MAY 0 3 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING ______ B. WING ______	C 03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F 272 1. Corrective action has been accomplished for the alleged deficient practice by assessing Resident #5's risk for developing pressure ulcers and completion of the Care Area Assessment (CAA) related to pressure ulcers. The Admission Assessment MDS with ARD 3/12/13 for resident #5 was modified on 3/25/13 to include the Stage IV pressure ulcer and to include the Care Area Assessment related to pressure ulcers. 2. Residents admitted with pressure ulcers have the potential to be affected by the same alleged deficiency. The Resident Care Management Director (RCMD) or Designee reviewed the most recent MDS completed for residents admitted with pressure ulcers, during the last 30 days, to verify accurate assessment of pressure ulcer risk and completion of Care Area Assessments related to pressure ulcers by April 17, 2013. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Re-education by the RCMD or Designee, for Licensed Nurses completing the MDS, on accurate assessment and coding of the Section M of the MDS and completion of the associated Care Area Assessment for pressure ulcers by April 17, 2013. The RCMD or Designee will randomly review 10 MDSs weekly for 12 weeks to **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 5/1/13

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess a stage four pressure ulcer on the admission Minimum Data Set, failed to assess the risk of developing pressure ulcers and failed to accurately complete the Care Area Assessment for pressure ulcers for one (Resident #5) of one sampled residents. The findings included: The admission Minimum Data Set (MDS) dated 3/12/13 recorded Resident #5 as having short term memory problems and no behavior problems. This MDS recorded the functional status of Resident #5 as requiring extensive assistance by one staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Review of the information under " Skin Conditions " for this MDS revealed there were no unhealed pressure ulcers at stage one or higher. The assessment required the stage of the ulcer, if unstageable with a non-removable dressing, unstageable with slough and/or eschar or deep tissue injury. Other required information for this assessment included the length, width and depth of the pressure ulcer. Resident #5 was assessed as not being at risk of developing pressure ulcers. The treatments included turning and repositioning, surgical wound care and application of nonsurgical dressings. The use of a pressure reducing for the chair/bed, pressure ulcer care and applications of ointments/medications were not checked as treatments for Resident #5.	F 272	verify accurate coding of Section M and CAA completion. Discrepancies identified as a result of these reviews will be corrected weekly via modification of the MDS. 4. The RCMD will report the results of the audits and monitoring in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. 5. Date of Compliance: April 17, 2013. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/1/13

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F 272	Continued From page 2 Review of the Care Area Assessments dated 3/13/13 revealed a care plan would be developed to " provide the resident functional assistance in an effort to reduce risk of alteration in skin integrity. No alteration in skin integrity noted at time of this assessment. " Review of the initial care plan dated 3/5/13, completed on admission by the floor nurse, revealed a problem of " Skin " which listed " actual " and " potential " for pressure ulcer due to mobility, history of ulcers, incontinence, nutritional impairment and other. The nurse checked potential, and under pressure ulcers checked mobility and incontinence. The interventions checked for staff were to provide wound care/preventive skin care per order, observe wound healing, skin checks weekly per facility protocol, document findings, Notify MD of changes in wound, or emerging wounds, turn and reposition frequently to decrease pressure. The finalized care plan was not completed as of the survey date. An interview was conducted on 3/20/13 with MDS nurse #2 at 1:55 PM. During the interview he was asked to explain the process he uses to obtain the information used on the MDS. MDS nurse #2 replied he used the medical record and " the most recent information " which was a " skin tear. " MDS nurse #2 explained he did not view Resident #5 ' s wounds before doing the MDS assessment, and he had not reviewed the medical records from the hospital, or the nurse practioner ' s progress note. Both of these documents recorded a pressure ulcer. He was asked if he had received communication from the	F 272		

