STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155669	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW TCU	395 WESTFIELD RD TCU NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 27, 28, 29, and 30, 2016 Facility number: 011046 Provider number:155669 AIM number: N/A Census bed type: SNF/NF: 8 SNF: 0 NF: 0 Total: 8 Census payor type: Medicare:5 Medicaid: 0 Other: 3 Total: 8 These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on July 5, 2016.	F 0000	Preparation and /or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with state and federal laws. The plan of correction constitutes our Credible Allegation of compliance with all regulatory requirements. This provider requests A Desk Review in lieu of a Post Survey revisit. Our Date of compliance is: 7/30/2016	
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure a resident's physician was notified regarding changes in skin condition and the possible need to alter treatment for 2 of 6 residents reviewed for wound care and treatment (Residents #16 and #78).	F 0157	**F 157 NOTIFY OF CHANGES** It is the practice of this provider to ensure that patient, patient's physician and if known, patients legal representative or an	07/30/2016

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	Findings include: 1. Resident #16's closed clinical record was reviewed on 6/29/16 at 1:54 p.m. Resident #16's diagnoses included, but were not limited to, anemia, history of urinary tract infections, diabetes mellitus and dementia. Resident #16 had a 4/29/16, "Interim/Admission Nursing Care Plan" which indicated the resident was at risk for skin tears or skin break down. Resident #16 had a 5/9/16, care plan problem/need regarding a risk for skin breakdown related to required assist with bed mobility, frequent bowel incontinence, occasional bladder incontinence, needing assistance for gait and transfers due to weakness. The goal for this problem was "resident will be free from skin breakdown." Approaches to this problem included, but were not limited to, "weekly skin assessments and monitor skin for signs of skin breakdown." Resident #16 had a 5/27/16, 9:17 p.m., unscheduled wound assessment note which indicated the resident had a pressure area on the right buttock. The area was measured at 0.5 cm length by		interested family member are notified when there is a significant change in the patients physical, mental, or psychosocial status that has the potential for required physician intervention or a need to alter treatment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Patient #16 was admitted on April 29, 2016 and discharged on May 27,2016. Patient # 78 was admitted on May 20,2016 and discharged June 11, 2016 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Patients at risk for skin break down have potential to be affected by this alleged deficient practice. · Licensed nursing staff will be provided an inservice that will review policies and procedures regarding notification for a change of patient's condition and documentation of physical assessments. · Patient skin assessments will be completed on admission and at least weekly with changes noted and proper notification of physician and appropriate family/patient documented. · These weekly skin assessments will be monitored through Quality Assurance reviews **What measures will be put into place or what systemic changes you**	

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	0.5 cm width by 0.1 cm depth with a red wound bed. The clinical record lacked any indication that the resident's physician was notified of the newly developed 5/27/16, pressure area. The clinical record lacked any documentation that the resident had an ordered treatment for this pressure area. Resident #16 had a 5/21/16, order for zinc/oxide. menthol (Calmoseptine) - apply ointment topically 3 times per day. During a 6/30/16, 1:14 p.m., interview, the Director of Nursing (DON) indicated this ointment was ordered as a barrier cream to protect the skin due to frequent bowel incontinence. The DON indicated the 5/21/16, treatment order was not intended to treat a pressure ulcer. Resident #16's treatment administration record for 5/25/16 to 5/27/16 indicated the resident had zinc/oxide menthol applied to her pressure area on the right buttock 3 times daily on 5/26/16 and 2 times daily on 5/27/16. During a 6/29/16, 3:22 p.m. interview, the Director of Nursing indicated the facility had no documentation that the physician was notified of the newly developed pressure area on 5/25/16. She additionally indicated the facility had no		**will make to ensure that the deficient practice does not recur** · Licensed nursing staff will be instructed as to proper documentation and notification on physical/skin assessments, Staging of pressure areas, prevention, and plans of care. · Changes will be made in the current assessment plan that will trigger the nurse to provide proper notification on change in condition of patient's skin. Informational systems will assist in enhancing the current wound assessment documentation · New skin concerns will be reviewed daily in the clinical stand up meeting to determine that proper MD and family notification was completed and treatment orders obtained. · Quality Assurance reviews/audits will be made by DON or designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** § The DON or designee will audit wound assessments 5 times per week for 30 days then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months § Results of findings will be submitted to the CQI committee. If threshold is not met, an action plan will be developed. Noncompliance may result in disciplinary action and/or re-education **Compliance date: 7/30/2016**	

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	documentation to indicate the physician would desire the barrier cream to be the course of treatment for the pressure area. 2. The closed clinical record for Resident #78 was reviewed on 6/29/16 at 2:13 p.m. Diagnoses for Resident #78 included, but were not limited to, diabetes, atrial fibrillation, and chronic obstructive pulmonary disease. A "Nursing Physical Assessment-Admission" note for Resident #78, dated 5/20/16 at 1643 (4:43 p.m.), indicated "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/20/16 at 1800 [6:47 p.m.], indicated Resident #78's skin was "warm dry pink skin. red blanchable coccyx area..." A "Nursing Physical Assessment-Shift" note, dated 5/21/16 at 7:35 a.m., indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; except for			

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	redness to coccyx noted below...." A "Nursing Physical Assessment-Shift" note, dated 5/21/16 at 1800 [6:00 p.m.] indicated Resident #78's skin was "warm dry skin, redness to coccyx...." Resident #78 had a new order, dated 5/27/16 at 8:47 a.m., for barrier cream to the coccyx two times a day and as needed. The clinical record contained no order for wound treatment to the coccyx prior to this date. During an interview on 6/30/16 at 8:26 a.m., the DON indicated if skin redness (blanchable or non-blanchable) was still present on the next assessment (after the admission assessment) then the physician should have been contacted and a treatment implemented. She further indicated the barrier cream ordered on 5/27/16 was a "preventive measure for Resident #78's dry, chaffed skin." During an interview with the DON on 6/30/16 at 1:31 p.m., information for Resident #78 was requested regarding physician notification of the skin assessments and any skin treatments before 5/27/16. During an interview on 6/30/16 at 1:52 p.m., RN #2 indicated Resident #78 was			

