STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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 000	INITIAL COMMENTS VKK 6/29/17 Correction date 6.9.17 The following deficiencies relate to the investigation of complaint #67877 & #68262. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000	Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 279	**F-279 DEVELOPMENT COMPREHENSIVE CARE PLANS** The facility does develop and implement a comprehensive person-centered care plans for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. Resident #3 care plan has been updated to include a turning and repositioning program which includes rest periods in bed 1-2 x daily per MD order on 2.23.17. The overnight shift has been educated to provide Resident #3 with turning and repositioning q2 hours or more frequently if the resident so desires, in keeping with the current plan of care. Resident #3 was provided with a new call light on 6.7.17 to enable increase ease of use. The overnight shift has been directed that to seek the assistance of staff on the adjoining units if Resident #3 requests turning and there is only one staff member currently available on the unit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtney Herman	Interim Administrator	06/22/2017

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

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F 279	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, the facility failed to review and revise 1 of 4 resident care plans to reflect the individual care provided by staff. (Resident #3) The facility census was 81 residents. Findings include:	F 279	All other residents who are dependent for bed mobility, per MDS assessment have had their plans of care audited and updated accordingly to reflect turning and repositioning schedules necessary to prevent pressure injury. Nursing Staff have been educated on the importance of adhering to turning and positioning schedules to prevent pressure injury. An audit tool has been created. Compliance will be audited weekly x4, monthly x2 with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. Responsible Party: DON/Designee Compliance Date: 6.9.17	

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F 279	Continued From page 2 1. The Minimum Data Set (MDS) assessment dated 3/28/17, indicated Resident #3 had diagnosis that included quadriplegia, abnormal posture, adult failure to thrive and chronic pain and the resident had a Brief Interview for Mental Status (BIMS) score of 13 of 15, indicating intact cognition. The MDS assessment documented the resident as dependent on staff with bed mobility, had impairments on both sides of his/her upper and lower extremities, was at risk for pressure ulcers and had 2 stage III pressure ulcers and 1 stage IV and as not on a turning and repositioning program. A Care Plan initiated 12/11/16, indicated the resident had focus areas that included an activities of daily living (ADL) self care performance deficit and with impaired skin related to having been a quadriplegic, preferred to stay up in wheel chair all day, with a chronic stage 4 sacral/coccyx ulcer, a chronic stage 3 left ischial ulcer and left scapula ulcer and an unstageable right thumb wound with surgical repair. The approaches included the following: a. Assistance of 2 staff with bed mobility. b. Encourage the resident to lay down between meals. Position side to side. No laying on his/her back when in bed as resident tolerated and allowed. Resident often had been non complaint and stayed up in the wheel chair for long periods of time and refused repositioning. (revised 3/17/17) A Physician Order form dated 2/23/17 at 4:00 p.m., revealed a Nurse Practitioner directed staff the resident required rest periods in bed 1-2 times	F 279		

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F 279	Continued From page 3 daily. Record review 6/8/17 at 11:30 a.m., revealed no directive on the resident's repositioning expectations. During interview on 6/8/17 at 8:08 a.m., a Physician confirmed he/she would have expected staff to reposition the resident, while in bed as needed (PRN) and certainly upon the resident's request. During interview on 6/6/17 at 2:45 p.m., the resident stated some of the night shift staff only repositioned him/her every 3 to 4 hours and he/she wanted repositioned more often at times. The resident indicated he/she called out for staff assistance as he/she had been unable to use the call light. The resident also confirmed he/she had not been on a routine repositioning program. During interview on 6/7/17 at 12:00 p.m., the resident stated the repositioning at night remained a problem up until last night as he/she received a new call light. The resident confirmed there had been times he/she refused to be repositioned in bed because he/she had been comfortable however there had also been times there had been only 1 staff member who worked at night on his/her hallway and one person could not reposition him/her up in bed and get a pillow properly positioned behind the back so no repositioning occurred on those nights. During interview on 6/7/17 at 3:18 p.m., the resident stated he/she allowed the facility staff to reposition him/her in the wheel chair in fact he/she had been the one that asked the staff to pull him/her back in the wheel chair.	F 279		

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F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review,	F 309	**F-309 PROVIDE CARE/SERVICES FOR HIGHEST PRACTICABLE WELL-BEING** The facility does provide care the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Based on the comprehensive assessment of a resident, this facility does ensure that residents receive treatment and care in accordance with professional standards of practice and the resident's choices. Resident #3's non-pressure areas are cared for as prescribed and are measured and assessed weekly with evaluation of current course of treatment, in consult with MD/APRN. All residents in the facility had full body audits completed by 6.9.17 to ensure that there were no areas that were not addressed in the residents' plans of care. No such areas were identified. Nursing Staff have been educated on the professional standard and facility expectation when identifying new non-pressure skin conditions. These expectations include: 1. Assessment of area and root cause. 2. Completion of incident report. 3. Notification of MD. 4. Notification of Resident Representative. 5. Obtaining appropriate treatment order. 6. Completing a non-pressure skin sheet.	

