STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. BUILDING _____ B. WING _____	11/16/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARKANSAS CONVALESCENT CENTER	**6301 SOUTH HAZEL PINE BLUFF, AR 71603**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 805) were substantiated (all or in part) with these findings: Based on record review and interview, the facility failed to ensure necessary care and services were provided to address non-pressure-related skin conditions, as evidenced by failure to regularly conduct and document assessments of a skin rash and failure to provide treatments to the rash at the physician-ordered frequency, to promote healing for 1 (Resident #5) 3 (Residents #3, #5 and #8) case mix residents who had topical treatments ordered. The failed practices had the potential to affect 8 residents who had orders for topical treatments, as documented on a list provided by the Director of Nursing (DON) on 11/13/15 at 4:00 p.m. The findings are: Resident #5 had [DIAGNOSES REDACTED]. The Minimum Data Set with an Assessment Reference Date of 10/17/15 documented the resident scored 3 (0-7 indicates severely impaired) on the brief interview for mental status, was totally dependent for bed mobility, transfers and personal hygiene and had no open [MEDICAL CONDITION], other than ulcers, rashes, or cuts. a. The Advanced Practice Registered Nurse (APRN) notes dated 10/12/15 documented, Chief complaint 1. Neck Rash . Staff Nurse reports that pt (patient) has a red rash on the right side of her shoulder. States that the rash appeared on yesterday . reports that the pt sweats a lot in that area which may be the cause of the rash. Denies using any therapy to the area. No acute changes to the rash reported from the staff Nurse . b. A Physician's Telephone Order dated 10/12/15 documented, Clean right neck rash with 0.9% NS (Normal Saline) apply Mirin [MEDICATION NAME] Ointment 2% apply TID (3 times daily) x (times) 10 days . c. The October 2015 Treatment Administration Record (TAR) documented, Clean R (right) neck rash (with) NS apply Muritrain ([MEDICATION NAME]) TID (three times per day) x 10 days; however, nurses' initials documented the treatment was provided to the resident once daily on the 6:00 a.m. to 2:00 p.m. shift, instead of 3 times daily as ordered by the physician. A Discharge Summary dated 10/26/15 documented the resident was discharged to the hospital. d. As of 11/13/15, there was no documentation in the clinical record to indicate the rash was routinely assessed to determine if it was spreading or improving. e. On 11/13/15 at 11:52 a.m., the Treatment Nurse was shown the Telephone Order dated 10/12/15 and the October 2015 TAR. The Treatment Nurse looked at the documentation and stated, Did I do that? The Treatment Nurse was asked if the [MEDICATION NAME] had been administered as ordered by the Physician. The Treatment Nurse stated, No. The Treatment Nurse was also asked, Did you document an assessment related to the rash? The Treatment Nurse stated, No. f. On 11/13/15 at 11:52 a.m., the DON was shown the Telephone Order dated 10/12/15 and the October 2015 TAR. The DON was then asked if the treatment had been administered as ordered by the Physician. The DON stated, No.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 793), Complaint # (AR 805) and Complaint # (AR 825) were substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure necessary treatment and services were provided to promote the healing of pressure ulcers for Residents #1, #3, #7 and #8: The facility failed to ensure pressure ulcer treatments were promptly initiated and were provided at the frequency ordered by the physician to promote healing and prevent potential deterioration for 2 (Residents #3 and #8). The facility failed to ensure the physician was promptly consulted regarding newly identified pressure ulcers or deterioration of existing pressure ulcers to allow the physician to determine if a change in treatment was needed for 2 (Residents #3 and #8) of 7 (Residents #1, #3 and #5 through #9) case mix residents who had pressure ulcers. The