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	not seen by the wound staff during his stay and no additional information was provided. A current, October 2010, facility policy, titled "Change in a Resident's Condition or Status" was provided by Administrator on 6/30/16 at 1:33 p.m. It indicated: ..."our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payment, resident rights, etc.)... 1...The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: ...d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly; 2...A "significant change" of condition is decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not			

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	"self-limiting"); b. Impacts more than one area of the resident's health status; and c. Requires interdisciplinary review and/or revision to the care plan. ...4... Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. ...6... The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. A current, March 2013, facility policy, titled "Pressure Ulcer Identification", provided by Director of Nursing on 6/30/16 at 8:25 a.m., indicated: "...Pressure ulcers are localized injury to the skin and /or underlying tissue usually over a bony prominence (e.g., the sacrum, trochanter, ischium, or heel), such as a result of pressure, or pressure in combination with shear and/or friction...." ...4. ...Skin assessments should be completed by the nurse upon admission			

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	to the unit, and each shift for the acute care patient. Patients assigned to the Rehabilitation Care Unit should have a skin assessment upon admission to the unit, and at least once in every 24 hour period. 5. ...If a patient is identified with a pressure ulcer, initiate the patient care plan-Alteration of Tissue Integrity. ...7. ...The patient's physician is to be informed if any pressure ulcers are noted." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0314 SS=E Bldg. 00	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. Based on interview and clinical record review, the facility failed to provide services to prevent the development of pressure ulcers or promote the healing of	F 0314	**F 314 TREATMENT/S**	07/30/2016

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	pressure ulcers regarding the failure to notify the physician of newly developed or worsening areas, the failure to obtain treatment for newly developed or worsening areas, and the failure to develop a system to accurately assess and monitor the progress, appearance and stage of pressure areas for 4 of 4 residents reviewed for the prevention and treatment of pressure ulcers. (Resident #16, #70, #41 and #78) Findings include: 1. Resident #16's closed clinical record was reviewed on 6/29/16 at 1:54 p.m. Resident #16's diagnoses included, but were not limited to, anemia, history of urinary tract infections, diabetes mellitus and dementia. Resident #16 had a 5/6/16, admission, Minimum Date Set (MDS) assessment which indicated the resident was cognitively impaired and rarely or never understood communication, required extensive assistance for bed mobility, toileting and personal hygiene, required assistance for bathing, was occasionally incontinent of urine, was frequently incontinent of bowel and did not have a pressure area during this assessment period.		**VCS TO PREVENT/HEAL PRESSURE SORES.** It is the practice of this provider to ensure that based on comprehensive assessment of patient 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 patient having pressure sores receives necessary treatment and services to promote healing, prevents new sores from developing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Patient #16 was admitted on April 29, 2016 and discharged on May 27,2016. Patient # 78 was admitted on May 20,2016 and discharged June 11, 2016 Patient #70 was admitted on March 18, 2016 and discharged on April 15, 2016 and Patient #41 was admitted on January 20, 2016 and discharged on February 2, 2016 . **How will you identify other residents having the potential to be affected by the same deficient**	

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	Resident #16 had a 4/29/16, "Interim/Admission Nursing Care Plan" which indicated the resident was at risk for skin tears or skin break down. Resident #16 had a 5/9/16, care plan problem/need regarding a risk for skin breakdown related to required assistance with bed mobility, frequent bowel incontinence, occasional bladder incontinence, needing assistance for gait and transfers due to weakness. The goal for this problem was "resident will be free from skin breakdown." Approaches to this problem included, but were not limited to, "weekly skin assessments and monitor skin for signs of skin breakdown." Resident #16 had a 5/23/16, 4:00 p.m., Braden Scale wound consult which identified the resident as having no open area at that time and being at high risk for skin breakdown, Resident #16 had a 5/27/16, 9:17 p.m., unscheduled wound assessment note which indicated the resident had a pressure area on the right buttock. The area was measured at 0.5 cm length by 0.5 cm width by 0.1 cm depth with a red wound bed. The clinical record lacked any indication		**practice and what corrective action will be taken** · Patients at risk for skin break down have potential to be affected by this alleged deficient practice. · Licensed nursing staff will be provided an inservice that will review policies and procedures regarding notification for a change of patient's condition and accurate and complete documentation of skin concerns · Patient skin assessments will be completed on admission and at least weekly with changes noted and proper notification of physician and appropriate family/patient documented. · These weekly skin assessments will be monitored through Quality Assurance reviews **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Licensed nursing staff will be instructed as to proper documentation and notification on physical/skin assessments, progress, appearance, staging, prevention, and plans of care for pressure areas. · Changes will be made in the current assessment plan that will trigger the nurse to provide proper notification on change in condition of patient's skin. Informational systems will assist in enhancing the current wound assessment documentation · New skin concerns will be reviewed daily in the clinical stand up meeting to	

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	that the resident's physician was notified of the newly developed 5/27/16, pressure area. The clinical record lacked any documentation that the resident had an ordered treatment for this pressure area. Resident #16 had a 5/21/16, order for zinc/oxide. menthol (Calmoseptine) - apply ointment topically 3 times per day. During a 6/30/16, 1:14 p.m., interview, the Director of Nursing (DON) indicated this ointment was ordered as a barrier cream to protect the skin due to frequent bowel incontinence. The DON indicated the 5/21/16, treatment order was not intended to treat a pressure ulcer. Resident #16's treatment administration record for 5/25/16 to 5/27/16 indicated the resident had zinc/oxide menthol applied to her pressure area on the right buttock 3 times daily on 5/26/16 and 2 times daily on 5/27/16. The "Wound Assess" section of Resident #16's record for 5/25/15 to 5/27/15 indicated she had a pressure area on her right buttock which measured 0.5 cm x 0.5 cm depth 0.1 cm with red granulation to the wound bed. No wound staging was documented on this form in the indicated box. No dressing was documented on this form in the indicated box. No treatment was documented as		determine proper MD and family notification was completed and treatment orders obtained. · Skin assessments will be reviewed daily in the clinical stand up meeting to determine the documentation is thorough and accurate · Quality Assurance reviews/audits will be made by DON or designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** § The DON or designee will audit wound assessments 5 times per week for 30 days then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months § Results of findings will be submitted to the CQI committee. If threshold is not met, an action plan will be developed. Noncompliance may result in disciplinary action and/or re-education **Compliance date: 7/30/2016**	

