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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 2 seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to accurately assess and identify residents at risk, implement interventions to prevent the development of pressure ulcers, failed to promptly notify the physician, provide timely appropriate treatments, infection management, and interventions to prevent the worsening progression of pressure ulcers for 4 of 7 residents (R1, R2, R8, R14) reviewed for pressure ulcers in the sample of 20. This failure resulted in R1 developing a facility acquired Stage 4 pressure ulcer to the coccyx which became infected, develop a reoccurring Stage 3 pressure ulcer to right ear and develop an unstageable pressure ulcer to the left ankle. R4 developed a facility acquired Stage 4 pressure ulcer to the coccyx with undermining which also became infected.	S9999		

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In Addition, the facility failed to follow their policy and procedures for pressures ulcers for 3 of 7 residents (R1, R2, R8) reviewed for pressure ulcers in the sample of 20.

Findings include:

1. R1's current face sheet documents diagnosis of asthma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, pressure ulcers unstageable, open wounds, and vitamin deficiency.

R1's Physicians Order Sheet documents: Admit to Hospice with Terminal Diagnosis of Alzheimer's, Z1, Medical Doctor (MD) attending and managing pain and symptoms.

The most recent Minimum Data Set (MDS) dated 11/21/14, documents R1's Brief Interview of Mental Status (BIMS) was left blank. The MDS documents R1 is totally dependent on two or more staff members for transferring, bed mobility, toileting, and is totally dependent on one staff for dressing, eating, personal hygiene and bathing. R1 is always incontinent of bowel and bladder. The 11/21/14, MDS, documents R1 has no limitations in range of motion. The MDS documents no weight loss or gain of 5% or more in last 6 months. The MDS documents Determination of Pressure Ulcer risk: resident has a Stage 1 or greater pressure area. "Skin and Ulcer Treatments" identified for R1's pressure area were as follows: A. pressure reducing device for chair, B. pressure reducing device for bed, D. Nutrition or hydration intervention, E. Pressure Ulcer care. G. Application of nonsurgical dressings(with or without topical medications) and H. Applications

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of ointments and medications. The MDS did not identify as interventions: C. Turning and repositioning program, F. Surgical wound care, and Applications of dressing to feet.

R1's, hospital laboratory results done just prior to admission, dated 4/14/14 document; R1's protein 6.7 g/dl (grams per deciliter) with a normal range of 6.3-8.7 g/dl, and an albumin 3.5 g/dl with a normal range of 3.5-5.2 g/dl.

R1's review of R1's weekly " Skin Condition " reports beginning 5/22/14 through 7/11/14, document repeatedly that R1 had redness to her coccyx and was treated with Calazime per Standing Order of Z1. On 7/11/14, this treatment, and a new Standing Order was started to begin treating R1's buttocks with "stock antifungal cream" three times per day.

On 5/16/14, Z10, Dietician, documented in R1's Nutritional Progress Notes: " R1 labs from 4/23 WNL (Within Normal limits), weight 124. Skin 4/27 excoriation butt and peri area. Notes dated 6/17/14 document; weight 115, R1's labs 5/6 TP/Alb (total protein/albumin) WNL. Notes dated 8/15/14 document: weight 110, skin 8/2 excoriated butt, 8/1 s/t (skin tear) to right ear 1.2 x 6, 8/12 s/t right ear 1x8; excoriation butt .2 x.4. "

On 8/8/2014, R1's, Skin Condition report documents "Duoderm applied to excoriated area on buttocks." On 8/15/14 through 8/29/14 the skin report continues to document R1 has an open area on Right ear, treatment continues to left buttock, Duoderm applied. R1's medical record and nursing notes for this time evidenced no documentation that Z1 MD, had been informed R1's buttocks continued to be excoriated and the facility staff were using

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S9999	Continued From page 5 Duoderm to treat it. On 9/5/14, R1's Skin Condition report documents "open area to right ear, sero-sanguineous. Left Buttock / Duoderm on wound noted, Right Buttock, 2 open areas, each measuring 1.0cm (centimeter) x .5cm and another 1.0cm x .5cm area." On 9/19/14, E3, Licensed Practical Nurse, Wound Nurse, (LPN) documented in R1's Nursing Notes: "N.O. (Nurse Order) from Hospice regarding incontinent associated lesion to buttock, for wound gel and to cover with optifoam. Change daily and PRN (as needed) as area has declined. On 10/4/14, R1's Nurses Note documents: "late entry: spoke with Hospice and family re: decline in residents wound to buttock. Asking for Santyl, as slough remains to wound bed. Hospice continues to want wound gel and Mepilex every 3 days to wound." On 9/17/14, R1's Nutrition Notes document: " wound report 9/4 excoriation butt .2 x.4, s/t right ear .6 x .8. Notes dated 10/17/14 document; R1's wound report 10/9 incontinent lesion butt, 2.3 x 2.1x Necro and 4.2 x1. On 10/20/14, Z2, Hospice Nurse documents "R1 seen today face to face for hospice recertification. R1 with dementia, with continuing decline. R1 resides at LTC facility and is totally dependent on staff for all ADLS. R1 is incontinent of bowel and bladder. R1 sits in a broda chair or is bed bound. R1's husband is present during my visit today and states R1 continues to drinks 2 boost per day and eats 50-75% of her meals. R1 rarely verbalizes, only yes or no occasionally and nonsensically. R1 has recurrence of Stage 2 to her right upper	S9999		

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helix. R1 leans on that ear chronically in her broda char. Repositioning techniques have been started." IDT/Services: "sitting in broda chair leaning to right. This puts pressure on right ear which is beginning to show reddened scabbed area again. Positioned with C- pillow to keep pressure off of ear. Also spoke with nurse asking to keep pressure off ear."

On 11/4/14, R1's Nutrition Notes document; R1 skin 10/30 incontinent lesion butt 2.1 x 3.1 x necrosis; wound left ankle .5 x .5. Nurse says butt worse."

On 11/13/14 Z3, Wound Manager/Nurse Practitioner, (WM/NP) documents: F/u (follow up) of this 72 year old female with a coccyx ulcer, currently treating with Santyl, Dakins', moistened gauze and dry dressing. Nursing requests that I examine her right ear, which was noted on 11/12/14 to have a pressure ulcer. Currently treating with TAO (triple antibiotic ointment). Nursing reports that the coccyx ulcer has increased necrosis and odor noted. Physical Exam: well nourished, groomed and normal body habitus; Wound #1 Pressure Ulcer/Coccyx, Unstageable; Status: Not healed; Pre-Debridement length: 4.50cm Width: 5cm (increased size) Unable to determine pre-depth area: 22.5 cm 2. Description: Wound base color: yellow 40%, black 50%, Pink 10%: Necrotic tissue: Extensive; Procedures: Excisional debridement; Pre Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue, viable tissue obtained for tissue C&S (culture and sensitivity) today. Wound #2 Pressure Ulcer/Right Ear; Pressure ulcer/Stage III ; Acquired: 11/12/14; Pre-Debridement length: 2.00cm Width: 0.50cm Depth area: 0.30cm:

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Area: 1 cm 2, Volume: 0.3cm Description: Slough: minimal, Wound base color: yellow 30%, Pink 70%: Notes: Nursing to obtain pillow to help off-load pressure of ear."

