STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145615	A. BUILDING _____ B. WING _____	02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY LIVING CENTER	612 WEST ST MARY'S STREET STERLING, IL 61081

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F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident had a medical indication for the use of bilateral side rails, and the facility failed to assess and remove a side rail after a resident injury. This applies to 1 of 1 residents (R13) reviewed for side rails in the sample of 20. The findings include: The Minimum Data Set (MDS) of 12/26/14 shows R13 has severe cognitive impairment, memory impairment, and requires extensive physical assistance from staff with repositioning in bed, transfers, dressing,toileting, and personal hygiene. R13's facility face sheet shows diagnoses to include Dementia, Anxiety, Weakness, Depression, Psychosis, and Osteoarthritis. R13's Restorative Program Note dated 9/4/14 shows "Restorative program changed from active range of motion (arom) to passive range of motion (prom) due to resident change in condition and staff assistance needed to complete program". R13's 12/26/14 Restorative Quarterly note states "Continue current plan of care"...	F 221		

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

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R13's Side Rail Assessment dated 10/2/14 and 12/26/14 shows "Resident requires the use of bed rails for bed mobility with ADL [Activities of Daily Living] care. Staff to cue resident to hold onto rail when care is needed. Will assess quarterly for bed rail need"..."Recommendations: When side rails are recommended, complete the blank with the medical symptom being treated by the side rails". The medical symptom line was not completed and there was no medical symptom listed on R13's side rail risk assessment form. There was not consent available for the use of the bilateral side rails.

R13's Care Plan through 3/29/15 shows "The resident is dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t Physical Limitations, Cognitive Deficits".
R13's potential for pressure ulcer care plan through 3/29/15 shows "The resident needs assistance to turn/reposition at least every 2 hours...".
R13 did not have a side rail care plan in place, and did not have interventions to include size of the size rails, padding of the side rails, which side (right, left, both) should be used nor interventions to reduce the risk of entrapment.

On 2/3/15 at 1:00 PM, E5 and E12 (Certified Nurse Assistant -CNA) transferred R13 from her reclining wheelchair to her bed using a mechanical lift. R13 had bilateral (both sides) padded side rails in the upright position from the top half of the bed (half side rails). E12 placed her hands on R13's buttock and thigh and pulled R13 onto her left side. E5 placed her hand on R13's buttock and helped push her over onto her right side. R13's soiled incontinence brief was

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partially removed. (during the turn) E5 then helped pull R13 to her left side while E12 placed her hands on her buttocks and helped push R13 to her right side. E5 then removed R13's soiled incontinence brief and pants. E5 and E12 provided incontinence care to R13, and used their hands to hold R13 on her side, and to roll her side to side in the bed. E5 and E12 rolled R13 side to side in bed without giving R13 verbal cues to hold onto the side rails to help with repositioning. R13 did not move her arms at all to grab on to the side rail while turning in bed.

On 2/4/15 at 9:55 AM, E5 and E7 (CNA) transferred R13 to her bed with a mechanical lift. R13 had bilateral padded rails on the top half of her bed in the upright, raised position. E5 placed her hand on R13's buttock, and helped push R13 onto her right side. E7 placed her hands on R13's thighs and helped pull R13 onto her left side. E7 used her hands to hold R13 on her side while E5 provided incontinence care. E5 had one arm outstretched on R13's buttock to help hold her over, while she used the other hand to perform incontinence care. E5 then helped push R13 onto her right side, while E7 helped pull her on her right side. E5 then held R13 on her side while E7 provided incontinence care. E7 had one arm outstretched, on R13' buttock to help hold her on her side while E7 used the other hand to complete incontinence care. E5 and E7 did not prompt R13 to use the side rail to assist with rolling and repositioning in bed. R13 did not reach for the side rail while rolling side to side.

On 2/3/15 at 1:15 PM, E5 said R13 had padded side rails because R13 "was rolling and hit her head on the rail...now she has padded rails".

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On 2/4/15 at 10:45 AM, E2 (Director of Nursing-DON) looked at R13's padded raised side rails and said "those are half side rails" because they are from the middle to the top of the bed. E2 said R13 has the side rails for bed mobility and should be cued to use the rails while rolling in bed, during care. E2 said it would be appropriate for R13 to only have the rails upright during care, and lowered after the care was given because R13 is dependent on assistance from staff to reposition to her side while in bed. E2 said it was reported to her that R13 hit her head during care on the side rail, causing a bump to her head. E2 said the injury is why R13 has padded side rails.

