STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00201205. Complaint IN00201205 - Substantiated. Federal/State deficiencies are cited at F157, F280 and F314. Survey dates: June 1 and 2, 2016 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 13 Medicaid: 61 Other: 14 Total: 88 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	It is the request of the facility to get a desk review for this survey Thank you!	

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

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F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 notify the physician and family of an elevated blood sugar for 1 of 3 residents reviewed for	F 0157	**F-157** It is the policy of the facility to inform the resident,the resident's physician and the resident's legal representative when theresident has	06/24/2016

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	physician/family notification. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 6/1/16 at 11:15 a.m. Diagnosis included, but was not limited to, diabetes. The physician order, dated 2/17/16 at 3:34 p.m. included, but was not limited to, the following: "...[Resident #B's name]...Order Summary: Blood Glucose Monitoring...Check and record one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for Diabetes Mellitus [sic] Notify MD [Medical Doctor] if < [less than] 70 or > [greater than] 350...." The Medication Administration Record for May, 2016 indicated, on 5/4/16, Resident #B had a blood sugar level of 441. The clinical record lacked documentation of physician and family notification of the elevated blood sugar level. During an interview on 6/2/16 at 2:30 p.m., the Director of Nursing (DON) indicated she could not find where the physician and family were notified of the		an accident with injury, a change in their room or roommate, or a blood sugar or lab/test value that falls within aspecified range or parameter which the physician has ordered that they be madeaware of or a significant change in condition as per stated criteria. Resident #8 discharged from the facility. Residents who reside in the facility and who have bloodsugar values that fall within a range that requires notification of thephysician as per order have the potential to be affected by this finding. Note: The family would also be notified of a blood sugarlevel that requires physician notification. A facility wide audit was conducted in order to create alist of targeted residents who have orders for physician notification based ontheir blood sugar level parameters. Note: The family would also be notified of a blood sugar level thatwould require physician notification. A30 day “look back” was done to ensure that any notifications that met thecriteria for notifications had in fact been reported to the physician and thefamily. Additionally, all medication records of these targeted residents wereaudited to ensure that they contained a cue to notify the physician asappropriate based on the blood sugar value. Note: The family would also be notified. Going forward, the	

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	elevated blood sugar. On 6/2/16 at 9:39 a.m., the DON provided a copy of the document titled, "Physician Notification of Resident Change of Condition, dated 7/1/11, and indicated as current. It included, but was not limited to, the following: "...Guideline: It is the intent of the facility for the attending physician to be notified of a change in a resident's condition by licensed personnel as warranted...Responsibility: All Licensed Personnel...Procedure: 1. Physician notification is to include but is not limited to:...Blood glucose reading below 50 or above 200...2. Make an entry into the Nurse's notes regarding condition/physician notification and change in physician's orders...." On 6/2/16 at 9:39 a.m., the DON provided a copy of the document titled, "Responsible Party Notification of change in Resident Condition", dated 7/1/11, and indicated as current. It included, but was not limited to, the following: "...Guideline: It is the intent of the facility to have a family member or responsible party made aware of a change in a resident's condition by licensed nursing personnel...Responsibility: All Licensed Nursing Personnel...Procedure: A family member or responsible party		DON/Designee will reviewthe orders daily at the CQI meetings to see that the cue to notify thephysician of blood sugars that meet the ordered criteria for notificationappear on the medication administration screen. Further, the DON/Designee will monitor the blood sugars daily (that weredocumented the previous day) to see that proper notifications were made. Any concerns will beaddressed as discovered. This process will be ongoing as part of the CQImeeting agenda and will be followed up on at these meetings by the DON/Designeeto ensure proper and timely notifications are made. There will be a specific monitoring tool totrack the blood sugars of any resident who has reportable blood sugarparameters. Note: In addition tonotifications of blood sugars that have specifically ordered notificationparameters, per company policy, blood sugars of less than 70 or greater than300 meet notification criteria. At an in-service held for the nursing staff on June8,2016, the following was reviewed: 1.Notifications—What criteria triggers a notificationto physician/family? (Emphasis on notification of blood sugar or lab/testresults which fall within a specific range or parameter which the physician hasordered that they be made aware of—including facility policy of	