facility failed to conduct and document thorough pressure ulcer assessments on at least a weekly basis, to include measurements, staging and condition of the wound and surrounding tissue to facilitate the ability to track healing progress or deterioration of pressure ulcers for 2 (Resident #3 and 8) of 7 (Residents #1, #3 and #5 through #9) case mix residents who had pressure ulcers. The facility failed to ensure planned pressure relief interventions were consistently implemented to decrease the potential for development of new pressure ulcers and to prevent deterioration in existing pressure ulcers for 2 (Residents #1 and #3) of 7 (Residents #1, #3 and #5 through #9) case mix residents who had pressure ulcers of 7 (Residents #1, #3 and #5 through #9) case mix residents who had pressure ulcers. These failed practices resulted in patterns of actual harm to Residents #3 and #8, who experienced deterioration in existing pressure ulcers and development of new pressure ulcers, and had the potential to cause more than minimal harm to 4 residents who had pressure ulcers, as documented on a list provided by the Director of Nursing on 11/17/15. The facility also failed to ensure a [DEVICE] (vac) was applied as ordered by the physician to promote healing for 1of 1 (Resident #7) case mix residents who had pressure ulcers and physician orders [REDACTED]. This failed practice had the potential to cause more than minimal harm for 1 residents with pressure ulcers and physician orders [REDACTED]. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/21/15 documented the resident scored 2 (0-7 indicates severely impaired) on the brief interview for mental status, was totally dependent on 2-plus persons for bed mobility and transfers, was incontinent of bowel and bladder, was at risk for developing pressure ulcers and had 1 Stage 3 and one Stage 4 pressure sore. a. The Braden Scale for Predicting Pressure Ulcer Risk form dated 8/21/15 documented the resident's total pressure ulcer risk score was 15, with a score of 15-16 indicating a mild risk for pressure ulcers. The categories on the form that contributed to this score documented the following: 1) Scored 3 for Sensory Perception: Ability to respond meaningfully to pressure-related discomfort slightly limited responds to verbal commands, but cannot always communicate discomfort or need to be turned or has some sensory impairment which limits ability to feel pain discomfort in 1 or 2 extremities. 2) Scored 3 for Moisture: Degree to which skin is exposed to moisture - occasionally moist - skin is occasionally moist, requiring an extra linen change approximately once a day. 3) Scored 2 for Activity: Chair fast - ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair. 4) Scored 3 for Mobility: Ability to change and control body, slightly limited - makes frequent though slight changes in body or extremity position independently. 5) Scored 3 for Nutrition: Usual food intake pattern: Adequate - Eats over half of most meals. Eats a total of 4 servings of

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

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 0314 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, or is on a tube feeding or TPN (Total [MEDICATION NAME] Nutrition) regimen, which probably meets most of nutritional needs. 6) Scored 1 for Friction and Shearing: Problem - Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requires frequent repositioning with maximum assistance. Spastic contrarieties or agitation leads to almost constant friction. b. The Comprehensive Care Plan dated 9/10/15 documented, .I have a Pressure Ulcer . date initiated 9/10/15. Goal - My Pressure Ulcer will show signs of healing and remain free from s/sx (signs and symptoms) of infection through review date . Intervention/Task - Assess/record/monitor healing weekly. Measure length, width and depth; where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvement and declines to the MD (Medical Doctor) . Monitor/document/report to MD PRN (as needed) changes in skin status; appearance, color wound healing, s/sx of infection, wound