On 11/16/14, Z3, WM/NP, documents, "Nursing reports that this 72 year old female was noted on 9/29 to have a coccyx ulcer, which appears to be secondary pressure. Wound #1 Pressure Ulcer/Coccyx, Pressure ulcer/unstageable, Coccyx, acquired: 9/29/14; Acquired at outside facility: No (in facility); Pre-Debridement length: 4.50cm (cm), Width: 4.00 cm, Unable to determine pre-depth area: 16 cm 2. Description: Wound base color: yellow 100%, necrotic tissue: Extensive; Procedures: Excisional debridement; Pre-Op Diagnosis: Necrotic Tissue; Post Op diagnosis: Necrotic Tissue; Notes: Debrided tissue was surgically excised with a rim of viable tissue.

On 11/17/14, laboratory results for R1 document organisms of: 1) Proteus Mirabilis-moderate growth; 2) streptococcus agalactiae-Grp B-Heavy growth; 3) alpha hemolytic streptococci-heavy growth in coccyx wound.

On 11/20/14, Z3, WM/NP, documents "R1's tissue culture of her coccyx was + (positive) for Proteus Mirabilis and Streptococcus Agalactiae. Notes: Nursing to obtain pillow to help off-load pressure of ear." (2nd mention)

The American Society for Microbiology, "Infection and Immunity" dated May 2004, documents: Proteus Mirabilis, is a common cause of urinary tract infections. Website: www.ncbi.nlm.nih.gov/. Mayo Foundation for Medical Education and Research, 1998-2015, documents: Group B Streptococcus is a common bacterium carried in

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the intestines or lower genital tract. Website: Mayoclinic.org/.

R1's Nutritional Status/Quarterly Progress Record documented by E26, Food Service Manager, on 8/30/14 and 11/21/14 both indicate, "Plan/Follow-up: current pressure ulcer(s): No.

On 11/24/14, Z3,WM/NP documents: F/u (follow up) of this 72 year old female with a coccyx ulcer, currently treating with Santyl, Bactroban, and Calcium Alginate and dry dressing. F/u of right ear ulcer, currently treating with Santyl. Nursing reports that she has a left lateral ankle ulcer that they would like me to evaluate, currently treating with skin prep, which was noted on 10/29/14. Physical Exam: well nourished, groomed and normal body habitus; Wound #1 Pressure Ulcer/Coccyx, unstageable; Acquired: 9/29/14; Pre-Debridement length: 5.00cm Width: 4.20cm Unable to determine pre-depth; Area: 21 cm 2. Undermining: 1 cm from 12 O'clock, Undermining: 2 cm from 3 O'clock; Wound base color: yellow 30%, Pink 70%: Wound #2 Pressure Ulcer/Right Ear; Wound type/grade: Pressure ulcer/Stage III; Body Part: Ear right; Acquired: 11/12/14; Acquired in facility ; Status: healed. Wound #3 Pressure ulcer/left ankle; Unstageable; Ankle left lateral; Acquired 10/29/14; Acquired in facility; Pre-Debridement length: 1.0cm Width: 1.0cm Unable to determine pre-depth Area: 1 cm 2. Description: Euchar: fully covered; Wound base color: black 100%;

On 12/18/14, R1's Change of Condition-Skin Condition report documents "new onset, excoriation, open area and redness, side of/under left breast. Current size of wound: length=3.2 cm, width 1.3 cm, depth=n/a (not applicable).

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Progress Note update: staff notified this nurse of open area noted under R1's left breast. Upon assessment 3.2 x 1.3 cm excoriated area noted to left area under left breast with 1.6 x 0.4 cm reddened area next to open area."

On 12/19/14, R1's Change of Condition-Skin Condition documents "new onset, blister/scab, left side of chest and left arm. Current size of wound: length=0.3 x 0.3 blister, width= blank, depth=1.2 x 2.2 scab. Skin prep to blister TID (three times a day) and monitor scabbed area every shift for any changes until healed. Progress note update: R1 noted to have a scabbed area to left chest by breast that measured 1.2 x 2.2 cm. R1 also was noted to have a blister intact to left arm that matched area to chest that measured 0.3 x 0.3 cm. Wrote orders from hospice for skin prep to intact blister TID to arm and monitor area to chest every shift till healed.

On 12/19/14, R1's, Non-Pressure Skin condition report documents: Site/locations: left side of chest, Condition is: scab, Length 1.2, Width 2.2 cm, Depth: Scab. On 12/26/14, R1's Measurements: Length: 1.4, Width, 1.6, Depth: Scab.

On 12/19/14, R1's "Skin Integrity Care Plan: Non-Pressure Wound", documents: scab intact blister to left chest, left arm. Skin Prep TID (three times daily) to intact blisters and monitor scabbed area every shift for any changes until healed.

On 12/19/14, Hospice documentation indicates: "R1 has a 4.8 x 3.6 cm - Stage 4 wound to sacrum, Stage 2 wounds to left ankle and under left breast, 3.2 x 1.3 cm, and Stage 1 wound to right ear helix."

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S9999	Continued From page 10 On 12/30/14 at 9:45 AM, E3, Wound Nurse stated that R1 is being treated by Z3, WM/NP for the Stage 3 pressure ulcer to her right ear, the unstageable wound to R1's left outer ankle and the Stage 4 wound to her coccyx. On 12/30/14 at 9:45 AM, E3, Wound Nurse and E5, Certified Nurses Aide, CNA, changed R1's dressing to R1's coccyx. R1's dressing to her coccyx had visible brown feces saturating the dressing covering her coccyx pressure ulcer. E3 removed R1's dressing that was saturated with bowel and cleansed the area around R1's stage 4 pressure ulcer with gauze soaked in normal saline. E3 stated she was finished changing R1's dressing to her coccyx and that she cleansed the wound and area surrounding the wound with normal saline. E3, stated she normally uses soap and water to clean visible feces from wound area not normal saline. E3 did not say why she failed to use soap for this cleaning. On 12/30/14 at 12:35 PM, E3, Wound Nurse stated R1's redness to her coccyx started in 5/2014, as an " incontinent lesion " and has since declined to a Stage 4 pressure ulcer. E3 stated that Z3, WN/NP started seeing R1 in 11/2014, but only after a 3-4 week delay in treatment due to internal issues with Hospice. E3 stated R1's pressure areas were declining during this time. E 3 stated she noted the area to be declining in 8/2014 or 9/2014, and knew the wound needed debridement. The Hospice provider was supposed to have a wound nurse come, but never did during that time. E3 stated she had never called R1's physician (Z1) to update him on R1's progression of pressure ulcer because she thought hospice took care of getting the physician ' s orders.	S9999		

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On 12/30/14 at 1:00 PM, E4, Care Plan Nurse stated she is not sure if R1's care plan is individualized for interventions for R1's three pressure areas. E4 stated she will have to ask E3, Wound Nurse.

On 4/23/14, 5/30/14, 8/30/14, and 11/21/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able.

On 12/30/14 at 1:10 PM E3, stated that R1's Care Plan does not individualize interventions to keep R1's three pressure areas from declining. E3 further stated that no interventions were written for R1's pressure areas to keep them from declining until 11/6/14 when Z3 WM/NP began visiting R1.

On 12/30/14 at 2:30 PM, E2, DON stated that R1 had pressure area on her coccyx and her ear. E2 stated that E3 monitors the areas and she is not aware of any other pressure areas to R1. E2 stated there were issues with Hospice and E3 was reporting to Hospice that R1's pressure ulcer on her coccyx had gotten worse and was not healing. E2 stated she was not sure how long the pressure areas to coccyx and ear had been going on and she would have to look at the record. E2 stated, E3 fills out a monthly wound report that E2

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reviews. E2, stated she would expect staff to turn and reposition R1 frequently, apply a low air loss mattress and be calling Z1, MA/MD, E2 further stated that there is no documentation on turning and repositioning of residents, staff does not document on that.