On 2/5/15 at 9:20 AM, E4 (Restorative Nurse) said R13 has bilateral side rails in place for bed mobility. E4 said if a resident cannot move on command and use a side rail for mobility it would be considered a restraint. E4 said the CNAs should be cuing R13 to use the side rails during care for mobility, and if R13 cannot follow the command the side rails should be discontinued. E4 said a Side Rail assessment is completed on each resident on admission, and quarterly. E4 said the Side Rail Assessment should be completed if a resident has a significant change or if an injury occurs because of the side rail. E4 said R13 has padded side rails because R13 hit her head on the side rail during care and sustained a bump to her forehead/eyebrow. E4 said the CNA reported the injury to her the day after it happened (on 12/27/14), and after investigating the incident she decided pads should be placed on the side rails.

R13's Bruise Incident Description dated 12/26/14 at 7:02 PM, shows "Small bump on left browline observed while administering eye drops. CNA

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F 221	Continued From page 4 asked if she knew what happened. CNA stated she thought it may have happened while turning resident toward wall while she was in bed to place lift sling". This report shows "resident bumped object" and "per investigation of area on residents eyebrow, as reported by CNA area lines up with 1/4 side rail on bed. Area happened when staff rolled her for ADL care..." R13 did not have a Side Rail and Entrapment Risk Assessment completed after the injury occurred on 12/26/14 at 7:02 PM, to include the injury to her head. The last documented Side Rail and Entrapment Risk Assessment completed on 12/26/14 shows R13 has not had any injury from the side rail. The undated facility "Side Rail Policy and Procedure" states "Any resident being considered for using side rails is assessed by the interdisciplinary team to determine whether or not the resident's functional status and bed mobility is improved through the use of side rails, to identify any side rail that might constitute physical restraint, and to identify individual characteristics that may increase the risk of entrapment by side rails. Side rails will not be used as a method to prevent falls or used as a physical restraint."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;	F 225		

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F 225	Continued From page 5 and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to identify an injury of unknown origin, failed to immediately report an injury of unknown origin to the nurse, failed to immediately report an injury of unknown origin to the administrator, and failed to report an injury of unknown origin to the state agency.	F 225		

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This applies to 1 of 8 residents (R13) reviewed for abuse in the sample of 20.

The findings include:

The Minimum Data Set (MDS) of 12/26/14 shows R13 has severe cognitive impairment, memory impairment, and requires extensive physical assistance from staff with repositioning in bed, transfers, dressing ,toileting, and person hygiene.

R13's facility face sheet shows diagnoses to include Dementia, Anxiety, Weakness, Depression, Psychosis, and Osteoarthritis.

On 2/3/15 at 1:00 PM, E5 and E12 (Certified Nurse Assistant -CNA) transferred R13 from her reclining wheelchair to her bed using a mechanical lift. E12 placed her hands on R13's buttock and thigh and pulled R13 onto her left side. E5 placed her hand on R13's buttock and helped push her over onto her right side and partially removed her soiled incontinence brief and pants. E5 then helped pull R13 to her left side while E12 placed her hands on her buttocks and pushed R13 to her right side. E5 then removed R13's soiled incontinence brief and pants. R13 had green, circular, and irregular shaped bruises to the top, outside, and inside of her left thigh. R13 had 4 irregular, circular shaped green bruises to her right inner and outer thigh. E5 and E13 placed R13 on her back and each placed a hand on her inside thigh to open her legs to provide peri-care.

On 2/4/15 at 9:55 AM, E5 and E7 (CNA) transferred R13 to her bed with a mechanical lift. E5 placed her hand on R13's buttock, and helped

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push R13 onto her right side to remove her incontinence brief and pants. E7 placed her hands on R13's thighs and pulled R13 onto her left side. E7 used her hands to hold R13 on her side while E5 pulled her incontinence brief and pants off. R13 had 4 green, circular, and irregular shaped bruises to the top, outside, and inside of her left thigh. R13 had 4 irregular, circular shaped green bruises to her right inner and outer thigh. E5 had one arm outstretched on R13's buttock to help hold her over, while she used the other hand to perform incontinence care. E5 then helped push R13 onto her right side, while E7 helped pull her on her right side. E5 then held R13 on her side while E7 provided incontinence care. E7 had one arm outstretched, on R13' buttock to help hold her on her side while E7 used the other hand to complete incontinence care. E5 used her left and right hand to open R13's legs and E7 used her left hand to open R13's legs to perform perineal care.

