stage 4 after debridement. After the wound care, on 7/28/2016 at 11:33 am, the wound care nurse was interviewed. She explained that she had not been assigned to wound care because she was assigned to a hall of residents most of the last month. When asked if the lack of wound assessments had impacted the wound progression for Resident #2, she indicated that it had, explaining further that the interventions that were identified today could have been implemented earlier. On 7/28/2016 at 3:42 pm the Director of Nursing was interviewed. She explained that for the last three weeks the wound care nurse was not assigned to wound care. She used the wound care nurse for resident care, so the halls would be covered, and she expected the floor nurses to do their own wound care. She indicated that would include assessing wounds.	F 282		
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	F 314		8/22/16

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F 314	Continued From page 9 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and physician interview the facility failed to accurately assess and oversee treatment of a pressure ulcer, which progressed to an unstageable pressure ulcer with eschar, for 1 of 3 residents (Resident #2) reviewed for pressure ulcers. The findings included: Resident #2 was admitted on 6/16/2016 with diagnoses of stage 4 chronic kidney disease, Alzheimer ' s dementia and type II diabetes. An admission skin assessment was completed by the admitting nurse on 6/26/2016, which noted a reddened area with possible opening on the coccyx. No measurements or staging were noted on this assessment. A review of the Minimum Data Set (MDS) admission assessment dated 6/29/2016 indicated the presence of a stage 2 pressure ulcer, with granulation tissue, present on admission. A review of the care plan dated 7/6/2016 indicated that Resident #2 had a pressure ulcer interventions included turning and positioning, incontinent care, wound care as ordered, supplements as ordered, and weekly wound assessments. A review of the treatment record indicated that starting on 7/9/2016 a dressing of hydrocolloid was to be applied every 7 days and as needed, no area was identified for the application and no staging or measurements were indicated.	F 314	Ftag 314 Treatments What measures did the facility put in place for the resident affected: On 7/26/16 resident #2□s wound was assessed by MDS Nurse. On 7/26/16 a referral was made to the wound doctor by MDS Coordinator. On 7/28/16 a wound ulcer flow sheet was completed for resident #2 by the treatment nurse. Resident #2 was seen by wound doctor on 7/28/16. New treatment orders were received by the wound doctor. On 7/28/16 the resident RP was made aware of condition of wound and new orders received by Treatment Nurse. On 7/28/16the new orders were transcribed to resident #2□s TAR and initiated. On 7/28/16 an air mattress was applied to resident bed. On 7/31/16 resident #2 had a Foley catheter placed by staff nurse per physician order. What measures were put in place for residents having the potential to be affected: On 8/22/16 a 100% skin audit was completed on all residents by the MDS Nurse, QI and DON for new skin	

