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F 497	Continued From page 67 aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide yearly performance reviews, and inservice training, of a minimum of 12 hours, for the year 2007, for 33 of 33 Certified Nurses Aides employed at the facility. Findings include: On 1/16/07, E1, Administrator was asked to compile the inservice training records for the Certified Nurse Aides, (CNA), for 2007. On 1/23/07, at 1:56 PM, E1 reported he was unable to show employee inservice records, indicating 12 hours of training. E1 stated, "I went through every piece of information, just didn't have enough for 12 hours for any of the CNA's. The people responsible, the DON, E2, (Director of Nursing), and the Staff Development Coordinator, E18 have been fired. They were responsible for keeping these records, and tracking it. It was not being done. They had given me nothing."	F 497		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b) 300.1210b)2) 300.1210b)3) 300.1210b)5)	F9999		

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F9999	Continued From page 68 300.1220b) 300.1220b)1) 300.1220b)2) 300.1220b)3) 300.1820c) 300.1820c)3) 300.1820c)4) 300.3240a) 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, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be	F9999		

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F9999	Continued From page 69 administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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.	F9999		

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F9999	Continued From page 70 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 in 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 300.1820 Content of Medical Records c) In addition to the information that is specified above, each resident's medical record shall contain the following: 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. 4) An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on record review, interview, and observation it was determined that the facility failed to provide the necessary treatment and services to promote healing, prevent infection and prevent new pressure sores from developing	F9999		

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F9999	Continued From page 71 for 4 of 4, (R1, R3, R6, and R7), sampled residents and failed to implement their written policy to avoid pressure sores to ensure that 4 (R1, R3, R6, R7) of four residents were free from neglect. Facility documentation does not show that pressure sores were measured timely and accurately. Observations and record review show the facility did not follow physician orders and/or care plans for the residents. They failed to assess, monitor, implement and modify interventions, and notify physicians regarding avoidable, facility acquired, multiple Stage II; stage IV; and unstageable pressure sores. This failure resulted in neglect and harm to the residents. These failures resulted in R1developing a stage 4 pressure sore to her coccyx; R3 developing a stage 2 pressure sore on his left buttocks, stage 4 pressure sores on both heels and left outer foot, and unstageable pressure sores on his left hip and left ankle; R6 developing a stage 4 pressure sore to her heel; and, R7 developing a stage 4 pressure sore to her heel. The findings include: 1. Per Physician's Order Sheets for 1/08, R1 has diagnoses, in part, of Senile Dementia, Alzheimer's Disease, Hypertension, Renal Failure, Diabetes Mellitus, and Congestive Heart Failure. The assessment, dated 12/18/07, shows R1 is severely cognitively impaired, requires extensive assistance from staff for eating, bed mobility, transfers, and personal hygiene, and is incontinent of bowel and bladder. The assessment, in Section M-1. and 3., shows R1 has no pressure ulcers, or history of pressure ulcers.	F9999		

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F9999	Continued From page 72 The Assessment of Pressure Ulcer Risk, dated 12/18/07, only indicates a risk for R1 as incontinent of bowel. This assessment fails to address R1's incontinence of the bladder, bed mobility problem, or history of a previous ulcer. The Wound Evaluation Form, dated 12/14/07, shows R1 has a facility acquired, Stage 2 to the coccyx, measuring 3 centimeters, (cm), X 3cm, with the treatment, per physician's orders, as "DuoDerm to coccyx/change every 3-5 days." The Wound Evaluation Form, dated 1/13/08, shows the pressure area to the coccyx has developed into a Stage 4, measuring 17cm X 9cm X 6.5cm, with a large amount of purulent, foul smelling drainage. The physician's order, dated 12/28/07, reads, "cleanse coccyx with Saf Cleanse and apply Santyl ointment, cover with 4 X 4 dressing daily, and PRN, (as needed)." Z2, Clinical Nurse Practitioner, (CNP), examined R1 on 1/03, 1/09, and 1/14/08. No change in treatment orders, or an order to address the infection to the coccyx wound was noted. In an interview on 1/17/08, at 10:42 AM, Z2 reported she saw R1 on 1/09/08, the day Z1, Physician, took over the case. Z2 reported she knew R1 had multiple advanced pressure ulcers, but did not examine the wounds because they were covered. Z2 stated, "I think one was a Stage 3." A physician's order, dated 1/14/08, written by Z2 reads, "Straight cath for U/A, (urinalysis), set up C&S, (culture and sensitivity). Leave Foley catheter in for wound healing." The Wound Evaluation Form, dated 12/30/07, shows R1 has a facility acquired Stage 2 to the left shin, measuring 7cm X 5cm. The physician's	F9999		

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F9999	Continued From page 73 order, dated 12/28/07, reads, "cleanse left lower leg with Saf Cleanse and apply Santyl ointment. Cover with a 4 X 4 daily and PRN." The Wound Evaluation Form, dated 1/08/08, shows the area to the left shin has increased to a Stage 3, measuring 7.75cm X 4cm X 1.5cm, with no change in treatment. The Wound Evaluation Form, dated 12/08/07, shows a facility acquired Stage 2 to the right buttock measuring 3.5cm X 1cm, and unstageable, blackened with eschar, and pressure ulcers to the left heel measuring 2cm X 3cm, and right heel, measuring 2cm X 2cm. There is no Wound Evaluation Form since 12/28/07 for the pressure ulcer to the right buttock. The physician's order, dated 12/28/07, reads, "Cleanse buttock decub with Saf Cleanse and apply DuoDerm, change every 3 days." The Wound Evaluation Form, dated 1/08/08, shows a measurement of the left heel as 2cm X 2.5cm, black, with no open areas. The treatment ordered by the physician 12/28/07 is shown as "apply skin prep and heel protectors daily." The right heel measured at 2cm X 2cm, with the same treatment order. The Wound Evaluation Form, dated 12/28/07, shows R1 has a facility acquired Stage 2 to the inner aspect of the right knee measuring 3.5cm X 1cm. The Wound Evaluation Form, dated 1/08/08 measures the ulcer as 3cm X 2cm, with a physician's order for treatment, dated 1/03/08 as, "Apply DuoDerm, change every 3 days and PRN." The Nurses Notes for R1 from 12/19/07 through 1/14/08 fail to address all of the pressure areas	F9999		

