STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 01/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		2/1/18

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

Electronically Signed | 01/15/2018

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the physician and family of new pressure ulcers for 1 of 3 residents reviewed for pressure ulcer (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/19/17 with the diagnoses of dementia, Peripheral Vascular Disease and malnutrition. Resident's #1 Quarterly Minimum Data Set dated 8/21/17 revealed the resident was severely cognitively impaired and required extensive assistance with bed mobility, dressing, and personal hygiene. The resident had one stage 2 pressure ulcer that was present on entry and one unstageable pressure ulcer that was present on entry. The resident had a pressure reducing device for the bed, nutrition and hydration interventions and was receiving pressure ulcer care. From 8/18/17 through 11/28/17, it was only documented that the resident had a pressure ulcer to her sacrum. A shower sheet skin check from Nursing	F 580	This plan of correction constitutes Hillcrest Raleigh at Crabtree, LLC's (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F580 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON was notified during the complaint survey that the nurse failed to communicate with the physician and family regarding discovery of new wounds found on Resident #1 on 11/28/17. Resident #1 was discharged from the facility on 12/7/17. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same	

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F 580	Continued From page 2 Assistant #1 dated 11/28/17 revealed the resident had 2 new areas to the outside of her left and right foot that "looks like black scabs". A nursing note dated 11/28/17 revealed the "patient's left foot had a new lesion forming, pink in color with blackish tinge at the center, Zinc Oxide was applied." "On the patient's right foot is a darkened open lesion, zinc paste applied and the patient tolerated the treatment well." The resident went to the hospital on 12/7/17. Hospital records dated 12/8/17 revealed that the resident had a urinary tract infection, 2 right Deep Tissue Injuries on her foot, one laterally that measured 7.5 cm x 6 cm and one anteriorly that measured 2.8 cm x 2 cm. The resident also had a left lateral unstageable pressure ulcer to her foot that measured 2.5 cm x 2.5 cm and a mid- lateral unstageable pressure ulcer to her left foot that measured 1 cm x 1 cm. There was also a left medial abraded blanch-able area that measured 3 cm x 1 cm and a sacral pressure ulcer that measured 8 cm x 5.5 cm x 0.3 cm. The resident also had an area of wet gangrene to the right foot. The note also stated that the resident's family had a difficult time digesting the information as they was not aware of the wound (of right foot) prior to today. The wound care nurse was interviewed on 12/29/17 at 11:21 AM. She stated that on 11/28/17, a nurse wrote in note that the resident had a new lesion to the left foot and one forming to the right foot that was an darken open lesion. The note stated that the nurse found 2 lesions and applied zinc paste to both areas. She stated that per the nursing note, it did not state who was	F 580	deficient practice. The DON audited 100% of all residents with wounds for notification documentation to the physician and responsible party. For instances where there was no documentation demonstrating communication with physician and responsible party regarding a particular wound, notification occurred and was appropriately documented . The facility will implement new documentation procedures, and update education of staff in regards to notification of changes to physician and responsible party. All nurses will receive updated education on procedures for notification of changes in regards to communicating with the physician. This education will be conducted by the DON/designee. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The facility will update education of staff in regards to notification of changes to physician and responsible party. All nurses will be educated on procedures for notification of changes in regards to communicating with the physician. This education will be conducted by the DON/designee. Communication documentation in resident charts will be audited/monitored by the DON/designee weekly x4 weeks, bi-weekly x2 weeks and monthly x 1 month.	

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F 580	Continued From page 3 notified about the wounds. The resident's family was contacted on 12/29/17 at 12:57 PM. He stated that he was Resident's #1 Power of Attorney. He stated he was not notified of the resident's #1 wounds until she went to the hospital on 12/7/17. He was told she was sent to the hospital for a possible stroke. When she got the hospital, he was notified of the wounds. He stated he was never notified by the physician at the facility about the resident's wounds. He stated that he has been gone for 3 weeks on a trip but had asked the facility to still contact him about any changes to Resident #1. Nursing Assistant #1 was interviewed on 12/29/17 at 3:12 PM. She stated that the resident required total care and she gave the resident showers. She stated that back in November, 2017, the resident had scabs noted on the lower part of her legs/ankle. She also added that the resident wore "bunnies" on her feet. She stated she reported the new areas to the nurse. She stated that one time the wound was bleeding a little and she told the nurse. The nurse put a bandage on it and cleaned it. She was not sure who the nurse called about the wound or about the treatment. She also added that she could not remember the name of the nurse working that day. She stated that she had documented the new area. Nurse #1 was interviewed on 12/29/17 at 4:28 PM. She stated that she had only cared for Resident #1 twice. One time was in November, 2017 and the resident had a sacral wound. She stated that there were also 2 red spot on the outside of the resident foot and she put zinc oxide on them and left the area open. She stated that when he NA was cleaning the resident, the NA	F 580	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The Plan of Correction is Monitoring of these changes, specifically, the communication by nurses to the physician and responsible party concerning change of conditions will be performed by the DON/designee weekly x4, bi-monthly x2 months, and monthly x1. The facility QA committee and administrator/designee will review the monitoring results during QA meetings. DON/designee will be responsible for monitoring and reporting.	

