

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2013
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F000000	<p>This visit was for the Investigation of Complaint IN00140168.</p> <p>Complaint IN00140168-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: December 2 & 3, 2013</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 15 Medicaid: 43 Other: 19 Total: 77</p> <p>Sample: 5</p> <p>These deficiencies reflect State</p>	F000000	<p>December 19, 2013 Kim Rhoades, Director of Long Term CareIndiana State Department of Public Health2 North Meridian St., Sec 4-BIndianapolis, IN 46204-3006 Dear Ms. Rhodes Please reference the enclosed 2567L as "Plan of Correction" for the December 3, 2013 Complaint (IN00140168) survey that was conducted at Lake County Nursing and Rehabilitation Center. I am respectfully requesting paper compliance for this survey. I will submit signature sheets of the in-servicing, content of in-service and audit tools December 18, 2013. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on December 19, 2013 serves as our allegation of compliance. Should you have any question or</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on December 6, 2013, by Janelyn Kulik, RN.		concerns regarding the Plan of Correction, please contact me. Respectfully, Neysa Holman Stewart, HFA	

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the necessary treatment and services were provided to maintain the resident's highest physical well being related to surgical wound dressings not in place for 1 of 3 residents reviewed for wounds in the sample of 5. (Resident #E) (CNA #2) (CNA #4)</p> <p>Findings include:</p> <p>On 12/2/13 at 2:00 p.m., Resident #E was observed sitting in a wheelchair in the hallway. CNA #2 took the resident into her room and transferred the resident into her bed. The resident had several staples in place to the right leg stump site. There was no dressing in place on the right leg stump incision site.</p> <p>On 12/2/13 at 2:35 p.m., Resident #E was observed in bed. CNA #4</p>	F000309	<p>F309 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #E - Dressing was applied by charge nurse on 12/3/13 Treatment orders were reviewed and updated Care plan updated Resident # E - was assessed by the Wound Doctor on 12/3/13 2. The corrective action for those residents having the potential to be affected by the same deficient practice: Audits were completed on 12/02/13 of all residents with surgical wounds without any problems identified. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccurs: Nursing staff were re-educated on application of</p>	12/30/2013	

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	<p>entered the resident's room. The CNA removed the resident's cover at this time. There was no dressing in place to right leg stump incision line. There were several staples in place to the incision. The CNA indicated she was not aware of any bandages the resident was to have in place.</p> <p>The clinical record for Resident #E was reviewed on 12/2/13 at 2:25 p.m. The resident was originally admitted to the facility on 9/12/2002. The resident was sent to the hospital on 11/5/13 and was readmitted to the facility on 11/18/13.</p> <p>The resident's diagnoses included, but were not limited to, above the knee amputation, cerebral artery occlusion, peripheral vascular disease, high blood pressure, dermatitis, schizophrenia, cellulitis, and anemia.</p> <p>The 11/2013 Nursing Progress notes were reviewed. An entry made on 11/5/13 at 12:21 p.m. indicated swelling was noted to the resident's right foot and blisters were noted to the right side of the foot, the right foot first toe, and the right foot second toe. Redness was also noted around the right ankle.</p> <p>The hospital records were reviewed</p>		<p>dressings by the DON on 12/2/13 & 12/03/13 Nurses found to be deficient were given disciplinary action. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor residents with surgical dressing five days a week for four weeks. Then one surgical wound daily three times a week for six months Any issues found will be addressed immediately The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 12/30/13</p>				

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	<p>for the hospitalization between 11/5/13 and 11/8/13. A Cardiology consult dated 11/8/13 indicated the resident was admitted for an infection of the right foot and gangrene(non viable tissue) and infection were noted to the right foot wound. The consult also noted femoral pulses were present and the pedal pulses were absent. Severe ischemic changes and cellulitis of the right foot were also noted. The 11/15/13 Surgery Report indicated the resident's preoperative diagnoses included right foot and ankle gangrene anemia, dementia, sever contracture of the right knee, and coronary artery disease. A right above the knee amputation was performed on 11/15/13.</p> <p>Review of the current Physician orders indicated there was an order written on 11/20/13 to leave the right lower leg dressing in place for one week and then the dressing was to be changed every shift. There was an order on the 12/2013 Treatment Administration Record (TAR) to remove the right lower extremity dressing, cleanse the area with normal saline or wound cleanser and wrap loosely with Kerlix (a gauze rolled bandage) once a day.</p>			