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F 272	Continued From page 3 nurses or administrative nurses informing him Resident #5 had a stage 4 pressure ulcer. He responded he was not aware of a pressure ulcer. It was explained the MDS computer had the forms used for wound reports on a " shared drive. " He could access those for information about the wounds. He was asked if he had received a report on 3/6/13 and he stated he would check his office. The copy of the report dated 3/6/13 received from Administrative Nurse #1 was shared with MDS nurse #2. This report listed Resident #5 as having a stage four pressure ulcer on the right elbow. Upon return from his office, MDS nurse #2 gave a copy of the wound report dated 3/6/13 and Resident #5 was not on the list of residents with pressure ulcers. He could not account for the discrepancies in the reports dated the same date. Review of the wound physician ' s report dated 3/13/13 with MDS nurse #2 revealed he would have documented the right elbow wound as " unstageable. " The wound would not have been a stage four until after debridement due to the slough covering the wound bed. Further interview with MDS nurse #2 revealed he was not aware of a blanchable reddened area on the coccyx of Resident #5. MDS nurse #2 stated the wound should have been documented on the admission MDS as an unstageable wound and interventions put in place. Interview with MDS #1 on 3/20/13 at 2:15 PM revealed the reports are updated throughout the day. She was asked at what point the MDS nurses would be aware of the changes to ensure accurate information was on the MDS. She replied the MDS nurses would need to review the	F 272		

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F 272	Continued From page 4 report daily.	F 272	F 309 1. Resident #4 was discharged to an acute care facility on 3/3/2013.	5/1/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to assess and monitor a resident ' s change in condition for 1 of 5 sampled residents. (Resident #4) who had gross hematuria and hypotension 3 days prior to being sent to the hospital. Findings include: Resident #4 was admitted to facility on 2/23/13 and discharged to the hospital on 3/3/13. Resident #4 had a history of hematuria, when he was admitted to the facility on 2/23/23 his urine was amber colored. It wasn ' t until his fall on 2/28/13 that the resident had gross hematuria, from 2/28/13 to 3/3/13 his blood pressure began dropping and at discharge on 3/3/13 Resident #4 had a blood pressure of 67/50. Admission diagnosis included Hematuria, Hyponatremia, Urinary Tract Infection, Staphylococcus Aureus Bacteremia, not Methicillin Resistant Staphylococcus Aureus,	F 309	2. Residents with an acute change of condition have the potential to be affected by the same alleged deficiency. The Director of Nursing (DON) or Designee will review the 72 hour reports completed during the last 30 days to verify residents with an acute change of condition have been assessed and received intervention as required by April 17, 2013. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: Re-education by the Staff Development Coordinator (SDC) or Designee for Licensed Nurses regarding assessment, intervention, and documentation related to an acute change of condition by April 17, 2013. During the Clinical Meeting the Director of Nursing (DON) or Designee will review the 24 hour reports, Physician Orders, and any documented change of condition received to identify residents with an acute change of condition 4 times per week. The DON or Designee will verify required assessment, intervention and documentation related to identified acute changes of condition 4 times per week. 4. The Director of Nursing will report the results of the audits and monitoring in the monthly Quality Assurance Performance **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 5 Prostatic Hypertrophy, Acute Pulmonary Embolism, History of Alcohol Abuse, Anemia with Acute Blood Loss Secondary to Hematuria, Chronic Congestive Heart Failure. The discharge summary on 2/23/13 from named hospital indicated that the lab values were, White Blood Count 9.8, Hemoglobin 11.6, Platelets 188, Blood Urea Nitrogen 5, Creatinine .66. and the hospital course was Hematuria, the patient was noted to have significant hematuria with drop in Hemaglobin consistant with acute blood loss anemia. Resident #4 was seen in consultant with urology who ultimately had to place the Foley catheter secondary to difficult placement. Resident #4 did continue to have Hematuria, however it did improve. Resident #4 was transfused packed red blood cells and remained stable. Resident #4 was discharge to Skilled Nursing Facility on 2/23/13 and was to follow up with urology the next week. The Minimum Data Set with an Assessment Reference Date of 3/2/13 had Bladder and Bowel coded Indwelling catheter and coded frequency of pain or possible pain in the last 5 days, none of these signs observed or documented. The History and Physical dated 2/26/13 completed by the physician indicated that the resident was admitted with new anemia, found to be chronic. Assessment and plan for chronic anemia indicated to follow for now. Blood pressure documented to be 116/78 Pulse 72. History of Hematuria. The Nursing Admission Assessment documented	F 309	Improvement (QAPI) Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. 5. Date of Compliance: April 17, 2013. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/1/13

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F 309	Continued From page 6	F 309		

by nurse # 2 on 2/23/13 indicated a blood pressure of 109/74, pulse 93 and Resident #4 was incontinent with a foley catheter draining dark amber urine.