size (length x (times) width x depth), stage. Administer treatments as ordered and monitor for effectiveness. The November Physician order [REDACTED].Positioning Devices . The order was dated 5/30/14. c. A physician order [REDACTED]. The Wound Center Progress Note dated 10/6/15 documented, Integumentary . Wound #17 Left Heel is a Stage III Pressure Ulcer and has received a status of not healed. Sequela wound encounter measurements are 1.3 cm (centimeters) length x 1.1 cm width x 0.1 cm depth with an area 1.43 sq (square) cm and a volume of 0.143. There is a small amount of sero-sanguineous drainage noted which has no odor. The wound margin is flat and intact. Wound bed is 1-25% adherent, yellow slough, 76-100% red granulation . Physical exam notes; His heel wound continues to improve it is presently 97% closed. He is wearing the protective boot 24/7 . Wound orders, Wound #17 cleanse wound and peri-wound with soap and water. [MEDICATION NAME] - apply [MEDICATION NAME] Cream in wound/bed. Cover and secure with dressings of choice. Change as directed - change BID (two times per day). Change Dressing BID and PRN (as needed) for excessive drainage. Off Loading. Follow up Appointment, Return appointment in 3 weeks. 1) The facility's Weekly Pressure Ulcer Record documented measurements obtained by the Treatment Nurse on 10/9/15 and 10/29/15 as follows: 10/15/15: 1.2 centimeter (cm) by (x) 1 cm x 0 cm 10/22/15: 1.3 cm x 2 cm x 0 cm 10/29/15: 3.8 cm x 2.5 cm x 0.1 cm 2) On 11/13/15 at 12:20 p.m., the Treatment Nurse was asked, When you obtain your measurements of the wounds, when do you do your documentation? The Treatment Nurse stated she obtained her measurements and then documented them, .later in the week or when I get a chance . 3) The October 2015 Treatment Administration Record (TAR) documented, Cleanse Left Heel with Normal Saline and apply [MEDICATION NAME] and cover with 4 x 4 dressing, pad with ABD (abdominal) pad and secure with Kerlix and tape order date: 12/17/14 first shift 7-3 (7:00 a.m. - 3:00 p.m.) every day. The TAR documented nurses' initials to indicate the treatment was provided once daily from 10/1/15 through 10/24/15 and 10/26/15 through 10/30/15. There were no initials to indicate that the dressing change was provided on 10/25/15 and 10/31/15. The October 2015 TAR did not document the physician order [REDACTED]. d. The Wound Center Progress Note dated 10/27/15 documented, Integumentary . Wound #17 Left Heel is a Stage 3 Pressure Ulcer and has received a Status of not healed. Sequela wound encounter measurements are 4.9 cm length 7 cm width x 0.1 cm depth with an area of 34.3 sq (square) cm . There is a large amount of Sero-sanguineous drainage noted which has no odor. The wound margins are flat and intact. Wound bed is 26-50% adherent, yellow slough. 26%-50% adherent, yellow slough, 26-50% bright red granulation . Physical Exam: .Today the wound is larger. It is obvious that the NH (Nursing Home) is not keeping pressure off of the heel . Wound Orders . Wound #17 Wound cleansing & Dressing Cleanse wound and peri-wound with soap and water. [MEDICATION NAME] - Apply [MEDICATION NAME] Cream to wound bed. Cover and secure with dressing of choice. Change as directed. Change dressing BID (two times daily) for excessive drainage . Off Loading; Mattress Overlay/Specialty Bed Mattress - Turn every 2 hours. Avoid position directing pressure to wound site. Limit side lying to 30 degree tilt. Limit HOB (head of bed) elevation to 30 degrees in bed. Use/wear Heel Lift for offloading as directed - wear at all times . Wound #21 Left Lateral Ankle . Stage II Pressure Ulcer . has received a status of not healed. Initial wound encounter measurements are 1 cm length x 0.8 cm width x 0.1 cm depth with an area of 0.8 sq cm. There is a small amount of Sero-Sanguieous drainage noted which has no odor. The wound margins are flat and intact. Wound bed is 26%-50% adherent, yellow slough, 26%-50% bright red granulation .Wound #21 Left Lateral Ankle, Wound cleansing & Dressing Cleanse wound and peri-wound with soap and water. [MEDICATION NAME]- Apply [MEDICATION NAME] Cream to wound bed. Cover and secure with dressing of Choice. Change as directed. Change dressing BID (two times daily) for excessive drainage . Return appointment in 3 weeks. Nurse visit as needed. Follow wound care orders for nurse only visits. Contact panel Physician with any significant changes . There was no documentation in the facility clinical record of an assessment or physician consultation regarding a pressure ulcer to the left lateral ankle, prior to the Wound Center encounter on 10/27/15. e. The November 2015 Physician order [REDACTED]. Pad and secure with Kerlix and tape 7-3 every day. The physician order [REDACTED]. f. The November 2015 Treatment Administration Record documented, Cleanse Left Heel with Normal Saline and apply [MEDICATION NAME] and cover with 4 x 4 dressing, pad with ABD, pad and secure with Kerlix and tape order dated 12/17/14 first shift every day. As of 11/10/15, the TAR documented nurses' initials to indicate the treatment was provided once daily from 11/2/15 through 11/10/15, instead of twice daily as ordered by the physician. There were no initials to indicate the treatment was provided on 11/1/15. The November 2015 TAR also documented 2 handwritten orders dated 11/11/15 as follows: 1) Cleanse Lt (left) heel (with) NS (Normal Saline) apply [MEDICATION NAME] cover with 4 x 4s apply ABD pad secure with Kerlix, tape, q (every) day . 2) Cleanse Lt (left) lateral ankle (with) NS apply [MEDICATION NAME] cover with 4 x 4s, ABD pad, wrap (with) Kerlix tape, q day. g. On 11/9/15 at 2:54 p.m., the resident was lying in bed with the head of bed elevated to approximately 30 degrees. The resident had a heel lift boot on the left foot with the heel of the boot resting directly on the bed. h. On 11/10/15 at 8:40 a.m., 12:10 p.m. and 3:10 p.m., the resident was lying in bed with a heel lift boot on the left foot, with the heel of the boot resting on the bed. The resident's right foot was resting directly on the bed, not offloaded. i. As of11/6/15 at 5:25 p.m., the MDS Kardex Report utilized by the facility's Certified Nursing Assistants did not document instructions for offloading the resident's heels, and the Comprehensive Care Plan dated 9/10/15 had not been updated to include the use of heel lift boots to relieve pressure to the resident's heels. j. On 11/11/15 at 2:50 p.m., the resident was in bed. The Treatment Nurse provided wound care for the resident. The resident was in bed and had a heel lift boot on the left foot. When the Treatment Nurse began removing the heel lift boot, the resident's heel was resting directly on the inner foam lining of the boot and was not suspended in the heel lift boot to prevent pressure to the left heel wound. The left lateral ankle was also in direct contact with the solid foam lining of the boot. The foam edges of the boot were torn. The Treatment Nurse measured the heel wound as approximately 5 cm in length x 7 cm in width x 0.1 cm in depth. The wound bed was red with yellow slough, and there was a moderate amount of serosanguinous drainage on the dressing. The left lateral ankle measurements were approximately 2 cm in length x 2 cm in width x 0.1 depth, and the wound bed had a reddish appearance with a scant amount of reddish drainage. The Treatment Nurse stated, The boot has torn foam and needs to be replaced. 1) On 11/12/15 at 12:50 p.m., the Treatment Nurse provided the manufacturer's instructions for the Heellift AFO (ankle-foot orthosis) boot and stated this was the type of boot that was in use on Resident #3's left lower extremity. The instructions documented, .Application & (and) Fitting Guide . Each boot comes with a spare elevation pad that can be trimmed to further ensure a customized fit . Place the foot inside the boot with the heel positioned above the heel suspension opening. The heel should hang over the bottom elevation pad . Test for the proper fit. You should be able to fit your fingers between the heel opening and the bed . Customizing the Fit, Malleolar Decubitus, cut away the bumps surrounding the ankle. Cut a portion of the fixed pad if necessary .