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F 580	Continued From page 4	F 580		

had told her that she noticed the wounds so she went and assessed them. She stated that the areas were pinkish and were circular. The resident did not have any pain that she knew of that was related to those spots. She stated that she told the nurse during the hand off because she was the regular nurse for that resident and that they communicate to the doctor during the day. She stated she did not contact the family at all because it was not urgent and it was at night. She added that the resident did have a very small black spot on the right outside aspect of the right foot wound. She stated that she could not remember specifically if the resident's left foot had a "black spot" in it.

The day shift nurse that worked on 11/28/17 was attempted to be interviewed but was unavailable.

The Medical Director was interviewed on 12/29/17 at 6:45 PM. He stated that he was very familiar with this resident as he cared for her at the facility and at the hospital. Her baseline status was really poor and she had circulation problem. He stated that when she arrived to the hospital, there were some wounds to her extremities and sacrum. They were considering surgery but due to the resident's condition called palliative care. The resident was placed on palliative care at another facility. The resident went to the hospital because she was not doing good and stuporous and was in and out. He stated that the resident did have a wound at the facility. He stated he did not know about the wound to the resident's feet until till she went to the hospital. He stated that he expected and usually was notified if there was a wound. He stated that the morning shift nurse would usually notify him but he was available to be notified anytime.

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F 580	Continued From page 5	F 580		

The Director of Nursing was interviewed on 12/29/17 at 6:46 PM. She stated that it was nurse's responsibility for doing the dressing changes on the hall. The wound care nurse rounded weekly to assess the wounds or if any changes occurred. If a resident got a new wound then the nurse should notified the doctor and family (unless the resident is alert and oriented) and get orders for treatment. The nurse that finds the new area/wound and would be the one to make the calls.

The Unit Nurse Manager was interviewed on 12/19/17 at 7:14 PM. He stated that Resident #1 was a bit lethargic at the nursing station (the day she was sent to the hospital) and they didn't want to take any chances so they sent the resident out. He stated he did not know how many wounds the resident had and had never done her dressing changes before. If there was a new wound then they would call the doctor and each nurse would implement wound care. The family was also contacted if there was any change of regimen.

The Administrator was interviewed on 12/29/17 at 7:19 PM. She stated that there was no concerns with this resident beside the one grievance that was filed. The resident's family was unrealistic about Resident's #1 condition. She stated she offered to meet with the resident's family three times after the grievance was filed. She stated that she did not know how many wounds the resident had went she left the facility. She stated her expectation was to follow their policy and notify the Resident's representative and the physician as indicated and for the wound care policy to be followed.

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F 686	Continued From page 6	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician's interviews the facility failed to provide pressure ulcer care to the resident's sacrum and to a new pressure ulcers on the left lateral foot and a Deep Tissue Injury to the right lateral foot for 1 of 3 residents reviewed for pressure ulcers (Resident #1). Findings included: 1a. Resident #1 was admitted to the facility on 5/19/17 with the diagnoses of dementia, Peripheral Vascular Disease and malnutrition. Resident's #1 Quarterly Minimum Data Set dated 8/21/17 revealed the resident was severely cognitively impaired and required extensive assistance with bed mobility, dressing, and personal hygiene. The resident had one stage 2 pressure ulcer that was present on entry and one	F 686	This plan of correction constitutes Hillcrest Raleigh at Crabtree, LLC's (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F686 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON was notified during the complaint survey that the nurse failed to provide treatment to “new lesions” for	2/1/18