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F9999	Continued From page 74	F9999		

and their decline. The Nurses Notes do not address the foul smelling purulent drainage to the coccyx wound.

The Care Plan for R1, dated 12/28/07, reads, "Patient has unstageables to bilateral heels, one unstageable to coccyx, and a Stage II to the left lower extremity, and Stage II to her right inner knee as of 1/03/08." The Stage 2 to the right buttock is not addressed in the Care Plan. The Care Plan has not been revised to show the progression of the pressure areas to the coccyx, heels, right knee, and left shin, or the current treatment approaches. The Care Plan fails to address the infection to the coccyx wound, or the use of heel protectors. In an interview with E13, Registered Nurse Consultant, on 1/14/08, it was confirmed that the Care Plan for R1 was not revised, and up to date, with the current skin or nutritional status.

The Quarterly Nutritional Re-evaluation, dated 12/10/07, shows R1 on a no added salt diet, with a significant weight loss of 7 pounds since 9/19/07, and has to be fed by staff. A Nurses note, dated 12/26/07 at 2:39 PM, by E16, Licensed Registered Dietitian, reports R1 weighs 157 pounds, and the diet was changed to regular, with whole milk and healthshakes 3 times daily, by the hospice nurse. The last Laboratory Report, dated 12/07/07, shows results as; Glucose-123-high (74-118); BUN-24-high, (blood, urea, nitrogen) (8-20); BUN/Creatinine Ratio-24-high (6-20); Total Protein-5.6-low (6.1-7.9); and Serum Albumin-2.6-low (3.5-4.8). The Care Plan, undated, to address R1's weight loss has not been updated or revised to include her significant weight loss in the past 6 months, change in diet, or that R1 requires feeding by

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F9999	Continued From page 75 staff. On 1/14/08, at 11:05 AM, R1 was observed laying on her back, with her knees toward the window. E3, Licensed Practical Nurse (LPN) was preparing to do treatments and dressing changes to R1's pressure ulcers. R1 was observed to have both legs contracted in, with the right knee rubbing directly on the inner aspect of the left shin. No pillow was noted between R1's legs, to prevent the legs from rubbing. A large pressure area was observed to the right inner knee, with no dressing on it. E3, LPN, confirmed R1 should have a pillow in place between the knees, and a DuoDerm dressing should be in place to the right knee. E3 stated R1 is turned and repositioned every 2 hours. E3 removed the 4 X 4, drainage soaked, gauze dressing from R1's coccyx. A very large amount of foul smelling, purulent drainage was observed. E3 confirmed R1 was not receiving any antibiotics for the wound infection. The left inner shin ulcer was observed to be very large, open and draining. E3 reported the left inner shin as a Stage 3. After removal of the heel protectors, R1's heels were observed to have large, blackened and closed blisters. The right heel was noted to be mushy to the touch. No dressing were noted to the heels. R1 was observed to be on a low air loss mattress. On 1/14/08, at 1:30 PM, Z3, Hospice Nurse, reported she had referred R1 to a special wound management service on 1/11/08. R1 was observed to be laying on her right side. Z3 removed the drainage soaked dressing to the	F9999		

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F9999	Continued From page 76 coccyx, and stated, "This is a Stage 3 to 4, with tunneling. I would expect the wound to need debridement, with a change of ointment from Santyl, and an antibiotic ordered." At 3:50 PM, and at 4:30 PM, R1 remained sleeping on her right side. On 1//15/08, at 9:30 AM, R1 was observed in bed on her right side. An indwelling catheter bag was observed to be laying on the floor, dated 1/15/08. It was draining dark yellow urine. A foul odor was permeating the room. The DuoDerm to the right inner knee was observed to be weeping a large amount of serosanguinous drainage. The drainage soaked dressing to the coccyx was foul smelling. The gauze dressing to left inner shin was also soaked with drainage. E3, LPN, reported R1 had not been referred to a special wound management service, as recommended by the hospice nurse, but thought the plan was to send R1 to a physician who was a wound specialist. E3 reported an appointment had not yet been made. On 1/16/08, at 9:00 AM, R1's left and right heels remained closed. The right inner knee ulcer was open and draining. E3, LPN, reported, "It's not bigger, just open now, a Stage 2 now. Will be a Stage 3 or 4 when it opens." At 10:12 AM, E3 reported R1 had a scheduled appointment with Z6, a wound specialist, on 1/17/08, at 8:15 AM. R1's room continued to smell of the purulent drainage from the coccyx wound. E3 also reported she had notified Z1, the physician, and had received an order from Z2, CNP, for Santyl ointment on the right inner knee, and cover with a dry dressing, change daily and PRN. E3 confirmed no antibiotic order had been received.	F9999		

