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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)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	S9999	Attachment A Statement of Licensure Violations	

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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) 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:

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2) All treatments and procedures shall be 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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to a) implement preventative treatment and services for individuals at risk for Pressure Ulcer, b) timely identify and treat an area of compromised skin and/or pressure ulcer, c) follow the facility policy for preventative skin care and the facility Decubitus Care/Pressure Area Policy for 2 of 3

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residents (R1 and R2) reviewed for pressure ulcers in the sample of 3. This failure resulted in R1 developing three unstageable pressure ulcers with (MRSA) methicillin resistant staphylococcus aureus infection that have not shown consistent improvement.

Findings Include:

1)R1's Minimum Data Sets (MDS) dated 01/29/18 documents R1 was admitted to the facility from the hospital on 1/22/18 and has a BIMS (Brief Interview for Mental Status) score of 01 (Severe Impairment). R1's diagnoses include; orthostatic hypertension, pneumonia, septicemia, and seizure disorder.

R1's MDS dated 01/29/18 continues to document R1 requires extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. This assessment also documents R1 is at risk for developing pressure ulcers with no current pressure ulcers documented. R1's assessment documents, a pressure reducing device should be in place for R1's chair and bed and a turn/reposition program.

R1's quarterly MDS dated 4/06/18 documents R1 has a cognitive skill score for daily decision making of 3 (severely impaired); requires extensive assistance with bed mobility, transfers, locomotion on/off unit, dressing, toilet use, and personal hygiene; and R1 remains at risk for pressure ulcers.

R1's baseline care plan dated 01/22/18 documents R1 requires assist of 2+ staff for bed mobility, transfer, and toileting, and assist of 1 staff for locomotion, grooming/hygiene, and bathing. R1's baseline care plan continues to

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document turn and reposition as a skin break intervention. The care plan does not document a turn and reposition schedule or instructions for staff on how or when to turn and reposition R1.

R1's current care plan (not dated) does not document a focus problem, goals, or interventions related to prevention of skin breakdown. R1's care plan has a focus problem with an initiation date of 5/22/18 that documents "R1 is on isolation R/T (related to):ESBL (extended spectrum beta-lactamases) in urine and MRSA in wound."

R1's Braden Scale for predicting Pressure Sore Risk dated 1/29/18, 5/2/18, and 7/7/18 document R1 as being at high risk for developing pressure sores.

R1's hospital admission history and physical dated 2/26/18 includes diabetes mellitus as a diagnosis under "Past Medical History."

R1's laboratory results document high blood sugar results of 133 on 3/1/18, 177 on 3/5/18, 128 on 4/5/18, 166 on 4/6/18, 126 on 5/3/18, and a normal blood glucose reading of 88 on 7/9/18.

On 7/10/18 at 12:20 PM, R1 was observed in an isolation room on a bed without an air mattress. V3 (Licensed Practical Nurse-LPN), V6 (Certified Nurse's Assistant-CNA), and V7 (Regional Director of Nurses) were present. V3 performed wound treatments as ordered by the physician for three unstageable wounds to R1's left back, right back, and coccyx. R1's left back wound had black eschar and a thick yellow center with pink and red surrounding tissue. R1's coccyx wound was deep with a red and yellow center and clear drainage noted. R1's right back wound had a black and red

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center. R1's right heel was black in color and V3 treated the area with betadine as ordered by the physician. R1 only had one heel protector in R1's room at this time. V6 stated, V6 had to go find R1's other heel protector and that R1's air mattress had stopped working sometime over the weekend and the facility had moved R1 to a bed with a regular mattress until R1's air mattress could be fixed or replaced. V3 verified R1 was on isolation for an infection in R1's wounds.

R1's nurses notes document on 4/29/18 orders received from primary care physician to send R1 to the emergency room for evaluation of urinary symptoms. R1's nurses notes continued on 4/29/18 to document R1 was admitted to the local hospital with a diagnosis of urinary tract infection. On 5/1/18 R1's nurses notes document R1's return to the facility and R1 has "open areas on bilateral feet, reddened coccyx, red area on R (right) hip and (R) back." There is no further documentation related to R1's reddened and/or opened areas until 5/3/18.