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F 686	Continued From page 7 unstageable pressure ulcer that was present on entry. The resident had a pressure reducing device for the bed, nutrition and hydration interventions and was receiving pressure ulcer care. Resident #1 had a care plan in place for pressure ulcers (Initiated 5/31/17). The Resident's care plan was last updated on 11/10/17 and stated that the resident had a sacrum pressure ulcer that presented as a stage 3. Standing orders for pressure ulcer care (no date) revealed if "Eschar other than heels" to "apply hypergel daily and cover with composite dressing." The standing orders also revealed to obtain physician's orders as appropriate and to document interventions. From 10/19/17 through 11/28/17, it was only documented that the resident had a pressure ulcer to her sacrum. A shower sheet skin check from Nursing Assistant #1 dated 11/28/17 revealed the resident had 2 new areas to the outside of her left and right foot that "looks like black scabs". A nursing note dated 11/28/17 revealed the "patient's left foot had a new lesion forming, pink in color with blackish tinge at the center, Zinc Oxide was applied." "On the patient's right foot is a darkened open lesion, zinc paste applied and the patient tolerated the treatment well." There were no treatment orders from the physician specific to the "new lesions" from 11/28/17 through resident #1 discharge on 12/7/17. The only orders during this time were for skin prep to the resident's heels and dressing	F 686	11/28/17 thru 12/7/17 to Resident #1. Resident #1 was discharged from the facility on 12/7/17. 2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. The DON audited 100% of all residents for wounds and treatment orders. Any undocumented wounds found were documented and treatment orders put in place; there were no other instances where wounds were identified but corresponding treatment was not documented. The facility will implement documentation procedures, and update education of staff in regards to treatment orders and documentation of treatments. All nurses will be educated on procedures for treatment orders and documentation. This education will be conducted by the DON/designee. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. The facility will update education of staff in regards to skin assessments, treatment orders and wound care documentation. All nurses will be educated on procedures for skin assessments, treatment orders, and wound care documentation. This education will be conducted by the DON/designee. Communication/treatment	

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F 686	Continued From page 8 changes to the resident sacrum. There was no documentation in Resident #1 chart that care was provided to these areas. The resident went to the hospital on 12/7/17. Hospital records dated 12/8/17 revealed that the resident had a urinary tract infection and 2 right Deep Tissue Injuries (DTI) on her foot. The lateral DTI to the right foot measured 7.5 centimeters (cm) x 6 cm and the anterior DTI measured 2.8 cm x 2 cm. The resident also had a left lateral unstageable pressure ulcer to her foot that measured 2.5 cm x 2.5 cm and a mid- lateral unstageable pressure ulcer to her left foot that measured 1 cm x 1 cm. There was also a left medial abraded blanchable area that measured 3 cm x 1 cm and a sacral pressure ulcer that measured 8 cm x 5.5 cm x 0.3 cm. The wound care nurse was interviewed on 12/29/17 at 11:21 AM. She stated that on 11/28/17, a nurse wrote in note that the resident had a new lesion to the left foot and one forming to the right foot that was a darkened open lesion. The note stated that the nurse found 2 lesions and applied zinc paste to both areas. The resident already had skin prep in place to her feet on a previous order (per order it was for heels only), which was appropriate. She stated that she pulled the shower sheets and the Nursing Assistant noted the areas on there too. She stated she wouldn't not have put the zinc oxide on the (new) areas but that the skin prep was the appropriate order. However, there were standing orders for pressure ulcer care that was the physician would sign off on. Nursing Assistant #1 was interviewed on 12/29/17 at 3:12 PM. She stated that the resident required	F 686	documentation in resident charts will be audited/monitored by the DON/designee weekly x4 weeks, bi-weekly x2 weeks and monthly x 1 month. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The Plan of Correction is Monitoring of these changes, specifically, skin assessments, treatments orders and wound care documentation will be performed by the DON/designee weekly x4, bi-monthly x2 months, and monthly x1. The facility QA committee and administrator/designee will review the monitoring results during QA meetings. DON/designee will be responsible for monitoring and reporting.	

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F 686	Continued From page 9	F 686		

total care and she gave the resident showers. She stated that back in November, 2017, the resident had scabs noted on the lower part of her ankle. She also added that the resident wore "bunnies" on her feet. She stated she reported the new areas to the nurse. She stated that one time the wound was bleeding a little and she told the nurse. The nurse put a bandage on it and cleaned it. She was not sure who the nurse called about the wound or about the treatment. She also added that she could not remember the name of the nurse working that day. She stated that she had documented the new area.