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F9999	Continued From page 77 On 1/17/08, at 10:35 AM, Z6, Wound Specialist and Surgeon, was interviewed, after examining R1. Z6 stated, "If someone would have turned her all the time, and paid more attention to her, it (pressure ulcers) may not have happened so bad. Should have been treated before they got that bad. It's bad. If her family wants to treat her aggressively, she(R1) would be admitted to the hospital, treated with antibiotics, maybe surgery." Z6 confirmed the coccyx wound smelled like an infection, and if the bone was infected, R1 would become septic and die. Z6 reported he had spoken to Z1, the physician, and Z1 reported he would talk to R1's family. Z1 reported R1 was not a candidate for surgery, and he just wanted to make her comfortable. The facility's Assessment and Treatment of Pressure Ulcers/Guide for Wound Assessment and Documentation, revised 7/07, list procedures, in part, of; "4. Assess and evaluate further interventions that may be indicated to promote healing and prevent infection. 6. The physician is to be notified if there is no improvement in area, signs, symptoms of infection or signs of deterioration. 7. The Director of Nursing Services and/or designated Licensed Nurses will make pressure ulcer rounds on a weekly basis. Documentation of the area will be addressed. Resident progress or lack of progress will be evaluated. Directives may be given for further interventions, and changes in plan of care. The resident's care plan will also be reviewed." The facility's Policy and Procedure, entitled Weekly Skin Assessment/ Wound Evaluation/ Skin Condition Form, revised 7/07, reads, in part; "2. Any skin abnormalities identified during this	F9999		

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assessment will be documented in the Interdisciplinary Notes and weekly until healed.
5. Skin issues identified requiring continued monitoring/assessments/documentation should be updated on the Care Plan for those interventions that have been implemented." This had not been done in R1's Interdisciplinary Notes for R1, or Care Plan.

2. R3 was admitted to the facility on 9/27/07 from a sister facility with diagnoses, in part, of congestive heart failure, psychosis, diabetes type two, and depressive disorder. R3 was admitted to hospice services at the other facility on 4/9/07 for "Debility" according to Z7, Hospice Nurse.

On admission on 9/27/07, R3 was noted to have a stage 2 pressure sore to the sacrum as documented on the "Admission/Readmission Assessment." There are no other open areas noted. The "Skin Record" dated 10/29/07 through 11/11/07 does not identify R3 had any pressure sores. The "Skin Record" dated 11/12/07 through 12/16/07 identified R3 had a stage 2 pressure sore on his sacrum identified on admission 9/27/07. There is a physician order for a DuoDerm to the left buttocks dated 10/4/07. Pressure sores to both heels are not documented on the "Skin Record" even though the bilateral heel pressure sores were identified on 11/13/07 on the facility "Wound Evaluation Form" and on 11/2/07 on the Hospice "Skin Assessment and Wound Care Record". The "Skin Record" dated 12/17/07 through 1/6/08 identified R3 had unstageable "in house" pressure sores on both heels and stage 2 to the left outer foot with the date identified as 11/1/07. A stage 2 to the sacrum was listed and identified 9/27/07. No order for treatment was documented until

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F9999	Continued From page 79 11/12/07 for the heels and outer foot when granulex spray to both heels and accuzyme ointment to the left outer ankle was ordered. There are no measurements documented on the "Skin Record." On 12/10/07 the physician ordered to use Santyl ointment twice a day to both heels. This was discontinued on 12/21/07 when the hospice physician, Z9, ordered triple antibiotic ointment to the left outer ankle and the left outer foot and Polysporin and Santyl slurry to both heels. On 1/8/08 the Hospice nurse recommended to increase the pain medication and cleanse wounds with normal saline and apply Flagyl powder 1%. This was changed to Flagyl powder 5% on 1/14/08. The "Wound Evaluation Form" done by the facility for the coccyx, left outer ankle, and left and right heel begins on 11/13/07 even thought the Hospice "Skin assessment and Wound Care Record documented the areas on 11/2/07. The facility also documented on the 9/27/07 "Admission/Readmission Assessment that R3 had a stage 2 area on the sacrum. No treatment for the sacrum was documented as obtained until 10/4/07. Treatment for the bilateral heels and left outer ankle was not obtained until 11/12/07 according to the "Physician's Orders Medications and Treatments" and the "Treatment Administration Record" for November. Review of the "Wound Evaluation Form" for R3's pressure ulcers on the bilateral heels, sacrum, and left outer ankle from 11/13/07 until 1/4/08 noted that many of the areas on the form were not completed. Sections such as "Stage or Thickness," "Drainage," "Drainage Type," "Wound Bed," "Undermining Tunneling," and "Periwound," "Response to Treatment,"	F9999		

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F9999	Continued From page 80	F9999		

"Comments," or "Document Care Plan Interventions" are not completed. Many times the response to "Document Care Plan Interventions" is "float heels" or "will continue to monitor." On 1/4/08 the left heel was noted to have an "increase in size" as a response to "Response to Treatment" but there are no interventions documented.

The facility policy and procedure "Assessment and Treatment of Pressure Ulcers/Guide For Wound Assessment and Documentation" states "Upon identification of a pressure ulcer, whether developed in the facility or upon admission, the area will be assessed and documented. Complete assessment should be documented on the Admission Assessment Form and the Wound Evaluation form...." The procedure also includes contacting the physician, initiating appropriate treatment, assessing and evaluating for further interventions to promote healing and prevent infection, and notifying the physician if there is no improvement or there are signs and symptoms of infection.