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	given on this form in the indicated box. Resident #16 had a 5/26/16, 000 time (time listed as 000) "Nursing Rounds" note which indicated the resident had 2 small red areas to watch on inner right buttock and medication was applied. No other area of the clinical record indicated the resident had 2 areas. Resident #16's 5/27/16, "Discharge Summary Continuum Of Care" indicated the resident had a open sheared area to the inner right buttock which measured 0.5 cm by 0.5 cm by 0.1 cm. The form indicated the treatment to this area was Calmoseptine to buttock. The measurements on the 5/27/16 discharge form were consistent with the 5/25/16 wound measurements. Resident #16 had a 5/27/16, 6:57 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the residents skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; fragile" and "Date/Time Initial Assessment: Wed. 25 May 2016 2117 [917 p.m.] Location: rt [right] buttock Type: pressure ulcer Size: length 0.5 cm x width 0.5 cm depth Bed: red granulation Closure: no closure Surrounding: blanchable Drainage/Odor:			

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	no drainage Pain: no." During a 6/29/16, 3:22 p.m. interview, the Director of Nursing indicated the facility had no documentation that the physician was notified of the newly developed pressure area on 5/25/16. She additionally indicated the facility had no documentation to indicate the physician would desire the barrier cream to be the course of treatment for the pressure area. 2. Resident #70's closed clinical record was reviewed on 6/30/16 at 1:02 p.m. Resident #70's diagnoses included, but were not limited to, depression, anemia, hypertension and diabetes mellitus. Resident #70 was admitted to the Transitional Care Unit on 3/18/16. Resident #70 had 3/17/16, 4:00 p.m., hospital wound assessment which indicated the resident had a stage 2 pressure ulcer on her coccyx. The area measured 1.5 cm length by 1.5 cm width by 0.1 cm depth with a pink granular base. The ulcer had a small amount of serous (clear, thin watery) drainage. Resident #70 had a 3/18/16, "Interim/Admission Nursing Care Plan" which indicated she had a current coccyx wound.			

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	Resident #70 had a 3/18/16, 1:15 p.m., "Wound Assess" section entry which indicated the resident had a stage 2 pressure area on her sacrum that measured length 1 cm X width 0.4 cm X depth 0.2 cm. Resident #70 had a 3/19/16, 8:00 a.m., Wound Consultant note which indicated the resident had a dressing change to an area on her coccyx. The area was documented as having a moist pale pink wound bed and no active drainage. No measurements were documented in this note. This note was documented by LPN #8. Resident #70 had a 3/20/16, 8:00 a.m., "Wound/Incision Care" note which indicated the wound bed was covered 100% by yellow slough and the resident experienced mild discomfort while the wound was being cleansed." This note was completed by LPN #8. This documentation was a change in the appearance of the wound bed since the 3/17/16 preadmission observation. Resident #70 had a 3/22/16, 1:40 p.m., "Wound/Incision Care" note which indicated the wound bed had slough and a small amount of serous fluid." This note was completed by LPN #6.			

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	Resident #70 had a 3/23/16, 8:33 a.m., "Weekly Wound Assessment", which indicated the resident had a pressure ulcer to the coccyx which measured 1 cm length by 0.8 cm width by 0.1 cm depth. The wound bed had yellow slough and the surrounding area had balanceable erythema. The resident had pain in the wound area. This area was documented by LPN #6. Resident #70 had a 3/23/16, 4:01 p.m., Wound Consult note which indicated the resident had a coccyx ulcer which remained at 0.4 cm length by 0.3 cm width and 0.1 cm depth. The wound had serosanguinous drainage (a fluid which is yellowish with a small amount of blood) and redness to the periwound (area surrounding the wound). This note was completed by RN #5. This measurement and observation was inconsistent with the measurements and documentation at 8:33 a.m. on the same day. Resident #70 had a 3/25/16, admission, Minimum Date Set (MDS) assessment which indicated the resident required extensive assistance for bed mobility, transferring and toileting, and the resident had 1 unstageable pressure ulcer. The assessment indicated the ulcer was unstageable due to slough (a mass of dead tissue separated from surrounding			

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	tissue) and or eschar (a dry dark scab or falling away of dead skin). Resident #70 had a 3/26/16, 9:00 a.m., "Wound/Incision Care" note which indicated the resident had a pressure ulcer on her coccyx. The area was measured at 2 mm by 2 mm with a whitish yellow wound bed. This was entry documented by LPN #4. Resident #70 had a 3/29/16, 8:00 a.m., "Wound/Incision Care" note which documented the wound as having yellow slough and being "nearly closed." This note was documented by LPN #4. Resident #70 had a 3/29/16, 4:30 p.m., Wound Consultant note which indicated the resident had a pressure ulcer on her coccyx. The area was measured at 1 cm length by 0.8 cm width and 0.1 cm depth. The wound was identified as an unstageable wound due to 100% yellow slough in the wound bed. This entry was documented by Nurse Practitioner #3 (NP #3). This measurement was inconsistent with the measurements made earlier that day by LPN #4. Resident #70 had a 3/30/16, 9:14 a.m., "Weekly Wound Assessment" which indicated the resident had a pressure ulcer to her coccyx. The ulcer measured			