According to the documentation from Nurse #1 dated 2/23/13 at 1:00 am, indicated that urine was yellow. On 2/24/13 at 1:00 am, Nurse #1 documented that the urine was dark amber with hematuria and blood pressure was 120/74 and on 2/25/13 urine was dark amber with hematuria and blood pressure was 121/78. There was no documentation found on the Nursing Daily Skilled Summary for 2/26/13 or 2/27/13 regarding resident ' s foley catheter or appearance of urine.

A Nursing Daily Skilled Summary could not be located for 2/28/13. The careplan was updated on 2/28/13 and indicated that resident was observed on the floor after trying to go to the bathroom without injury at 9:30 pm. On 3/1/13 the fall was reviewed in weekly meeting and indicated that Resident #4 attempted to get out of bed, go to the bathroom unassisted and fell to floor pulling catheter. Resident #4 was bleeding from catheter and penile site on 2/28/13.

On 3/1/13 Nurse #4 documented at 10:30 am that the foley was patent and draining bloody urine, bright red in bag and a call was placed to urology and a message was left on the nurse line with details of urine condition. The blood pressure documented on the Vital Sign and Flow Sheet for 3/1/13 was 90/66. At 2:00 pm a second call was placed to urology and an order was received to do a stat CBC (Complete Blood Count). Nurse #4 indicated that she notified the physician, but failed to document the notification in the record.

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On 3/2/13 at 8:00 pm Nurse #1 documented on a change of condition form that Resident #4 became diaphoretic and hypotensive with decreased level of conciousness when resident got up from wheelchair. Blood pressure 82/66. At 12:00 am Nurse #1 emptied 250 cc of bright red drainage from foley catheter. On 3/3/13 at 5:30 am Nurse #1 documented that Resident #4 continues to have bright red drainage around foley requiring changing every 2 hours. At 11:30am physician ordered a 2nd CBC (Complete Blood Count) and to push fluids. At 1:20 pm the daily skilled summary indicated that the resident reported to the med tech that he continues to have blood coming from his penis and around catheter , blood pressure 67/50, resident reports he feels weak and not good. Hemoglobin is 8.1 and resident was sent to emergency room.

Resident #4 was discharged to named hospital on 3/3/13 and readmitted to the facility on 3/16/13. The hospital discharge summary dated 3/16/13 indicated that the resident was presented to the emergency room secondary to recurrent hematuria as well as hypotension. The resident received 8 units of packed red blood cells, blood pressure in emergency room was 80/40. Re-admission diagnosis is prostate adenocarcinoma . The Nursing Admission Assessment for 3/16/13 indicated that resident does not have a foley catheter and he is resting without complaints of pain or discomfort. No bleeding noted in diaper.

During an interview with medication aide #3 on 3/20/13 at 2:45 pm, she indicted that on 3/3/13 the resident was bleeding around his catheter

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and that the resident reported that he did not feel good and that he felt cold. The nurse asked her to take the residents ' blood pressure every hour and she did as requested. She then documented it on a piece of white paper and gave it to the nurse, medication aide #3 reported that she obtained about 4 blood pressures and that she noticed that the blood pressures were going down and she let the nurse know. Medication aide #3 also indicated that she noticed dark red blood for about 3 days prior to Resident #4 discharge to the hospital.

During an interview with Nurse #2 on 3/20/13 at 12:00 pm, she indicated that she did not notice a change in the resident ' s urine until the night he pulled his catheter, when he fell. The urine was amber in color and after he pulled his catheter the urine became bright red. Nurse #2 also reported that she contacted the physician and the family on 2/28/13 and she knows that she did an incident report, but she can not remember if she documented it in the nurses notes or not.

During an interview on 3/20/13 at 11:00 am, the Medical Director indicated that the nurses will call his cell phone that he has with him at all times. He reported that the nurses are beginning to text him, which is working well. When asked, what is your expectation of the nurses when there is a change in condition? He indicated that the nurses are to notify him of any changes in condition, but they are free to use their evaluation and judgement and send the resident to the hospital if the family agrees. The Medical Director could not remember or recall Resident #4 having a fall or change in condition.