The "Weekly Skin Assessment," which states is to be completed by the licensed nurse on shower day, documented for R3 11/6/07 that R3 did not have a pressure sore. On 11/13/07, 11/20/07, and 11/27/07 the assessment identified R3 did have pressure sores but no documentation as to where the areas were. The assessments dated 12/2/07, 12/4/07, 12/11/07, 12/14/07 12/18/07 12/21/07 and 12/25/07 had marked "no" under "Pressure Ulcer." Interview with E13, Corporate Nurse, confirmed that there was no other documentation available regarding the pressure sores for R3. The facility policy and procedure "Weekly Skin Assessment/wound evaluation/skin

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F9999	Continued From page 81 condition Form" states, "Skin assessment will be documented on residents weekly. Any identified skin conditions will be documented and treatment initiated. Continued assessment and documentation of identified areas will occur on a weekly basis." R3 was observed on 1/14/08 seated in his geriatric chair at 9:50 AM in is room. R3 was observed seated in this position until 11:50 AM when he was observed pushed to the dining room for the noon meal. R3 was observed in the dining room in the geriatric chair until 12:49 PM when R3 was pushed out of the dining room into the TV area. At 1:00 PM E4, Assistant Director of Nursing, was informed that R3 had been up in the geriatric chair for 3 hours. R3 was taken to his room and placed in bed at 1:15 PM. Observation of R3 on 1/14/08 after he was placed in bed noted there was no pressure relief cushion in the geriatric chair. R3 had a DuoDerm on his left buttocks that was peeling off dated 1/11/08. R3 had dressings on both heels dated 1/13/08 with paper surgical footies on both feet. There were no pressure relieving boots nor was there any pillows or pads to float R3's heels. Two long red areas with a purple center approximately 3 inches long to the largest area were observed on his left outer buttocks. The largest was approximately 6 and the other 4.5 inches long, and no dressing, were observed. A smaller third red area approximately 2 inches long was also observed. E3, licensed practical nurse, who was present in the room stated at 1:25 PM that the areas were "New to me." E7, Certified Nurse Aide, stated that she had come in to work a little after breakfast and R3 was already up in the geri-chair. According to the facility	F9999		

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F9999	Continued From page 82 policy and procedure "Turning and Positioning Program" states "All residents will be turned and positioned as per the plan of care in an organized system." On 1/15/07 at 10:25 AM R3 was observed in the positioning chair with no heel protectors or pillows noted to the feet. R3's feet were resting on the foot pedals. Observation of R3 on 1/16/08 at 11:40 AM noted R3 did not have any heel protectors or pillows on his heels. The dressing to the right heel had light colored brown drainage soaked thru the dressing. R3 was taken to the dining room with his feet exposed. The feet and heels were resting directly on the foot rest of the geri-chair. On 1/17/08 at 10:25 AM R3 was observed in the positioning chair with his right foot and heel on the foot rest. During the noon meal R3 was observed to sit in his geri-chair from 11:50 AM to 12:20 PM with no assistance to eat provided. R3 was positioned with his geri-chair next to the table with his left side to the table. R3 had to reach his right hand over his body onto the table to eat his food. R3 ate 90% of his corn muffin and drank 75% of his water. At 12:20 PM surveyor asked R3 if he had enough to eat and he shook his head no. Staff then handed R3 a glass of juice. At 12:22 PM E15, Certified Nurse Aide, came and sat down with R3 and stated "They told me to come and help you." E15 stated "Don't like that" referring to the chili. E15 then stated R3 needed to be pulled over. R3 stated he wanted to get out of that hole in the chair. Two staff shifted R3 in his chair and R3 groaned with the movement. There were no pillows of pads noted in the geri-chair. R3's left leg was drawn up and his heels were not floated in the chair. E15 did get R3 another plain bowl of	F9999		

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F9999	Continued From page 83 chili. The chili was steaming and R3 only ate one bite of the chili. A glass of 2% milk was given to R3 and he drank 100% of the milk within a minute. There was no other milk or supplement offered to R3. R3 ate 90% of the muffin, 100% of the milk and one bite of chili. At 12:45 PM E15 left. At 12:47 PM staff asked R3 if he was done and a kitchen staff stated ""Hey, he's done. They tried everything and he's done." At 12:49 PM R3 was taken to the television area. E16, Registered Dietitian, who is also the dietitian at the sister facility, identified in her progress note dated 5/10/07 that R3 weighed 226 pounds. On 8/2/07 the nutrition progress note documented that R3 weighed 218 pounds. E16 also identified that "wound has healed." On 10/3/07 E16 noted R3 had a stage 2 pressure sore and that R3 weighed 172.3 pounds with a 42.7 pound weight loss. The note states that R3 was reweighed 3 times. E16 recommended to change the diet to regular. R3 was on a Low concentrated sweets, no added salt, skim milk and no fried foods diet. On 11/21/07 E16 noted in the departmental notes that R3 was receiving a multivitamin and Vitamin C but that had been discontinued. E16 recommended to add a healthshake twice a day. A note on 12/12/07 noted the multivitamin and Vitamin C had been ordered and there were no further recommendations. The notes from E17, Food Service Supervisor, dated 12/28/07 documented R3 was on a low concentrated sweets diet and there was no documentation R3 was receiving the supplement. The physician order sheet for January identified R3 is on the original diet until 1/10/08 when it was changed to a regular diet. The weight log noted that on 1/7/08 R3 weighed 167.9 pounds-a 25% weight loss from 5/07.	F9999		