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F 309	Continued From page 5 resident, staff and physician and wound care nurse interviews and facility policy review, the facility failed to provide timely resident assessments and interventions to maintain the resident's highest physical well being for 1 of 4 residents reviewed (Resident #3). The facility identified a census of 81 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 3/28/17 indicated Resident #3 had diagnosis that included anemia, peripheral vascular disease (PVD), multi-drug resistant organisms, wound infection, quadriplegia, abnormal posture, adult failure to thrive and chronic pain. The assessment revealed he/she scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS assessment revealed the resident as dependent on staff with bed mobility; with impairments on both sides of his/her upper and lower extremities, at risk for pressure ulcers and with 2 stage 3 pressure ulcers and 1 stage four and as not on a turning and repositioning program. A Care Plan initiated 12/11/16 indicated the resident had focus areas that included an activities of daily living (ADL) self care performance deficit and with impaired skin related to having been a quadriplegic, preferred to stay up in wheel chair all day, with a chronic stage 4 sacral/coccyx ulcer, a chronic stage 3 left ischial ulcer and left scapula ulcer and an unstageable right thumb wound with surgical repair. The	F 309	An audit tool was created. Compliance will be audited weekly x4, monthly x2 with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. Responsible Party: DON/Designee Compliance Date: 6.9.17	

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F 309	Continued From page 6 approaches included the following: a. Assistance of 2 staff with bed mobility. b. Administer treatments as ordered and monitor for effectiveness. c. Blue/green positioning pillow under the right arm when in bed. The Occupational Therapy (OT) would have liked the pillow placed at all times but the resident refused to use the pillow when up in the wheelchair. d. Encourage the resident to lay down between meals. Position side to side. No laying on his/her back when in bed as resident tolerated and allowed. Resident often had been non complaint and stayed up in the wheelchair for long periods of time and refused repositioning (revised 3/17/17). e. Padded mitt with velcro for positioning of the right arm when in the wheel chair. f. The resident required a pressure reducing mattress and wheel chair cushion. A Injury/Incident Report form dated 2/22/17 at 10 a.m. indicated the resident rubbed his/her right thumb on the call light multiple times and obtained an open area. Review of the facilities Progress Notes form dated 2/17/17 at 7:48 p.m. through 2/22/17 at 2:48 p.m. revealed no assessment of the resident's right thumb. Review of the facilities Progress Notes form dated 2/22/17 at 3:40 p.m., revealed the resident obtained an open area on his/her right thumb by	F 309		

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F 309	Continued From page 7 rubbing the thumb on his/her call light and the Physician had been notified at that time. The documentation revealed no measurements or a thorough assessment of the wound. According to a N*Weekly Nursing Skin Assessments form dated 2/20/17 at 6 a.m., the facility staff observed a 3 centimeter (cm) x (by) 2 cm open area on the resident's right thumb. A Physician's Order form dated 2/23/17 at 4 p.m., revealed a Nurse Practitioner directed the staff the resident required assistance of staff with trimming of his/her finger nails. According to N-Non Pressure Wound Sheet forms the Resident had a right thumb ulcer that measured as follows: a. 2/28/17 - 2.0 cm x 2.8 cm, no depth, tunneling or undermining, a moderate amount of serosanginous drainage, beefy red granulation and normal surrounding skin. b. 3/7 - 1.7 x 2.2 - no depth, tunneling or undermining, a moderate amount of serosanginous drainage, beefy red granulation, epithelial cells filling in at the edges, and with the entire thumb as edematous. c. 3/14 - 1.8 x 2.2 - no depth, tunneling or undermining, a moderate amount of serosanginous drainage, beefy red granulation and with the entire thumb as edematous. d. 3/20 - 2.0 x 2.9 - no depth, tunneling or undermining, a large amount of serous drainage, beefy red granulation and with the entire thumb as edematous.	F 309		