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F 314	Continued From page 10 Another treatment was started on 7/9/2016 to apply a tegaderm dressing daily and as needed to a busted blister on the right buttock. Further review of this treatment record indicated a treatment for a stage 4 measuring 4 centimeter (cm) x 3 cm x 1 cm to sacrum with black eschar, to clean with normal saline and cover with a hydrogel dressing starting on 7/22/2016. The previous dressing for hydrocolloid was discontinued at this time. A referral for the wound care physician to evaluate was also noted at this time. Treatments were documented as completed. A review of the nursing notes revealed a care plan wound note dated 7/26/2016 at 12:16 pm, by the MDS nurse, which identified an unstageable pressure ulcer with measurements of 6 cm x 5 cm, unable to determine depth. A description of the wound was circular with thick dark eschar covering the entire wound bed, surrounding tissue was sensitive to the slightest touch, no purulent drainage. The note indicated that a dressing saturated with serous drainage was removed and the resident was placed on the physician board for a wound care referral. A review of dietary notes revealed a dietary assessment completed on 7/26/2016. The assessment indicated that the resident consumed 45% of her meals on average with full staff assistance for the last 4 days. Dietary supplements were noted as a frozen dietary supplement served three times a day and a shake supplement between meals and at night. The note also identified the presence of a sacral wound with eschar. On 7/27/2016 at 1:40 pm the wound care nurse was interviewed. She indicated that she has been scheduled on the floor instead of being assigned to wound care. She explained that she	F 314	conditions, skin referrals created, treatment initiated, physician and responsible party are notified with documentation in the clinical record to include Wound Ulcer Flow Sheet, Non-Ulcer Flow sheets and Treatment Record as indicated. On 8/22/16 100% of all existing skin conditions were assessed by MDS Nurse and DON for worsening with appropriate interventions put in place, and MD/RP notification. On 8/22/16 wound ulcer flow sheets were completed to include staging, measurements, signs/symptoms of infection, wound description, RP/MD notification and current treatment. On 8/22/16 a 100% audit of all TARs was completed by 8/22/16 to ensure all existing skin conditions have treatments in place. On 8/22/16 a wound meeting was held with the RD,DON,QI, Treatment Nurse. Starting 8/22/16 a staff member or members will be assigned to complete resident treatments daily as ordered What systems were put in place to prevent the deficient practice from reoccurring: On 8/18/16 an n-service for all RN□s and LPN□s was initiated by DON related to completing treatments as ordered, wound ulcer flowsheets and flowsheet of non-ulcer skin sheets, TARS, and skin referrals will be 100% complete by 8/22/16. On 8/18/16 an in-service was initiated for all RN□s and LPN□s by the DON related to s/s of infection of a wound, to include 1) induration, 2) fever, 3) erythema, 4) edema, 5) increased pain at the wound site, 6) increased WBC	

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F 314	Continued From page 11 has not been assigned to wound care for the last month. She explained that one nurse had been out on leave and another nurse was gone and she had been taking a hall assignment since then. When asked who is responsible for wound care she explained that the nurses on the halls are supposed to do their own resident ' s wound care. When asked about the assessments, she indicated that the nurses on the hall are supposed to do the weekly assessments as well. First shift is responsible for the even number rooms and second shift does the odd number rooms. On 7/27/2016 at 3:16 pm the MDS nurse was interviewed. She explained that she went in Resident #2 ' s room to do a wound assessment as part of the Change of Therapy assessment that she was doing. She explained that the last documented assessment was on the treatment record, where a nurse had noted a busted blister which would be a stage II ulcer. She verified that the reference to a blister was the last assessment of the wound and that no formal skin assessments with measurements existed. She indicated that she knew the wound care doctor would be here on Thursday and she wanted to make sure Resident #2 was seen. On 7/27/2016 at 4:15 pm the nurse caring for Resident #2 was interviewed. She indicated that she did do the dressing change as expected last night. She explained that the nurse aide came to her and told her that there was no dressing on Resident #2. The nurse indicated that the wound was very black and necrotic with a foul odor. She explained that she had the resident when she was first admitted and the skin was just red, but has turned black. She that she does not do wound assessments and measurements. She explained that the wound nurse would do that.	F 314	count, 7) foul smelling, purulent wound drainage, 8) decreased appetite, 9) general malaise, 10) failure to heal or sudden worsening of wound, staging of wounds, interventions, and MD/RP notification, will be 100% by 8/22/16. On 8/18/16 an in-service for all CNA□s and medication aides by DON related to notification to nurse of new skin condition observed and dressings being off or saturated and will be 100% complete by 8/22/16. On 8/22/16 the treatment Nurse was in-serviced by DON related to completing treatments as ordered, TARS, skin referrals , completion of wound ulcer flowsheets and flowsheet of non-ulcer skin sheets (how to complete and must be completed every 7 days), notification of MD and RP of new areas and worsening of areas. On 8/16/16 the director of nursing, nursing supervisors, and all on-call nurses were in-serviced by the administrator that a staff member or members must be assigned to complete treatments daily as ordered.. . No staff will be allowed to work after 8/22/2016 until in-services are completed. All new hires will receive in-services during new employee orientation. On 8/22/16 a wound meeting was held with the RD,DON,QI and Treatment Nurse in attendance and will continue to be held weekly. How the facility will monitor systems put in place:	