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	<p>When interviewed on 12/2/13 at 3:05 p.m., the Director of Nursing indicated the resident was readmitted to the facility after surgery and had staples in place to the right above the knee surgical site.</p> <p>When interviewed on 12/2/13 at 5:00 p.m., the Wound Nurse indicated the resident was admitted with staples to the right knee amputation surgical site. The Wound Nurse indicated the dressing to the stump surgical site was left in place per the Physician orders when the resident was first admitted. The Wound Nurse indicated the Physician orders were changed and the dressing to the right leg stump surgical site was to be wrapped with a Kerlix dressing every day.</p> <p>This Federal tag relates to Complaint IN00140168.</p> <p>3.1-37(a)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to dressings not in place as ordered by the Physician, dressings not changed as ordered by the Physician, and weekly skin assessments not completed as per the facility policy for 3 of 3 residents reviewed for pressure ulcers in the sample of 5. (Residents #B, #C, and #E) (CNA #1) (LPN #2)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 12/2/13 at 12:55 p.m., Resident #B was observed in bed. The resident was not receiving care at this time. The resident had blue boots on both feet</p>	F000314	F314 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident # B,E Treatment nurse completed skin assessment during survey on 12/2/13. R#C was D/C on 12/3/13. Resident # B,C,E Care plans was updated. Resident # B, continues to be followed by the Wound MD. Resident #E no longer needs to be followed by Wound MD. CNA was given disciplinary action and re-educated concerning notification of nurses when treatment is not in place for (Resident # B) Nurses responsible for completion of treatments for (Residents #B &	12/30/2013			

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	<p>with dressing wrapped about both of his feet. The Director of Nursing loosened the boots. There was a date of 11/26/13 written on both of the dressings. The resident was repositioned by the Director of Nursing and LPN #2. The resident had a small open areas to the sacrum area. The open area was approximately .5 cm x .5 cm. The wound was pink and no drainage was noted. There was no dressing on the wound. No dressing, wraps, or bandages were observed in the resident's brief or in his bed.</p> <p>When interviewed at this time, LPN #2 indicated she was assigned to care for the resident this shift. The LPN indicated she thought the CNA had just given the resident a shower. The LPN indicated she had not removed any dressing from the sacral wound prior to the shower. The LPN indicated the CNA had not informed her the resident did not have dressing in place to the coccyx area.</p> <p>When interviewed on 1:00 p.m., CNA #1 indicated she was assigned to care for the resident on this shift. The CNA indicated the resident did not have a dressing on the the coccyx area when she provided care to the resident.</p>		<p>#E) were given disciplinary action. Spa Assistants were re-educated on proper documentation of shower sheets on 12/3/13 (Resident # B,C, E) 2. The corrective action for those residents having the potential to be affected by the same deficient Practice: Audits were completed on 12/02/13 of all residents with Treatment orders to ensure MD orders were being followed without any problems identified. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccurs New system was put in place for charting of weekly skin assessmentsNurses were educated on12/2, 12/3, and 12/11/13 concerning the new system and proper signage of TAR for (Resident # B,C,E)Nursing staff were re-educated on wound prevention 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will audit skin assessment five days per week for four weeks. Then 50% daily three times a week for six months.Any issues found will be corrected immediately.The audits will be discussed during our monthly QA meeting.QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when</p>				

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	<p>On 12/2/13 at 1:25 p.m., the Wound Nurse was observed assessing the resident's wounds. The Wound Nurse indicated she had just measured the open area to the resident's sacrum and the open area measured 0.8 cm x 0.3 cm. The Wound Nurse also assessed the wound to the resident's right and left feet at this time. There was a dark purple hard area to the left heel which measured 3.3 cm x 3.8 cm. There was a deep purple area to the resident's right lateral foot which measured 1.9 cm x 1.5 cm. There was also an irregular shaped dark purple area to on the distal part of the right lateral foot which measured approximately 0.5 cm x 0.5 cm and was intact. The Wound Nurse indicated the area to the distal part of the right lateral foot was not present before and was first identified at this time.</p> <p>The record for Resident #B was reviewed on 12/2/13 at 4:10 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, dysphagia(difficulty swallowing), pneumonia, gastrostomy tube, acute kidney failure, peripheral vascular disease, and cerebrovascular disease. The</p>		indicated. 5. Completion date systemic changes will be completed: 12/30/13	

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	<p>resident was last hospitalized on 11/10/13 and was readmitted to the facility on 11/13/13. The resident was also hospitalized on 10/9/13 and returned to the facility on 10/18/13.</p> <p>The 11/13/13 Readmission full body assessment indicated the resident had pressure ulcers to the left heel and the coccyx areas.</p> <p>The 10/18/13 Braden scale for predicting pressure ulcer development indicated the resident's score was (12). A score of (12) indicated the resident was at high risk for development of pressure ulcers.</p> <p>The resident's care plans were reviewed. A care plan initiated on 8/5/13 indicated the resident was at risk for skin breakdown related to decreased mobility. The care plan had a goal date of 11/9/13. Care plan interventions included for staff to conduct a systemic skin inspection on scheduled shower days. The Restorative Nurse provided the printed care plan and indicated these were all the current care plans available.</p> <p>The September 2013 and November 2013 Bath and Skin Report sheets were reviewed. The November 2013</p>			