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	0.7 cm length by 0.5 cm width with a depth of 0.1 cm. The wound bed was noted to have yellow slough. The note indicated the resident experienced pain with the treatment. This documentation was completed by LPN #7. Resident #70 had a 3/31/16, care plan problem/need regarding an unstageable pressure ulcer on her coccyx. Approaches to this problem included, but were not limited to, "Measure area(s) weekly and Notify MD [medical doctor] if interventions are not effective and/or for s/s [signs or symptoms] of infection: redness, warmth, drainage, foul odor." Resident #70 had a 4/6/16, 9:00 a.m., "Weekly Wound Assessment" which indicated the resident had a pressure ulcer on her coccyx. The ulcer measured 0.5 cm length by 0.5 cm width 0.1 cm depth. The wound bed was noted to have yellow slough. The note documented the resident experienced pain with the treatment. This documentation was completed by LPN #7. Resident #70 had a 4/13/16, 9:07 a.m., "Weekly Wound Assessment" which indicated the resident had a pressure ulcer on her coccyx. The ulcer measured 0.5 cm length by 0.5 cm width 0.1 cm depth. The wound bed was noted to have yellow			

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	slough. The note documented the resident experienced pain with the treatment. This documentation was completed by LPN #7. This note indicated no change or improvement in the area in a 1 week period. Resident #70's clinical record indicated she was discharged from the facility on 4/15/16. The record indicated the resident was discharged with a 4/14/16, order for barrier cream to the coccyx to be applied to the coccyx "until soreness improves."3. The closed clinical record for Resident #41 was reviewed on 6/30/16 at 9:43 a.m. Diagnoses for Resident #41 included, but were not limited to, intestinal obstruction, hypertension, and gas esophageal reflux disease. An admission Minimum Data Set (MDS) assessment, dated 1/27/16, indicated Resident #41 was cognitively intact and required extensive assistance from the staff for bed mobility, transfers, and toilet use. The assessment indicated Resident #41 did not have any pressure areas upon admission. Resident #41 had a health care plan, initiated on 1/30/16, which indicated "Skin: Resident has a prophylactic dressing to coccyx from recent area of			

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	breakdown, hx [history] of psoriasis." One of the interventions for this problem was to notify the physician if the interventions were not effective and/or for sign and symptoms of infection. A Wound Consult note, dated 1/20/16 at 8:30 a.m., and corrected at 12:11 p.m., indicated Resident #41 had "an area of pink blanchable skin ncompasing [sic] the coccyx that measures 3cmL [sic] x 4 cmW [sic] x 0depth[sic]. Within this area on both sides of the coccyx are darker red non blanchable areas that measure 1.0cm in diameter and not depth." In the "Comment" section it was noted "Correction: the initial evaluation of wound was that it was blanchable upon admission." The note indicated the wound Nurse Practitioner had been notified and orders obtained. A "Nursing Physical Assessment-Admission" note, dated 1/20/16 at 2247 (10:47 p.m.), contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed			

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	Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/21/16 at 8:05 a.m., contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/22/16 at 1518 (3:18 p.m.), contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "COLOSTOMY" and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift"			

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	note, dated 1/25/16 at 8:00 a.m., contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "dry" and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/26/16 at 8:00 a.m., contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "colostomy" and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/27/16 at 8:02 a.m., contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "WNL [within normal limits skin color normal warm & dry to touch, intact; good skin turgor with immediate recoil" and			

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	"Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/27/16 at 1802 (6:02 p.m.), contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "urostomy" and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/28/16 at 8:00 a.m., contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "WNL [within normal limits] skin color normal warm & dry to touch, intact; good skin turgor with immediate recoil" and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges:			

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	closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Nursing Physical Assessment-Shift" note, dated 1/28/16 at 1608 (4:08 p.m.), contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "colocstomy [sic]" and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #41 had an order for "Wound/Incision Care" note, dated 1/20/16 to "cleanse the coccyx with bedside care and cover with foam, every Tuesday and Friday." A "Wound/Incision Care" note for Resident #41, dated 1/22/16 at 1200 (12:00 p.m.), indicated the dressing had been changed as instructed. The note further indicated "skin dry, redness that blanches. pt [patient] stated that she has had psoriasis in the area 'for years'. periwound skin pink, blanchable. no erythema, warmth odor or edema. 'tailbone' is painful." No wound			

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	measurements were documented. A "Wound/Incision Care" note for Resident #41, dated 1/26/16 at 9:00 a.m., indicated coccyx dressing changed as instructed and skin was "pink." No wound measurements were documented. A "Weekly Wound Assessment" for Resident #41, dated 1/27/16 at 8:09 a.m., indicated "no wounds". A Wound Consult note for Resident #41, dated 1/29/16 at 1330 (1:30 p.m.), indicated "here to follow up on stage II pressure ulcer to coccyx and at risk heels." The note further indicated "open areas are all closed, skin is dry, peri wound skin remains non blanchable in this area." No wound measurements were documented. The clinical record lacked any other documentation regarding a stage 2 pressure area. A "Wound/Incision Care" note for Resident #41, dated 1/29/16 at 1444 (4:44 p.m.), indicated the dressing on the coccyx was changed as directed. The skin was "red nonblanchable directly over bony prominence. periwound skin WNL [within normal limits]." No wound measurements were documented. A "Wound/Incision Care" note, dated			