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F 309	Continued From page 8 A History and Physical form dated 3/15/17 at 10 a.m. documented the resident's symptoms to his/her right thumb began on 2/20/17 with what had been then at an open wound the IP joint (end joint of the thumb) exposed and necrotic bone. The Physician discussed treatment options and the resident agreed to a partial amputation of the right thumb. An Operative Report form dated 3/21/17 indicated the Physician performed a right thumb amputation. A Pathology Report form dated 3/23/17 at 5:42 p.m. indicated the resident received a right thumb amputation with diagnosis that included the following: a. A necrotic ulcer with underlying acute osteomyelitis. b. Excision margins grossly free of the ulcer. During an interview 6/6/17 at 2:45 p.m., the resident indicated he/she received a skin tear while he/she used a call light and did not know it because he/she felt no pain and the next thing he/she knew the wound had been to the bone and the physician took of the thumb. During an interview 6/7/17 at 12:00 p.m., the resident stated in a way he/she had been upset about the amputation of the right thumb and in a way he/she had to accept it. During an interview 6/7/17 at 11:16 a.m., the Director of Nursing (DON) confirmed Staff A, Licensed Practical Nurse (LPN) observed the abrasion on the resident's right thumb on Friday 2/17/17, placed a Band-Aid to the site but failed to perform a nursing assessment of the area and/or	F 309		

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F 309	Continued From page 9 report the area to any other staff member. On 2/22/17 the resident's granddaughter asked Staff B, LPN to change the dressing on the resident's thumb. The DON confirmed the first assessment had been performed on 2/22/17 with proper follow-up. During an interview 6/7/17 at 12:24 p.m., Staff A confirmed she could not remember the day but it had been a Friday when an aide told her the resident had blood on his/her shirt. The staff member assessed the resident and found a small, (as she pointed to the end of a pen which measured 0.4 and 1/2 cm) superficial skin tear with no drainage on the resident's anterior right thumb which she covered with a Band-Aid. The staff member stated she failed to assess the area and follow through per facility policy because she had been unaware of the policy. The staff member also confirmed she failed to report the incident to the next shift. During an interview 6/7/17 at 9:54 a.m., Staff B confirmed the resident's granddaughter found the bandage and requested she look at the area. The staff member felt there had been a white telfa pad that covered the area but really could not recall however she remembered there had been sanguineous drainage present, no treatment ordered for the area and she had been unaware who placed the bandage. During an interview 6/7/17 at 8:08 a.m., a Physician confirmed the following: a. The resident had predisposing factors that may have contributed to the amputation such as	F 309		

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F 309	Continued From page 10 contractures and his/her medical condition however, the facility staff should have assessed the area immediately and notified the office as a means to properly treat the area immediately b. He/she had not been aware if the amputation could have been avoided however the resident would have had a better chance to save his/her thumb if assessed and treated when the area had been first observed. During an interview 6/8/17 at 12:44 p.m., a wound care nurse practitioner confirmed the following: a. He/she would have expected staff to report the resident's skin tear to a Physician and/or himself/herself as the area may have started as a skin tear however over any bony prominence could change to pressure related. So, in light of the location and the resident's medical condition the area should have been reported. He/she had been unaware if it would have changed the outcome but at least there would have been eyes on the area. b. The first time he/she observed the area had been on 2/23/17. c. Any medical change with the resident warranted medical attention right away. d. He/she had been concerned because the resident's finger nails had been long, rough and jagged and with the resident's compromised medical condition and contractures that put him/her at risk for pressure related injuries. According the facilities Policy and Procedure Manual form dated 1/09, the purpose had been to assure each resident with a pressure ulcer/wound received the necessary treatment and services to promote healing, prevent infection and prevent	F 309		

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F 309	Continued From page 11 new ulcers/wound from developing. The protocol included the following: a. An initial assessment would have been performed by a designated wound nurse at admission or if the ulcer/wound had not been present at admission, at the time of the discovery of the ulcer/wound. The assessment included the following: 1. Type 2. Location 3. Peri-wound condition 4. Size i. Length ii. Width iii. Depth 5. Undermining 6. Sinus tracts 7. Tunneling 8. Exudates 9. Odor 10. Necrotic tissue 11. Pain 12. Presence or absence of granulation tissue and epitheliazation.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident, staff and physician interview, the facility failed to ensure staff properly trimmed 1 of 4 resident's finger nails. (Resident #3) The facility census was 81 residents.	F 312	**F-312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** The facility does provide necessary services to maintain good nutrition, grooming, and personal and oral hygiene for residents who are unable to carry out activities of daily living.	

