STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	06/09/2016

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 157 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on nurse practitioner interview, staff interviews, and record review, the facility failed to notify the physician of a fever for 1 of 1 residents	F 157	Immediate Action; Resident #2 no longer resides at the facility. No further actions needed for	7/8/16

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

Electronically Signed | 07/03/2016

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F 157	Continued From page 1 reviewed for elevated temperatures, Resident #2. The Infectious Disease Society of America (IDSA) revealed clinical practice guideline, updated 2008, for the evaluation of fever and infection in older adult residents of long-term care facilities as follows: Infection should be suspected in long-term care facility (LTCF) residents with: decline in functional status, new increasing confusion, incontinence, falling, deteriorating mobility, reduced food intake, or failure to cooperate with staff. Fever is defined as: 1) A single oral temperature greater than 100 F (Farenheit), or 2) repeated oral temperatures greater than 99 F, or 3) an increase in temperature of greater than 2 degrees F over the resident's baseline temperature. The Physician Standing Orders for Resident #2 included: fever - notify MD, urinary tract symptoms - notify MD. Resident #2 was admitted to the facility on 09/10/15 and discharged to the hospital on 04/19/16 with the following diagnoses: osteomyelitis, hypertension, chronic sacral pressure ulcer stage 3, colostomy, thyroid neoplasm, anemia, artificial opening of urinary tract with ureterostomy, anxiety, major depression, chronic pain, insomnia, history of urinary tract infections (UTIs), stage 2 pressure ulcer other site, paraplegia, and traumatic amputation of both legs with bilateral below the knee amputations (BKAs). Resident #2's Minimum Data Set (MDS) dated 02/22/16 revealed the resident's cognition was intact, and the resident needed extensive	F 157	resident #2 Identification of Others 100% audit of all current resident nurses notes documented between 6/1/2016 and 7/4/2016 will be reviewed on 7/5/2016 & 7/6/2016 by the DON, ADON and/or Supervisor to determine any resident with any documented condition changes, specifically; A single oral temperature greater than 100 F (Farenheit), or repeated oral temperatures greater than 99 F,(consecutive findings) or an increase in temperature of greater than 2 degrees F over the resident's baseline temperature. This audit will also capture any changes in resident's activities of daily living, decrease in oral intake as well as any change of room or roommate in that time frame. Findings will documented on the "notification of changes audit form" any negative findings will be reported to MD and Resident family promptly. Systemic Changes Effective 7/1/2016, daily, (Monday through Friday), the Director of Nursing or designated licensed nurse will review clinical documentation,24 hour report sheets, and interview with the nurses responsible for reporting the change in condition to the physician,to determine any changes of condition occurred. Findings will be documented on "notification of changes form". This system will also cover type of change happened, whether or not physician and family was notified and if not, what	

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F 157	Continued From page 2 assistance with his activities of daily living (ADLs). Resident #2's 02/22/16 care plan identified problems involving colostomy, urostomy care, and pressure ulcers. A nursing note dated 04/11/16 at 12:54 PM written by Nurse #3 documented Resident #2 was out of bed in a wheelchair. The note documented, "The resident propelled self to courtyard to smoke and socialize earlier that day in AM (morning). Resident #2 returned to desk and requested Tylenol (acetaminophen), I feel like I'm getting septic. Resident's temperature was 99.4 F. I informed resident that his Tylenol was scheduled for every 6 hours, and that his last dose was given at 8:20 AM. Resident requested PRN oxycodone, and his request was honored. Resident #2 stated, "I've been sick the last four days." I informed resident that this writer had been here the last four days and he had not mentioned anything nor displayed any illness, was getting OOB (out of bed) daily, and was alert and made needs known without difficulty. Resident's appetite was adequate and fed himself. I then asked resident #2 if he would like to go to the hospital, and resident stated, "If I don't get to feel any better, I ' ll let you know" and propelled himself to his room to watch TV." A nursing note dated 04/13/16 at 1:26 PM written by Nurse #3 documented that Resident #2 was out of bed in a wheelchair and that the resident appeared sleepy upon rounds this AM (morning.) The resident stated, "I didn't sleep all night." The 11:00 PM to 7:00 AM nurse informed this writer of resident #2's request for Tylenol at 6:10 AM. The resident also requested Tylenol at 8:20 AM. The resident was reminded of the time he received Tylenol on 11-7 (11:00 PM to 7:00 AM shift) . Patient was alert and was able to verbalize his	F 157	action(s) taken. The DON will assure that proper notification occurs when warranted. The DON will provide counseling to the employee that fails to make proper notification of change in condition. Licensed nurses will be in-serviced on the importance of reporting change in resident's condition to the physician,including elevated temperature and signs of symptoms of infection by the DON, ADON and/or Designated Registered Nurse. All current licensed nurses will be educated by 7/8/2016, any licensed nurse not educated by 7/8/2016 will not be allowed to work until educated. This education has been added to the facility orientation program for all new licensed nurses. Monitoring Process The Director of Nursing (DON) will monitor compliance by reviewing "notification of changes form" daily Monday-Friday) x 30 days, then weekly x 4weeks then monthly afterwards until 100% compliance of this system is maintained for three consecutive months. The information from the "notification of changes form" will be compiled, any identified trends will be reported monthly by the DON in the monthly Quality Assurance Performance Improvement committee (QAPI)	