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F 309	Continued From page 9 During an interview on 3/20/13 at 3:40 pm, the Director of Nurses reported that if a resident has a change in condition, the residents are evaluated and we try to get our physician to do interventions at the facility unless hospitalization is required then we send them to the hospital. Observation of Resident #4 on 3/20/13 at 1230pm revealed resident resting in bed. He indicated that if he needed help he would use the call bell and get assistance to the bathroom. He had no concerns to report.	F 309	F 314 1. Corrective action was accomplished for the alleged deficient practice for by the Director of Nursing (DON) for Resident #5 by completing an assessment of the pressure ulcer, initiating treatment orders and implementing preventative measures for pressure ulcers on 3/23/2013. 2. Residents with pressure ulcers, including new admission and re-admission, have the potential to be affected by the same alleged deficiency. The Director of Nursing (DON) or designee will identify current residents, including new admissions and re-admissions, with pressure ulcers, verify current assessment and review physician's orders to verify appropriate treatments and preventative measures are in place by April 17, 2013. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Staff Development Coordinator (SDC) or Designee will re-educate Licensed Nurses on the assessment, treatment, prevention, and documentation related to residents with pressure ulcers by April 17, 2013. The DON or Designee will review current residents and new admissions with pressure ulcers weekly for 12 weeks to verify appropriate assessment, treatment, implementation of preventative measures, and documentation of pressure ulcers. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/1/13
F 314 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to assess the wound as a pressure ulcer and provide treatment on admission of a pressure ulcer and failed to implement preventative measures for one (Resident # 5) of one sampled residents with a pressure ulcer. The findings included:	F 314		

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F 314	Continued From page 10 Review of the " Skin Management " policy dated 8/12, page 7 of 12, included suggested care instructions for a stage 4 pressure ulcer. " #2. Special emphasis is used to avoid any pressure over the wound as much as possible. Site of wound is avoided during position changes. Thirty-degree (30 degree symbol) oblique positioning of resident may be effective if tolerated by the resident. #4. Licensed Nurse to assess weekly and document progress. " Resident # 5 was admitted to the facility on 3/5/13 with diagnoses including neck fracture with surgical repair, dysphagia requiring tube feedings, coronary artery disease, hypertension, arthritis and chronic obstructive pulmonary disease. The Nursing Admission Assessment dated 3/5/13 recorded " Resident has a skin tear to R (right) elbow. " The Nursing Admission Assessment for " Braden Scale - For Predicting Pressure Sore Risk dated 3/6/13 recorded a score of 13 which indicated a high risk for developing pressure ulcers. The nurse assessed " Additional Risk Factors " of urinary and/or fecal incontinence, nutrition/hydration deficits. The nurse assessed the " Skin Condition " as " warm, bruises/ecchymosis, and skin tear. " The area of " Pressure Ulcer was not checked as yes or no. The stages of pressure ulcers for stage one, two, three or four were not checked. A drawing of a body with instructions to " Mark the locations of skin conditions/wounds on illustrations below " included the gastrostomy tube site, a bruise on the back of the left hand , a scab on the back of the right hand and a " skin tear " on the back of	F 314	During the Clinical Meeting the DON or Designee will review Physician Orders received to identify residents admitted with pressure ulcers or newly acquired pressure ulcers and verify assessment, treatment, prevention and documentation of pressure ulcers, 4 times per week. 4. The Director of Nursing will report the results of the audits and monitoring in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. 5. Date of Compliance: April 17, 2013. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/1/13

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

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the right elbow. The signature box on the front of this assessment form was blank.

Review of the admission orders dated 3/5/13 and signed by the physician revealed a treatment to the gastrostomy tube. There were no other orders for treatments on the day of admission. The orders were signed by Nurse #4.

Review of a telephone order dated 3/6/13 instructed the nursing staff to have the wound care physician see the right elbow wound. There were no orders for treatment of the wound. The orders were signed by Nurse #4.

Review of a progress note by a nurse practioner dated 3/6/13 revealed Resident #5 had an area on the right elbow, measuring 1.5 centimeters, full thickness ulcer with no drainage and surrounding area had no redness.
Review of a nurse's notes dated 3/6/13 at 7:00 PM written by Nurse #2 revealed Resident #5 had a " skin tear to R elbow. "

Review of a telephone order dated 3/8/13 revealed nursing staff were to clean the right elbow with normal saline, apply Santyl and a dressing every day. The skin tear to the right arm was to be cleaned with normal saline and apply a dressing every day. The signature of Nurse #3 was the signature of the nurse receiving the order.