On 2/3/15 at 1:00 PM, E5 and E12 were asked how R13 got the bruises on her thighs. E5 said "I don't know how she got them".

On 2/4/15 at 10:10 AM, E5 said R13 clamps her legs together during care and we have to help pull her legs open so we can clean her.

On 2/4/15 at 10:10 AM, Director of Nursing (DON) said she was not aware R13 had bruises on her upper legs and did not think anyone had reported any. E2 looked at the bruises on R13's legs while R13 was lying in bed and said they should have been reported and investigated. E2 said any bruising, skin tear, injury, or new injury of unknown origin should be reported immediately to the nurse, and the nurse should report to the

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administrator immediately. E2 said the bruises on R13's thighs should have been reported immediately and investigated as an injury of unknown origin to determine the cause.

R13's Monitoring facility form dated 2/5/15 shows R13 had a total of 4 bruises to her left thigh, and 4 bruises to her right thigh.

R13's Weekly Skin Observation Assessments were reviewed from 1/11/15 to 2/1/15. Each assessment showed "no new skin issues". On 2/5/15 at 10:45 AM, E1 (Administrator) said they could not find any assessments of the bruises prior to 2/4/14, and could not find evidence any of the Skin Observation Assessments included documentation of the bruises.

On 2/4/15 at 10:30 AM, E9 (Licensed Practical Nurse- LPN) said she was the nurse assigned to R13. E9 said she was not aware of any bruises on R13 and no bruises had been reported. E9 said the CNA's should report any bruising, immediately to the nurse and the nurse will assess the resident and initiate the injury of unknown origin process. E9 said the nurse will then immediately report the injury to the DON and administrator.

On 2/4/15 at 10:25 AM, E7 said bruises, scratches, open areas, redness, and anything that does not seem normal should be reported to the nurse immediately. E7 said R13 has had those bruises "on and off" and "the ones she has now have been there for awhile".

R13's Bruise Incident Description dated 12/26/14 at 7:02 PM, shows "Small bump on left browline observed while administering eye drops. CNA

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asked if she knew what happened. CNA stated she thought it may have happened while turning resident toward wall while she was in bed to place lift sling". This report shows "resident bumped object" and "per investigation of area on residents eyebrow, as reported by CNA area lines up with 1/4 side rail on bed. Area happened when staff rolled her for ADL care..."

On 2/5/15 at 9:20 AM, E4 (Restorative Nurse) said she was notified of the bump to R13's head "the next day" when the CNA told me. E4 said the incident should have been reported immediately to the nurse and should have been treated as an injury of unknown origin. E4 said she did not notify the administrator until after she assessed R13's head, which was during the morning team meeting.

On 2/5/15 at 10:45 AM, E1 (administrator) said all injuries of unknown origin should be reported to the nurse and the administrator immediately. E1 said the bruises to R13's thighs should have been reported immediately and an assessment and investigation should have been conducted. E1 said she did not report the injury to the "State Agency" because after I talked to the CNAs and looked at her [R13], I could determine that the bruises were caused by the CNAs "prying her legs open to give care", and because of the lift sling. E1 said the nurse should have notified the administrator immediately when she found the resident with the bump on her head. E1 said she did not find out until the next morning (over 12 hours after the nurse found the injury). E1 said all injuries of unknown origin should be reported to her immediately and should be reported to the state agency within 24 hours. E1 said she did not report the bruises or the injury to R13's head to

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F 225	Continued From page 10 the state agency as an injury of unknown origin or an abuse allegation. The undated facility policy "Abuse Policy" states "Report all alleged violations and all substantiated incidents to the State Agency and to all other required agencies as required...The facility will investigate and report incidents or occurrences in accordance with federal and state regulations and guidelines". The undated "Investigation of Injury of Unknown Etiology" states "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of allegations of activities or situations that may constitute abuse...Staff are to immediately report any new observations of injury including bruising, skin tears, scratches, abrasions, swelling, or redness, to a licensed nurse for assessment...If the injury is of unknown origin and should be reported to appropriate state agencies in accordance with the facility policy".	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident's body was covered during personal cares.	F 241		

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This applies to 1 of 8 residents (R13) reviewed for dignity in the sample of 20.