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needs and wants. Resident #2 used a trapeze bar to reposition and transfer himself. Tylenol was given at 12:10 PM per patient request, and his temperature was 99.4 F. Resident was able to propel self to surroundings of choice, had no coughing or nasal drip, and his skin was warm and dry to the touch.

A nursing note dated 04/19/16 at 5:00 PM written by Nurse #2 documented that when Resident #2 was out in the courtyard that day, and a CNA had to bring the resident back inside because he was unable to propel self. The nurse observed Resident #2 had a hard time speaking, and complained of having a fever. Nurse #2 checked the resident's temperature, which was 103.3 F so, she administered 2 PRN (as needed) Tylenol. Resident #2 was observed to be leaning over in his wheelchair, had a problem staying awake, was sweating, had shortness of breath, was slow to respond, had thick mucus coming from his nose, was weak, and complained that he felt like he had pneumonia. Nurse #2 then called the on-call physician who ordered Resident #2 to the hospital. The resident was made aware of nursing order and he said he wasn't going to the hospital. The resident's responsible party (RP) spoke to him and the resident cursed him out and refused to go to the hospital. The facility had already called 911, and when they arrived, with a lot of encouragement, the resident agreed to go to the hospital. The resident refused to change his soiled clothes or put a clean shirt on, and left the facility without a shirt on.
Physician order dated 04/19/16 for Resident #2 documented to send to hospital to evaluate temperature of 103.2F.
Mediation Administration Record (MAR) for the month of 04/2016 listed vital signs to be taken

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every week on Saturday.
Resident #2's current medications 04/2016:
Tylenol 650 mg every 6 hours as needed (PRN).

Interview on 06/8/16 at 10:27 AM with Resident #2's Nurse Practitioner revealed that she had no memory of Resident #2; however, she stated it was her expectation that if a resident had a temperature of 99.0 F or greater, that the MD would be notified.

In an interview on 06/9/16 at 10:30 AM with Nurse #3 she stated it was her understanding that if Resident #2's temperature was greater than 100 F, she would notify the MD, and that she would not notify the MD for a low grade fever less than 100 F. The nurse stated if the resident had a low grade fever (less than 100 F) that there was a standing order for Tylenol to be given PRN (as needed) every 6 hours.

An interview on 06/9/16 at 11:24 AM with the Director of Nursing (DON) revealed it was her expectation that if any resident stated they were sick, a nurse would do an assessment on the resident as well as take their vital signs. The DON stated if the resident's assessment showed a fever above 100 F or a low grade fever below 100 F with symptoms, the nurse would call the MD for additional guidance, even if the resident was alert and oriented.