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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
F 312	Continued From page 12 Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/28/17, indicated Resident #3 had diagnosis that included quadriplegia, abnormal posture, adult failure to thrive and chronic pain and the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS assessment documented the resident as dependent on staff with bed mobility and had impairments on both sides of his/her upper and lower extremities. A Physician Order form dated 2/23/17 at 4:00 p.m., revealed a Nurse Practitioner directed staff to assist the resident with trimming of all fingernails. Observation on 6/1/17 at 12:05 p.m., revealed the resident's finger nails on both hands as rough, long and jagged. Observation on 6/6/17 at 10:23 a.m., revealed the resident's finger nails on both hands as rough, long and jagged. During observation and interview 6/6/17 at 2:45 p.m., the resident's finger nails on both hands as rough, long and jagged with the left pointer finger embedded in the skin of the resident's edematous thumb however no open area had been present. The resident stated staff cut his/her fingernails the day prior. During interview on 6/8/17 at 8:08 a.m., the Physician confirmed he/she would have expected staff to properly trim the resident's fingernails, especially the left pointer finger nail pressed onto	F 312	Resident #3's nails have been trimmed/filed. Resident #3 has very thick/long quicks so it is not possible for nails to be trimmed as close as desired without incurring pain or injury. The care plan has been updated to address this as well as the need for filing to prevent jagged edges that may cause injury. All residents have had their nails assessed to ensure that they are clean, smooth, and trimmed to their individual preferences. Nursing Staff have been educated that nail care is part of ADLs and is to provided weekly with showers and prn. An audit tool has been created. Compliance will be audited weekly x4, monthly x2 with results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. Responsible party: DON/Designee Compliance Date: 6.9.17	

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	165580	A. BUILDING _____ B. WING _____	C 06/08/2017

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F 312	Continued From page 13 the edematous skin of the left thumb. During interview on 6/8/17 at 12:44 p.m., a wound care nurse practitioner confirmed the resident's fingernails had been typically rough, long and jagged and was concerned long finger nails put him/her at risk for pressure related injuries.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident, staff and physician interview, facility policy review, the facility failed to promote the healing of current pressure sores for 1 of 4 residents reviewed and failed to provide measures to reduce the potential for the development of additional or worsening pressure ulcers for 1 of 4 residents reviewed with pressure sores (Resident #3). The facility identified a	F 314	**F-314 PRESSURE SORES** The facility does and will continue to ensure that a resident who enters the facility without pressure sores does not develop pressure sores do not develop unless the individual's clinical condition demonstrates that they were unavoidable and that residents having pressure sores receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident #3's pressure areas are cared for as prescribed and are measured and assessed weekly with evaluation of current course of treatment, in consult with MD/APRN. All residents in the facility had full body audits completed on 6.9.17 to ensure that there were no pressure areas that were not addressed in the residents' plans of care. No such areas were identified.	

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F 314	Continued From page 14 census of 81 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 3/28/17 indicated Resident #3 had diagnosis that included anemia, peripheral vascular disease (PVD), multi-drug resistant organisms, wound infection, quadriplegia, abnormal posture, adult failure to thrive and chronic pain. The assessment revealed he/she scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS assessment revealed the resident as dependent on staff with bed mobility, with impairments on both sides of his/her upper and lower extremities, at risk for pressure ulcers and with 2 stage 3 pressure ulcers and 1 stage four and as not on a turning and repositioning program. A Care Plan initiated 12/11/16 indicated the resident had focus areas that included an activities of daily living (ADL) self care performance deficit and with impaired skin related to having been a quadriplegic, preferred to stay up in wheelchair all day, with a chronic stage 4 sacral/coccyx ulcer, a chronic stage 3 left ischial ulcer and left scapula ulcer and an unstageable right thumb wound with surgical repair. The approaches included the following: a. Assistance of 2 staff with bed mobility. b. Administer treatments as ordered and monitor for effectiveness. c. Blue/green positioning pillow under the right arm when in bed. Occupational Therapy (OT) would have liked the pillow placed at all times but the resident refused to use the pillow when up in the wheel chair.	F 314	The facility does measure skin issues on admission and weekly. The facility will review prescribed treatments for pressure injuries a minimum of every two weeks in the event that the pressure injury has made no progress towards healing. Nursing Staff have been educated on professional standards and facility expectation for pressure injury prevention and interventions to promote healing. An audit tool was created. Compliance will be audited weekly x4, monthly x2 with the results forwarded to the Quality Assessment and Assurance Committee for further review and recommendation. Responsible Party: DON/Designee Compliance Date: 6.9.17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 15 d. Encourage the resident to lay down between meals. Position side to side. No laying on his/her back when in bed as resident tolerated and allowed. Resident often had been non complaint and stayed up in the wheel chair for long periods of time and refused repositioning (revised 3/17/17). e. Padded mitt with velcro for positioning of the right arm when in the wheel chair. The resident required a pressure reducing mattress and wheel chair cushion. A Weekly Wound Assessment MGM form from a previous facility dated 11/29/17 indicated the resident's wounds measured as follows: a. Left gluteal fold - 2 centimeters (cm) x (by) 0.5 cm and 1.3 cm deep, erythema, maceration, no tunneling or undermining and a small amount of serosanginous drainage. b. Coccyx - 5 cm x 3 cm and 2 cm deep, 1.0 cm undermining at 2 o'clock and 0.5 cm at 5 o'clock, no tunneling or exudate. A N-Nursing Admission Assessment - V 1 form dated 12/7/16 indicated the resident had a coccyx and left buttock wound area that required an assessment by the Nurse Practitioner or the wound care nurse. Review of the facilities Progress Notes dated 12/7/17 at 8:40 p.m. failed to reveal an assessment of the resident's coccyx and/or left buttock ulcered areas. Review of the facilities N-Pressure Ulcer Wound Sheet - V2 forms revealed the following:	F 314		