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F9999	Continued From page 84 E16 was interviewed on 1/17/08 at 11:45 AM regarding the weight loss of R3. E16 stated she did know R3 at the sister facility and that R3 did show a wight loss. E16 stated she questioned the scales between the two facilities as R3 did not appear to have lost that much weight. E16 confirmed that she had not verified the accuracy of the scales or the weight loss. The assessment dated 12/28/07 assessed R3 as requiring limited assistance with one person physical assist to eat. The MDS does not identify any functional limitations in his right or left arm but does identify partial loss on both sides of the neck. The assessment dated 10/9/07 assessed R3 as moderately cognitively impaired, with extensive assist of one person to transfer and extensive assist of two for bed mobility. R3 was assessed as having two stage 2 pressure sores. There was no weight loss identified. The assessment dated 12/28/07 remained the same for cognition, bed mobility and transfer. There is no weight loss noted on the MDS. R3 was assessed as having two stage 2 and two stage 4 pressure sores. The care plan dated "12/30/1899" identified "Potential for skin breakdown R/T bowel incontinence and immobility (unable to reposition self)." On 11/1/07 the care plan identified as a problem "1 L heel & 2 Rt heel have stage II unstageable areas 3 Lt ankle Stage II 4 Lt outer foot stage 2." The care plan identified on 1/4/07 as a problem " Lt heel Rt heel stage IV Lt outer ankle IV Lt outer foot unstageable Lt ischium stage II." On 1/14/08 the care plan identified as a problem "Unstageable purple to L Hip". The approaches states "Provide diet as ordered.	F9999		

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F9999	Continued From page 85 Monitor food intake at each meal. Offer food substitutes as needed. Reposition resident as needed. Use supportive/protective and/or pressure reducing devices as needed. Incontinence care following incontinent episodes. Tx as ordered. Pt is on Hospice. Turn and reposition q 2 (hours) & prn. Educate staff on positioning. Educate staff on catheter positioning." On 1/4/07 the hospice nurse added to the care plan "Medicate c 20 mg MSO4 15-20 minutes prior to drsg (change). Cleanse c NS/Sterile Water." On 12/14/07 the "Podiatric Evaluation and Treatment" noted the podiatrist performed a "Debridement of Skin Ulcer" with the location identified as "B/L heels". The "Dermatologic Examination" noted "ulcers c eschar B/L heels (greater than) 2 cm in diameter". Under the section "Other unlisted procedures" the podiatrist noted "Surgically debrided ulcers x 2. DSD. Orders written for dressings. Rx multipodus boots B/L". There were no measurements documented. There is no documentation that the wound was infected or red. Review of the facility policy and procedure "Assessment and Treatment of Pressure Ulcers/Guide For Wound Assessment and Documentation" states for a "Black Wound" to "cleanse site with Normal Saline-Check site daily: *Eschar-(100% dry, stable eschar over the heel should not be derided-keep dry and protect from pressure). Surgical Debridement by the physician, avoid heel debridement unless infection is present." Review of the Physician "Progress Note" dated 10/1/07 by Z2, Nurse Practitioner, did not identify any pressure sores. The "Progress Note" dated 10/5/07 Z2 identified R3 had "coccyx decubs".	F9999		

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F9999	Continued From page 86 Z2 stated she was unable to visualize coccyx wounds as R3 was in a recliner chair. The "Assessment/Plan stated to "Keep pt off coccyx as much as possible-Turn q 2 hr." The next note on 10/15/07 by Z1, Physician, on the "Progress Note" did not identify any pressure sores for R3. A "Progress Note" on 10/22/07 by Z8, Nurse Practitioner, did not identify R3 had any pressure sores. A lesion on the scalp that was positive for colonized MRSA was identified. A "Progress Note" by Z8 dated 10/29/07 did identify a 5% weight loss but no pressure sores were identified under "Skin Condition" or anywhere on the note. The "Progress Note" by Z 8 dated 11/1/07 identifies "blister c intact skin to R heel-DuoDerm to open area L ankle-open area noted between 4th, 5th toe" "Skin ulcers-cont DuoDerm patches to L ankle...Start cleaning between toes with NS & place TAO & gauze in affected area." There is no mention of the left heel. The "Progress Note" by Z8 dated 11/8/07 noted "L open area to L 4th & 5th toe...lack area to R heel skin intact (no) draining." "Will monitor R heel". The "Progress Note" by Z8 dated 11/19/07 states "area between L 4th & 5th toe is red and open L outer ankle-yellow slough black area to R heel intact." "Skin ulcer-continue TAO between 4th & 5th toes continue accuzyme to L lateral heel". The "Progress Note" dated 11/29/07 by Z8 noted "seeing pt to f/u on skin decubs L lateral ankle, L heel & R heel-see skin assessment". The notes describes the areas as "L lateral ankle-small open area c yellow drainage. L heel-black eschar. R heel-skin intact c black discoloration". The plan was to "L lateral ankle-continue accuzyme c adhesive dressing R& L heels-continue granulex spray bil. heel". The "Progress Note" dated 12/6/07 states "L heel-black eschar peeling off R heel- black	F9999		

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F9999	Continued From page 87	F9999		

eschar R ankle-decub R outer foot-eschar". The "Progress Note" dated 12/24/07 by Z2 stated "Pt seen to follow on U/A results. Pt has Foley. pt is on hospice. Pt is non-compliant c care refuses meds, treatments" There is no mention of the pressure sores. The "Medical Director/Physician:History/Physical Assessment and Care Plan Review" dated 12/27/08 by Z8 did not identify any notations under "Skin Condition" nor any notations regarding the pressure sores.