R1's hospital stay with an admission date of 4/29/18 and a discharge date of 5/1/18 includes a wound assessment dated 4/30/18 that documents a red area that does not blanch located on R1's upper right back, and a red area that does not blanch on R1's coccyx. The wound assessment continues to document an aquacel foam sacral pad was applied. R1's hospital record continues to document a discharge summary dated 5/1/18 that includes under "Physical Exam: ...Patient (R1) was awake this morning wound care was in the room assisting with skin examination ...They were marking room (sic) and taking pictures patient has several superficial and deep tissue areas of concern."

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On 5/3/18 R1's nurses note document the primary care physician saw R1 and ordered "betadine sol (solution) 10% to (R) heel and (L) lateral foot once daily, heel protector's bilat (bilateral) feet. Consult (V4)." R1's nurses notes do not document information related to R1's wounds until 5/10/18 when they document, the wound specialist (V4) saw R1 and new treatment orders were given for R1's right heel and left medial foot and an attempt was made to reach R1's guardian (V8). R1's nurses notes document the wound specialist (V4) visit on 5/17/18 with new orders for a wound on R1's left knee. R1's nurse's notes then document V4's visit on 5/24/18 and new treatment orders for R1's coccyx and right upper back. On 5/31/18 the next nurses note related to R1's wounds document V4's visit and that R1 had a culture of R1's right back wound done. R1's nurses notes do not document when new wounds are acquired and/or an assessment of R1's wounds when they are identified between the wound specialist visits.

The facility weekly pressure ulcer reports for accurate MDS 3.0 coding documents the following for R1;

5/3/2018- no wounds documented for R1

5/10/18- site #1 right heel unstageable DTI (Deep Tissue Injury) 7 x 7 x nmcm (non-measurable centimeter) > (greater than) 20 days, site # 2 left medial foot unstageable DTI 1.5 x 2 x nmcm >2 days.

5/17/18- site #1 measures at 5 x 5 x nmcm and site #2 measures at 1.5 x 2 x nmcm.

5/24/18- site #1 measures at 5 x 5 x nmcm and site #2 measures at 3 x 1 x nmcm. Site # 4 upper

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right back unstageable DTI 2 x 2 x 0.2 cm >2 days and site # 5 coccyx unstageable DTI 5 x 5 x 0.1 cm > 5 days.

6/07/18- site #1 measures at 5 x 5 x nmcm, site #2 measures at 2 x 2 x nmcm, site #4 measures at 3 x 2 x 0.2, site #5 measures at 5 x 5 x 0.1 cm, and site #6 upper left back unstageable DTI > 11days measures at 5 x 5 x nmcm.

6/14/18- site #1 measures at 5 x 5 x nmcm, site #2 measures at 1.5 x 1 x nmcm, site #4 measures at 3 x 2 x 0.2 cm, site #5 measures at 5 x 4 x 0.1 cm, and site #6 measures at 7 x 5 x nmcm.

6/21/18- site #1 measures at 5 x 5 x nmcm, site #2 measures at 1.5 x 1 x nmcm, site #4 measures at 3 x 2 x 0.2 cm, site #5 measures at 5 x 4 x 0.1 cm, and site #6 measures at 5 x 5 x 0.2 cm.

6/28/18- site #1 measures at 5 x 5 x nmcm, site #2 measures at 1.5 x 1 x nmcm, site #4 measures at 3 x 3 x 0.2 cm, site #5 measures at 5 x 3 x 0.1 cm, and site #6 measures at 7 x 4 x 0.8 cm.

7/5/18- site #1 measures at 5 x 5 x nmcm, site #2 measures at 1.5 x 1 x nmcm, site #4 measures at 3 x 2 x 0.2 cm, site #5 measures at 5 x 3 x 0.1 cm, and site #6 measures at 7 x 4 x 0.8 cm.

R1's treatment records dated 2/2018, 3/2018, 5/2018, 6/2018, and 7/2018 do not document weekly skin assessment notes. The facility was unable to provide reproducible evidence of R1's April 2018 treatment records.

R1's resident data collection records document

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R1's coccyx was red on R1's return from the hospital on 5/1/18. On 5/7/18 R1's resident data collection records document a "7 cm (centimeter) black area on right heel, 10 ½ cm x 4 cm red area right hip, 1 x 2 cm open area R (right) back, 5 cm black (area not designated), 2 x 1 cm open area (area not designated), inner aspect L (left foot) 4 cm red area, 2 x 1 cm black area little toe outer aspect of left foot, 9 cm red (area not designated), 8 x 7 cm discolored area L lower leg."