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	will be notified of any significant change in a resident's condition...." This Federal tag relates to Complaint IN00201205 3.1-5(a)(2)		notificationsof blood sugars less than 70 or greater than 300 2.Who should be notified? When? How? 3.Care planning 4.Follow up 5.Documentation Any staff who fail to comply with the points of thein-service will be further educated and/or progressively disciplined asindicated. At the monthly QA meetings the monitoring of the bloodsugar levels on residents with ordered reportable parameters will be reviewedfor any patterns, however any concerns will have been addressed asdiscovered. If necessary, an Action Planwill be written by the committee. AnyAction Plan will be monitored weekly by the Administrator until resolution.	
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion			

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	of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to update a resident's plan of care (Resident #B) when there was a significant decline in the residents ability to turn and reposition independently for 1 of 3 residents reviewed for bed mobility. Findings include: The clinical record for Resident #B was reviewed on 6/1/16 at 11:15 a.m. Diagnosis included, but was not limited to, dementia. The Minimum Data Set assessment (MDS), dated 3/16/16, indicated Resident #B's cognition was severely impaired with a BIMS (Brief Interview of Mental Status) score of 6. Resident #B was admitted to the facility on 2/17/16. Resident #B's care plan, included, but was not limited to, the following: "...Focus...Resident at risk for skin breakdown related to cognitive	F 0280	**F-280** It is the policy of the facility to ensure that eachresident has a comprehensive plan of care prepared by an interdisciplinary teamincluding the attending physician, a registered nurse with responsibility forthe resident as well as any other appropriate staff to determine the resident'sneeds and how they can best be met. The resident and their responsible partyare encouraged to participate in this planning. Further, This plan of care is to be reviewed and updated asindicated as the resident's needs change. Resident #8 discharged from the facility. Residents who reside in the facility and who subsequentlyhave a plan of care, have the potential to be affected by this finding. All care plans of all residents were reviewedby the IDT (Interdisciplinary Team) to ensure that they are current and thatthey accurately reflect the current status and the	06/24/2016

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	impairment; immobility...Date Initiated: 02/18/2016...Goal...Resident will have no skin breakdown through next review...Date Initiated: 02/18/2016...Target Date: 05/31/2016...Interventions...Resident to T&R [turn and reposition] self while in bed related to independent with bed mobility...Date Initiated: 02/18/2016...." The MDS assessments, Section G, dated 2/24/16, included, but was not limited to, the following: "...[Resident #B's name]...Functional Status...A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while abed...Self Performance...3 [Extensive assistance - resident involved in activity; staff provide weight-bearing support]...Support...3 [Two + persons physical assist]...." The MDS assessments, Section G, dated 3/2/16, included, but was not limited to, the following: "...[Resident #B's name]...Functional Status...A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while abed...Self Performance...3 [Extensive assistance - resident involved in activity; staff provide weight-bearing support]...Support...3 [Two + persons		current needs of theresidents. Care plans are reviewedquarterly or as appropriate, based on changes of a resident's condition. Additionally, at the daily CQI meetings, careplans are revised as appropriate based on new or changed orders, a significantfinding or event or as a result of IDT discussion. This practice is ongoing and is theresponsibility of the DON/Designee with input from appropriate IDT members. Further,the DON/Designee and appropriate IDT members will monitor 10 care plans weeklyfor completeness and accuracy. Thismonitoring will continue until 4 consecutive weeks of zero negative findings isachieved. After that, 5 care plans willbe reviewed weekly for a period of not less than 6 months to ensure ongoingcompliance. Then random monitoring willoccur. Any needed revisions will be madeas found. At an in-service held for staff who are involved inwriting the care plans the following was reviewed: 1.Definition of a "Care Plan" 2.Assessment process as related to the care plan 3.Who writes the care plan? When? How? Why? 4.When should the care plan be revised/updated? 5.Care Plan meetings How often? Who should attend? 6.MDS/Care Plan/CNA	