On 1/7/15 at 9:07 AM, E2, DON, and E3 Wound Nurse, stated; when R1 was admitted to the facility on 4/17/14 she had a pressure reducing mattress, which is standard for all residents admitted to their facility. E2 stated on 8/2/14 through 9/19/14, R1 had excoriation to coccyx, developed an incontinence lesion and a Duoderm was applied. E3, stated during this time R1's pressure ulcer on her coccyx had started to decline and knew it needed debridement. On 9/29/14, Hospice wound nurse was supposed to come and evaluated R1 but never came. E2 stated they had no further orders from Hospice, and on 10/4/14, E3 was becoming impatient with hospice and requested orders for Santyl. Hospice did not want to do Santyl. E3 stated "No doctor was called /notified at that time". On 11/3/14 a low air loss mattress ordered from wound management. On 11/6/14 wound management started seeing R1 and noted R1 had unstageable pressure ulcer to coccyx and debrided it.

On 1/7/15 at 11:45 AM, E2 and E3 stated that R1's right ear pressure ulcer initially broke open 10/5/14 and then healed. The both stated that a neck pillow was provided by R1's husband upon admission and then it was lost for a week or two and Hospice provided another pillow. E2 and E3 stated that R1 was on a pressure reducing mattress since admission and R1, but did not have low air loss mattress implemented until wound management involved. E2 and E3 both

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stated they were unsure why it took so long to get R1 a low air loss mattress. Both stated that R1's wounds had been declining prior to wound management involvement on 11/6/14. E2 and E3 stated that R1 is turned and repositioned every 2 hours or more when needed and even turned and reposition every hour since 11/3/14. E2 stated "there is no documentation to provide to show that R1 has been turned and repositioned every hour or every 2 hours. E3 stated that R1 is currently turned and a pillow is placed behind R1's back to keep R1 on side. E3 stated that she doesn't think that the pillow is providing enough support to off load R1's pressure areas to coccyx, right ear and left ankle. E3 further stated that a wedge would be more appropriate for R1 to ensure proper off loading and is "something I need to get."

On 1/7/15 at 1:45 PM, E2, DON stated she cannot find any notes from Hospice for R1 and does not know where hospice keep their chart in the facility. On 1/8/15 at 8:45 AM, E2 produced R1's hospice record and stated she had called the Hospice Provider, and had her bring the records to the facility that morning for review.

On 1/7/15 at 2:00 PM, Z2, Registered Nurse/Hospice Case Manager, stated she cared for R1 once a week for the past 6 months. Z2 stated that R1 developed a Stage 1- Stage 2 on coccyx and now it has declined to --"what you see is what you get". Z2 stated " the facility was supposed to be getting orders for treatment of R1's pressure areas from Z1. Z2 stated the hospice medical director is not allowed to give orders at this facility due to his inability to access the electronic computer system. Z2 further stated that Hospice nurses make recommendations or suggestions to the facility staff and the facility is

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S9999	Continued From page 14 supposed to get the order from R1's attending physician. " On 1/7/15, Z2, continued, stating "R1 had a pressure area to the right ear from a cervical collar that hit the tip of the ear and pressed against the right ear. The right ear was open, and would heal then reopen off and on. R1 favored laying her head to the right side against the wheelchair. R1's left outer ankle is a Stage 2 to Stage 3 that had recently opened up--around after 10/2014. Z2 stated that R1 would be sitting continuously in the recliner in her room and then in the wheelchair. Z2 stated Hospice did supply a neck pillow when R1's C-collar was lost, to help keep the ear pressure ulcer from opening up. Z2 stated that she would classify R1 as High Risk for pressure ulcers. Z2 also stated R1 has an infection in her coccyx wound. " On 1/7/14 at 2:30 PM, Z1, Medical Doctor, stated that he recalled R1, R1 is under the care of Hospice and her care is with Hospice. Z1 further stated he does not know anything about any of R1's pressure areas and is not involved in R1's care of pressure ulcers. Z1 stated the Facility contacted him once for a referral for wound management for R, 1 but was never notified by facility of R1's pressure ulcers since that time. On 1/8/15 at 10:45 AM, E2, DON, and E3 were asked if there were other pressure areas on R1. E2 stated she was not aware of any other areas. E3, Wound nurse stated at that time that there were no other areas on R1. On 1/8/15 at 10:45 AM, E3, Wound nurse did a skin check on R1. R1 was lying in bed, alert and answering questions appropriately. R1's left breast/side was observed as E3 did a skin check.	S9999		

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R1 had a quarter-sized reddened area to the underside of her left breast. E3 stated R1 is receiving no treatment or skin prep to the area at this time. E3 further stated that Hospice orders the treatments for R1's pressure areas.

On 1/8/15 at 11:50 AM, E3, Wound nurse stated she classified pressure areas as incontinence lesions, but was told by Z3, WM/ NP, that the areas should not be classified that way.

On 1/13/15 at 1:40 PM, E2, Director of Nursing stated E3, Wound Nurse would take orders from the Hospice nurse and input them into the computer. E2 stated she is unsure how the Facility coordinates R1's care with Hospice since this was new to her. E2 further stated that she would expect nursing staff to notify Z1, MA/MD, if R1 had no current physician on file or if residents don't have any preference.

On 1/8/15 at 9:20 AM, Z3, WM/NP stated that she started seeing R1 on 11/6/14 and that R1 has really done well since starting with wound management. Z3 stated that R1 had a pressure ulcer to right ear that has closed and reopened at least twice since she started treated her. Z3 stated that R1's right ear recently reopened again and that R1 likes to lay on the right side. Z3 stated that R1 was provided with a neck pillow and is on low air loss mattress. Z3 stated the facility needed to figure out a way to keep R1 off her right side. Z3 further stated that gel pillows could help R1's right ear heal. Z3 stated that R1 has a Stage 4 pressure ulcer to her coccyx that the facility told her started 9/29/14. Z3 stated when she first started seeing R1 her pressure ulcer on her coccyx was unstageable. Z3 stated R1 needs a wound vac and would be healed by now but R1 is on hospice. Z3 stated R1 initially

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had necrosis to her coccyx but has improvement since R1 was debrided. Z3 stated that R1's pressure ulcer to her coccyx currently has undermining. Z3 further stated that R1 has " group B strep " in her coccyx wound and feces and urine could be the cause of R1's wound infections. Z3 stated that R1 has a left lateral ankle that is looking better but slow healing since starting with wound management, and at this time is unstageable. Z3 stated she gives E3, wound nurse recommendations for each resident ' s interventions to keep pressure areas from progressing. Z3 further stated that she does not think that placing a pillow under R1's back off-loads R1 enough to provide relief to the Stage 4 pressure area to coccyx. Z3 further stated a wedge would be more appropriate for R1 to offload pressure areas for R1's three pressure ulcers.

On 1/12/15, E3 stated R1's wound continued to decline and wound management requested for R1 to be laid down more frequently and that R1 should be turned every hour from side to side and only on her back only for meals. Both stated, on 11/3/14, the facility implemented turning every residents every 1 hour if they have active pressure ulcers. E3 stated that R1's right ear was sloughing on 11/13/14 and that R1 leans to right side and puts pressure on it.

On 1/12/15, E2, and E3, reviewed R1's Risk for Pressure Ulcers form dated 4/17/14, which documented R1 as "no risk" for pressure ulcers. The Pressure Ulcer form continued to document on 5/14/14, 8/30/14 and 11/21/14 that R 1 was a "mild risk" , even after though R1 had developed of a Stage 3 to right ear, an unstageable to left ankle and a Stage 4 to coccyx. E2 stated, "R1's assessments were not accurate and R1 was at a

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high risk for pressure ulcers". E3 agreed with the assessments being inaccurate.