R1's resident data collection notes, daily skilled notes and nursing notes do not document assessments of R1's skin prior to 5/1/18. R1's notes do not document the facility notifying the primary care physician or the wound specialist of new wounds acquired between the wound specialist visits.

R1's current care plan includes a focus problem of actual impairment to skin integrity with an initiation date of 5/10/18. The focus problem of actual impairment to skin documents under Interventions; "6/14/18 Prostat 30 ml in per g-tube (feeding tube), avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry. MD (physician) treatments as ordered. Monitor for side effects of the antibiotics and over the counter pain medications: gastric distress, rash, or allergic reactions which could exacerbate skin injury. Obtain blood work such as CBC with diff, Blood cultures and C&S (culture and sensitivity) of any open wounds as ordered by Physician. Skin checks as scheduled. The resident needs pressure relieving/reducing mattress to protect the skin while in bed. Use caution during transfers and bed mobility to

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prevent striking arms, legs, and hands against any sharp or hard surface.

R1's structured turning and repositioning program documentation dated 6/12/18 through 7/11/18 documents R1 was not turned and repositioned every two hours for 11 of the 29 days.

On 7/17/18 at 2:08 PM V7 (Regional Director of Nurses) stated if a new area of skin breakdown was identified or if there were any concerns regarding the skin when the weekly skin assessment was completed the nurse should document that on the back of the Treatment Records or in the nurses notes.

On 7/11/18 at 10:44 AM, V9 (Licensed Practical Nurse) stated when residents return from a hospital visit, nurses should do skin assessments and document type, stage, and measurement of any wounds.

On 7/12/18 at 9:40 AM, V6 (Certified Nursing Assistant) stated there was not a specific turn and reposition schedule in place for R1. V6 stated staff just knew if R1 was on R1's left side then R1 would need to go to R1's right side or back. When asked if R1 had any preventative measures in place prior to R1's skin break down V6 stated, "No, we report skin issues and nurses get stuff in place then." R1 was observed at this time sitting in R1's wheelchair in R1's room. R1's wheelchair had a cushion in the seat but no padding/support was observed for R1's back. When asked if R1 had any type of pad/cushion in place for R1's back wounds V6 stated, "No."

On 7/12/18 at 11:58 AM V4, (Wound Specialist) stated the facility had not notified V4 between visits of each new wound R1 developed. V4

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stated V4 would expect the facility to follow the recommendations V4 made for R1's pressure ulcers and R1 should have been turned and repositioned at least every two hours. V4 stated the facility had not communicated to V4, R1 had a diagnosis of diabetes mellitus.

On 7/12/18 at 1:01 PM, V2 (Director of Nurses) stated V2 would expect the nursing staff to notify the physician of any new wounds that occurred between the physician's visits. When asked where the notifications were documented in R1's record V2 stated, "I am not seeing it documented." V2 confirmed V2 was not aware R1 had a diagnosis of diabetes mellitus. When asked if it would have been part of R1's interventions if the facility had been aware R1 was diabetic V2 stated, "Obviously."

On 7/12/18 at 1:01 PM, V2 (Director of Nurses) stated R1 did not have a care plan in place or preventative measures in place after being assessed as high risk for pressure ulcer upon admission. When asked if the facility implemented new interventions after R1's initial skin integrity care plan dated 5/10/18 and R1's continued skin breakdown V2 stated, "I don't believe so." V2 confirmed the facility did not have reproducible evidence of R1 having a turn and reposition schedule in place with specific directions for the staff to follow. V2 also confirmed the facility did not have reproducible evidence R1 had been turned and repositioned every two hours.

On 7/13/18 at 2:40 PM V4 stated V4 did not think R1's wounds could have been prevented if V4 had known of R1's diagnosis of diabetes. V4 stated R1's wounds would have responded better to treatment if R1's blood sugars were controlled.

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When asked if R1's wounds were avoidable if the facility had put interventions in place to prevent pressure ulcers, made changes to R1's interventions when R1 began to develop additional wounds, and followed V4's recommendations, V4 stated, "I don't really know ...the only one that may have been avoidable would have been the wound on the coccyx."