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	2/2/16 at 9:00 a.m., indicated Resident #41's "area healed." In the "Wound Assess" section of Resident #41's record the following information had been documented on 1/21/16 at 8:05 a.m.: "Location-coccyx, type-stage 1, stage was blank, size-3 cm x 4 cm x 0 cm, bed-pink, edges-closed, skin was blank, surrounding skin-blanchable, drainage/odor-no, skin closure-no closure, wound pain-no, wound care was blank, and alternated dressing change was blank." The same documentation was entered for each of the following days and times: 1/21/16 at 1510 [3:10 p.m.], 1/22/16 at 7:30 a.m., 1/22/16 at 1518 [3:18 p.m.], 1/23/16 at 8:40 a.m., 1/23/16 at 1736 [5:36 p.m.], 1/24/16 at 7:50 a.m., 1/24/16 at 1600 [4:00 p.m.], 1/25/16 at 8:00 a.m., 1/25/16 at 1542 [3:42 p.m.], 1/26/16 at 8:00 a.m., 1/26/16 at 1527 [3:27 p.m.], 1/27/16 at 8:02 a.m., 1/27/16 at 1802 [6:02 p.m.], 1/28/16 at 8:00 a.m., 1/28/16 at 1608 [4;08 p.m.], 1/29/16 at 7:30 a.m., 1/29/16 at 1652 [4:52 p.m.], 1/30/16 at 6:45 a.m., 1/30/16 at 1600 [4:00 p.m.], 1/31/16 at 7:35 a.m., 1/31/16 at 1600 [4:00 p.m.], 2/1/16 at 8:00 a.m., 2/1/16 at 1547 [3:47 p.m.], 2/2/16 at 6:44 a.m.,			

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	2/2/16 at 8:00 a.m., and 2/2/16 at 1559 [3:59 p.m.]. During an interview on 6/30/16 at 1:46 p.m., the Director of Nursing (DON) indicated the wound nurse reports directly to the wound nurse practitioner. The DON indicated the nursing staff had the ability to view the wound staff documentation in a resident's chart. During an interview with the DON on 6/30/16 at 2:09 p.m., additional information was requested regarding Resident #41's wound documentation from admission to discharge. During an interview on 6/30/16 at 2:17 p.m., RN #2 indicated the facility did not have any additional information to provide for Resident #41. 4. The closed clinical record for Resident #78 was reviewed on 6/29/16 at 2:13 p.m. Diagnoses for Resident #78 included, but were not limited to, diabetes, atrial fibrillation, and chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS) assessment, dated 5/27/16, indicated Resident #78 was cognitively intact and required extensive assistance from the staff for bed mobility, transfers, and toilet			

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	use. Resident #78 had a health care plan, initiated on 5/20/16, which indicated the problem "Potential for skin breakdown." The health care plan was updated on 6/1/16 to include "does have reddened blanchable coccyx." A "Nursing Physical Assessment-Admission" note, dated 5/20/16 at 1643 (4:43 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "fragile dry skin to BUE [bilateral upper extremities]...coccyx is red and blanchable...." and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/20/16 at 1800 [6:47 p.m.], indicated Resident #78's skin was "warm dry pink skin. red blanchable coccyx area...." A "Nursing Physical Assessment-Shift"			

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	note, dated 5/21/16 at 7:35 a.m., indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; except for redness to coccyx noted below....; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/21/16 at 1800 (6:00 p.m.) indicated Resident #78's skin was "warm dry skin, redness to coccyx; and "Date/Time Initial Assess: Fri, 20 May 2016 1646[4:46 p.m.] Location: coccyx Type: stage 1 Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." Resident #78 had a new order, dated 5/27/16 at 8:47 a.m., for barrier cream to the coccyx two times a day and as needed. The "Weekly Wound Assessments", dated 5/25/16, 6/1/16, and 6/8/16,			

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	indicated "no wounds" for Resident #78. During an interview on 6/29/16 at 2:49 p.m., the Director of Nursing (DON) indicated the initial wound assessment "sinks" or is "prepopulated on the 'Nursing Physical Assessment' completed two times a shift." She indicated staff had the ability to access the wound assessment and update or change the information. She further indicated the correct wound measurements for residents were documented in the "Wound Care/Incision" tab (section) of the record. During an interview on 6/30/16 at 8:26 a.m., the DON indicated if skin redness (blanchable or non-blanchable) was still present on the next assessment (after the admission assessment) then the physician should be contacted and a treatment implemented. During an interview with the DON on 6/30/16 at 1:31 p.m., information for Resident #78 was requested regarding physician notification of the skin assessments and any skin treatments before 5/27/16. During an interview on 6/30/16 at 1:52 p.m., RN #2 indicated Resident #78 was not seen by the wound staff during his			

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	stay and no additional information was provided. A current, March 2013, facility policy, titled "Pressure Ulcer Identification", provided by Director of Nursing on 6/30/16 at 8:25 a.m., indicated: "...Pressure ulcers are localized injury to the skin and /or underlying tissue usually over a bony prominence (e.g., the sacrum, trochanter, ischium, or heel), such as a result of pressure, or pressure in combination with shear and/or friction...." 3. Pressure Ulcer Stages: ...Stage I: Non-blanchable erythema... intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' person... ...Stage II: Partial thickness... partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguineous filled			

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	blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation, *Bruising indicates deep tissue injury. 4. ...Skin assessments should be completed by the nurse upon admission to the unit, and each shift for the acute care patient. Patients assigned to the Rehabilitation Care Unit should have a skin assessment upon admission to the unit, and at least once in every 24 hour period. 5. ...If a patient is identified with a pressure ulcer, initiate the patient care plan-Alteration of Tissue Integrity. ...7. ...The patient's physician is to be informed if any pressure ulcers are noted. 3.1-30(a)(1) 3.1-30(a)(2) 3.1-30(a)(3)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted			

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	professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, interview and record review, the facility failed to ensure clinical records where completely and accurately documented regarding wound monitoring, wound measurements and wound assessments for 3 of 6 residents reviewed for accurate and complete monitoring of wounds. (Resident #83, #41, and #78) Findings include: 1. Resident #83's clinical record was reviewed on 6/30/16 at 8:54 a.m. Resident #83's diagnoses included, but were not limited to, history of urinary tract infection, hypertension, and neuropathy. The clinical record indicated the resident was admitted to the Transitional Care Unit on 6/16/16. Resident #83 had a 6/16/16 hospital "Discharge Summary Continuum Of Care" form which indicated the resident had a stage 1 pressure area on his bottom.	F 0514	**F 514 RECORDS WILL BE COMPLETE ACCURATE/ACCESSIBLE** It is the practice of this provider to maintain clinical records on each patient in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible and systematically organized. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Patient # 78 was admitted on May 20,2016 and discharged June 11, 2016 and Patient #41 was admitted on January 20, 2016 and discharged on February 2, 2016 . Patient #83 was admitted on June 16, 2016	07/30/2016