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 2) 2) On 11/13/15 at 11:45 a.m., the Treatment Nurse was asked who was responsible for ensuring the resident's heels were properly off loaded and that the resident's foot was positioned correctly inside the heel lift boot. The Treatment Nurse stated, I am, along with the Nurses and CNAs (Certified Nursing Assistants), to ensure that pillows are placed on the bed so the heels are off loaded. The Treatment Nurse was asked what type of boot the resident was wearing and stated, I don't know; it starts with H. It has foam inside the boot. He had the same boot on in September (2015) . I got out of school in May (2015). I'm a new nurse. The Treatment Nurse was asked if she had received any wound training. The Treatment Nurse stated, No, people have come in, and the DON and ADON (Assistant Director of Nursing) have helped me. The Treatment Nurse was asked if the resident's heel should be resting directly on the foam inside the heel lift boot. The Treatment Nurse stated, Yes, it is foam inside the boot. The Treatment Nurse was asked if this would cause increased pressure on the heel. The Treatment Nurse stated, I guess. The Treatment Nurse was asked, With a heel lift suspension boot, should the heel be suspended inside the boot? The Treatment Nurse stated, Yes, I changed his boot this morning; the other boot had been washed and the foam was tearing off. The Treatment Nurse also stated the resident's wife had informed her in October 2015 that the resident's feet / heels were not being properly positioned and, .I did another in-service. 3) The Treatment Nurse provided the survey team with in-service documentation dated 10/2/15 through 10/4/15, which documented that the ADL (Activity of Daily Living) book would contain the turn schedule for residents that had suspension boots. A return demonstration of proper positioning was documented, including how to bridge residents' heels with pillows. There was no documentation that staff were instructed on properly positioning residents' feet in heel lift boots to prevent pressure to the heels. The Treatment Nurse was asked, How did you ensure (residents') heels were off loaded and the heel suspension boots were applied correctly? The Treatment Nurse stated, I documented the monitoring in my notes. 4) The Nurses Note dated 10/5/15 and signed by the Treatment Nurse documented, Rounds were made on hall to make sure heels were being bridged properly. Will continue to observe. k. On 11/11/15 at 3:55 p.m., the Treatment Nurse was asked, Do you read the documentation when the resident returns from the Wound Clinic? The resident went to the Wound Clinic on 10/27/15 and there was an increase in the size of the pressure ulcer to the left heel. The Treatment Nurse stated, The CNAs are not keeping the resident's heel bridged properly on the hall, and the resident has gained weight. The Treatment Nurse was asked about the Wound Clinic Physician order [REDACTED]. The Treatment Nurse stated she had called the wound clinic and did not receive the orders on 11/4/15 and, I went over and picked up the orders. The Treatment Nurse stated she wrote a clarification order on 11/11/15. The Treatment Nurse and this surveyor reviewed the telephone order dated 11/11/15, which documented the same once-daily treatment with normal saline and [MEDICATION NAME] that had been in place since December 2014. The order did not document the name of the person who provided the order to the Treatment Nurse. The Treatment Nurse was then asked who she had spoken with at the wound clinic to obtain this order. The Treatment Nurse provided 2 different names. The Treatment Nurse was asked if she knew the person's title and stated, No. l. On 11/12/15 at 12:50 p.m., during a telephone interview, the Clinical Manager of the Wound Clinic was asked if the facility had called her regarding Resident #3. The Clinical Manager stated she had spoken with them. The Clinical Manager was asked if the facility had called regarding the frequency of the dressing changes to the resident's left heel. The Clinical Manger stated she would check the computer and the paper documentation. After review of the documentation, the Clinical Manger stated, The dressings are to be changed BID (twice daily). The Clinical Manager was asked if she had spoken to anyone at the facility to decrease the frequency of the dressing changes back to daily. The Clinical Manager stated, I don't recall that or have documentation of that . to my knowledge, the dressing is to be changed BID. m. On 11/12/15 at 1:40 p.m., the Director of Nursing (DON) and this surveyor observed the positioning of the resident's foot in the heel lift boot. The DON was