In an interview with Z2, Nurse Practitioner for Z1, Physician, on 1/17/08, she stated she was familiar with R3 and had followed him at the sister facility. Z2 stated that R3 was progressively getting worse and had vascular disease and was non-compliant with medication and nutrition. Z2 stated R3 had been on Hospice for about a year and wound care was both hospice and staff responsibility. The lack of turning and repositioning, heel floating, wound monitoring and assistance with eating was discussed with Z2. Z2 was asked if this would contribute to the skin breakdown and she replied that it would and R3 needed to have good positioning. Z2 stated R3's heels should be floated and he should be turned and repositioned every 2 hours. Z2 stated as far as avoidable vs unavoidable that to a certain extent the areas were unavoidable due to the patient condition and nutrition but would be lessened if the positioning and nutrition was better. Z2 stated that the foot pain was "pretty painful." Z2 stated she had not seen R3's feet or bottom since the end of December.

In an interview with Z4, Hospice Nurse, on 1/14/08 at 4:42 PM, Z4 stated he had just completed the dressing change to the heels. Z4

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F9999	Continued From page 88 stated he or another nurse came to the facility 3-5 times per week and did the dressing change. Facility staff were to do the dressing change on the other days. Z4 stated the new open areas on the buttocks were from sitting on the catheter tubing. Z4 stated the areas on R3's heels have progressively gotten worse and R3 had problems with his feet before admission to this facility. Z4 stated R3's feet were rotting off and probably needed to be amputated, however R3 was a poor surgical risk. Z4 stated the Santyl and polysporin treatment was not working, and due to the foul odor of the heels R3 needed some Flagyl powder to keep the odor down and the areas dry. Z4 stated R3 was getting 40 mg of Roxanol and a Duragesic patch prior to the dressing change due to the pain. In an interview on 1/17/08 Z4 confirmed that R3's heels should be elevated and not resting on the foot board. Review of the Hospice Progress Notes on the "Skin Assessment and Wound Care Record" from 11/2/07 until 12/10/07 identified the areas on both heels were unstageable with black eschar, no drainage and no measurements. On 12/14/07 the hospice wound care record documents that the area on the left heel measures 6.0 x 3.0 cm with 75% eschar and 25% slough and bloody drainage.. The right heel was measured at 2.0 x 2.0 cm with black eschar. On 12/19/07 the hospice note describes the left heel as 7.0 x 3.6 cm with 50% slough with yellow green and bloody drainage and a foul odor. The right heel is 3.0 x 3.0 cm with 50% eschar. On 12/21/07 the left and right heel were both still described as unstageable and were measured at 7.0 x 3.5 and 3.4 x 3.4cm. The drainage was described as purulent. On 12/28/07 the hospice wound care record staged both heels at stage 4.	F9999		

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F9999	Continued From page 89 The left heel measured 6.0 x 8.0 with necrotic base. The right heel measured 4.2 x 4.2 with necrosis and purulent drainage. The drainage was described as bloody, purulent, malodorous and necrotic. On 1/4/08 the hospice record measured the left heel at 7.0 x 6.0 cm and the right heel as 4.5 x 6.0 cm with yellowish green, purulent, bloody drainage. It was also described as malodorous, painful and necrotic with "no improvement-getting worse". On 1/8/08 the hospice record documented the left heel as 7.2 x 8.5 cm and the right heel 5.0 x 7.0 cm. The wounds were described as "malodorous, painful and gangrenous." It was recommended to increase the pain medication and to use Flagyl for the odor. A wound management firm was recommended for input. The Hospice wound record dated 1/11/08 measured the left heel at 8.0 x 9.0 and the right at 5.0 x 7.0 cm. The wounds were described as bloody, purulent, yellow with further description of the wounds as "black, necrotic, festering wounds-gangrenous?". Hospice again recommended the wound management company to consult for the wound. Hospice wound record measured the areas on 1/14/08 for the left heel at 9.0 x 9.0 cm and the right heel at 5.0 by 6.4 cm. On 11/2/07 the Hospice Skin Assessment and Wound Care Record also noted, in addition to the heel pressure sores, a stage 1 pressure ulcer on R3's left outer foot and an excoriated coccyx. On 12/10/07 the record staged the left outer ankle at a 3 and noted an unstageable pressure sore on the left outer foot. On 1/14/08 the hospice wound record noted, in addition to the heels, a stage 4 (3.0 x 2.5 cm) to the left outer ankle, an unstageable (3.0 x 6.0 cm) to the left outer foot, a stage 3 (3.0 x 4.0 cm) to the left buttocks, and, an	F9999		

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F9999	Continued From page 90 unstageable (1.0 x 2.5 cm) to the left hip. The hospice nurse, Z4, recommended "pressure relief-(pressure relief) chair, turn and position and bed rest-up for meals only." In an interview with E13, Corporate Nurse, on 1/16/08 at 10:00 AM she stated that last week they had identified a problem with pressure sores and had done a whole house skin check. E13 stated they had done a skin record on 1/14/08. Review of the "Skin Record" for R3 identified he had a stage 2 (1.5 x 0.5 cm) to the ischium; a stage 4 pressure sore(7.0x6.0x1.0) to the left heel; a stage 4 (4.5x6.0x0.6cm) to the right heel; An unstageable pressure sore to the left outer foot(2) and left ankle (1.3x1.0x0.5); and, a "UP" pressure sore to the left hip. Review of the facility policy and procedure "Assessment and Treatment of Pressure Ulcers/Guide For Wound Assessment and Documentation" states, "It is the practice of this facility to ensure residents with pressure ulcers receive necessary assessment and treatment to promote healing, prevent infection and prevent new ulcers from developing." The procedure to ensure this practice includes that upon identification of a pressure ulcer the area will be assessed and documented with complete assessment documented on the "Admission Assessment Form" and the "Wound Evaluation" form. It further states that assessment and evaluation for further treatment may be indicated to promote healing and prevent infection. Documentation of the wound status will occur at least once per week on the "Wound Evaluation" form. The physician is to be notified if there is no improvement in the area or if there is signs and symptoms of infection or deterioration. The	F9999		