The findings include:

The Minimum Data Set (MDS) of 12/26/14 shows R13 has severe cognitive impairment, memory impairment, and requires extensive physical assistance from staff with repositioning in bed, transfers, dressing ,toileting, and person hygiene.

R13's facility face sheet shows diagnoses to include Dementia, Anxiety, Weakness, Depression, Psychosis, and Osteoarthritis.

On 2/3/15 at 1:00 PM, E5 and E12 (Certified Nurse Assistant -CNA) transferred R13 from her reclining wheelchair to her bed using a mechanical lift. E5 and E12 rolled R13 to the left side and partially removed her soiled incontinence brief and pants. E5 and E12 then rolled R13 to her right side and removed R13's pants and incontinence brief. R13 remained uncovered, and without clothes from the waist down while E5 and E12 provided incontinence care, rolling her side to side in bed. E5 and E12 completed incontinence care, bagged up the dirty linens, and removed their gloves while R13 remained lying on her back uncovered from the waist down. E5 and E12 then repositioned R13 in bed, and placed pillows under legs prior to covering her with a sheet or blanket.

On 2/4/15 at 9:55 AM, E5 and E7 (CNA) transferred R13 to her bed with a mechanical lift. E5 and E7 rolled R13 side to side, and removed her pants and incontinence brief. R13 remained uncovered from the waist down while E5 and E7

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F 241	Continued From page 12 provided incontinence care. While R13 was exposed from the waist down, E5 and E7 used the incontinence pad to reposition R13 in bed. R13 was not covered from the waist down until the soiled linens were removed, and care was completed. On 2/5/15 at 10:45 AM, E2 (Director of Nursing) said residents' personal areas should be covered during care. E2 said the CNA's could drape the resident and still provide care. The facility's 2013 "Residents' Rights" brochure states " Privacy...Your medical and personal care are private..."	F 241		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop specific prevention interventions for a resident who had reddened areas, that progrssed to stage II pressure ulcers, and deep tissue injury to the heel. The facility failed to follow the treatment order to the residents heel. (R1) The facility failed	F 314		

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to reduce or elimate pressure to a residents heel to avoid a stage II pressure ulcer. (R2) The facility failed to monitor and document a callous area (previous pressure ulcer) to a residents heel. (R3) This applies to 3 of 3 residents (R1, R2, R15) reviewed for pressure sores in the sample of 20. The findings include:
R1 ' s Resident Profile Screen lists R1 ' s diagnoses to include Dementia, Generalized Muscle Weakness, Intestinal Infection due to C. difficile and Urinary Incontinence. The Minimum Data Set (MDS) of 11/21/14 shows R1 needs extensive assistance from staff with transfer, ambulation, dressing, bathing and hygiene. The same MDS shows R1 is frequently incontinent of bowel and bladder. The Braden Scale for 09/29/14 shows that R1 ' s score was 17, which is considered mild risk for the formation of pressure ulcer. No Skin Assessment Risk monitoring was done for October and November of 2014. R1 ' s Brief Interview for Mental Status (BIMS) score is 10 (moderately impaired for decision making).
On 02/03/15 at 12:43 PM, E7 (Certified Nursing Assistant-CNA) assisted R1 in the bathroom. R1 complained of soreness in the buttocks area when E7 wiped R1 ' s buttocks. A small raw area was in the middle portion of the left buttock. E7 assisted R1 to bed. When E7 removed R1 ' s socks, R1 jerked her foot and complained of pain to the left heel area. Left heel has a spot with a black skin surface. No dressing was on top of the affected spot.
On 02/03/15 at 1:08 PM, E4 said that R1 ' s pressure ulcers were all acquired here in the facility. The right and left heel areas both started out as blisters. The treatment for the right heel is skin prep to heel and the treatment for the left heel is granulex spray and then leave open to air.
On 02/03/15 at 1:25 PM, E5 (CNA) stated that

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skin checks are done every 2-3 times per week with the resident ' s shower schedules and the report sheet will go to the nurse. E5 stated, " The nurse will check behind us if there are areas of concern. "

R1 ' s Skin Observation Sheet Report (documented by the CNAs) for November 2014 shows " red area " (no location documented) on 11/18/14, 11/20/14, 11/22/14, 11/23/14, 11/25/14, 11/27/14 and " open area " on 11/30/14. The Skin Observation Tool-(completed by a Licensed Nurse) on 11/24/14 shows notes of " no new areas observed. " The wound nurse progress note shows " open areas " on 12/01/14.