Nurse #1 was interviewed on 12/29/17 at 4:28 PM. She stated that she had only cared for Resident #1 twice. One time was in November, 2017 and the resident had a sacral wound. She stated that there were also 2 red spot on the outside of the resident legs and she put zinc oxide on them and left the area open. She stated that when the NA was cleaning the resident, the NA had told her that she noticed the wounds so she went and assessed them. She stated that the areas were pinkish and were circular. The resident did not have any pain that she knew of that was related to those spots. She stated that there were standing order for if there are "red spots" then you put Zinc oxide ointment on it. She added that the resident did have a very small black spot on the right outside aspect of the right foot wound. She stated that she could not remember specifically if the resident's left foot had a "black spot" in it.

The day shift nurse that worked on 11/28/17 was attempted to be interviewed but was unavailable. Nurse #6 (who worked on 12/4/17) was interviewed on 1/4/17 at 1:55 PM. He stated that

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F 686	Continued From page 10	F 686		

he was not really familiar with the resident. He could not remember if he did the wound care of not. He stated that if the wound care nurse does not do the dressing change then the nurses were supposed to do it. He stated that he does not remember if the resident had any wounds to her heels before she went to the hospital.

The Medical Director was interviewed on 12/29/17 at 6:45 PM. He stated that he was very familiar with this resident as he cared for her at the facility and at the hospital. Her baseline status was really poor and she had circulation problem. He stated that when she arrived to the hospital, there were some wounds to her extremities and sacrum. They were considering surgery but due to the resident's condition called palliative care. The resident was placed on palliative care at another facility. The resident went to the hospital because she was not doing well, was stuporous and was in and out. He stated that the resident did have a wound at the facility. He stated he did not know about the wound to the resident's feet until till she went to the hospital. The sacrum wound was bad and was infected and her white blood cell count was high and he was not sure it was from the UTI or the wounds. If dressing changes were not done regularly then it could cause the wound to go deeper.

The Director of Nursing was interviewed on 12/29/17 at 6:46 PM. She stated that it was nurse's responsibility for doing the dressing changes on the hall. The wound care nurse rounded weekly to assess the wounds or if any changes occurred. If a resident got a new wound then the nurse should notify the doctor and family (unless the resident is alert and oriented) and get orders for treatment. The nurse that finds the new

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(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 686	Continued From page 11	F 686		

area/wound and would be the one to make the calls.

The Unit Nurse Manager was interviewed on 12/19/17 at 7:14 PM. He stated that Resident #1 was a bit lethargic at the nursing station (the day she was sent to the hospital) and they didn't want to take any chances so they sent the resident out. He stated he did not know how many wounds the resident had and had never done her dressing changes before. If there was a new wound then they would call the doctor and each nurse would implement wound care.
The Administrator was interviewed on 12/29/17 at 7:19 PM. She stated that she did not know how many wounds the resident had went she left the facility. She stated her expectation was for the wound care policy to be followed.

1b. Resident #1 was admitted to the facility on 5/19/17 with the diagnoses of dementia, Peripheral Vascular Disease and malnutrition.

Resident's #1 Quarterly Minimum Data Set dated 8/21/17 revealed the resident was severely cognitively impaired and required extensive assistance with bed mobility, dressing, and personal hygiene. The resident had one stage 2 pressure ulcer that was present on entry and one unstageable pressure ulcer that was present on entry. The resident had a pressure reducing device for the bed, nutrition and hydration interventions and was receiving pressure ulcer care.
A physician's telephone order dated 10/9/17 revealed to clean the open area on sacrum with Normal Saline, apply hydrogel, and cover with a dry dressing and change daily.

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	345555	A. BUILDING _____ B. WING _____	C 01/04/2018

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F 686	Continued From page 12	F 686		

Review of the pressure ulcer assessments from 10/19/17 through 11/16/17 revealed that the resident's sacral pressure ulcer had decreased in size and was slowly healing. On 11/16/17, the sacral pressure ulcer was a stage 3 and measured 0.8 cm x 0.4 cm.

Review of the resident's Treatment Administration Record (TAR) for 10/2017 revealed to clean open areas to sacrum with normal saline, apply hydrogel and dry dressing and to change daily. The TAR was blank for the following dates for the dressing change for 2nd shift: 10/10/17 through 10/14/17, 10/17/17, 10/18/17, 10/20/17 10/21/17, 10/23/17, 10/25/17 through 10/27/17, 10/29/17, and 10/30/17. It was only documented that the resident refused wound care on 10/16/17. There was no other documentation on the TAR of the rationale for the blank documentation.