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	<p>sheets indicated the Nurse was to perform skin checks during the resident's bath and shower days and the Nurse was to record any observation on the sheet or check "skin intact." There were four entries on the November report. The entries were dated 11/1/13, 11/5/13, 11/8/13, and 11/28/13. There were no entries made between 11/8/13 and 11/28/13.</p> <p>There were only two entries on the October Bath and Skin Report sheet. The entries were made on 10/1/13 and 10/17/13 and both indicated the resident was in the hospital. No entries were made between 10/18/13 - 10/31/13.</p> <p>The 11/26/13 Skin Integrity Skin Condition reports were reviewed. There were three reports completed on 11/26/13. The reports were as follows: Sacrum pressure ulcer: Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) measuring 2.3 cm x 2.6 cm x < 0.1 cm. The report indicated the pressure ulcer was acquired on 11/26/13.</p> <p>Right Lateral Foot pressure ulcer: Unstageable (full thickness tissue</p>			

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	<p>loss in which the base of the ulcer is covered by slough(necrotic or avascular tissue) or eschar(thick leathery necrotic or devitalized tissue) pressure ulcer measuring 1.5 cm x 1.3 cm x undetermined depth. The report indicated the wound was acquired on 11/26/13 and was black in color.</p> <p>Left Heel pressure ulcer: Unstageable pressure ulcer measuring 3.3 cm x 4.0 cm x undetermined depth. The report indicated the wound was first observed on 8/13/13 and was black in color.</p> <p>The 11/2013 TAR(Treatment Administration Record) was reviewed. The TAR indicated there was an order to cleanse the left heel wound with wound wash or normal saline, paint the wound with Betadine and cover with a dry dressing every other day. This treatment was signed out as completed on 11/19/13, 11/25/13, and 11/27/13. The treatment was not signed out as completed on 11/21/13 or 11/23/13 or 11/23/13.</p> <p>The 11/2013 TAR also indicated there was an order to cleanse the right lateral foot wound with wound cleanser or normal saline, apply skin</p>			

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	<p>prep and cover with a dry dressing every other day. The treatment was signed out as completed on 11/27/13. The treatment was not signed out as completed 11/28/13 thru 11/30/13.</p> <p>The 11/2013 TAR also indicated there was an order to cleanse the sacrum wound with wound wash and apply a Hydrocolloid dressing every three days. The treatment was signed out as completed on 11/26/13. The treatment was not signed out as completed 11/27/13 thru 11/30/13.</p> <p>The 12/2013 TAR was reviewed. The TAR indicated there was an order to cleanse the left heel wound with wound wash or normal saline, paint the wound with Betadine and cover with a dry dressing every other day. This treatment was signed out as completed on 12/2/13.</p> <p>The 12/2013 TAR also indicated there was an order to cleanse the sacrum wound with wound wash and apply a Hydrocolloid dressing every three days. The treatment was signed out as completed on 12/2/13.</p> <p>When interviewed on 12/2/13 at 2:30 p.m., the Director of Nursing indicated the wound treatment should have been completed as ordered by the</p>			

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	<p>Physician.</p> <p>2. During orientation tour on 12/2/13 at 12:45 p.m., Resident #C was observed in bed. The resident had dressing in place on both feet with blue heel boots also in place.</p> <p>The record for Resident #C was reviewed on 12/3/13 at 8:00 a.m. The resident's diagnoses included, but were not limited to, dysphagia (difficulty swallowing), peripheral vascular disease, dementia, anemia, impaired renal function, depressive disorder, congestive heart failure, diabetes mellitus, and osteoporosis. The resident was sent to the hospital on 9/30/13 and returned to the facility on 10/1/13.</p> <p>The 10/1/13 Braden Scale assessment for predicting pressure ulcer development indicated the resident's score was 13-14. This score indicated the resident was at moderate risk for the development of pressure ulcers.</p> <p>The 11/29/13 2013 Skin Integrity Condition reports were reviewed. The sheets indicated the Nurse was to perform skin checks during the resident's bath and shower days and</p>			

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	<p>the Nurse was to record any observation on the sheet or check "skin intact." There were two reports completed on 11/29/13. The reports were as follows:</p> <p>Right Lateral foot pressure ulcer: Onset date of 8/17/13- admitted with condition Unstageable ulcer measuring 2.3 cm x 1.1 cm x undetermined depth.</p> <p>Left lateral foot pressure ulcer: Onset date of 10/1/13-acquired condition Unstageable ulcer measuring 1.8 cm x 1.6 cm x undetermined depth.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 12/13/10 indicated the resident was at risk for skin breakdown related to age, a history of diabetes mellitus, decreased mobility, incontinence of bowel and bladder and a preference to stay in bed most of the time. The care plan was last updated with a target goal date of 1/22/14. Care plan interventions included for skin checks to be done with ADL's (Activities of Daily Living) and full body checks were to be done on shower days.</p> <p>Review of the 10/2013 Bath and Skin Report sheet indicated three entries were made. The 10/1/13 entry</p>			