R1's wound care specialist (V4) evaluation notes document the following;

"5/10/18 Patient has a wound on their heel ... (R1) presents with an unstageable DTI (deep tissue injury) of the right heel (site 1) of at least 20 days duration ...There is no indication of pain associated with this condition ...etiology: pressure ...wound size 7 x 7 x not measurable cm (centimeter) ....wound of the left medial foot (site 2) ...wound size 1.5 x 2 x not measurable cm ... Recommendations: elevate leg(s), float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

"5/17/18 ...Unstageable DTI of the right heel (site 1) ...wound size 5 x 5 x not measurable cm, wound progress: improved; wound of left medial foot(site 2) ...wound size 1.5 x 2 x not measurable cm, wound progress: no change; ...shear wound of the left knee (site 3) ...duration >3 days ...wound size 1 x 0.7 x not measurable cm ... recommendations elevate leg(s) float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

"5/24/18 ...Unstageable DTI of the right heel (site 1) ...wound size 5 x 5 x not measurable cm ...wound progress: no change ... wound of left

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medial foot (site 2) ... wound size 3 x 1 x not measurable cm ...wound progress: no change ...shear wound of the left knee (site 3) ...wound progress: resolved ...unstageable (due to necrosis) of the right upper back (site 4) ...etiology: pressure ...duration > 2 days ...wound size: 2 x 2 x 0.2 cm ... Unstageable (due to necrosis) coccyx (site 5) ...etiology: pressure ...duration > 5 days ... wound size 5 x 5 x 0.1 cm ...recommendations: elevate legs, float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

"5/31/18 ...unstageable DTI of the right heel (site 1) ...wound size 5 x 5 x not measurable cm ...wound progress: no change ...wound of the left medial foot (site 2) ...wound size 3 x 1 x not measurable cm ...wound progress: no change ...unstageable of the right upper back (site 4) ...wound size 2 x 2 x 0.2 cm ...wound progress: no change ...unstageable coccyx (site 5) ... wound size 4 x 4 x 0.1 cm ...wound progress: improved ... unstageable (due to necrosis) of the left upper back (site 6) ...etiology: pressure ...duration > 5 days ...wound size: 5 x 4 x 0.1 cm ...arterial wound of the left foot (site 7) ...etiology: arterial ...duration: > 3 days ...wound size: 2 x 2 x not measurable cm ...investigations deep swab (culture) technique performed on unstageable (due to necrosis) of the right upper back on 5/31/2018...recommendations: elevate leg(s), float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

"6/7/18 ...unstageable DTI of the right heel (site 1) ...wound size: 5 x 5 x not measurable cm ...wound progress: no change ...wound of the left medial foot (site 2) ...wound size 2 x 1 x not

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF MARION	1301 EAST DEYOUNG MARION, IL 62959

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measurable cm ...wound progress: improved ...unstageable (due to necrosis) of the right upper back (site 4) ...wound size: 3 x 2 x 0.2 cm ...wound progress: no change ...unstageable (due to necrosis) coccyx (site 5) ....wound size: 5 x 5 x 0.1 cm ....wound progress: no change ....unstageable (due to necrosis) of the left upper back (site 6) ...wound size 5 x 5 x not measurable ...wound progress: improved ...arterial wound of the left foot (site 7) ...wound size 2 x 2 x not measurable cm ...wound progress: no change ...arterial wound of the left fourth toe (site 8) ...etiology: arterial ...wound size: 0.5 x 0.5 x not measurable cm ...investigations deep swab technique of unstageable (due to necrosis) of the right upper back demonstrates morganella morgana, MRSA (methicillin resistant staphylococcus aureus on 6/7/18 ...recommendations: elevate leg(s), float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ...antibiotic choice, doxycycline 100 mg (milligrams) BID (twice daily) x 10 days ...."