On 4/23/14, 5/30/14, 8/30/14, and 11/21/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able. There is no therapeutic devices listed for pressure ulcer prevention, and repositioning of R1 is not adequately addressed in this care plan, as the MDS documents she would need assistance for 2 staff.

2. R2's Physician Order Sheet (POS) documented an admission date of 10/7/14, and a diagnoses that includes; Altered Mental Status, Hypertension, Cerebral Vascular Accident, Dementia, Hearing Loss. R2 had no pressure ulcers on admission to this facility.

In the nurses notes dated 11/17/14, E3, Licensed Practical Nurse, documented an "incontinence associated lesion on R2's right and left buttock with measurements of (0.6 x 0.6) on the right side and (0.8 X 0.9) on the left side " . The Facility Standing orders for Incontinence Associated Lesion dated 11/17/14 were started. The treatment is documented: cleanse area with normal saline, apply Duoderm every 3 days, and monitor dressing every shift and for signs and symptoms of infection.

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On 11/17/14 a Skin Integrity Care Plan: Non-Pressure Wound, was implemented, for incontinence associated lesion to buttock with interventions for pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm care, maintain head of bed in lowest possible position, encourage resident to reposition as able.

R2's Minimum Data Set (MDS) dated 11/5/2014, documented R2's Brief Interview for Mental Status (BIMS) as a 2, moderately impaired. Under functional status, Activities of Daily Living, Bed Mobility documents R2 as a 3/2 (Extensive assist/One person physical assist). R2's MDS dated 12/5/14, under skin and ulcer treatments documents A. Pressure reducing device for chair. B. Pressure reducing device for bed. The MDS did not identify for skin ulcer interventions; C. Turning/repositioning program.

On 11/18/14 at 11:50 AM, E3 Licensed Practical Nurse (LPN) Wound Nurse, documented on the Change of Condition report, "Area to right buttock has been compromised due to pressure and has developed into a pressure area. A low air loss mattress was implemented on 11/18/14.

On 11/18/14, the Skin Integrity Care Plan Non-Pressure Wound, documented "Area was compromised by pressure and order changed to Santyl, Resident seen by Z3 Specialized Wound Management (SWM) Nurse Practitioner (NP).

Z3, SWM/NP documented in her notes she saw R2 on 11/20/14, not on 11/18/14 as was documented on R2 ' s care plan. Z3 documented R2's pressure ulcer as unstageable, with

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measurements of 1.0 X 1.5. Z3 changed R2's treatment to clean wound with normal saline, apply Santyl to wound, cover with gauze and dry dressing. Change daily and as needed.

On 11/24/14, Z3 saw R2 and documented pressure ulcer to coccyx unstageable with measurements of 1.5 X 1.5. Continue to cleanse pressure ulcer with normal saline, apply santyl to wound, cover with gauze and dry dressing. Change daily and as needed.

The facility's pressure ulcer evaluation record dated 11/2014, documented wound measurements to be 1.5 x 1.5, unable to determine stage.

On 12/4/14, Z3 was at the facility, but R2 was unavailable. Nursing reported to Z3 that R2 was stable. Z3 documented will follow up next week.

On 12/11/14, Z3 saw R2 and documented unstageable pressure ulcer to coccyx with measurements of 1.5 X 1.5. Z3 performed excisional debridement of necrotic tissue. Treatment of the pressure ulcer continues with clean with normal saline, apply Santyl to wound, cover with gauze and dry dressing.

On 12/18/14, Z3 saw R2 and documented unstageable pressure ulcer with measurements of 1.1 X 1.0. Continue to cleanse pressure ulcer with normal saline, apply Santyl, cover with gauze and dry dressing. Change daily and as needed.

The facility's pressure ulcer determination record dated 12/19/14, documented, unable to determine stage, with measurements of 1.1 X 1.0. See SWM notes.

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On 12/22/14, Z3 saw R2 and documented Stage IV pressure ulcer with measurements of 1.0 X 1.0 X 1.5, with undermining of 1 centimeter (cm) from 12 O'clock and 0.7 cm from 9 O'clock. Exposed structure: tendon. Z3 documented instructions for staff on importance of R2 being up for 2 hours max at a time to help with off-loading and promote in healing.

The facility's pressure ulcer determination record dated 12/22/14 documented stage IV pressure ulcer with measurements of 1.0 x 1.0 x 1.5. See SWM notes.

On 12/25/14 at 3:30 PM, E30, Licensed Practical Nurse, LPN,documented on Nurses Notes that Z4, Power of Attorney (POA), notified E30, that R2 had an odor coming from R2's coccyx wound. Z4 told E30 "I know the wound is getting worse and there is an odor to it. I know the odor is not coming from bowel movement (BM)." E30 notified Z6, Nurse Practitioner of Z4's concerns of the odor coming from R2's wound and new orders were received for one time dose of Rocephin 1 gram intramuscular (IM) now. Culture coccyx wound. Complete Blood Count (CBC) in AM.

Laboratory results from wound culture obtained 12/25/14, documented; Positive for Escherichia, many white blood cells, gram negative rods, many gram positive cocci, many gram positive rods.

In reviewing Nurses Notes and TAR for 12/25/14, no documentation was found by E23, Licensed Practical Nurse, LPN, who did R2's dressing change on 12/25/14. No documented Change of Condition report or mention of the odor to R2's pressure ulcer was written in the nursing notes, even though orders for treatment of R2's infected

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pressure ulcer was sought for that same day.

In a later interview on 1/13/15 at 9:15 AM, E23 was asked if she recalled an odor to R2's pressure ulcer on 12/25/14 when changing R2's dressing. E23 said "No, I don ' t remember smelling a foul odor". E23 was asked what she would do if there was a change in a wound. E23 said "If there was a change in a wound she would chart it in the Nurses Notes and do a change of condition report".

On 12/29/14, Z3 saw R2 and documented stage IV pressure ulcer with measurements of 3.00 X 5.00 X 1.50. Undermining: 9 cm from 3 O'clock. Undermining: 1 cm from 9 O'clock. Undermining 2.5 cm from 12 O'clock. Undermining:1 cm from 3 O'clock. Exposed structure: Bone, Tendon. Treatment changed to cleanse pressure ulcer with normal saline, apply Santyl, Dakins' 0.125% moisten gauze packing, cover with gauze dry dressing. Change daily and as needed. Z3-instructed staff on importance of R2 being side to side turn only to help with off-loading and promote in healing. R2 is currently on bed rest. Foley catheter was placed for wound healing.

On 12/30/14 at 12:30 PM, E2 Director of Nurses (DON), was asked if the facility has any documentation of when staff turn and reposition residents. E2 said "No".

The facility's pressure ulcer evaluation record dated 12/30/14 documented Stage IV with measurements of 3 X 5, see SWM notes.

The facility's Resident Treatment Administration Record (TAR) for December 2014, documents the nurses initials in a box each day the dressing change was done. No Nurses Notes were

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available to describe the wounds characteristics or odors. On 12/25/14, the TAR initials that E23 LPN did the wound treatment and dressing change. No documentation or description of the wound size, odor or condition was available.

On 1/5/15 at 12:25 PM, E3 LPN Wound Nurse was asked where she documents the size, depth, tissue, drainage of a wound after doing treatment. E3 said," whoever does the dressing change signs it off on the TAR, there is no documentation of the wounds except when SWM comes." When E3 was asked if the measurements on the facility's pressure ulcer evaluation record were her measurements and assessment of R2's wounds, E3 said "No, they are SWMs measurements and assessments". E3 said the pressure ulcer evaluation record dated 12/30/14 were SWMs measurements for 12/29/14. They were not E3's measurements for 12/30/14 as documented.