On 02/04/15 at 8:54 AM, E7 assisted R1 to bed. E7 removed R1 ' s socks. No dressing was on top of the affected area of the left heel.

R1 ' s Treatment Record Sheet of 02/2015 shows an order of " Granulex Spray apply topically to left heel. Cover with non-adherent dressing daily. "

On 02/04/15 at 9:56 AM, E9 (LPN) said the nurses will do the treatments and dressings whenever they can throughout the day.

R1 ' s Care Plan specific to the pressure ulcers and deep tissue injuries was not initiated until 12/30/14.

On 02/04/15 at 3:16 PM, E10 (Licensed Practical Nurse- LPN/ Resident Care Coordinator) said that the members of the Interdisciplinary Team (IDT) will have clinical meetings every morning. The care plans could be done right away as soon as issues are brought up since the entire IDT is there. E10 remarked, " The most it would take for the care plan to get done would be a week from the time these issues are brought to our attention. "

The Weekly Pressure Ulcer Progress Report of December 2014 shows R1 had Stage 2 pressure

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ulcers on the right buttock, medial left buttock and left buttock. All were listed as facility acquired and the date of development was 12/03/14. The cause of the right and left buttocks pressure ulcer was listed as due to shearing and the left medial ulcer was due to increased use of bedpans during bowel incontinent episodes from a recent Clostridium difficile infection. The right and left heel affected areas are listed as suspected deep tissue injury (SDTI). The right heel area became a stage 1 ulcer on the report dated 12/18/14. The left heel area continued as SDTI but the wound bed was listed as an eschar on the report starting 01/16/15.

R1 ' s initial assessment date was 12/04/14 and the physician was notified on that same date. The five wound measurements were as follows: right heel: 1 x 1.2 x 0.1 cm; left heel: 2 x 1.5 x 0.1 cm; right buttock: 2 x 2.5 x 0.1 cm; medial left buttock: 2.2 x 2.5 x 0.1 cm; left buttock: 0.5 x 0.3 x 0.1 cm.

The facility ' s Policy and Procedure for Pressure Ulcers with revised date 1/27/15 shows ... " If areas of concern are noted on body assessment, MD and POA are notified and treatment implemented per MD orders ...CNA will do body assessment on each resident receiving a shower and address areas of concern on shower sheet et turn into appropriate nurse for follow up of area, shower sheets are then turned into wound nurse for review ...Nursing Staff will take steps to increase monitoring, reduce or alleviate pressure, redistribute weight and/or eliminate friction/sheer to prevent skin breakdown ... "

2. R2 ' s undated Resident Profile Screen shows R2 was admitted on 7/22/13 with the following diagnoses: Dementia with behaviors and Legal blindness. The 1/30/15 Braden Scale Sheet (prediction of pressure ulcers) shows R2 has a

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moderate risk for developing pressure sores. R2 ' s Minimum Data Set (MDS) of 6/27/14 shows R2 has a Brief Interview of Mental Status BIMS of 8 (moderate cognitive impairment). R2 ' s MDS of 12/26/14 shows R2 requires extensive assist of 1 for transfers, dressing, and bed mobility.
On 2/4/15 at 8:35 AM, R2 was lying in bed on her back with heels touching the bed. No pillow or other device was under R2 ' s lower legs to keep her heals floated.
On 2/4/15 at 8:35 AM, a Stage II pressure sore was observed on the back of R2 ' s left heel that measured 2 inches by 1 ¾ inches. Skin around the area was pink. No drainage noted to wound or on dressing.
On 2/4/15 at 8:40 AM, E8 (Licensed Practical Nurse-LPN) stated " Those are the shoes she (R2) has worn for a long time. " R2 ' s shoes were sitting in her wheel chair. The back of the heel was covered with white scuff marks. The back edge of the sole was worn to where it was rounded. The tread was worn at least ¾ inch along the bottom of both of R2 ' s shoes.
On 2/4/15 at 9:00 AM, E8 stated the treatment for R2 ' s pressure sore is to " apply skin prep to area on left heel every shift and cover with a dry dressing. Monitor until healed. E8 stated she thought that was the only thing the staff were doing. E8 checked the Treatment Administration Record (TAR) and stated " There is no order to float her (R2 ' s) heels.
On 2/4/15 at 9:10 AM, R2 was still lying in bed on her back with her heels touching the bed.
On 2/4/15 at 9:10 AM, E11 stated " I don ' t think they are floating her heels. If we need to see what the resident ' s care needs are, we could look " in the care plan or on the resident ' s care sheet located inside the resident ' s closet. " E11 opened the closet to check the sheet and stated