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	physical assist]...." The MDS assessments, Section G, dated 3/16/16, included, but was not limited to, the following: "...[Resident #B's name]...Functional Status...A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while abed...Self Performance...3 [Extensive assistance - resident involved in activity; staff provide weight-bearing support]...Support...3 [Two + persons physical assist]...." The nurses note, dated 3/24/16 at 11:26 p.m., included, but was not limited to, the following: "...Resident transfer extensive assist x [times] 2 and extensive assist x [times] 2 with bed mobility...." The nurses note, dated 3/26/16 at 5:37 p.m., included, but was not limited to, the following: "...Resident is an extensive assistance of 2 staff for Bed [sic] mobility...." The nurses note, dated 3/27/16 at 1:19 a.m., included, but was not limited to, the following: "...Extensive assist x [times] 2 with transfers and bed mobility...." The nurses note, dated 3/27/16 at 3:57 p.m., included, but was not limited to, the		Assignments---How are theyrelated? 7.Questions/Answers Any staff who fail to comply with the points of thein-service will be further educated and/or progressively disciplined asindicated. At the monthly QA meetings, the results of the care planmonitoring will be reviewed. Anypatterns will be identified. Ifnecessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly bythe Administrator until resolution. Note: Any concerns noted during the monitoring will be corrected asfound.	

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	following: "...Resident is an extensive assist of two for transfers, bed mobility...." The nurses note, dated 3/28/16 at 6:29 p.m., included, but was not limited to, the following: "...resident requires two assist with transfers and ADL's [Activities of Daily Living]...." On 6/1/16 at 4:45 p.m., the MDS Coordinator provided a copy of Resident #B's ADL (Activities of Daily Living) report, dated 4/21/16 - 5/6/16. The ADL report indicated Resident #B required and extensive assist, 1 person physical assist, 9 out of 30 times for bed mobility; extensive assist, 2 person physical assist, 11 out of 30 times; total dependence (full staff performance) of 1 person 7 out of 30 times; and total dependence of 2 person physical assist 3 out of 30 times. The physical therapy discharge summary, dated 4/23/16 at 7:47 a.m., included, but was not limited to, the following: "...Dates of Service: 3/27/2016 - 4/23/2016...Patient: [Resident #B's name]...Short-Term Goals...Discontinue on 04/23/2016...Bed Mobility...Baseline...(3/27/16)...Max/2 [Maximum assist of 2 persons]...Previous... (4/17/2016)...Max/2...Discharge...			

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	(4/23/2016)...Max/2...Comments:...Pt. [patient] requires MAX A [Maximum Assist] with bed mobilities...." During an interview on 6/1/16 at 4:20 p.m., the MDS coordinator indicated Resident #B was cognitively unaware to help with bed mobility. During an interview on 6/1/16 at 5:02 p.m., the DON (Director of Nursing)indicated Resident #B could reposition, while abed, independently until the end and then required an assist of 1 with bed mobility. During an interview on 6/2/16 at 2:09 p.m., the Therapy Manager indicated Resident #B was a 2 person physical assist with bed mobility. The Therapy Manager also indicated Resident #B could not turn and reposition her/himself while in bed. On 6/2/16 at 9:58 a.m., the DON provided a copy of the document titled, "Care Plans", and indicated as current. It included, but was not limited to, the following: "...Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...Responsibility: All members of the			

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	interdisciplinary team...Definitions:...Care Plan - contains resident problems/needs/strengths, resident goals and interdisciplinary approaches...Procedure...All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change in condition...." This Federal tag relates to Complaint IN00201205 3.1-35(d)(2)(B)			
F 0314 SS=G 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 record review, the facility failed to ensure a resident,	F 0314	**F-314** It is the policy of the facility to see that residentswho are admitted to	06/24/2016