An interview on 06/09/16 at 12:23 PM with the DON revealed that it was her expectation that the physician be notified of a resident's fever if he had two consecutive temperatures of 99 F without symptoms, or one 99 F temperature with symptoms, or a temperature 2 degrees above the resident's baseline, or one 99 F temperature and

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F 157	Continued From page 5 the resident stated, "I think I am getting septic." An interview on 06/9/16 at 3:20 PM with Nurse #2 revealed that Resident #2 had a colostomy and ureterostomy. The nurse said Resident #2 would often disconnect his ureterostomy and would clamp it off or let the urine just run on the floor. She said she would let the resident know that once the tube was disconnected it would open him up to a possible urinary tract infection, and that he would not listen. She said Resident #2 was non-compliant with care and ADLs (activities of daily living.) Nurse #2 said on 04/19/16 Resident #2 was not acting right, was lethargic, and slow acting so she took his vital signs, noted an elevated temperature and called the on-call physician, who gave her an order to send the resident to the hospital for evaluation. She also said she notified the RP (responsible party) and physician. The nurse said Resident #2 was on her normal assignment and that he appeared normal days before 04/19/16. The nurse said on 04/19/16 the resident's change in health status was sudden, and that it was normal for her to call the physician if a resident had a temperature of 101 F or greater, or a low grade fever of 100 F or below with symptoms.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this	F 164		7/8/16

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F 164	Continued From page 6 does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to ensure the personal privacy during a pressure ulcer treatment for 1 of 3 residents reviewed for pressure ulcer treatment, Resident #32. Findings included: A review of the admission assessment dated 05/17/2016 revealed Resident #1 was admitted to the facility 05/10/16 with a partial list of diagnoses which included hypertension, diabetes mellitus, renal insufficiency. The same assessment indicated Resident #32 was at risk for pressure ulcers, but that he had no pressure ulcers present at the time of the assessment.	F 164	Immediate Action A privacy curtain was installed in Resident #32's room on 6/8/2016. Resident #32 no longer resides at the facility. No further action needed for resident #32 Identification of Others All residents residing in the facility have a potential to be affected by this alleged deficient practice. On 7/5/2016, 100% of resident rooms will be audited by the House-keeping Supervisor, Maintenance Director and/or Director of Social Services to ensure each resident bed has a capability to provide total privacy during care. Findings will be, correc documented	

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F 164	Continued From page 7 The nursing care plan which was initiated on 05/17/2016 and updated on 05/28/16 revealed Resident #32 had a goal and interventions in place to address his left heel, right heel, and sacral pressure ulcers which had developed. An observation was made on 06/08/2016 at 9:42 AM of Resident #32's pressure ulcer treatment provided by Nurse #3 and Nurse #5. The care was provided in Resident #32's private room. After Nurse #3 and Nurse #5 turned Resident #32 on his left side to provide treatment to his sacral pressure ulcer, Nurse #3 left the room to gather some additional supplies. Nurse #5 continued to provide care after Nurse #3 left the room. When Nurse #3 did not return with the necessary supplies after 10 minutes, Nurse #5 left Resident #32's bedside, approached the door to the room, opened it, and stood outside the room to locate Nurse #3. The door remained open and Resident #32 was left uncovered as he lay on his left side facing the hall with his abdomen, groin, scrotal area, and penis exposed. There was no privacy curtain in the room and there was no towel or sheet provided for privacy during the care. Nurse #5 returned to the room, waited a few more minutes for Nurse #3, then went back to the resident's door, opened it, and called for Nurse #3. The resident again lay exposed, facing the hallway. In an interview with the Corporate Consultant Nurse on 06/08/16 at 12:15 PM, he stated he did not know why there was no privacy curtain in the room as there was a track on the ceiling for one. The corporate Consultant Nurse stated that privacy should be provided for residents during care.	F 164	on "Privacy curtain audit form" and communicated to the administrator promptly. Systemic Changes Effective 7/5/2016, second staff member will be present to assist and ensure total privacy is provided for residents in private rooms that uses room door for privacy. The Director of nursing, Assistant Director of Nursing and/or designated Registered nurse conduct re-education for all current Licensed nurses and Nursing assistants on the importance of protecting the resident's privacy when rendering care, this re-education will be completed by 7/8/2016, any Licensed nurse or nursing assistant not educated by 7/8/16 will not be allowed to work until educated. Nurse #3 and #5 were counseled on 6/8/16 by the Administrator on the importance of providing privacy during wound care. This education has been added to new hires orientation for all new Licensed nurses and Certified Nursing Assistants. Monitoring Process The Activity Director will poll the residents during resident council meeting monthly for any breach in privacy, findings will be documented on resident council minutes and reported to the Administrator promptly The Director of Nurses will monitor wound care of 5 random residents weekly x 8 weeks for privacy during care. The findings of the wound care observation will be evaluated for any trends and additional	