Review of the Treatment Administration Record (TAR) for the dates of 3/5/13 to 3/8/13 revealed no treatments were documented as being provided to the pressure ulcer on the right elbow until 3/8/13. The treatment ordered on 3/8/13

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was provided per the nurse's initials on the TAR for the dates of 3/8/13 and 3/9/13. The treatment order to clean the right elbow with normal saline, apply Santyl and dressing every day were crossed out with no date,
nurse's initials or explanation. Review of the orders revealed no order was obtained to discontinue this treatment. There were no new orders to use a different treatment to the right elbow after discontinuing the current treatment.

Review of the TAR for 3/10/13 and 3/11/13 revealed the nurses did not initial the TAR indicating the treatment was provided to the pressure ulcer on the right elbow.

Review of an assessment " Head To Toe Skin Checks " for the date of 3/11/13 revealed a skin tear was identified on the right elbow. A wound was not identified on the right elbow. The nurse signature for completion of this assessment was Nurse #2.

The admission Minimum Data Set (MDS) dated 3/12/13 recorded Resident #5 as having short term memory problems and no behavior problems. This MDS recorded the functional status of Resident #5 as requiring extensive assistance by one staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Review of the information under " Skin Conditions " for this MDS revealed there were no unhealed pressure ulcers at stage one or higher. Resident #5 was assessed as not being at risk of developing pressure ulcers.

Review of the " Medical Nutritional Therapy Review " completed by a registered dietician on

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F 314	Continued From page 13 3/12/13 revealed a skin condition of " skin tear noted R elbow per nursing. " A multivitamin was ordered every day to prevent further skin breakdown. Review of the Care Area Assessments dated 3/13/13 revealed a care plan would be developed to provide the resident functional assistance in an effort to reduce risk of alteration in skin integrity. " No alteration in skin integrity noted at time of this assessment. " There was no initial care plan for a problem of " actual " wounds for Resident #5. Review of the TAR revealed instructions for a treatment to the right elbow. The instructions included cleaning the wound with normal saline and applying hydrogel every day on 7-3 shift. This treatment was initialed as being provided on 3/12, 3/14, 3/18 and 3/19/13. Review of the orders revealed no orders for this treatment were obtained. Nurse #3 wrote the orders on the TAR. Review of a progress note by the wound physician dated 3/13/13 revealed a wound on the right elbow that measured length 1 centimeter (cm) by width 1 cm by depth 0.1cm. The cause of the wound was " pressure. " There was serous exudates with 20% necrotic tissue and 80% granulation tissue. Additional information included " bony exposure. " The wound stage was a 4. Surgical debridement was performed to remove the necrotic tissue. The depth of the wound increased to 0.2 cm after debridement. The wound physician recorded the dressing to the pressure ulcer was " Bactroban, dry protective dressing, Santyl once daily. "	F 314		

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F 314	Continued From page 14 Review of the " Head To Toe Skin Checks " dated 3/18/13 revealed the skin intact was check as " No " and the areas listed were right elbow, gastrostomy tube, skin tear right upper arm and buttocks. Review of the body illustration revealed there was an open area at the right elbow and on the coccyx. The nurse signature for completion of this assessment was nurse #3. Review of a telephone order dated 3/19/13 revealed the buttocks were to have an application of barrier cream each shift. Review of a telephone order dated 3/20/13 revealed " Clarification of 3/8/13 " Clean right elbow with normal saline apply Santyl and dry dressing every day. This was a telephone order from the primary physician. Observations on 3/20/13 at 10:00 AM revealed Nurse # 3 removed the gauze dressing from the right elbow wound. The gauze was stuck to the wound bed. Nurse #3 moistened the gauze with normal saline two times to remove it. The area was cleansed with normal saline, Santyl was applied to the wound bed and gauze dressings were reapplied. Kerlix (qauze roll) was used as a cover dressing. The wound bed was yellow with scant amount of yellow drainage which had no odor. The surrounding area around the wound was dark pink. Nurse # 3 referred to the wound on the right elbow as a " skin tear. " Observation on 3/20/13 at 10:10 AM of the coccyx area revealed an irregular shaped faint outline of a border that was dark pink. The surround skin was a bright pink. Nurse #3	F 314		