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F9999	Continued From page 91 procedure also states that pressure ulcer rounds will be done on a weekly basis and an evaluation of the progress or lack of will be done. 3. Per Physician's Order Sheet, for 1/08, R7 has diagnoses, in part, of Diabetes Mellitus-Type II, Hypertension, Aspiration Pneumonia, and Congestive Heart Failure. The assessment, dated 11/28/07, shows R7 has no cognitive impairment, requires extensive assistance from staff for bed mobility, and is incontinent of bowel and bladder. The Assessment of Pressure Ulcer Risk, dated 11/15/07, assesses R7 as not having a bed mobility problem, or incontinence, and is not a risk for the development of pressure ulcers. The Weekly Skin Assessment, dated 1/02-1/12/08 shows R7 has normal skin condition, with no pressure ulcers. On 1/14/08, at 11:28 AM, R7 was observed laying on her back, with the head of the bed elevated. R7's feet were floated on a pressure relieving cushion. No heel protectors were observed on the feet, but were located on the chair in the room. At 12:25 PM, R7 was sitting up in the chair in her room, with her feet covered by knitted socks, resting directly on the floor. The heel protectors remained in the chair. At 12:58 PM, R7 was asleep in the chair, with her head resting on the bedside table. Her feet remained on the floor, with no heel protectors. On 1/15/08, at 10:30 AM, R7 was in bed, with the head of the bed elevated, placing pressure directly on the buttocks. Dressings were noted to both feet, dated 1/15/08. R7's heels were directly on the mattress. Pressure relieving boots were observed in the wheelchair. The heel protectors were on a chair. The pressure relieving cushion	F9999		

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F9999	Continued From page 92	F9999		

was above the head of the bed. R7 was observed to be in respiratory distress, with respirations at 40 per minute. The liquid oxygen tank was observed empty, with the gauge reading below "0." The nurse was summoned. At 10:38 AM, R7's percentage of oxygen saturation was 79 per cent, with a heart rate of 147 per minute. E5, Licensed Practical Nurse, (LPN), reported, after looking at the oxygen tank's gauge, "I don't know if the tank is empty."

At 10:56 AM, E2, Director of Nursing, (DON), reported she had put R7 back to bed after eating breakfast, but did not check the oxygen tank. E2, DON, reported this was the responsibility of each nurse, when rounds are done at the beginning of each shift. E2 confirmed their was no policy or procedure in place to ensure the tanks were not empty. At 11:50 AM, R7 was observed in bed, laying on her back, with the head of the bed elevated. The heel protectors were on her feet. At 12:33 PM, E5, LPN reported R7 had been sent to the hospital for evaluation, and would probably be admitted.

The Skin Record, dated 12/10/07-12/16/07, shows R7 has a facility acquired, Stage 2 pressure ulcer to the left ischium, measuring 0.5 centimeter, (cm) X 5cm X 0.1cm, developed on 12/10/07, and healed on 12/18/07. The treatment ordered by the physician was DuoDerm to the area. The Skin Record, dated 12/31/07-1/06/08, shows a Stage 2 to the left buttock, with no measurements, developed on 12/31/07, with a treatment of DuoDerm to the area; a facility acquired "other" to the left heel, developed on 12/31/07, with a treatment of to float heels; and a Stage 2, with no measurement, to the coccyx, developed 12/31/07. The Wound Evaluation

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F9999	Continued From page 93 Form, dated 1/14/08, shows a Stage 2, 2.3cm X 2.1cm pressure ulcer to the left ischium, with DuoDerm as the treatment ordered. The Skin Record dated 1/14/08, reports the same information for the left ischium. The Skin Record shows a facility acquired, Stage 2 to the coccyx, measuring 1.4cm X 1.1cm, with the treatment as DuoDerm to the area; a Stage 3 to the right heel, measuring 3.7cm X 3.4cm, with the treatment as clinging gauze; and a Stage 4, to the left heel, measuring 2.4cm X 2.3cm, described as purple, black, and boggy, with a treatment as clinging guaze. The Wound Evaluation Form, dated 1/14/08, describes the area to the right heel, as a fluid filled blister. The Departmental Notes, dated 12/24/07-1/14/07, do not document the development of all of the pressure ulcers. The Departmental Note, dated 12/19/07, by E16, Licensed/Registered Dietitian, reads, "Obtained wound report which indicates resident has a new Stage 2 decubitus. While looking in chart, noticed an order for a dietary consult regarding controlling residents carbs (carbohydrates). 12/04/07-glucose-744/Critically high, sodium 134-low, BUN-30/high, probably related to high glucose. Diet: pureed with nectar thickened liquids, healthshakes 3 times per day and whole milk 3 times per day. Weight-145 pounds, weight has ranged between 147-155 pounds since the end of July. Estimated need 1885 calories, 81 gram of protein, 1680 milliliters fluid. Recommend adding LCS (low concentrated sweets) to diet in order to help control carbs and blood sugar. Will discontinue healthshakes to also help control blood sugar. For wound, recommend Multivitamin with minerals and 500 milligrams vitamin C twice daily. Will monitor."	F9999		