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F 314	Continued From page 12 She indicated that she would do the dressings as scheduled on evenings but no one has ever told her that she needed to do measurements. On 7/27/2016 at 4:29 pm the nurse supervisor for evenings was interviewed. She explained that evenings are responsible for the odd number room dressing changes. When asked about wound assessments and measurements, she indicated that the wound nurse would do those and that the nurses on the hall would not be responsible for wound measurements. On 7/28/2016 at 10:09 am wound assessment and care was observed with the consulting wound care physician and the wound care nurse. The resident was seated in an upright position in bed with her knees raised. The physician instructed the wound care nurse to make sure she was never raised higher than 30 degrees due to the pressure that position would put on her back. He also recommended an air mattress to relieve some of the pressure while in bed. The resident was lowered and turned to her side. The dressing was removed. A strong foul odor was noted. The physician explained that the smell was from necrotic tissue. He tapped the eschar and noted that it was firm and thick. He explained that it needed debriding. Measurements were completed by the physician and noted to be 7 cm x 5 cm x 1 cm, estimated depth due to eschar. The physician explained that it would probably be stage IV after debridement. Debridement was attempted by the physician with a large amount of black substance removed from the wound bed. The physician explained that he was not able to get it all today so he would come back next Thursday to do the rest. On 7/28/2016 at 11:12 am the wound care nurse was observed applying the dressing to Resident	F 314	On 8/19/16 the MDS nurse, QI nurse and or DON began auditing 100% of resident progress notes for any acute changes to include new or worsening of skin conditions using the Chart audit tool. On 8/19/16 the MDS nurse, QI and or DON began auditing 100% of the TARS, wound ulcer flow sheets, flow sheets of non-ulcer conditions and skin referrals for completion and accuracy using the TAR audit tool. A The Treatment nurse, or RN nurses will conduct a skin audit of 10% of the residents and observations for any acute change in condition 2x a week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month using a Chart Audit Tool to ensure any new or worsening skin abnormalities to include pressure ulcers have been identified, skin referrals created, treatment initiated, physician and responsible party are notified with documentation in the clinical record to include Wound Ulcer Flow Sheet, Non-Ulcer Flow sheets and Treatment Record as indicated. Any concerns will be addressed immediately by the treatment nurse or RN/LPN nurse with an assessment of the skin abnormality, initiation of treatment, creation of a Skin Referral, notification of the physician and responsible party, and documentation of findings in the clinical record to include Wound Ulcer Flow Sheet, Non-Ulcer Flow Sheet, and Treatment Record. All audits will be completed 2x a week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. The DON will present findings at the	

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F 314	Continued From page 13 #2 ' s sacral wound. She noted that urine was leaking when the resident was moved. She explained that she may benefit from a urinary catheter. She applied the recommended dressing of Santyl to the wound bed with calcium alginate over that and covered with a dry dressing. After the wound care, on 7/28/2016 at 11:33 am the wound care nurse was interviewed. She indicated that she does not see the wounds like she would like. She explained that she has not been assigned to be the wound care nurse because they do not have enough nurses scheduled. She said, " They schedule me to take a hall and I can ' t do two things at once. " She explained that the nurses rely on the direct care staff to report changes to them. She indicated that most nurses try to do a good job with dressings but they are assigned 40 plus residents at times. When asked if the lack of wound assessments had impacted the wound for Resident #2, she indicated that it had, explaining further that the interventions that were identified today could have been implemented earlier. She indicated that when Resident #2 came to the facility her wound was small. As a wound care nurse, she indicated that she had been trained to assess wounds for changes and identify interventions. She explained that her priority would have been to change treatments per protocol, ask for wound care referrals, change her positioning, and possible ask for a catheter to keep the urine from soaking the wound. She explained she would have been aware of these interventions and communicated them to the physician to put them into place. Staffing for June and July were reviewed. Beginning in June, the wound care nurse was not assigned to wound treatments about half of the	F 314	quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	