asked if the heel of the resident's foot was resting directly on the foam. The DON stated, Yes, it's partly lying on the foam. The DON was asked if the heel was properly suspended in the heel lift boot. The DON stated, No. The DON was asked who was responsible for ensuring that the heel lift boots were properly applied and the heels were properly positioned. The DON stated. The Nurses. The DON was asked if the improper positioning of the resident's heel in the boot would increase pressure on the resident's heel. The DON stated, Yes. The DON was shown the Wound Clinic measurements for 10/6/15 and 10/27/15, which also documented Physician order [REDACTED]. The DON was then shown the facility's October and November 2015 TARs, which documented the wound care to the left heel had been provided once daily. The DON was asked if the treatments should have been provided BID. The DON stated, Yes, that's what it (physician order) says. The DON was asked if the treatments had been provided BID and stated, It doesn't look like it was done. The DON was then asked to review the Comprehensive Care Plan and MDS Kardex to determine if they addressed the need for the heel lift boot and offloading of the resident's heels. The DON reviewed the Care Plan and Kardex and stated, No, it's not documented. The DON was asked who was responsible for updating the Comprehensive Care Plan and MDS Kardex and stated, The Care Plan Coordinator. There has been a problem with getting the Care Plans and Kardex to contain all information that is related to the resident; we are working on that. n. On 11/12/15 at 2:25 p.m., the Assistant Director of Nursing (ADON) was asked how long she had been the ADON. The ADON stated, One year. The ADON was asked, What are your job duties? The ADON stated, A little bit of everything; I oversee the wounds, staffing, stuff like that. The ADON was asked, When a resident goes to the Wound Clinic, how long does it take for the orders to be received from the wound clinic? The ADON stated, Sometimes a couple of days. When I was Treatment Nurse, I had to call them and ask them to fax the orders. The ADON was asked if she had spoken with the Director of Nursing about the timeframes for the orders being sent, received and processed from the Wound Clinic. The ADON stated, No. The ADON was asked who checked the documentation received from the Wound Clinic for new orders. The ADON stated, The Treatment Nurse. The ADON was asked, What is the expected timeframe for transcribing a Physician Order? The ADON stated, Immediately. The ADON was asked how often Resident #3 went to the Wound Clinic. The ADON stated, Every 3 weeks. The ADON was asked, Did you call the Wound Clinic on 11/11/15? The ADON stated Yes, I called because the orders documented clean with soap and water and had it changed to Normal Saline. The ADON was asked if she called about anything else. The ADON stated, No. The ADON was asked who she spoke with and stated, (Clinical Manager.) The ADON was asked if the Treatment Nurse had called the Wound Clinic and stated, If she did, I wasn't in there. The ADON was asked if she was aware of the increase in size of the pressure ulcer to the resident's left heel. The ADON stated, She (Treatment Nurse) told me that it had gotten bigger and we're trying to keep it offloaded. The ADON was asked if she had checked the resident or checked the positioning, removed the boot and checked the positioning of the resident's foot in the boot. The ADON stated, The first part of October, I did. The ADON was asked if she saw a problem with the positioning of the foot in the heel lift boot at that time. The ADON stated, No. The ADON was asked if she was aware the Treatment Nurse had stated she picked up the Wound Clinic Orders on 11/4/15 for the Wound Clinic appointment dated 10/27/15, and that those orders were not processed until 11/11/15. The ADON stated, I don't know. The ADON was asked about the Wound Clinic Physician order [REDACTED]. The ADON stated, I didn't check the wound clinic orders; the Treatment Nurse did. o. On 11/13/15 at 11:52 a.m. the DON was asked to review the October and November 2015 Treatment Administration Record and to verify the frequency of the dressing changes to the resident's left heel from 10/6/15 -11/11/15. The DON stated, Only daily. The DON was informed the Treatment Nurse stated that she had called the Wound Clinic on 11/11/15 for clarification of the Wound Orders that she had received on 11/4/15, and had documented a Physician order [REDACTED]. The DON was informed there was no documentation on the order of who she had received the Physician order [REDACTED]. The DON was also informed that the wound clinic was called by the surveyor on 