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F9999	Continued From page 94 The Laboratory Report, dated 12/04/07, confirms the values, with reference ranges as: sodium,135-145, glucose-70-99, and BUN(blood, urea, nitrogen)-8-24. The Creatinine level was 1.14, (reference range 0.6-1.3). The Care Plan for R7, dated 10/08, reads, "Impaired skin evidenced by blister to left heel, and right heel. Stage II pressure area to left buttock. Stage II pressure ares to coccyx." The Approaches read, in part, "Daily skin checks. Heel elevator while in bed. Shift position every two hours." No documentation of daily skin checks were noted. The Care Plan failed to document use of the heel protectors. The Treatment Administration Record (TAR) documents a physician's order for treatment as, "Heel protectors at all times when in bed," dated 1/05/08. No mention of the heel elevator cushion is documented on the TAR for 1/08. The facility's Assessment and Treatment of Pressure Ulcers/Guide for Wound Assessment and Documentation, revised 7/07, lists procedures, in part, of; "4. Assess and evaluate further interventions that may be indicated to promote healing and prevent infection. 6. The physician is to be notified if there is no improvement in area, signs, symptoms of infection or signs of deterioration. 7. The Director of Nursing Services and/or designated Licensed Nurses will make pressure ulcer rounds on a weekly basis. Documentation of the area will be addressed. Resident progress or lack of progress will be evaluated. Directives may be given for further interventions, and changes in plan of care. The resident's care plan will also be reviewed."	F9999		

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F9999	Continued From page 95 The facility's Policy and Procedure, entitled Weekly Skin Assessment/ Wound Evaluation/ Skin Condition Form, revised 7/07, reads, in part; "2. Any skin abnormalities identified during this assessment will be documented in the Interdisciplinary Notes and weekly until healed. 5. Skin issues identified requiring continued monitoring/assessments/documentation should be updated on the Care Plan for those interventions that have been implemented." This had not been done in R7's Interdisciplinary Notes for 12/07 or 1/08. On 1/17/08, at 11:50 AM, Z5, Physician, reported seeing R7 at the hospital on 1/16/08. Z5 reported the pressure areas he saw at that time were not significant, as he was worried about her respiratory status. Z5 did report he was aware of the Stage IV pressure ulcer to the left heel. Z5 reported if R7 had had preventive measures in place, such as frequent turning and repositioning, heels floated with a protective garment or boot on feet, and a special mattress, then the pressure areas would have been unavoidable. Z5 reported R7 died on 1/16/08, with a diagnosis of pneumonia. 4. R6 was admitted to the facility on 5/17/04 with diagnoses, in part, of Alzheimer Disease, mental disorder, and pneumonia. R6 was assessed on the most current ssessment as severely cognitively impaired, and totally dependent on staff for bed mobility and transfer. The assessment did not identify that R6 had a history of pressure sores although on 12/18/07 the physician ordered DuoDerm to the left buttocks until healed. The care plan dated 1/4/08 identified a problem as "Impaired skin evidenced	F9999		

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by pressure sore to left heel." The approaches include, in part, "*Tx as ordered*Keep heels elevated while in bed.*Leave open to air daily.*Weekly skin checks.*Pressure relieving mattress to bed.*Shift position q 2 hrs."

On 1/4/08 the nurses notes states "Resident noted with necrotic area to left heel this am." The physician was called and on 1/4/08 and ordered "Cleanse L heel c Saf-Cleanse daily and keep open too air. No socks on while in bed. Air mattress to bed." On 1/5/07 the physician ordered to "Keep heels elevated while in bed."

The "Skin Record" dated 12/31/07 thru 1/6/08 identified R6 had an unstageable, facility acquired pressure sore to the left heel. There are no measurements noted. Treatment is noted as "Open to Air." The "Skin Record" for 1/14/08 has documented that R6 has a stage 4 pressure sore to the left heel, 3.9 x 4 cm. Treatment still includes "open to air."

R6 was observed on 1/14/08 at 10:55 AM laying in her bed on her back. R6 had socks on both feet and a multipodus boot on her left foot. Both heels were flat on the bed and there were no pillows under her legs or feet to elevate the heels off the bed. At 11:15 AM R6 was observed in bed in the same position with the socks and boot still on. E9, Licensed Practical Nurse, performed the pressure sore treatment and measured the area on the left heel as 3.9 x 4.0 cm. E9 confirmed that R6 should have no socks on her feet, open to air, and the heels should be elevated off the bed. E9 placed pillows under R6's legs and elevated her heels at 11:20 AM.

On 1/16/08 at 12:15 PM R6 was observed in her

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F9999	Continued From page 97 bed with both heels flat on the bed. R6 did not have socks on or a multipodus boot on. E19, Certified Nurse Aide, was informed and placed two pillows under R6's legs to elevate the heels. In an interview with Z2, Nurse Practitioner, on 1/17/08 at 10:45 AM, she stated she had just picked R6 up as a patient. Z2 stated she had seen the area and the edges were starting to peel and there was no drainage. Z2 confirmed that leaving R6's heels on the bed with the socks on would contribute the breakdown on R6's heel. Z2 stated pressure would contribute. Z2 stated R6's nutrition looked good and she hoped the area would heal. (A)	F9999		