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F 164	Continued From page 8 In an interview with Nurse #5 (the Director of Nursing) on 06/08/16 at 12:40 PM, she stated she did not realize she had left the door open when she went outside Resident #32's door. She stated Resident #32 should have been covered with a sheet or towel in order to prevent him from being exposed to the hallway at that time. Another observation of wound care was made on 06/09/16 at 2:10 PM with Nurse #3 and nursing assistant #2 (NA#2.) At the time of the observation, a privacy curtain had been installed and Nurse #3 closed the resident's door and pulled the newly installed privacy curtain before rendering care.	F 164	need for inservice training.The findings will be reported monthly by the DON during the monthly QAPI committee meeting for 3 months or until substantial compliance is achieved. The Activity Director will report the results related to resident's privacy from the resident counsel meeting during the QAPI meeting for 3 months or until substantial compliance is achieved. The results will be evaluated for identified improvement or need for additional in-service training.	
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 record review, observations, and staff interviews, the facility failed to provide complete and accurate skin assessment services to prevent the development and decline of an unstageable left heel pressure ulcer for 1 of 3 residents reviewed for pressure ulcer services, Resident #32. Findings included:	F 314	Resident #32 no longer resides at the facility. All residents that reside at the facility has a potential to be affected by this alleged deficient practice. Licensed nurses will be inserviced to conduct weekly skin assessments on all residents that reside	7/8/16

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F 314	Continued From page 9 A review of the admission assessment dated 05/17/2016 revealed Resident #1 was admitted to the facility 05/10/16 with a partial list of diagnoses which included hypertension, diabetes mellitus, renal insufficiency. The same assessment indicated Resident #32 was at risk for pressure ulcers, but that he had no pressure ulcers present at the time of the assessment. Resident #32's nursing care plan which was initiated on 05/17/2016 and updated on 05/28/16 revealed there was a goal with interventions in place to address his left heel pressure ulcer which had developed. A review of the Wound Assessment Report dated 05/28/16 for Resident #32's left heel pressure ulcer revealed it was identified for the first time on 05/28/16 and that the type of wound was a "pressure ulcer" which was unstageable upon discovery. In addition, the same report indicated the pressure ulcer measured 11.0 centimeters (cm) in length, 5.0 cm in width, and 0.5 cm in depth and that the wound bed was 100% eschar. The same wound assessment report indicated no treatment was required, and that the physician and responsible party were notified on 05/28/16. Review of a second Wound Assessment Report dated 05/28/2016 for Resident #32's left heel pressure ulcer indicated it was an "other unstageable" wound type and that the left heel eschar measured 11.0 cm in length, 5 cm in width, and 0.0 cm in depth. This wound assessment indicated that treatment was pending. A comparison of the two Wound Assessment	F 314	in the facility. The inservice will include accurate documentation and description of any alteration in skin integrity. Certified nursing assistants will be inserviced to report any alteration in skin condition to the charge nurse immediately upon discovery. The DON will monitor skin assessment documentation daily. The DON will conduct follow-up skin assessments on 5 residents, weekly, once the documentation related to skin assessments is The Interdisciplinary team which includes the Director or Nurses, Dietary Manager, Assessment Nurse and Administrator will conduct weekly wound rounds to assess resident's wounds and treatment modalities. The Director of Nurses will monitor wound documentation, weekly, to assure that wounds are being documented on weekly and accurately described. The DON will conduct a root cause analysis on any resident's wound that initially presents as un-stageable. The DON will compile the findings of her observations and documentation review to determine any identified trends. The findings will be evaluated for any additional need for in-service training. The findings will be reported by the DON monthly during QAPI committee meeting for 3 months or until substantial compliance is achieved.	