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	admitted with no pressure areas, did not acquire pressure areas for 1 of 3 residents reviewed for pressure ulcers. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 6/1/16 at 11:15 a.m. Diagnoses included, but were not limited to, dementia and diabetes. Resident #B was admitted to the facility on 2/17/16. The wound sheet for Resident #B, dated 4/22/16 at 5:55 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...23) Coccyx...b. Type of Wound...Pressure ulcer...b1. Stage of Wound...Stage II [2] [Partial thickness loss of dermis]...c. Size of Wound...3 cm [centimeters] x [by] 3 cm [centimeters]...Healing Process...1. New Wound...." The wound sheet for Resident #B, dated 4/27/16 at 1:52 a.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...23) Coccyx...b. Type of Wound...Pressure ulcer...b1. Stage of Wound...Stage II [2] [Partial thickness loss of dermis]...c. Size of Wound...3 cm [centimeters] x [by] 4.2		the facility with no pressure areas do not develop pressureareas unless their condition deteriorates as a result of disease processes tothe point that the areas are unavoidable based on their body's failure torespond to treatment(s). Thesecircumstances would be well documented by the physician. Further, it is the facility's practice to seethat resident's at risk or who become "at risk" for pressure ulcer developmenthave interventions in place to prevent pressure ulcer development as much aspossible. Resident #8 was discharged from the facility. Residents who reside in the facility and who have riskfor pressure areas or who have developed pressure areas since admission havethe potential to be affected by this finding. A facility wide audit was conducted in order to formulate a list ofresidents considered either "at risk" for developing a pressure area, or whomalready had a pressure area (either admitted with or developed in thefacility). These residents had a skinassessment performed. Note: Skinassessments are done on all residents weekly as a standard practice in thefacility. These residents had their careplans reviewed and updated by the IDT (Interdisciplinary Team) to ensure thatthey had appropriate interventions in place to address	

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	cm [centimeters] x [by] 0.2 cm [centimeters] [depth of wound]...Healing Process...1. No Change...Action Taken...8d. No new orders. Continue current treatment plan...." The wound sheet for Resident #B, dated 5/3/16 at 11:18 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...23) Coccyx...b. Type of Wound...Pressure ulcer...b1. Stage of Wound...Unstageable [Full thickness tissue loss]...c. Size of Wound...9.2 cm [centimeters] x [by] 3.7 cm [centimeters]...Wound Bed...2g. Black/Eschar...Drainage Type...3c...Odorous...3d...Purulent [brownish-yellow]...Healing Process...4. Worsening...Action Taken...8d...No new orders. Continue current treatment plan...." The wound sheet for Resident #B, dated 5/4/16 at 2:07 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...23) Coccyx...b. Type of Wound...Pressure ulcer...b1. Stage of Wound...Stage III [3] [Full thickness tissue loss]...c. Size of Wound...9.5 cm [centimeters] x [by] 3.0 cm [centimeters]...Wound Bed...2g. Black/Eschar...Drainage		either their risk or theiractual area(s). Further, the residentswith pressure areas were placed (if not already there) on the list of residentsto be reviewed at the weekly SWAT (Skin Weight Assessment Team) meetings. Theweekly SWAT meetings will be held each week and each resident who has an openarea will be reviewed to ensure that appropriate interventions are implementedto enhance healing. These interventions includebut are not limited to (unless contraindicated per physician order): 1.Appropriate mattress/cushions/positioningdevices 2.Turning (off-loading schedule) 3.Medications/Treatment 4.Dietary/Supplements/Vitamins 5.Wound Specialist/Clinic consults and/ortreatments All SWAT protocol will be followed for these residentsuntil they no longer meet the criteria for SWAT. At the daily CQI meetings the progress notes since theprior CQI meeting will be reviewed. Further, the results of the weekly skin assessments will be reviewed asthey are completed day to day (for the week). Any indication of a new pressure area will be addressedat this time to be certain the any needed additional interventions are	

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	155494	A. BUILDING 00 B. WING	06/02/2016