"6/14/18 ...unstageable DTI of the right heel (site 1) ...wound size 5 x 5 x not measurable cm ...wound progress: no change ...wound of the left medial foot (site 2) ...wound size 1.5 x 1. Not measurable cm ...wound progress: improved ...unstageable (due to necrosis) of the right upper back (site 4) ...wound size 3 x 2 x 0.2 cm ...wound progress: no change ....unstageable (due to necrosis) coccyx (site 5) ...wound size: 5 x 4 x 1 cm ...wound progress: improved ...unstageable (due to necrosis) of the left upper back (site 6) ...wound size 7 x 5 x not measurable cm ...wound progress: no change ...arterial wound of the left foot (site 7) ...wound size 2 x 2 x not measurable cm ...wound progress ...no

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change ...arterial wound of the left fourth toe (site 8) ...wound size: 0.5 x 0.5 x not measurable cm ...wound progress: no change ...recommendations: elevate leg(s), float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

"6/21/18 ...Unstageable DTI of the right heel (site 1) ...wound size 5 x 5 x not measurable cm ...wound progress: no change ...wound of the left medial foot (site 2) ...wound size 1.5 x 1 x not measurable cm ...wound progress: no change ...unstageable (due to necrosis) of the right upper back (site 4) ...wound size: 3 x 2 x 0.2 cm ...wound progress: improved ...unstageable (due to necrosis) coccyx (site 5) ...wound size 5 x 4 x 1 cm ...wound progress: improved ...unstageable (due to necrosis) of the left upper back (site 6) ...wound size 5 x 5 x 0.2 cm ...wound progress: improved ....arterial wound of the left foot (site 7) ...wound size 1 x 1 x not measurable cm ...wound progress: improved ...arterial wound of the left fourth toe (site 8) ...wound size 0.5 x 0.5 x not measurable cm ...wound progress: no change ...."

"6/28/18 ...unstageable DTI of the right heel (site 1) ...wound size: 5 x 5 x not measurable cm ...wound progress: no change ...wound of the left medial foot (site 2) ...wound size: 1.5 x 1 x not measurable cm ...wound progress: no change ...unstageable (due to necrosis) of the right upper back (site 4) ...wound size: 3 x 3 x 0.2 cm ...wound progress: no change ...unstageable (due to necrosis) coccyx (site 5) ...wound size 5 x 3 x 1 cm ...wound progress: improved ...unstageable (due to necrosis) of the left upper back (site 6) ...wound size 7 x 4 x 0.8 cm ...wound progress: no change ...arterial wound of the left foot (site 7) ...wound size: 1 x 1 x not measurable cm

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...wound progress: no change ...arterial wound of the left fourth toe (site 8) ...wound size 0.5 x 0.5 x not measurable cm ...wound progress: no change ....recommendations: elevate leg(s), float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

"7/5/18 ...Unstageable DTI of the right heel (site 1) ...wound size 5 x 5 x not measurable cm ...wound progress: no change ...wound of the left medial foot (site 2) ...wound size 1.5 x 1 x not measurable cm ...wound progress: no change ...unstageable (due to necrosis) of the right upper back (site 4) ...wound size: 3 x 2 x 0.2 cm ...wound progress: improved ....unstageable (due to necrosis) coccyx (site 5) ...wound size: 5 x 3 x 1 cm ...wound progress: no change ...unstageable (due to necrosis) of the left upper back (site 6) ...wound size: 7 x 4 x 0.8 cm ...wound progress: no change ...arterial wound of the left foot (site 7) ...wound size 1 x 1 x not measurable cm ...wound progress: no change ...arterial wound of the left fourth toe (site 8) resolved 7/5/18 ...recommendations: elevate leg(s), float heels in bed, limit sitting to 60 minutes, obtain consent for debridement, off-load wound, reposition per facility protocol ..."

R1's MD Wound Care notification forms dated 5/17, 5/24, 5/31, 6/7, 6/14, and 6/21/18 document notification made to R1's primary care physician which include each wound the size of the wound and the current treatment. R1's wound care notification forms do not document the wound specialists (V4) recommendations or a request for the primary care physician to write orders for V4's recommendations to be followed.

On 7/11/18 at 11:19 AM V2 confirmed R1 had not

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been seen by the wound specialist (V4) prior to 5/10/18.