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	The exact area was not indicated. The form appeared to be located on the left buttock. Measurements of the wound were not contained on this form. The form indicated the pressure area was being treated with xeroform (a petroleum wound dressing gauze) and foam dressing. Resident #83 had a 6/16/16, 6:00 p.m., TCU "Nursing Physical Assessment-Admission" record which changed the description of the wound to an "Open Lesion" with measurements of length 0.1 cm by width 0.1 cm and depth 0.1 cm. Resident #83 had a 6/16/16, "Interim/Admission Nursing Care Plan" regarding the potential for skin related to decreased mobility. Resident #83 had a 6/28/16, care plan problem regarding the risk for skin breakdown and a current scab on the coccyx. An approach to this problem was "area to coccyx will receive tx [treatment] as ordered and monitored for redness, warmth, or drainage, increase in size and dr [doctor] notification." Resident #83's "Wound Assess" section of his record included the first assessment of his wound on 6/16/16 at 6:00 p.m.		and discharged on July 8, 2016 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Patients at risk for skin break down have potential to be affected by this alleged deficient practice. · Licensed nursing staff will be provided an inservice that will review documentation policies and procedures regarding notification for a change of patient's condition and accurate documentation of skin concerns · Patient skin assessments will be completed on admission and at least weekly with changes noted and proper notification of physician and appropriate family/patient documented. · These weekly skin assessments will be monitored through Quality Assurance reviews **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Licensed nursing staff will be instructed as to proper documentation and notification on physical/skin assessments, progress, appearance, staging, prevention, and plans of care for pressure areas. · Changes will be made in the current assessment plan that will trigger the nurse to provide proper notification on change in condition of patient's skin. Informational systems will assist in enhancing	

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	The assessment documented the wound as measuring 0.1cmX0.1cm depth 0.1cm and having a foam dressing. Although other areas of documentation within the clinical record reflected changes in wound size the "Wound Assess" entries for 6/17/16, 6/18/16, 6/19/16, 6/20/16, 6/21/16, 6/22/16, 6/23/16, 6/24/16, 6/23/16, 6/24/16, 6/25/16, 6/26/16, 6/27/16, 6/28/16, 6/29/16 and 6/30/16 assessment entries all mirrored the 6/16/16 note. Resident #83 had a 6/17/16, 8:40 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0,1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/17/16, 4:00 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL		the current wound assessment documentation · New skin concerns will be reviewed daily in the clinical stand up meeting to determine proper MD and family notification was completed and treatment orders obtained · Skin assessments will be reviewed daily in the clinical stand up meeting to determine the documentation is thorough and accurate. · Quality Assurance reviews/audits will be made by DON or designee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** § The DON or designee will audit wound assessments 5 times per week for 30 days then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months § Results of findings will be submitted to the CQI committee. If threshold is not met, an action plan will be developed. Noncompliance may result in disciplinary action and/or re-education **Compliance date: 7/30/2016**	

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	[within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0,1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/19/16, 8:05 a.m, "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0,1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/20/16, 7;56 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and			

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	"Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0,1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/20/16, 2:28 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0,1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/21/16, 6:23 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location:			

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	buttocks Type: open lesion Size: length 0.1 cm x width 0,1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/22/16, 7:48 a.m., "Weekly Wound Assessment" which indicated the wound measurements and description as follows: "Location: Lt [left] buttocks Type: scab Size: length 0.4cm x width 0.4 cm x depth 0 cm Bed: dry, dark brown scab Surrounding: erythema blanchable Drainage/Odor: no drainage no odor Pain: No." Resident #83 had a 6/22/16, 8:09 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was			

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	identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/22/16, 3:55 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact." and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/23/16, 8:00 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size:			

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	length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/24/16, 8:00 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/24/16, 4:58 p.m., "Nursing Physical Assessment" which contained conflicting information			

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	regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/25/16, 8:00 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/25/16, 4:15 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/26/16, 2:40 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1			

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	cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/27/16, 8:00 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/27/16, 3:15 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL			

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	[within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/28/16, 7:57 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment".			

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	Resident #83 had a 6/28/16, 4:40 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment did not reflect the measurement increase nor development of a scab which was identified during the 6/22/16, "Weekly Wound Assessment". Resident #83 had a 6/29/16, 8:00 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding:			

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	blanchable Drainage/Odor: no drainage Pain: no." Resident #83 had a 6/29/16, 9:55 a.m., "Weekly Wound Assessment" which indicated the resident had no wound. Resident #83 had a 6/29/16, 3:26 p.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thud, 16 June 2016 1800 [6:00 p.m.] Location: buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment lacked any documentation that the wound had healed on 6/29/16. Resident #83 had a 6/30/16, 8:04 a.m., "Nursing Physical Assessment" which contained conflicting information regarding the resident's skin and indicated the resident's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; " and "Date/Time Initial Assess: Thu, 16 June 2016 1800 [6:00 p.m.] Location:			

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	buttocks Type: open lesion Size: length 0.1 cm x width 0.1 cm x depth 0.1 cm Bed: red: granulation dry Edges: opened Closure: no closer Surrounding: blanchable Drainage/Odor: no drainage Pain: no." This assessment lacked any documentation that the wound had healed on 6/29/16. During a 6/30/16, 2:04 p.m., skin observation, Resident #83 had light red, blanchable area on his coccyx. The area was approximately the size of a quarter. The area was closed and there was no drainage or odor. 2. The closed clinical record for Resident #41 was reviewed on 6/30/16 at 9:43 a.m. Diagnoses for Resident #41 included, but were not limited to, intestinal obstruction, hypertension, and gas esophageal reflux disease. A Wound Consult note, dated 1/20/16 at 8:30 a.m., and corrected at 12:11 p.m., indicated Resident #41 "an area of pink blanchable skin ncompasing [sic] the coccyx that measures 3cmL [sic] x 4 cmW [sic] x 0depth[sic]. Within this area on both sides of the coccyx are darker red non blanchable areas that measure 1.0cm in diameter and not depth." In the "Comment" section it was noted "Correction: the initial evaluation of wound was that is was blanchable			