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	Type...3d...Purulent [brownish-yellow]...Healing Process...4. Worsening...Action Taken...8d...No new orders. Continue current treatment plan...." The wound sheet for Resident #B, dated 4/19/16 at 5:32 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...right heel...b. Type of Wound...Pressure ulcer...b1. Stage of Wound...Unstageable [Full thickness tissue loss]...c. Size of Wound...2.4 cm [centimeters] x [by] 3.0 cm [centimeters]...Wound Bed...2g. Black/Eschar...Healing Process...1. New Wound...." The wound sheet for Resident #B, dated 4/28/16 at 2:39 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...right heel...b. Type of Wound...Pressure ulcer...b1. Stage of Wound... Stage III [3] [Full thickness tissue loss]...c. Size of Wound...3.8 cm [centimeters] x [by] 6.2 cm [centimeters] x [by] 0.2 cm [centimeters] [depth]...Wound Bed...2d. Red/Beefy...2g. Black/Eschar...2j. Slough (yellow/stringy)...Healing Process...4. Worsening...."		rolledout at that time. Further, this residentwill be added to the list of residents to be reviewed at the next and at futureSWAT meetings. A Braden Scale will becompleted and subsequent Braden Scales will be completed for the next 4weeks. Notifications will be made to thephysician and family or responsible party. The care plan will be reviewed and updated. This process will be ongoingand will part of the daily CQI meeting agenda. There is a specific monitoring tool to track onset of pressureareas. This process will be an on-goingpart of the daily CQI agenda and will be the responsibility of theDON/Designee. At an in-service held June 8, 2016 for nursing staff, thefollowing was reviewed: 1.Skin Issues/Pressure areas—What do you do if younotice a new skin issue/pressure area as a CNA?—as a nurse? 2.Notifications of new or worsening skin issues/pressurearea—Who is notified? When? By whom? 3.Skin Assessments—Why? How often? By whom? 4.What is a Braden Scale? How is it used? How often is it to bedone? By whom? 5.Care Planning interventions for skin issues/pressureareas 6.Documentation requirements of skinissues/pressure areas-	

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	The wound sheet for Resident #B, dated 5/03/16 at 11:19 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...right heel...b. Type of Wound...Pressure ulcer...b1. Stage of Wound... Unstageable [Full thickness tissue loss]...c. Size of Wound...5.3 cm [centimeters] x [by] 8.5 cm [centimeters]...Wound Bed...2g. Black/Eschar...2j. Slough (yellow/stringy)...Drainage Type...3c. Odorous...3d. Purulent (brownish-yellow)...Healing Process...4. Worsening...Action Taken...8d. No new orders. Continue current treatment plan...." The wound sheet for Resident #B, dated 5/04/16 at 2:06 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...right heel...b. Type of Wound...Pressure ulcer...b1. Stage of Wound... Stage III [3] [Full thickness tissue loss]...c. Size of Wound...8.2 cm [centimeters] x [by] 4.8 cm [centimeters]...Wound Bed...2g. Black/Eschar...2j. Slough (yellow/stringy)...Drainage Type...3c. Odorous...3d. Purulent (brownish-yellow)...Healing Process...4. Worsening...."		-nurses 7.CNA role in care planned interventions relatedto skin issues/pressure areas 8.Monitoring that interventions are in place 9.Efficacy of the interventions 10.SWAT meetings—Definition(Skin/Weight /Assessment/Team) and basic overview K.) Questions/Answers Any staff who fail to comply with the points of the in-servicewill be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, the results of the monitoringto track pressure ulcers as well as the SWAT meeting summations will bereviewed. Any concerns will beaddressed. Any patterns will beidentified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly bythe Administrator until resolved.	

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	The wound sheet for Resident #B, dated 5/04/16 at 2:18 p.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...Other...right outer foot blister...b. Type of Wound...Pressure Ulcer...c. Size of Wound...2 cm [centimeters] x [by] 2 cm [centimeters]...Wound Bed...2m. Blister...Healing Process...3. No Change...Action Taken...8d. No new orders. Continue current treatment plan...." There were no other wound sheets provided related to the blister on Resident #B's right outer foot. The wound sheet for Resident #B, dated 4/27/16 at 6:22 a.m., included, but was not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...Left heel...blister...b. Type of Wound...Pressure Ulcer...c. Size of Wound...[blank]...Wound Bed...2c. Pink...Healing Process...5. Resolved/Healed...." There were no other wound sheets provided related to a left heel blister. The wound sheet for Resident #B, dated 4/22/16 at 5:57 p.m., included, but was			