On 7/12/18 at 1:01 PM when asked if V2(Director of Nurses) would expect the wound specialist recommendations to be followed, V2 stated, that would depend on what the primary physician wanted. When asked to explain V2 stated when the wound specialist makes recommendations and gives orders for treatments the facility then fills out a "MD notification form" and sends it to the primary care physician for him to write orders on the recommendations he wants the facility to follow. When asked to review the MD notification form and show the surveyor where on the form the wound specialist's recommendations are documented, V2 confirmed the facility had not notified the primary care physician of the wound specialist's recommendations for R1. When asked what the facility was doing to heal R1's current wounds and prevent further wounds V2 stated, "We should be following our policy."

The facility Preventative Skin Care Policy dated (January 2014) documents, "To provide preventative skin care through repositioning and careful washing, rinsing, drying and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers." Under procedures the facility preventative skin care policy continues to document, "1. All residents will be assessed using the Braden Pressure Ulcer Scale at the time of admission and weekly x 4 then will be reassessed at least quarterly and/or as needed. 2. Staff on every shift and as necessary will provide skin care. After thorough cleansing of the skin, lotion may be applied and observation of any reddened areas will be reported to the Charge Nurse. 4. A thin layer of body lotion and/or barrier cream may

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be applied as a protective barrier to area(s) exposed to incontinence. 5. Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every (2) hours. 6. Special mattresses and/or chair cushions will be used on any resident identified as being at high risk for potential skin breakdown. 7. Pillows and/or bath blankets may be used between two (2) skin surfaces or to slightly elevate bony prominences/pressure areas off the mattress. Pressure relieving devices may be used to protect heels and elbows. 8. If resident is able to understand, teach the resident about good skin care. Inform them of the cause of pressure ulcers and encourage them to actively participate in the prevention of pressure ulcers. 9. Ensure proper fit of wheelchairs, splints, braces, prosthesis, etc. 10. Provide good nutrition and adequate hydration. A. Nursing assistants are to report decreased food or fluid intake to the Charge Nurse who will evaluate and contact the physician if indicated b. Keep fluids within reach of the resident and/or offer frequently. C. Monitor weight at least monthly, more frequently if indicated. 11. Practice care in moving and lifting residents ...12. Maintain wrinkle free, clean, dry bed linen. 13. Encourage resident activity, when feasible. Use repositioning techniques and Range of Motion exercises when indicated. 14. Keep incontinent residents clean and dry. 15. Keep resident's fingernails and toenails short and smooth to prevent them from accidentally scratching themselves.

The facility Decubitus Care/Pressure Area Policy dated (January 2014) documents, "To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. Procedure:

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S9999	Continued From page 18 Upon identification of skin breakdown the following will be completed; 1) the pressure area will be assessed and documented. 2) Complete all areas of a wound assessment following NPUAP (National Pressure Ulcer Advisory Panel) guidelines i) Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician) ii. Document the stages of the pressure ulcer as follows: (a) Suspected deep tissue injury: purple or maroon localized area of discolored intact skin or blood -filled blister due to damage of underlying soft tissue from pressure and/or shear. (b) Stage I: redness, which does not resolve 30 minutes after pressure is relieved, no broken skin. (c) Stage II: broken skin, an abrasion, blister or shallow crater (d) Stage III: broken skin, affects full thickness and presents as a deep crater (e) Stage IV: broken skin, muscle and/or bone exposed iii) Document the color according to the following: (a) Red: pale pink to beefy red with or without healthy granulation tissue (b) Yellow: whitish yellow, creamy-yellow, yellow-green, or beige (c) Black: black, stringy gray or gray scab 3. Notify the physician for treatment orders. The physician's orders may include: i) Type of treatment ii) Frequency treatment is to be performed iii) How to cleanse, if needed iv) Site of application v) No PRN (as needed) order is acceptable for a pressure ulcer. The order must have specific frequencies. vi) Initiate physician order on treatment sheet 4) Documentation of the pressure area must occur upon identification and at least once each week. The assessment may include: i) Characteristics (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.) ii) Treatment and response to treatment. 5) Reevaluate the treatment for response at least every two (2) to four (4) weeks. Most pressure areas will respond to treatment in	S9999		

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S9999	Continued From page 19 this amount of time. If no improvement is seen in this time frame, contact the physician for a new treatment order. 6. Nursing personnel are to notify dietary personnel of any pressure areas to seek nutritional support and monthly reviews by the Registered Dietician. 7) Initiate problem on care plan. 8) When the pressure area is healed, a preventative regimen is instituted." (B)	S9999		