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	<p>indicated the resident was in the hospital. The 10/24/13 and 10/31/13 entries were signed by the Nurse. There were no other entries.</p> <p>Review of the 11/2013 Bath and Skin Report sheet indicated two entries were made. The entries were made on 11/12/13 and 11/21/13. The 11/12/13 entry was not signed by the Nurse. There were no other entries on the sheet.</p> <p>3. On 12/2/13 at 2:00 p.m., Resident #E was observed sitting in wheelchair in the hallway. CNA #2 took the resident into her room and transferred the resident into her bed. There was a red dry area to the resident's left heel. The area was approximately 3 cm in diameter. There was no dressing covering the area. There was a scabbed area across the mid posterior thigh area. The area was approximately 2.5 cm x .5 cm. There was no dressing covering the area.</p> <p>On 12/2/13 at 2:35 p.m., Resident #E was observed in bed. CNA #4 entered the resident's room. The CNA removed the resident's covers at this time. There was a red dry area to the resident's left heel. The area was approximately 3 cm in diameter.</p>			

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	<p>There was no dressing covering the area. There was a scabbed area across the mid posterior thigh area. The area was approximately 2.5 cm x .5 cm. There was no dressing covering the area. The CNA indicated she was not aware of any bandages the resident was to have in place.</p> <p>The clinical record for Resident #E was reviewed on 12/2/13 at 2:25 p.m. The resident was originally admitted to the facility on 9/12/2002. The resident was sent to the hospital on 11/5/13 and was readmitted to the facility on 11/18/13. The resident's diagnoses included, but were not limited to, above the knee amputation, cerebral artery occlusion, peripheral vascular disease, high blood pressure, dermatitis, schizophrenia, cellulitis, and anemia.</p> <p>The 11/25/2013 Skin Integrity Condition reports were reviewed. There were two reports completed on 11/25/13. The report were as follows: Left heel pressure ulcer: Onset date 11/18/13- admitted with condition Stage I (intact skin with non blanchable redness) ulcer measuring 3.3 cm x 3.8 cm x <0.1 cm</p>			

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	<p>Right posterior thigh pressure ulcer: Onset date 11/25/13- acquired condition Stage II ulcer measuring 0.8 cm x 6.2 cm x <0.1 cm</p> <p>The 12/2013 TAR's (Treatment Administration Records) were reviewed. There was a Physician's order written on 11/18/13 to cleanse the left heel with wound cleanser or normal saline, apply skin prep, and cover with a dry dressing every other day. There was also an order written on 11/23/13 to cleanse the right thigh open area with normal saline or wound cleanser, pat to dry, apply Bactroban (an antibiotic ointment) and cover with Xerofoam (petroleum type gauze) and wrap loosely with Kerlix.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 6/12/11 indicated the resident was at risk for skin breakdown related to incontinence, decreased mobility, peripheral vascular disease, and scratching skin due to dermatitis. The care plan was last updated with a goal date of 1/15/14. Care plan interventions included for skin checks to be done daily with AM care and full body checks to be done twice weekly</p>			

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	<p>on shower days.</p> <p>The 10/2013 Bath and Shower Skin Report sheets were reviewed. The sheets indicated the Nurse was to perform skin checks during the resident's bath and shower days and the Nurse was to record any observation on the sheet or check "skin intact." The only entry made in October was 10/31/13. The date of 10/31/13 was written in a column and there was no Nurse's signature or check indicating there resident's skin was intact or open areas were noted.</p> <p>The 11/2013 Bath and Shower Skin Report sheets were reviewed. Entries were made on 11/7/13, 11/12/13, and 11/14/13. These entries all indicated the resident was hospitalized. There were no entries after 11/14/13.</p> <p>The facility policy titled "Pressure Ulcer and Wound Prevention/Management Program was reviewed on 12/21/13 at 5:15 p.m. The policy was dated "Updated 12/6/06. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated weekly skin assessment were to completed for residents who were at risk for skin breakdown. The policy indicated the the facility was to</p>						

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	<p>determine where the skin assessments by licensed Nurses were to be documented such as on the Treatment Administration Record or the shower sheet.</p> <p>When interviewed on 12/2/13 at 5:00 p.m., the Director of Nursing indicated the resident's the dressings to the resident's pressure ulcer should have been in place.</p> <p>This Federal tag relates to Complaint IN00140168.</p> <p>3.1-40(a)(2)</p>			