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Reports, both dated 05/28/2016, revealed inconsistent measurements and wound types.

A Wound Assessment Report dated 06/03/16 for Resident #32's left heel pressure ulcer measured 11.0 cm in length, 5.0 cm in width, and 0.5 cm in depth.

A Wound Progress Report documented that the left heel pressure ulcer was the same size on 05/28/16 and 06/03/16 as follows: 11.0 cm in length, 5.0 cm in width, and 0.1 cm in depth. This Wound Progress Report indicated that on 05/28/2016, the left heel pressure ulcer was a different measurement than listed on the Wound Assessment Reports dated 05/28/2016.

A review of the physician's telephone orders revealed an order dated 06/07/16 foot cleanse the left heel with normal saline, pat dry, apply hydrocolloid dressing, check placement daily and change dressing every 7 days and as needed.

An observation of Resident #32's left heel pressure ulcer care was made on 06/09/16 at 2:10 PM. As Nurse #3 removed the old dressing from the resident's heel, the wound was observed to have a large area of black eschar present over the entire heel, extending to the lateral sides of the heel and above and below the heel. A strong odor was present. A long strip of skin hung below the left heel from the medial side (inner heel.)

In an interview with Nurse #3 after the observation was made on 06/09/16 at 2:36 PM, she stated that she did not know the exact date when the left heel pressure ulcer was discovered. Nurse #3 explained there had been no reports made to her at any time by nursing assistants that

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Resident #32 had a skin concern on his left heel. Nurse #3 stated Resident #32 did not have the left heel pressure ulcer when she left for her vacation on 05/24/16, but when she returned on 06/01/16, the left heel pressure ulcer was present. She also stated that her first observation of the left heel pressure ulcer was when she provided the treatment on 06/09/2016 (that day.) Nurse #3 explained that the order for the left heel pressure ulcer treatment was to change the dressing was only every 7 days and as needed, and that there had been no need for her to change the dressing between 06/01/2016 and 06/09/2016. Nurse #3 acknowledged there was an odor present during the dressing change on 06/09/2016. Nurse #3 also explained there was no wound form where she would document any details about the wound. She stated the only place where she documented anything related to the left heel pressure ulcer was on the treatment record where she initialed when treatment was completed.

In an interview with Nurse #2 on 06/09/16 at 3:00 PM, she stated she first discovered the pressure ulcer when she was providing care for Resident #32 on 05/26/16. Nurse #2 stated she saw serosanguinous drainage on his bed sheet and discovered he had a large blister-type area on his left heel. Nurse #2 stated she had not received a report from a nursing assistant there was skin problem noted on his left heel. She added that if a nursing assistant noted skin integrity issues when providing care, they should report it to a nurse.

In an interview with NA #2 on 06/09/16 at 3:14 PM, she stated there was a place for nursing assistants to check off when care such as baths

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or skin checks was provided to residents in an activities of daily living notebook.

Upon review of the activities of daily living notebook, there was no category present for bathing or skin observation documentation during a bath.

In an interview with the corporate consultant nurse (CCN) at 3:15 PM, he stated that there was no indication in the electronic record that Resident #32's baths or skin checks had been completed. The CCN explained that the system only indicated whether Resident #32 had been available for bathing.

A review of the electronic documentation for Resident #32's bathing category revealed all entries indicated he was not available for a bath/shower.