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" There is nothing on the care sheet about floating her heels. "
On 2/4/15 at 1:30 PM, E5 (CNA) brought up the Point of Care for R2 on the 300 hall computer and stated " There is no information regarding floating her heels. Usually the nurse lets us know. There is also information in the CNA Communication Book.
On 2/4/15 at 1:35 PM, reviewed the CNA Communication Book. No information regarding floating R2 ' s heels was located in the book under the 300 hall information.
On 2/4/15 at 8:30 AM, E4 stated R2 " uses her heel to propel herself. " E4 stated R2 wears shoes when she propels. " We checked her shoes and there was no wear on the heel area. "
On 2/4/15 at 11:00 AM, E4 stated " Right now communication regarding floating heels is by word of mouth; we tell the nurses and they tell the CNAs. " E4 stated " Staff needs to try to put a pillow under her heels and do frequent checks to decrease the pressure. " E4 stated " There is a problem. I guess putting information on the care sheets inside the residents ' closet, that would probably be a good idea. "
R2 ' s Skin Observation CNA Notes of 1/2/15-1/11/15 show R2 had no skin issues. The notes show a red area on 1/12/15 during the day shift. The notes also show no skin issues were observed from 1/12/15(on the PM shift) -1/16/15 (3 days after the pressure sore was first documented on.)
R2 ' s Pressure Ulcer Investigation form shows on 1/13/15 " a stage II blister developed " on R2 ' s left heel. The investigation form identified the cause of R2 ' s stage II pressure sore was that R2 " propels self using heels. "
R2 ' s Wound Progress/Additional Comments sheet of 1/23/15 states " float heels. " The

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Wound Progress/Additional Comments sheet of 1/30/15 state the area measures 1.8 x 2 x 0.1. The sheet states " Continue same plan of care. "
The 1/16/15 Weekly Pressure Ulcer Progress Report shows R2 had a stage II pressure ulcer on her left heel measuring 2.5 x 3.3 x 0.1 centimeters with a red wound bed and pink wound edges/peri-wound.
The 1/13/15 Care Plan shows R2 " had potential for (impaired) skin integrity of the entire body related to fragile skin, incontinence of bowel and bladder at times, and self propels (with heels) ad lib around the facility throughout the shift. "
The Care Plan states " The resident needs a standard pressure relieving/reducing mattress, pillows, to protect the skin while in bed. "
R2 ' s Pressure Ulcer Assessment /Care Plan dated 1/16/15 states " float heels as tolerated. "
3. R15 has diagnoses of Dementia, Stroke, Left hemiplegia, and Weakness, and is receiving hospice care. The Minimum Data Set (MDS) assessment dated 11/21/14 shows R15 is severely impaired for decision-making, has range of motion impairments to both arms and both legs, and requires extensive assistance for activities of daily living (ADLs).
On 2/5/15 at 10:45 AM, R15's left heel had a 0.5 cm area of hardened skin with a dry center which was peeling open.
On 2/5/15 at 10:55 AM, E4 (treatment nurse) stated "it used to be a pressure area, now it's a callous." E4 added "the CNAs monitor the residents' skin on shower day, the nurse signs off on it (shower sheet), and then it comes to me."
The facility pressure ulcer care plan for R15 (initiated 10/30/2014) shows "Resident has potential for pressure ulcer development related to immobility. Resident has pink hard calloused area on left heel." Interventions from 10/30/14

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include "Administer treatments as ordered and monitor for effectiveness," and "monitor pink calloused are on left heel with MD/POA (Power of Attorney) notification of changes." The shower sheets with R15's skin assessments from the facility and hospice CNAs for the entire month of January, 2015 shows no documentation related to R15's left heel area. The policy and procedure for pressure ulcers (revised 1/27/15) includes " ...3. CNA will do body assessment on each resident receiving a shower and address areas of concern on shower sheet and turn into appropriate nurse for follow up of area, shower sheets are then turned into the wound nurse for review." R15's January and February 2015 treatment sheets showed no evidence of monitoring the left heel for changes.