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F 314	Continued From page 16 a. 12/12/16 at 6:30 a.m. - A left ischial ulcered area that measured 2.5 cm x 1.0 cm and 1.8 cm deep, tunneling at 1.8 cm in the crevice of the wound, a moderate amount of serosanginous drainage, no tissue description and normal surrounding skin. b. 12/12/16 at 6:30 a.m. - A coccyx ulcered area that measured 6.0 cm x 2.5 cm and 2.2 cm deep, undermining 1.0 cm along all edges of the wound, a moderate amount of serosanginous drainage, no tissue description and normal surrounding skin. During an interview 6/6/17 at 3:30 p.m., the Director of Nursing (DON) confirmed there had been no admission nursing assessment of the resident's ulcered areas and she would have expected the staff to assess the areas if not that day the next day. A Physician's Order form dated 2/23/17 at 4 p.m., revealed a Nurse Practitioner directed the staff the resident required rest periods in bed 1-2 times daily. During an interview 6/6/17 at 2:45 p.m., the resident stated some of the night shift staff only repositioned him/her every 3 to 4 hours and he/she wanted repositioned more often at times. The resident indicated he/she called out for staff assistance as he/she had been unable to use the call light however, there had been times no staff responded and he/she had not been on a routine repositioning program. During an interview 6/7/17 at 12:00 p.m., the resident stated the repositioning at night	F 314		

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F 314	Continued From page 17 remained a problem up until last night because he/she received a new call light. The resident confirmed there had been times he/she refused to be repositioned in bed because he/she had been comfortable however, there had also been times there had been only 1 staff member who worked at night on his/her hallway and one person could not reposition him/her up in bed and get a pillow properly behind the back so repositioning had not occurred on those nights. During an interview 6/7/17 at 3:18 p.m., the resident stated he/she allowed the facility staff to reposition him/her in the wheelchair in fact he/she had been the one that asked the staff to pull him/her back in the wheelchair. During an interview 6/8/17 at 8:08 a.m., a Physician confirmed he/she expected staff to reposition the resident as needed (PRN) when in bed and certainly upon the resident's request. The Physician also confirmed staff should have properly assessed the resident's ulcered areas upon admission to the facility especially with his/her compromised medical condition. During an interview 6/8/17 at 12:44 p.m., a wound care nurse practitioner confirmed the following: a. He/she expected staff to reposition the resident every 2 hours even if the resident had been positioned on the alternating air flow mattress. b. He/she confirmed there had been times the resident refused to go to bed during the day however, the staff should have still repositioned him/her in the wheelchair and/or shift positions. c. Any medical change warranted medical	F 314		

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F 314	Continued From page 18 attention right away for the resident. d. He/she had been concerned related to the resident's compromised medical condition and contractures long finger nails put him/her at risk for pressure related injuries. According the facilities Policy and Procedure Manual form dated 1/09, the purpose had been to assure each resident with a pressure ulcer/wound received the necessary treatment and services to promote healing, prevent infection and prevent new ulcers/wound from developing. The protocol included the following: a. An initial assessment would have been performed by a designated wound nurse at admission or if the ulcer/wound had not been present at admission, at the time of the discovery of the ulcer/wound. The assessment included the following: 1. Type 2. Location 3. Peri-wound condition 4. Size i. Length ii. Width iii. Depth 5. Undermining 6. Sinus tracts 7. Tunneling 8. Exudates 9. Odor 10. Necrotic tissue 11. Pain 12. Presence or absence of granulation tissue and epitheliazation.	F 314		