On 1/8/15 at 9:45 AM, Z3 SWM Nurse Practitioner was asked about the significant change in R2's pressure sore, Z3 said, a couple weeks ago she thought R2's wound was looking better, Z3 said she was concerned about an area to the wound which was necrotic, and was concerned maybe she had been sitting or lying on the wound for too long. Z3 said 2 hours was too long for R2 to be up at all. Z3 was asked if, in her opinion, the staff had not been turning and repositioning R2 as had been ordered. Z3 said "I cannot tell you what happened from one week to the next, but R2's wound had changed so quickly, it had been measured as 1 X 1 and now she is measured at 3 X 5. It looked like a completely different wound. It could have been from not being turned as often as she needed to be."

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The TAR for December 2014 documented per E23's initials, that E23 did the wound treatment and dressing changes for R2 on 12/6/14, 12/7/14, 12/9/14, 12/10/14, 12/16/14, 12/20/14, 12/21/14, 12/23/14 and 12/25/14.

The Facility's Policy "Skin Integrity Standard" dated March 2005 and updated June 2010, documented, Procedure:
- Documentation of the turning and repositioning at least every two (2) hours while in bed or in a chair. Dependent residents sitting or in bed may need a position change for 'tissue offloading' every hour. Weekly "head to toe" assessment of all residents by Licensed nurse with narrative documentation of findings.
- Weekly narrative documentation must include: description of skin tissue, color, turgor, rashes, bruising, skin tears, edema, incision lines and any other skin related issues.
- If skin integrity issues are identified post-admission to the facility the following documentation is required:
#2. Notation on the 24 hour report indicating the skin condition.
#5. Incident report completed for in house acquired Stage III and/or IV. Use in tracking/trending and QA&A program.
- Director of Nurses DON/Designee completes weekly random skin assessments.

On 1/7/15, at 11:45 AM, E2, DON, stated she had not been doing the weekly random skin assessments as directed by facility policy.

3. R8's was admitted to the Facility on 12/5/14 after discharge from a local hospital. Discharge documents indicate R8 had a Stage 1 pressure ulcer to the left heel and a blister on the right heel, no measurements were given by local

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hospital.

The Facility Nurses Notes dated 12/5/2014 at 10:00 pm document in part; "Pink area noted to coccyx." There is no documentation R8 ' s heels were observed or if measurements were taken of R8's heel ulcers upon readmission.

On 12/9/2014 the "Pressure Ulcer Evaluation Record" of the right heel documents a Deep Tissue Injury with a length of 2.6 centimeters with a width a 2.8 centimeters which were taken 4 days after readmission.

On 12/19/2014 the "Pressure Ulcer Evaluation Record" of the right heel documents a deep pressure area width a length of 2.6 centimeters with a width a 2.8 centimeters.

R8's Minimum Data Set (MDS) dated 12/17/14 documents R8 has a Brief Interview of Mental Status (BIMS) of 15 which indicates no mental impairment. This same MDS documents diagnoses, in part, of Congestive Heart Failure, Congenital Musculoskeletal deformities. On 1/13/15 at 1:00 PM, R8, stated he had gotten the pressure areas to his heels before admission, while in the hospital.

On 1/13/2015 at 10:30 AM, E2 Director of Nurses, stated, She is unsure why a full skin assessment was not completed upon readmission. E2 further stated, a full skin assessment should be completed upon resident admission and readmission.

On 1/13/2014 at 10:35 AM, E3 Wound Nurse, stated "yes 10 days had passed without measurements of R8's heel wounds during the period of 12/9/2014 and 12/19/2014". E3 stated,

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"I assess every week as long as the assessment happens sometime in the following week , it's ok". On 1/1/15 R8's left heel, previously a blister, now measures 1.7cm x 2.1cm x 0.2cm.
4. R14 was originally admitted to the Facility on 10/24/14, with diagnoses, in part, of Congestive Heart Failure, Cirrhosis of the Liver and Brain Damage. R14 was observed sitting in a high back wheelchair, while not in bed, throughout all days of the survey. R14 was observed with an alarmed self-releasing lap belt across the waist while sitting in the wheelchair.

R14's most recent Minimum Data Set (MDS), dated 12/22/14, documents that the Facility was unable to assess R14's cognitive ability; that R14 has short and long term memory problems; does not ambulate; and requires extensive assistance for transfers, and activities of daily living.

R14's "Pressure Ulcer Risk Assessment", dated 11/29/14, documents that R14 was at moderate risk for the development of a pressure ulcer.

R14's nurses notes, dated 12/2/14, documents "10:12 AM, resident noted to have skin breakdown to buttock. Area was cleansed with normal saline and protective bandage applied per standing orders. Resident also noted to be incontinent of both stool and urine".

There is no documentation regarding R14's open area on the "Pressure Ulcer Log" from 12/2/14 through 1/8/15.

R14's "Change of Condition SBar-Skin Condition" form dated 12/2/14, documents "skin breakdown from incontinence on R14's coccyx. Current size of wound: Length=2.2 centimeters (cm), Width=1.6 cm, Depth=0.2 cm". The form

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documents that R14's physician was notified of the open area and gave an order to "cleanse with normal saline. Apply protective bandage every 3 days and as needed until healed".

R14's "Non-Pressure Skin Condition Report", with an original date of 12/30/14, documents "incontinence associated lesion - 1.2 length, 0.6 width, 0.2 depth". The back of the form is dated 1/8/15 and documents "area is healed at this time - per wound nurse's assessment".

On 1/8/15 at 11:50 AM, E3, Treatment Nurse, was asked why the open area on R14's was not tracked on the "Pressure Ulcer Log". E3 stated that she had incorrectly classified R14's pressure sore as an "incontinent lesion". E3 said that the wound nurse consultant informed E3 that R14 did have a pressure sore.

R14's "Skin Integrity Care Plan: Prevention", dated 11/29/14, documents "Problem: potential for impaired skin integrity. Goal: No pressure ulcers will develop in the next 90 days". The "Interventions" for this "Problem" include "reposition every hour while in the wheelchair". On 1/8/15, R14 was kept under direct visual observation while he was sitting in his wheelchair, from 10:40 AM until 1:05 PM. R14 was not repositioned during that time period.

The Facility's Policy "Skin Integrity Standard" dated March 2005 and updated June 2010, documented, Procedure:
- Documentation of the turning and repositioning at least every two (2) hours while in bed or in a chair. Dependent residents sitting or in bed may need a position change for 'tissue offloading' every hour. Weekly "head to toe" assessment of

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S9999	Continued From page 28 of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facilty shall not abuse or neglect a resident (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 29 These requirements were not met as evidenced by: Based on interview and record review the Facility failed to timely resolve issues with the the Hospice provider and ensure coordination and implementation of services for 1 of 2 residents (R1) reviewed who received Hospice Services in the sample of 20. This failure resulted R1 having a coccyx Stage 1 pressure ulcer worsen into a Stage 4, in R1 developing a reoccuring Stage 3 pressure ulcer to right ear and R1 developing an unstageable pressure ulcer to the left ankle. Findings include: 2. R1's current face sheet documents diagnosis of ashtma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, presuure ulcers unstageable, open wounds, vitamin deficiency. R1's Physicians Order Sheet documents: Admit to Hospice with Terminal Diagnosis of Alzherimers, Z1, Medical Doctor attending and managing pain and symptoms. On 5/21/14, R1's Nurses Notes document the following orders; Admit to local hospice provider. Terminal diagnoses of Alzheimer's. Z1, Attending Physician of R1 (not hospice physician) to be managing pain and symptoms. Do Not Resussitate. Activity as tolerated. Diet as tolerated. Oxygen at 2 - 4 liters/as needed/for shortness of breath. Continue current medication. The Hospice Care Plan dated 5/30/14, documented the following; Hospice to provide medication as appropriate, pain medication as needed, services based on identifying needs 24/7, provide supplies, and provide visits and	S9999		

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assess pain every visit. Notify Hospice and MD of any changes as indicated. (Facility) nursing staff to communicate with and assist haopice. Decline in condition to be expected Related/To terminal Diagnoses and Hospice Care.