The nursing notes were reviewed from 10/10/17 through 10/29/17. A nursing note dated 10/20/17 from 2nd shift revealed that the dressing change to the resident's sacrum was completed.

Resident #1 was admitted to the hospital on 12/7/17.

Hospital records dated 12/8/17 revealed that the resident sacral pressure ulcer measured 8 cm x 5.5 cm x 0.3 cm. Hospital records stated that the sacral wound was "minimally a stage 3". The resident was admitted to the hospital with multiple wounds, altered mental status and a Urinary Tract Infection.

The wound care nurse (WCN) was interviewed on 12/29/17 at 11:21 AM. The pressure ulcer assessment were completed weekly and she

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F 686	Continued From page 13	F 686		

thought that the Resident's initial assessment was checked by the wound care nurse at that time and revealed the resident had a buttock, left and right ankle wound as was indicated in the initial assessment. She stated that resident only had the coccyx wound when she left the facility for personal reasons in 8/2017. She only had seen the resident's coccyx since then. If a nurse completed a dressing then they should sign off on the TAR. The rule of nursing was that if dressing change wasn't signed off then it wasn't done. The nursing staff were responsible for doing the treatments after the previous WCN quit her position. She stated that she was not informed that treatments was not completed for this resident for the month of 10/2017.

Nurse #3 (who worked 2nd shift on 10/20/17 for this resident) was interviewed on 12/29/17 at 4:11 PM. She stated that she could not remember if the resident's skin was intact. She stated that the resident was not getting dressing changes that she knew of. The nurses would be the ones responsible for doing the treatments to wounds. She stated she had never completed dressing changes on this resident before.

Nurse #4 (who worked 2nd shift on 10/10/17 for this resident) was interviewed on 12/29/17 at 4:19 AM. She stated that she could not remember this resident specifically. She added that usually the wound care nurse does the wound care in the facility and sometimes there was a book that tells you when to complete the wound care for a residents.
Nurse #5 (who worked 2nd shift on 10/11/17, 10/12/17, 10/18/17, 10/23/17, 10/25/17, 10/26/17) was attempted to be interviewed on 12/29/17 but was out of the country.

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F 686	Continued From page 14	F 686		

Nurse #7 (who worked second shift on 10/17/17 with the resident) was attempted to be interviewed via phone on 12/29/17 at 4:09 PM but was unsuccessful.

Nurse #6 (who worked on 10/13/17, 10/14/17, 10/21/17, 10/27/17, and 10/29/17) was interviewed on 1/4/17 at 1:55 PM. He stated that he usually worked as needed. He stated that the resident had a skin tear on her arm. He stated that he only remembers that he had done wound care to her arms. He stated that he was not really familiar with the resident. He could not remember if he did wound care to this resident or not. He stated that if the wound care nurse does not do the dressing change then the nurses were supposed to do it.

The medical director was interview on 12/29/17 at 6:45 PM. He stated that he was very familiar with this resident as he cared for her at the facility and at the hospital. If they dressing changes were not done regularly, then it could cause the wound to go deep. Usually even if pressure ulcer care to the sacrum ulcer was completed, the resident had poor circulation and the wound could get worse very easily even if it was done the right way and deteriorate despite all these things. He was not aware of any issues with this wound.

The DON was interviewed on 12/29/17 at 6:46 PM. She stated that the nurses on the hall were responsible for doing the dressing changes. She stated that she never known of a time that dressing changes were not completed. The wound care nurse rounded weekly to assess the wounds and if any changes occur. The nurses are supposed to document the dressing changes

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F 686	Continued From page 15 on the TAR. The nurse unit manager was interviewed on 12/19/17 at 7:14 PM. He stated that he had never known of a time that dressing changes were not being done for Resident #1 and the resident's family had never had any complaints. He stated he did not know how many wounds the resident had and had never done her dressing change before. He also added that the nurses could come to him if they couldn't get a dressing change done. The Administrator was interviewed on 12/29/17 at 7:19 PM. She stated that she was never made aware of a time that dressing changes were not being performed. She stated her expectation was to follow their policy and for the wound care policy to be followed.	F 686		