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F 314	Continued From page 14 time. In July the wound care nurse was assigned to wound care only 4 days. On 7/28/2016 at 3:42 pm the Director of Nursing was interviewed. She explained that for the last three weeks the wound care nurse was not assigned to wound care. One week she was on vacation and for two weeks she was assigned to take a hall. She explained that it was necessary. She staffed the floor with the wound care nurse so the halls would be covered and expected the floor nurses to do their own wound care. She indicated that would include assessing wounds.	F 314		
F 353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353		8/22/16

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F 353	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews the facility failed to provide adequate staffing to provide skin assessments and treatment management for 1 of 3 residents (Resident #2) reviewed for pressure ulcers. This tag is cross referenced to F 314. The findings included: F 314 Based on record review, observation, staff interviews and physician interview the facility failed to accurately assess and oversee treatment of a pressure ulcer, which progressed to an unstageable pressure ulcer with eschar, for 1 of 3 residents (Resident #2) reviewed for pressure ulcers. An interview with the Director of Nursing on 7/28/2016 at 3:42 pm revealed that to cover the resident halls with sufficient nursing staff the wound care nurse had been assigned to care for a hall of residents instead of providing wound care treatments. On many of the days the wound care nurse was assigned to the hall there were only 3 nurses and two med aides to care for all five halls, so the nurses would cover their own hall of about 30 residents and one of the med aide ' s halls for about 30 residents. She indicated that she has open positions for staff development nurse, restorative and rehab nurse and one MDS nurse. The MDS nurse will start next week. She explained that she has hired two registered nurses and two licensed practical nurses. She indicated that when they were trained the floors would be covered. She also explained that the wound care nurse had resigned with her last day to be tomorrow 7/29/2016, and that her position was open as well. She indicated that they had lost two nurses, one sick and one had to be let go. She identified	F 353	FTag 353 staffing What measures did the facility put in place for the resident affected: On 8/22/16 the Administrator (Adm) and the Director of Nursing(DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents to include completing all resident treatments treatments in accordance with resident care plans What measures were put in place for residents having the potential to be affected: On 8/22/16 the Adm and the DON reviewed the current schedule of staffing to ensure sufficient numbers of staff to provide nursing care to all residents to include all resident treatments in accordance with resident care plans in the next week. Starting 8/19/16 a staff member or members will be assigned to complete resident treatments daily as ordered. On 8/22/16, the Administrator met with/notified the Regional Vice President (RVP) of currently facility staffing needs to provide nursing care to all residents in accordance with resident care plans. What systems were put in place to prevent the deficient practice from reoccurring:	

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F 353	Continued From page 16 ideal staffing as having a nurse for each hall, plus a supervisor and treatment nurse and that with the new hires that would be possible.	F 353	On 8/16/16 the director of nursing, nursing supervisors, and all on-call nurses were in-serviced by the administrator that a staff member or members must be assigned to complete treatments daily. No staff will be allowed to work after 8/22/2016 until in-services are completed. All new hires will receive in-services during new employee orientation. How the facility will monitor systems put in place: On 8/22/16, the Adm and/or the DON initiated a QI monitoring tool titled Sufficient Staff tool to monitor for sufficient staff will be made based on the staff□s ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, psychosocial well-being, and including treatments being completed as ordered. The Adm and/or the DON will utilize the Sufficient Staff tool five times weekly to include weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately. The Adm and/or the DON will present findings from the Sufficient Staff tool at the monthly QI committee meetings for six months for further recommendations. Beginning 8/22/16, the Adm will monitor the Sufficient Staff tool to ensure proper completion of the Sufficient Staff tool. The Adm will initial the form with the date as completed to acknowledge completion	

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F 353	Continued From page 17	F 353	and follow-up. The administrator will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	