The Facility Social Service Care Plan dated 6/2/14, documents R1 is now receiving Hospice services for End Stage Dementia, and will be receiving with a goal to keep R1 comfortable and pain free.

R1's weekly Skin Condition reports from May 2014 through July 2014 document R1 had ongoing reddness to coccyx and was treated with antifungal cream (Calazime). No physician update or order for antifungal cream was found in R1's clinical record, and no care plan for this event is documented. There are no updates to either the Facility or Hospice Care plans identifying treatments or interventions during this time.

R1's Nursing Notes dated 9/19/14 document: "N.O. (Nurse Order) from hospice regarding incontinet associated lesion to buttock for wound gell cover with optifoam. Change daily and PRN (as needed) as area has declined. " R1's Nursing Notes dated 10/4/14 document: "late entry: spoke with hospice and family re: decline in residents wound to buttock. Asking for santyl as slough reamins to wound bed. Hospice continues to want wound gel and mepilex every 3 days to wound."

On 1/7/15 at 9:07AM, E2, Director of Nursing, and E3, Licensed Practical Nurse / Treatment Nurse, stated that R1 was admitted to the facility on 4/17/14. E2 stated that R1 had a pressure reducing mattress, which is standard for all

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residents admitted to their facility. E2 stated on 8/2/14, R1 had excoriation to coccyx and a duoderm was applied. On 9/19/14, R1 continued to have excoriation and incontinent lesion. E3 stated that R1's pressure ulcer on her coccyx had started to decline and she knew it needed debridement. On 9/29/14, Hospice wound nurse was supposed to come and evaluated R1 but never came. E2 stated they had no further orders from Hospice.

E3, continued, on 10/4/14, E3 was becoming impatient with hospice and requested orders for Santyl from hospice. Hospice did not want to do Santyl. No doctor was notified for the decline in R1's pressure ulcer. On 11/6/14 wound management started seeing R1 and noted R1 had an unstageable pressure ulcer to coccyx and debrided it. Additionally, Z3 ordered a low air loss mattress for R1.

On 11/12/14, E3 stated R1's wound continued to decline and wound management requested for R1 to be layed down more frequently and should be turned every hour from side to side and back only for meals. Both stated on 11/3/14, the facility implemented turning every 1 hour and staff should turn residents every 2 hours and if have active pressure ulcer then turn every hour. E3 stated that R1's right ear was sloughing 11/13 and that R1 leans to right side.

On 4/23/14, 5/30/14, 8/30/14, and 11/21/14, The Skin Integrity Care Plan: Prevention, documents in part; Potential for impaired skin integrity R/T: impaired mobility, Cognitive deficits, incontinence, Chronic Obstructive Pulmonary Disease. No pressure ulcers will develop in the next 90 Days. Interventions listed included (in part); Pressure reducing mattress to bed, Pressure reducing

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cushion to Wheel Chair, Lotion to skin after bathing, Observe skin integrity during AM/PM care. Notify MD promptly of skin breakdown, Monitor incontinence, provide peri-care, Evaluate Skin Weekly, Encourage to reposition as able. There are no therapeutic devices listed for pressure ulcer prevention. Repositioning of R1 is not adequately addressed in this care plan, as the MDS documents she would need assistance of 2 staff. The care plan documents that R1 is expected to decline and is receiving Hospice care. The care plan fails to document R1's pressure ulcers, or interventions to improve R1's wound status, or document treatment interventions prescribed by Hospice.

On 11/20/14 Z3, Wound Mangament notes document "R1's tissue culture of her coccyx was + (positivie) for Proteus mirabillis and steptoccus Agalactiae. Notes: Nursing to obtain pillow to help off-load pressure of ear."

Hospice documentation dated 12/19/14 indicates: "R1 has a 4.8 x 3.6 cm, Stage 4 wound to sacrum, a Stage 2 wounds to left ankle and under left breast, 3.2 x 1.3 cm, and Stage 1 wound to right ear helix." No Hospice care plans were provided for R1's pressure ulcers.

On 12/30/14 at 12:35 PM, E3, Wound Nurse stated R1's redness to her coccyx started in 5/2014, as an " incontinent lesion " and has since declined to a Stage 4 pressure ulcer. E3 stated that Z3, WN/NP started seeing R1 in 11/2014, but only after a 3-4 week delay in treatment due to internal issues with Hospice. E3 stated R1's pressure areas were declining during this time. E3 stated she noted the area to be declining in 8/2014 or 9/2014, and knew the wound needed debridement. The Hospice

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provider was supposed to have a wound nurse come, but never did during that time. E3 stated she had never called R1's physician (Z1) to update him on R1's progression of pressure ulcer because she thought hospice took care of getting the physician's orders.

On 1/7/15 at 11:45 AM, E2 and E3 both stated that Hospice was following R1 and the facility was getting orders from Hospice for R1's pressure areas.

On 1/7/15 at 1:45 PM, E2, DON stated she cannot find any notes from Hospice for R1 and does not know where hospice keep their chart in the facility. On 1/8/15 at 8:45 AM, E2 produced R1's hospice record and stated she had called the Hospice Provider, and had her bring the records to the facility that morning for review.

On 1/7/15 at 2:00 PM, Z2, Registered Nurse, RN/Hospice Case Manager stated she has cared for R1 once a week for the past 6 months. Z2 stated that R1 developed a Stage 1 to Stage 2 on coccyx and now it has declined to --"what you see is what you get". Z2 stated "the facility was supposed to be getting orders for treatment of R1's pressure areas from Z1, Physician of R1, (not Hospice Physician). Z2 stated the hospice medical director is not allowed to give orders at this facility due to his inability to access the electronic computer system. Z2 further stated that Hospice nurses make recommendations or suggestions to the facility staff and the facility is supposed to get the order from R1's attending physician (Z1)."

On 1/7/14 at 2:30 PM, Z1, Medical Doctor, stated that he recalled R1, and that R1 is under the care of Hospice. Z1 stated he does not medically

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manage R1 and her care is done with Hospice. Z1 further stated he does not know anything about any of R1's pressure areas and is not involved in R1's care of pressure ulcers. Z1 stated the Facility contacted him once for a referral for wound management for R1 but was never notified by facility of R1's pressure ulcers.

On 1/8/15 at 9:20 AM, Z3, Nurse Practicioner stated that she started seeing R1 on 11/6/14 and that R1 has really done well since starting with wound management. Z3 stated that R1 had a pressure ulcer to right ear that has closed and reopened at least twice since she started treated her. Z3 stated that R1's right ear recently reopened again and that R1 likes to lay on the right side. Z3 stated that R1 was provided with a neck pillow and is on low air loss mattress. Z3 stated the facility needed to figure out a way to keep R1 off her right side. Z3 further stated that gel pillows could help R1's right ear to heal. Z3 stated that R1 has a stage 4 pressure ulcer to her coccyx that the facility told her started 9/29/14. Z3 stated when she first started seeing R1 her pressure ulcer on her coccyx was unstageable. Z3 stated R1 needs a wound vac and would be healed by now, but R1 is on Hospice.