An interview was conducted with the director of nursing (DON) and the corporate consultant nurse (CCN) on 06/09/16 at 4:03 PM. During the interview, the DON stated she did not know how a new pressure wound could be as large as 11 cm in length and 5 cm wide upon discovery of the wound. The DON stated she expected for nursing assistants to report any skin problems they found during bathing or other care services to the nurse. The DON added that the resident also had an appointment now for the wound clinic to evaluate and treat Resident #32's wound care. The CCN stated the facility would be implementing a new documentation form where the nursing assistants would soon be recording when baths and showers were given and whether skin issues were noted. The CCN stated this would provide a system of accountability for observing and

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F 314	Continued From page 13 recording observations of the skin. In addition, the CCN stated that for now, the DON was providing measurements for all pressure wounds, however the facility was going to hire a nurse dedicated to pressure ulcer and wound services in the near future. The CCN explained that having a nurse dedicated to wound treatment would allow for coordination of pressure ulcer assessments, consistency in treatment, measurements, documentation, and tracking of pressure ulcers.	F 314		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		7/8/16

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F 520	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to pressure ulcers which resulted in a repeat deficiency at F314. The re-citing of F314 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F314 Pressure Ulcers: Based on record review, observations, and staff interviews, the facility failed to provide complete and accurate skin assessment services to prevent the development and decline of an unstageable left heel pressure ulcer for 1 of 3 residents reviewed for pressure ulcer services, Resident #32. Review of the facility's survey history revealed F314 was cited during the facility's 08/13/15 annual recertification survey, during a 04/15/16 complaint investigation, and during the current 06/09/16 annual recertification survey. At 3:50 PM on 06/09/16 the administrator stated her expectation was for pressure ulcers to be assessed weekly, and that these assessments were to include information regarding staging, measurements, location, wound bed, treatment, infection, exudate, pain, and tunneling. She reported she felt the facility had made progress in this area, but because of the lack of consistent clinical leadership, the facility's protocol for the	F 520	Immediate Action Resident #32 no longer resides at the facility. No further action needed for resident #32 Identification of Others All residents that reside at the facility has a potential to be affected by this alleged deficient practice. Systemic Changes On 7/7/2016, Regional Clinical Director will complete re-training with facility Administrator and The Director of Nursing, through telephone regarding Quality Assurance, Performance Improvement Program (QAPI) process. This education included how to identify quality deficiencies specifically on skin care and wound management program as well as ways to establish system that will ensure consistent, measurable outcomes. The education will also cover methods on how to track and trend data, as well as best practices on root cause analysis. The administrator and the Director of Nursing will then re-train QAPI committee members on how to properly complete the Quality Assurance and Performance Improvement Plan to prevent re-occurrence of any adverse outcomes regarding resident care, skin alteration and safety.	

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F 520	Continued From page 15 assessment and treatment of pressure ulcers needed further development and refinement. She explained there had been multiple turnovers in the adminstrator and director of nursing (DON) positions since the 2015 recertification survey. She commented that she and her current DON had only been in the facility for about four weeks.	F 520	The DON or administrative nurse will review the 24 hour report, physician□s telephone orders and resident incident report daily to ensure that all potential adverse events regarding resident care and safety are addressed and appropriate interventions are in place started 6/28/2016. Director of Nursing and/or administrative nurse will conduct a weekly standards of care meeting with review of any resident with alteration in skin. This meeting will include input from interdisciplinary team, including, nursing, Nutrition services, direct care staff, activities as well as the attending Physician when needed. The meeting will review current interventions and any necessary changes to the resident care to ensure residents are receiving timely interventions, starting 7/7/2016. Director of Nursing or Designated Registered Nurse will conduct re-training of current Licensed nurses on the importance to conduct weekly skin assessments for all residents that reside in the facility in a timely manner. 100% of all current licensed nurses will be re-educated by 7/8/2016. Any licensed nurse not educated by 7/8/2016 will not be allowed to work until educated. The in-service will include accurate documentation and description of any alteration in skin integrity. Certified nursing assistants will be inserviced to report any alteration in skin condition to the charge nurse immediately upon	

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F 520	Continued From page 16	F 520	discovery. The Administrator and DON will share audit results of skin assessment and wound tracking for 3 meetings or until 100% compliance is achieved. After 100% compliance is achieved skin assessment documentation and wound tracking results will be reported quarterly to monitor for continued compliance. Monitoring Process The DON will monitor skin assessment documentation daily. The DON will conduct follow-up skin assessments on 5 residents weekly x8 weeks. once the documentation related to skin assessments is achieved. Findings will be discussed on monthly basis on QAPI committee meeting.	