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	not limited to, the following: "...Resident: [Resident #B's name]...a. Document each wound...Include site...Site...Right buttock...b. Type of Wound...Pressure Ulcer...b1. Stage of Wound...2. Stage II [2] [Partial thickness loss of dermis]... Size of Wound...0.3 cm [centimeters] x [by] 0.5 cm [centimeters]...Wound Bed...2c. Pink...2d. Red/Beefy...Healing Process...1. New Wound...." There were no other wound sheets provided related to the Stage II pressure ulcer on the right buttock. The clinical record lacked documentation of interventions, provided by staff between 3/24/16 - 5/5/16, to ensure Resident #B did not develop pressure ulcers. The hospital discharge report, dated 5/6/16, included, but was not limited to, the following: "...[name of hospital]... [Resident #B's name]...Plan of Care Problems...Wound: Assessment...rt [right] calf outer...Wound Type...Pressure Ulcer...Length (cm) [centimeters]...2.5...Width (cm)...1.5...Wound Stage...II [2]...rt inner calf...unopened blister/pressure...Wound Type...ulcer...rt [right] heel...Wound Type...Pressure...General Appearance...Necrotic...Length			

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	(cm)...7.5...Width (cm)...5.5...Depth (cm)...0.5...Wound Stage...Unstageable...Wound Bed Assessment...Yellow (Slough)...Black (Eschar)...coccyx/sacrum...Wound Type...Pressure Ulcer...Foul Odor...Length (cm)...17...Width (cm)...8.5...Depth (cm)...0.5...Wound Stage...Unstageable...Wound Bed Assessment...Yellow (Slough)...Black (Eschar)...Surrounding Tissue...Purple...lt [left] heel...Wound Type...calloused with soft mushy skin...." The Braden Scale Score (assessment of a residents risk for pressure ulcers) for Resident #B, on admission, was 19, which indicated he/she was not at risk for the development of a pressure ulcer. The Braden Scale Score on 2/18/16 and 2/24/16 for Resident #B was 18, which indicated he/she was at risk for the development of a pressure ulcer. The clinical record lacked a Braden Scale Score after 2/24/16. The care plan for Resident #B, initiated on 2/18/16, included, but was not limited to, the following: "...Resident at risk for skin breakdown related to cognitive impairment; immobility; incontinence...Resident will have no skin			

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	breakdown...Resident to T & R [turn and reposition] self while in bed related to independent with bed mobility...." The Minimum Data Set assessments, dated 2/24/16, 3/2/16, and 3/16/16 indicated Resident #B was an extensive, 2 person assist with bed mobility. The physician order, dated 5/3/16, indicated to start Zinc Sulfate 220 mg (milligrams) daily, Vitamin C 500 mg a day for wound healing. The physician order, dated 5/3/16, indicated to start Prostat, 30cc (cubic centimeters) three times a day for wound healing. The physician order, dated 5/3/16, indicated to keep heels floated at all times while in bed, every shift, for prevention. During an interview on 6/1/16 at 5:02 p.m., the DON (Director of Nursing)indicated when a resident gets a wound, the Registered Dietician gets involved. The DON also indicated Resident #B could reposition, while abed, independently until the end and then required an assist of 1 with bed mobility. The clinical record lacked documentation			

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	from the Registered Dietician after the initial assessment was completed on 2/22/16. During an interview on 6/2/16 at 2:09 p.m., the Therapy Manager indicated, since admission, Resident #B could not turn and reposition independently while in bed. On 6/2/16 at 2:06 p.m., the Administrator provided a copy of the document titled, "Braden Scale and Comprehensive Evaluation of Skin Risk Factors, dated 7/1/11. It included, but was not limited to, the following: "...Guideline: It is the intent of the facility for a Braden Scale and a Comprehensive Evaluation of Skin Risk Factors to be completed for all residents to assess risk factors for developing pressure sores...Procedure...1. Complete Braden Scale...With a significant change in status (including pressure ulcer or wound development)...." During an interview on 6/2/16 at 5:45 p.m., the Administrator and DON indicated they were unaware that a Braden Scale had to be completed when new wounds developed. This Federal tag relates to Complaint IN00201205			

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