On 1/13/15 at 1:40 PM, E2, Director of Nursing stated that E3, Wound Nurse, would take orders from Z2, Hospice Nurse and input them into the computer. E2 stated she is unsure how the coordination of care with Hospice is supposed to happen as this was new to her. E2 stated that Hospice was writing orders for R1's pressure ulcers.

A review of R1's care plans from 10/29/14 through 12/11/14 found documentation that the facility had begun to individualize it's care plans

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for R1's three pressure ulcers, but all three updates failed to address ongoing problems for R1 with positioning and pressure relief. None of the updates included information that Hospice was involved in R1's care.

The Initial Care Plan of 5/30/14 remained unchanged, although it was documented as updated on 8/30/14 and 11/21/14.

A review of the Facility's "Service Agreement By and Between" signed by the Hospice Provider 8/31/99, and signed by the Facility 9/7/99, documents:

2:13 "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals established by the Interdisciplinary Group, which includes (a) an assessment of each Hospice Patient's needs, (b) an identification of the Hospice Services, Including management of discomfort and symptom relief, needed to meet such Hospice Patients needs and ...., (c) details concerning the scope and frequency of such Hospice Services, and (d) details concerning the Nursing Facility Services to be provided to the Hospice Patient....

3.2 Design and Maintenance of Care Plan, (a) Nursing Facility Residents: In accordance with the Federal and State laws and regulations, Hospice shall coordinate with Nursing Facility to develop a Plan of Care for each new Residential Hospice Patient. Hospice shall Furnish Nursing Facility with a copy of the Plan of Care. (c)Modifications ..... the Interdisciplinary Group will review and modify, if necessary, the Plan of Care. The Hospice will consult and coordinate with Nursing Facility... with respect to any modification of the Plan of Care, and will provide the Nursing Facility

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S9999	Continued From page 36 with any modification of the Plan of Care. In a previous interview on 12/30/14 at 1:00 PM, E4, Care Plan Nurse, stated she is not sure if Hospice had done a care plan, the she had not been involved in coordinating care with hospice. On 1/13/15 at 1:40 PM, When E2, DON was asked if the facility had any proceedures for coordinating care with the Hospice Provider, no additional information was given by E2. (B) 300.1210b) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	S9999		

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and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facilty shall not abuse or neglect a resident (Section 2-107 of the Act)

These requirments were not met as evidenced by:

Based on observation, interview and record review, the Facility failed to provide adequate pain management services to address pain for 1 of 9 residents (R13) reviewed for pain management in the sample of 20.

Findings include:

1. R13's Electronic Physician Order Sheet (POS) dated 01/2015 documents diagnoses of Chronic Pain Syndrome, Lumbago, Osteoarthrosis, Status Post Surgery Congenital Fusion of the Spine. R13's POS documents Oxycodone ER 20 mg tablet every 12 hours, Oxycodone 10 mg by oral route every 4 hours as needed, Lidoderm 700 mg/patch adhesive to each knee daily.

R13's most recent Minimum Data Set (MDS) dated 12/12/14 documents a BIMS (Brief Interview of Mental Status) score of 15 (no

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S9999	Continued From page 38 cognitive impairment). R13's Pain Assessment dated 10/29/14 documents, "...chronic and constant severe pain of both lower legs, an 8 on a scale of 1 (no pain) to 10 (worst pain). Pain Management includes Lidoderm 700 mg/Patch, Oxycodone ER 20 mg twice a day and Oxycodone 10 mg every 4 hours as needed. Pain Management Evaluation: Continue with current interventions as pain appears adequately managed. Interdisciplinary Team update on 12/12/14 documents pain management remains the same. " R13's Comprehensive Care Plan: Pain Management dated 10/29/14 and reviewed 12/12/14 documents, "Consult with MD when pain regimen changes are indicated: inadequate pain relief. Non pharmacological approaches: frequent position changes, exercise/physical activity, resting periods during activities of daily living. R13's POS with order date 10/22/14 documents, "Refer (R13) to Pain Management per (Z5, Nurse Practitioner). R13's POS with order date 11/12/14 documents, "Consult with pain management due to chronic leg pain. " On 1/5/15 at 10:08 AM, R13 was in bed and rubbing her right leg. R13 stated she was in pain, a '4' on her right leg and she just had her scheduled pain medication two hours earlier and it only worked for a short time. R13 stated she gets pain medication twice a day and she can ask in between as needed but the medication only helps temporarily. R13 stated she has told staff her pain medication is not working and has not worked for a long time. R13 stated she cannot do	S9999		

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her restorative exercises on her right leg because of the pain. R13 stated even if she asks for pain medication every 4 hours it will just work for an hour or so and the pain is back. R13 stated she has not been to any pain management consult since she was readmitted in October 2014 after a back surgery related to her spinal fusion.

On 1/8/15 at 9:02 AM, R13 was in bed, grimacing, and stated her pain was an '8' on her right leg and a '6' on her left leg and she just took a pain pill an hour ago. R13 stated it seems like she is having pain all the time.

On 1/12/15 at 10:05 AM, E19, Certified Nursing Aide, CNA, provided range of motion exercises to R13. R13 refused to do the right leg because it was painful. R13 stated it was a "6" on the right leg.

A review of R13's clinical record indicated no documentation that pain management consultation was done as ordered on 10/22/14 and again on 11/12/14.

On 1/8/15 at 9:25 AM, E23, Licensed Practical Nurse, stated she cannot recall R13 having a pain management consult since R13's return to the facility sometime in October 2014.

On 1/13/15 at 1:10 PM, E2, Director of Nursing stated she had called Z5 and asked where to go for R3's pain management consult. E2 stated Z5 never got back to them to provide information on pain management consultants. E2 added the facility does not have any pain consultants that they can send their residents to.

The Facility Operating Standard Pain Management Process dated 6/2009, documents,

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S9999	Continued From page 40 "The objective of the pain management process is to identify resident need and determine potential referrals/interventions to affect positive functional change through pain reduction, modification of the perception of pain, and enhancement of the quality of life...Guidelines, (in part): Review of continued effectiveness and appropriateness of Pain Management Plan of Care during routine IDT (Interdisciplinary Team) walking rounds." (B) 300.1210b)3) 300.1210d)4)B) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	S9999		

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catheterization was necessary.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide complete incontinent care for 3 of 6 residents (R1, R5 and R14) observed for incontinent care in the sample of 20.
Findings include:
R5's most recent MDS dated 11/28/14 documents R5 is totally dependent on staff for all activities of daily living and incontinent of bowel and bladder.

On 1/5/15 at 1:33 PM, E12 and E13, CNAs, provided perineal care to R5. R5's adult disposable briefs was slightly saturated with urine. E12 and E13 washed their hands and prepared a basin of soapy water using liquid soap from the wall soap dispenser and a second basin of water for rinsing. Using a soapy washcloth, E12 wiped R5's groin area and across the

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vaginal area with back to front strokes. E12 failed to spread the labial folds. E12 dried the area but did not rinse the soap off of R5. E13 turned R5 to her left side. E12 cleansed the buttocks and rectal area with a soapy washcloth and dried the area. E12 failed to rinse the soap off of R5.

2. R14's most recent MDS dated 12/6/14 documents R14 needs extensive assist with transfers, dressing and toileting and is incontinent of bowel and bladder.

On 1/8/15 at 3:30 PM, R14 was incontinent of bowel and bladder. E15, CNA, washed her hands and prepared washcloths wet with water and regular soap. E15 wiped the inner thighs and the shaft of the penis and rinsed the area. E16 failed to retract the foreskin. E15 failed to dry the wet area before turning R14 to his left side. E15 used a wet soapy towel to cleanse the buttocks and rectal area. E14 failed to dry the wet areas before applying protective barrier to R14's buttocks.