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F 314	Continued From page 15 checked for blanching which occurred immediately. You could see the coccyx bone outline under the skin. An interview with Nurse #3 was conducted on 3/20/13 at 11:20 AM. Nurse #3 provided treatment to the elbow pressure ulcer during the observation on 3/20/13. Nurse #3 reported Resident #5 had a skin tear on the elbow that may have occurred when he fell prior to hospitalization. Nurse #3 reported she does not stage or measure the wounds. Interview on 3/20/13 at 11:00 AM with the primary physician revealed the facility does not have standing orders for wound care. He was not aware of the wounds on Resident #5. The wound physician makes rounds and reviews the wounds. He accepted the wound physician ' s assessment and treatment for the wounds. An interview was conducted on 3/20/13 at 11:55 AM with Nurse #2. This staff member did the initial skin assessment on admission and the 3/11/13 weekly skin assessment for Resident #5. Interview revealed Resident #5 " had skin broke off " of the right elbow. This nurse did not remember any treatments she had to do for Resident #5 except the gastrostomy tube site. Nurse #2 stated she would obtain an order from the physician for wound care. Interventions for Resident #5 included turning and repositioning him in bed and applying barrier cream to the buttocks. Continued interview revealed she thought Resident #5 was " getting red on his bottom. " Nurse #2 stated pillows were used for positioning when Resident #5 was turned.	F 314		

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F 314	Continued From page 16 An interview was conducted with administrative staff #1 on 3/20/13 at 12:30 PM. This staff member provided an explanation for the wound physician documentation of the treatment and the actual written orders for treatment. Administrative staff #1 stated the Bactroban was not used on the right elbow wound. This staff member read the progress note by the wound physician and replied " he made a mistake, and the Bactroban should have been for the skin tear. I am not used to using Santyl on a skin tear. " Interview on 3/20/13 at 1:46 PM with Administrative Nurse #1 revealed either she or nurse #4 did the wound measurements and staging. The floor nurses were to report the wounds to them, and may say it is open, draining, etc. but do not stage the wound. The wound physician ' s first day to round at the facility was on 3/6/13. He did not see Resident #5 until the next week on 3/13/13. Administrative Nurse #1 stated she prepares the list of residents for the wound physician visits by reviewing the TARs. Interview with Nurse #4 on 3/20/14 at 4:05 PM revealed she had not measured or assessed the right elbow wound of Resident #5. Nurse #4 wrote the initial admission orders and signed the telephone order instructing staff to consult the wound physician for the elbow wound. Interview with MDS Nurse #2 on 3/20/13 at 1:55 PM . The most recent information in the record was used which referred to a " skin tear " and he had not viewed Resident #5 's wounds before doing the MDS assessment. Continued interview revealed he was not aware of a stage 4 pressure ulcer on the right elbow of	F 314		

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F 314	Continued From page 17 Resident #5. Interview on 3/20/13 at 2:52 PM with Nurse #3 revealed she would inform the Director of Nursing and the wound physician of any wounds on a resident. Further interview revealed she would obtain an order for wound care. The TAR was reviewed with Nurse #3 for the month of March 2013. After reviewing the TAR, Nurse #3 stated she had written the initial treatment order and provided the treatment on 3/8/13. That order had been crossed through when she wrote the second order on 3/11/13. Nurse #3 was asked where the order was located for the treatment change. Nurse #3 looked for orders for the second treatment for use of the hydrogel and was not able to locate the orders. Nurse #3 was not able to explain the lack of treatment or lack of orders for a treatment to the pressure ulcer on the right elbow. She stated she must have written the order on the wrong resident ' s TAR. Observations were made on 3/20/13 at 10:30 AM and revealed Resident #5 was in bed with his right elbow into the mattress and the head of the bed was elevated. The outstretched arm was palm side down, with the elbow joint and lateral arm bone (ulna) on the bed. There were no pillows for support under the arm to prevent the wound from pressing into the mattress. Random observations made on 3/20/13 at 12:45PM, 1:50 PM, 4:00 PM revealed Resident #5 was sitting upright with his feet on the floor in his personal recliner. The right elbow was on the arm of the chair. The arm was bent with the elbow joint and lateral side of the arm (ulna) resting on the arm of the chair. There was no	F 314		

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F 314	Continued From page 18 pillow to relieve the pressure of the wound off the chair arm. There was no special padding to the chair arm. There was no pressure reducing cushion in the seat of the chair.	F 314		