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	upon admission." The note indicated the wound Nurse Practitioner had been notified and orders obtained. A "Nursing Physical Assessment-Admission" note, dated 1/20/16 at 2247 (10:47 p.m.), contained conflicting information regarding Resident #41's skin and indicated Resident #41's skin was "WNL [within normal limits] Skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Wed, 20 Jan 2016 2230 [10:30 p.m.] Location: coccyx Type: stage 1 Size: length 3cm x width 4 cm x depth 0cm Bed: pink Edges: closed Closure: no closure Surrounding: blanchable Drainage/Odor: no drainage Pain: no." A "Wound/Incision Care" note for Resident #41, dated 1/22/16 at 1200 (12:00 p.m.), indicated the dressing had been changed as instructed. The note further indicated "skin dry, redness that blanches. pt [patient] stated that she has had psoriasis in the area 'for years'. periwound skin pink, blanchable. no erythema, warmth odor or edema. 'tailbone' is painful." No wound measurements were documented. A "Wound/Incision Care" note for Resident #41, dated 1/26/16 at 9:00 a.m.,			

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	indicated coccyx dressing changed as instructed and skin was "pink." No wound measurements were documented. A "Weekly Wound Assessment" for Resident #41, dated 1/27/16 at 8:09 a.m., indicated "no wounds". A Wound Consult note for Resident #41, dated 1/29/16 at 1330 (1:30 p.m.), indicated "here to follow up on stage II pressure ulcer to coccyx and at risk heels." The note further indicated "open areas are all closed, skin is dry, peri wound skin remains non blanchable in this area." No wound measurements were documented. The clinical record lacked any other documentation regarding a stage 2 pressure area. A "Wound/Incision Care" note for Resident #41, dated 1/29/16 at 1444 (2:44 p.m.), indicated the dressing on the coccyx was changed as directed. The skin was "red nonblanchable directly over bony prominence. periwound skin WNL [within normal limits]." No wound measurements were documented. A "Wound/Incision Care" note, dated 2/2/16 at 9:00 a.m., indicated Resident #41's "area healed." In the "Wound Assess" section of			

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	Resident #41's record the following information had been documented on 1/21/16 at 8:05 a.m.: "Location-coccyx, type-stage 1, stage was blank, size-3 cm x 4 cm x 0 cm, bed-pink, edges-closed, skin was blank, surrounding skin-blanchable, drainage/odor-no, skin closure-no closure, wound pain-no, wound care was blank, and alternated dressing change was blank." The same documentation was entered for each of the following days and times: 1/21/16 at 1510 [3:10 p.m.], 1/22/16 at 7:30 a.m., 1/22/16 at 1518 [3:18 p.m.], 1/23/16 at 8:40 a.m., 1/23/16 at 1736 [5:36 p.m.], 1/24/16 at 7:50 a.m., 1/24/16 at 1600 [4:00 p.m.], 1/25/16 at 8:00 a.m., 1/25/16 at 1542 [3:42 p.m.], 1/26/16 at 8:00 a.m., 1/26/16 at 1527 [3:27 p.m.], 1/27/16 at 8:02 a.m., 1/27/16 at 1802 [6:02 p.m.], 1/28/16 at 8:00 a.m., 1/28/16 at 1608 [4;08 p.m.], 1/29/16 at 7:30 a.m., 1/29/16 at 1652 [4:52 p.m.], 1/30/16 at 6:45 a.m., 1/30/16 at 1600 [4:00 p.m.], 1/31/16 at 7:35 a.m., 1/31/16 at 1600 [4:00 p.m.], 2/1/16 at 8:00 a.m., 2/1/16 at 1547 [3:47 p.m.], 2/2/16 at 6:44 a.m., 2/2/16 at 8:00 a.m., and 2/2/16 at 1559 [3:59 p.m.]. 3. The closed clinical record for Resident			

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	#78 was reviewed on 6/29/16 at 2:13 p.m. Diagnoses for Resident #78 included, but were not limited to, diabetes, atrial fibrillation, and chronic obstructive pulmonary disease. A "Nursing Physical Assessment-Admission" note, dated 5/20/16 at 1643 (4:43 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "fragile dry skin to BUE [bilateral upper extremities]...coccyx is red and blanchable...." and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/20/16 at 1800 (6:47 p.m.), indicated Resident #78's skin was "warm dry pink skin. red blanchable coccyx area...." A "Nursing Physical Assessment-Shift" note, dated 5/21/16 at 7:35 a.m., indicated Resident #78's skin was "WNL [within normal limits] skin color normal,			

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	warm & dry to touch, intact; except for redness to coccyx noted below....; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/21/16 at 1800 (6:00 p.m.), indicated Resident #78's skin was "warm dry skin, redness to coccyx; and "Date/Time Initial Assess: Fri, 20 May 2016 1646[4:46 p.m.] Location: coccyx Type: stage 1 Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/22/16 at 7:10 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "dry, poor turgor. and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no			

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	closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/22/16 at 1800 (6:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "warm dry pale skin; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/23/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "fragile; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1."			