On 1/13/15 at 9:39 AM, E27, Director of Staff Development, stated she expects staff to wash, rinse and dry and to thoroughly wash the the vaginal area in females and retract the foreskin in males during perineal care. E7 stated it is important to wash in a front to back direction to prevent infection.
The Facility Policy on Incontinent Care dated 8/2014 documents, "Purpose: To keep skin dry, free of irritation and odor. To prevent skin breakdown. To prevent infection. Procedure: 5. Wash all soiled skin areas including skin folds, washing from front to back, rinse and dry." The policy does not show specific procedure for cleaning male and female genitalia.
R1's December 2014 face sheet documents

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diagnosis of ashtma, COPD, HTN, Cerebral degeneration, TIA, cough, history of falls, presuure ulcers unstageable, open wounds, vitamin deficiency.

R1's Minimum Data Set dated 11/21/14 documents R1's Brief Interview of Mental Status (BIMS) was left blank. The MDS further documents that R1 is totally dependent on two or more staff members for transferring, bed mobility, toilieting and totally dependent on one staff member for dressing, eating, personal hygiene and bathing and that R1 is always incontinent of bowel and bladder.

On 12/30/14 at 9:00AM, E6, Certified Nurse Assistant (CNA) and E7, CNA provided incontinent care to R1, who had visible brown feces on her peri-anal area that saturated the coccyx wound dressing. E6 wiped R1's peri-anal area with a wet washcloth to remove brown feces. E6 then transferred the soiled washcloth to her (E6) opposite hand to dispose in trash bag. E6 placed both soiled gloved hands in the clean wash basin with clean washclothes to retrieve new washcloth. E6 wiped R1's peri-anal area again with brown feces on washcloth and E6 stated R1 was "still pooping." At no time did E6 rinse or dry R1's peri-anal area. E6 left visible brown feces around R1's wound to her coccyx and R1's wound dressing was visibly soiled with brown feces. E6 covered R1 back up and stated she was done with care.

On 12/30/14 at 9:45 AM, E3, Wound Nurse and E5, CNA changed R1's dressing to R1's coccyx. R1's dressing to her coccyx had visible brown feces saturating the dressing covering her coccyx pressure ulcer and also feces around the peri-anal area. E3 removed R1's dressing that

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S9999	Continued From page 44 was saturated with bowel and cleansed the peri-anal area around R1's Stage 4 pressure ulcer with gauze soaked in normal saline. E3 stated she was finished cleaning R1 coccyx and that she cleansed the wound and peri-anal area surrounding the wound with normal saline. E3 further stated she would normally used soap and water to clean visible feces from peri-anal area not normal saline. (B)	S9999		

F-224 483.13(c) Prohibit Mistreatment/Neglect/Misappropriation

The facility took the following corrective action(s) for residents found to have been affected by the alleged deficient practice:

R1's treatment orders and clinical status was reviewed by the FNP from the wound management provider on 1/08/15 to ensure orders were clinically appropriate for the resident's status.

R2 discharged on 1/06/15.

The facility completed the following actions to identify other residents having the potential to be affected by the alleged deficient practice:

Head-to-toe skin assessments were completed for all in-house residents by 1/09/15 to identify other residents having the potential to be affected by the alleged deficient practice.

All pressure ulcers were re-measured and assessed by 1/08/15.

The facility will take the following measures and/or altered systems to ensure the problem will be corrected and will not recur:

Residents with pressure ulcers will be reviewed to assure a pressure ulcer monitoring [assessment] sheet exists for recording ongoing assessments no less often than weekly.

Treatments orders will be re-evaluated to determine efficacy based on current wound status. Physician's will be notified and alternate treatment considered when wound deterioration presents or no progress within 2 weeks of treatment.

Licensed Nurses including the DON, ADON and MDS-C received re-education with a R.N./ WCC by 1/09/15 on facility practices of measuring wounds weekly and with significant wound changes. Emphasis was placed on providing appropriate treatment based on wound stage, and the need to escalate alternate treatment needs to the Medical Director when clinically indicated.

C.N.A's received re-education on the STOP & WATCH early warning tool utilized to report a change in a resident's status and the skin condition worksheet tool to report skin condition at the time of the resident's shower/bath to the licensed nurses.

Beginning 1/08/15, and weekly thereafter, wound measurements will be updated and treatment efficacy analyzed. Physician will be notified and alternate treatment considered when wound deterioration presents or no progress within 2 weeks of treatment. Wound status will be reviewed during clinical meeting and associated wound care documentation monitored by the DON/Supervising Nurse/Designee.

Facility staff will complete re-education on the policies prohibiting abuse, neglect, and mistreatment of residents and misappropriation of resident property.

The facility Quality Management Committee met on 1/09/15 to review skin management policies and establish compliance with F-314 guidance standards, wound documentation and physician notification of wound status with timely follow up as applicable.

The facility will complete the following Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and permanent:

The DON/Supervising Nurse, or designee will conduct a weekly pressure ulcer audit to monitor wound status and coordinate compliance with weekly measurements and physician notifications as indicated.

The DON will report any issues identified to the Quality Management Committee no less often than monthly for problem analysis and additional action planning as indicated.

Dates when corrective action(s) will be completed:

2/15/2015 Accepted

Attachment B
Imposed Plan of Correction

F-314 483.25(c) Treatment/Services to Prevent/Heal Pressure Sores

The facility took the following corrective action(s) for residents found to have been affected by the alleged deficient practice:

R1's, R-8's and R-14's treatment orders and clinical status was reviewed by the FNP from the wound management provider on 1/08/15 to ensure orders were clinically appropriate for the resident's status.

R2 discharged on 1/06/15.

The facility completed the following actions to identify other residents having the potential to be affected by the alleged deficient practice:

Head-to-toe skin assessments were completed for all in-house residents by 1/09/15 to identify other residents having the potential to be affected by the alleged deficient practice.

All pressure ulcers were re-measured and assessed by 1/08/15.

The facility will take the following measures and/or altered systems to ensure the problem will be corrected and will not recur:

Residents with pressure ulcers will be reviewed to assure a pressure ulcer monitoring [assessment] sheet exists for recording ongoing assessments no less often than weekly.

Treatments orders will be re-evaluated to determine efficacy based on current wound status. Physician's will be notified and alternate treatment considered when wound deterioration presents or no progress within 2 weeks of treatment.

Licensed Nurses including the DON, ADON and MDS-C received re-education with the R.N./ WCC by 1/09/15 on facility practices of measuring wounds weekly and with significant wound changes. Emphasis was placed on providing appropriate treatment based on wound stage, and the need to escalate alternate treatment needs to the Medical Director when clinically indicated.

C.N.A's received re-education on the STOP & WATCH early warning tool utilized to report a change in a resident's status and the skin condition worksheet tool to report skin condition at the time of the resident's shower/bath to the licensed nurses.
Beginning 1/08/15, and weekly thereafter, wound measurements will be updated and treatment efficacy analyzed. Physician will be notified and alternate treatment

considered when wound deterioration presents or no progress within 2 weeks of treatment. Wound status will be reviewed during clinical meeting and associated wound care documentation monitored by the DON/Supervising Nurse/Designee.

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The facility will complete the following Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and permanent:

The DON/Supervising Nurse, or designee will conduct a weekly pressure ulcer audit to monitor wound status and coordinate compliance with weekly measurements and physician notifications as indicated.

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Dates when corrective action(s) will be completed:

2/15/2015 Accepted

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Imposed Plan of Correction