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	A "Nursing Physical Assessment-Shift" note, dated 5/23/16 at 1542 (3:42 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "fragile; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/24/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "dry fragile; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/24/16 at 1600 (4:00 p.m.), contained conflicting information			

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	regarding Resident #78's skin and indicated Resident #78's skin was "dry fragile; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/25/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/25/16 at 1536 (3:36 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "dry;			

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	and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/26/16 at 8:00 a.m. contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; dry; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/26/16 at 1600 (4:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "dry; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155669		06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW TCU	395 WESTFIELD RD TCU NOBLESVILLE, IN 46060

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	length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: intact Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/27/16 at 7:45 a.m. contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "thin, dry. no redness to pressure points on heels, elbows, or oears [sic]... ; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/27/16 at 1800 (6:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/28/16 at 7:30 a.m. contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "thin, dry. no redness to pressure points on heels, elbows, or oears [sic]... ; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/28/16 at 1800 (6:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "thin warm dry skin, no redness to pressure points; and "Date/Time Initial Assess:			

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	Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/29/16 at 7:50 a.m. contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "thin, dry. poor turgor. chronic chooses. no redness to pressure points on heels, elbows, or ears... ; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulce r Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/29/16 at 1800 (6:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "warm			

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	dry skin; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/30/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil: and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/30/16 at 1455 (2:45 p.m.), contained conflicting information regarding Resident #78's skin and			

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	indicated Resident #78's skin was "pale warm dry poor skin turgor; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/31/16 at 7:56 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil: and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 5/31/16 at 1523 (3:23 p.m.),			

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	contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "warm dry poor skin turgor; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/1/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; dry; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift"			

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	note, dated 6/1/16 at 1553 (3:53 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "pale warm dry poor skin turgor; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/2/16 at 7:42 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1."			

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	A "Nursing Physical Assessment-Shift" note, dated 6/2/16 at 1601 (4:01 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "pale warm dry; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/3/16 at 8:29 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1."			

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	A "Nursing Physical Assessment-Shift" note, dated 6/3/16 at 1441 (2:41 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/4/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no			

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	drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/4/16 at 1800 (6:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/5/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure:			

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	no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/5/16 at 1800 (6:00 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/6/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type:			

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	pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/6/16 at 1541 (3:41 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was -no documentation except for following: "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/7/16 at 8:04 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646			

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	[4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/7/16 at 1602 (4:02 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/8/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm &			

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	dry to touch, intact; good skin turgor with immediate recoil; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6 cm x width 6 cm x depth 0 cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BM's [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/8/16 at 1555 (3:55 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "dry fragile; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6 cm x width 6 cm x depth 0 cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BM's [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/9/16 at 7:23 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within			

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	155669		06/30/2016

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	normal limit] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/9/16 at 1502 (3:02 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/10/16 at 6:10 a.m.,			

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	contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; good skin turgor with immediate recoil; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." A "Nursing Physical Assessment-Shift" note, dated 6/10/16 at 1437 (6:37 p.m.), contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limits] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1."			

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	A "Nursing Physical Assessment-Shift" note, dated 6/11/16 at 8:00 a.m., contained conflicting information regarding Resident #78's skin and indicated Resident #78's skin was "WNL [within normal limit] skin color normal, warm & dry to touch, intact; and "Date/Time Initial Assess: Fri, 20 May 2016 1646 [4:46 p.m.] Location: coccyx Type: pressure ulcer Size: length 6cm x width 6 cm x depth 0cm Bed: dry Closure: no closure Surrounding: other some chaffing form pericare after BMs [bowel movements] Drainage/Odor: no drainage Pain: no Comment: no open areas, area is red and blanchable, stage 1." The "Weekly Wound Assessments" dated 5/25/16, 6/1/16, and 6/8/16 indicated "no wounds" for Resident #78. In the "Wound Assess" section of Resident #78's record the following information had been documented on 5/20/16 at 1646 (4:46 p.m.): "Location-coccyx, type-pressure ulcer, stage was blank, size-6 cm x 6 cm x 0 cm, bed-dry, edges was blank, skin was blank, surrounding skin-intact, drainage/odor-no drainage, skin closure-no closure, wound pain-no,			

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	wound care was blank, and alternate dressing change was blank." The same documentation was entered for each of the following days: 5/20/16, 5//21/16, 5/22/16, 5/23/16, 5/24/16, 5/25/16, and 5/26/16. On 5/27/16 "surrounding skin" was changed from "intact" to "other some chaffing from pericare after BMs [bowel movements]." All other documentation stayed the same. The surrounding skin documentation was the only information changed and remained the same for each entry documented on 5/28/16, 5/29/16, 5/30/16, 5/31/16, 6/1/16, 6/2/16, 6/3/16, 6/416, 6/5/16, 6/6/16, 6/7/16, 6/8/16, 6/9/16, 6/10/16, and 6/11/16. Each day had 2 entries. The wound measurements did not change on any of the entries. During an interview on 6/29/16 at 2:49 p.m., the Director of Nursing (DON) indicated the initial wound assessment "sinks" or is "prepopulated on the 'Nursing Physical Assessment' completed two times a shift." She indicated staff had the ability to access the wound assessment and update or change the information. She further indicated the correct wound measurements for residents were documented in the "Wound Care/Incision" tab (section) of the record.A current, April 2008, facility policy, titled "Charting and Documentation", provided by the			

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	Administrator on 6/30/16 at 1:33 p.m., indicated: "...All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical records." 1....All observations, medications administered, service performed, etc., must be documented in the resident's clinical records. 3. ...All incidents, accidents, or changes in the resident's condition must be recorded. ...6. ...Documentation of procedures and treatments shall include care-specific details and shall include at a minimum:... a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care: c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated;...."			

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	A current, undated, facility document, titled "QCPR Wound Documentation", provided by the Director of Nursing on 6/30/16 at 8:25 a.m., indicated: the Director of Nursing (DON) contacted the person in charge of the computer program. The DON stated, "I have concerns that the wounds from the Admission Physical Assessment carry through to all other Nursing Physical Assessments. This carry over of the initial wound with initial measurements is not an accurate assessment for subsequent assessments." The DON indicated the wound care Nurse Practitioner was aware of the problem and had previously spoken to the computer program department. The DON stated, "this impacts viewing wound measurements in the Wound Assessment tab [section] as well i.e., if a wound is measured after the admission wound assessment is completed it will revert back to the initial wound measurements in the trend." 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(4)			

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