11/12/15 and the Clinical Manager had stated that, although she had spoken with staff from the facility, she had no knowledge of the dressing order being changed back to daily. The DON stated, I see the order for BID. The DON was informed that the Treatment Nurse stated that she had received the orders on 11/4/15 from the Wound Clinic, and according to the documentation in the clinical record and the Treatment Administration Record, there was a delay in processing and implementing the orders until 11/11/15. This was 35 days the resident did not receive the treatments BID as ordered. The DON stated, I see that. p. On 11/13/15 at 12:20 p.m., the Treatment Nurse, with the DON present, was asked if she had completed the treatments for the resident that morning. The Treatment Nurse stated she changed the dressings just before lunch, around 12 noon. The Treatment Nurse stated she had from 6:00 a.m. until 2:00 p.m. to change the dressing for her shift. The Treatment Nurse was asked, If a treatment is BID, should there be specific time (scheduled)? The Treatment Nurse stated, No, we don't put a time frame; its 6 to 2 (6:00 a.m. to 2:00 p.m.) and 2 to 10 (2:00 p.m. to 10:00 p.m.). The Treatment Nurse was asked, If you change the dressing at noon, and the 2 to 10 shift comes on and changes the dressing at 3:00 p.m., that would be 3

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 3) hours between dressing changes. The Treatment Nurse stated, The treatment is BID. The DON stated, That's something we are going to have to work on. The Treatment Nurse was asked, Regarding the pressure ulcer on the left lateral ankle, when was the onset date of this the pressure ulcer? The Treatment Nurse stated, It occurred a few days before he went to the Wound Clinic; he was going on 10/27/15. The area was at first just bleeding and then it got a little bit larger. The Treatment Nurse was asked if she had called the Physician upon identification of this pressure ulcer. The Treatment Nurse stated, No, he was scheduled for the wound clinic. The Treatment Nurse was asked if she had performed a treatment to this wound and stated she had used a previous order to provide treatment to the left lateral ankle wound. The Treatment Nurse was asked if she had obtained measurements of the pressure ulcer when it was discovered. The Treatment Nurse stated, No, he was scheduled to go to the wound clinic in a few days. The Treatment Nurse was asked, You did not notify the Physician of a new Pressure Ulcer, did not obtain measurements when you discovered the Pressure Ulcer, (you) performed a treatment without a Physician order [REDACTED].? The Treatment Nurse stated, He (resident) was going to the Wound Clinic in a few days. The Treatment Nurse was asked, When the area started on the left ankle, did you assess to determine what could have been causing the pressure on the left lateral ankle? The Treatment Nurse stated, There was an in-service on offloading and positioning the first part of October. The Treatment Nurse was asked if she had assessed the heel lift boot for pressure points on the ankle. The Treatment Nurse stated, No. 2. Resident #8 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 11/5/15 documented the resident scored 15 (13-15 indicates cognitively intact) on the brief interview for mental status, required total assistance for bed mobility and transfers, was at risk for Pressure Ulcers and had 1 Stage II, 1 Stage III and 1 Stage IV pressure ulcer. a. A physician's orders [REDACTED]. The record documented the wound care was provided to the resident once daily on the 6:00 a.m. to 2:00 p.m. shift from 10/9/15 through 10/30/15, as indicated by the nurses' initials. b. The Weekly Pressure Ulcer Record dated 10/29/15 documented the resident had 1 Abrasion, 1 Stage II pressure ulcer, 3 Stage III pressure ulcers, one of which had increased to Stage IV and 2 Stage IV pressure ulcers. c. The November 2015 Physician order [REDACTED]. Apply [MEDICATION NAME] to bil (bilateral) buttocks BID (two times daily) and PRN (as needed). Twice daily every day. Date 6/1/15 . Clean Scrotum with soap and water apply protective ointment BID and PRN. Treatment twice daily every day. Date-8/27/15 . Cleanse right heel with Dakin's apply Santyl and cover with 4x4s and kerlix with heel foam QD (every day) and PRN. Date 8/27/15 . Cleanse Right Lateral Heel with Dakins apply Santyl and cover with 4 x 4's and Kerlix QD and PRN. Date 8/27/15 . Cleanse Right Lower Anterior Leg with Dakins, apply TAO (Triple Antibiotic Ointment) and cover with 4 x 4's and Keri QD and PRN Contact Isolation for Wound Infection. Date - 8/27/15 . d. The Wound Clinic Records dated 11/2/15 documented the following: 1) Wound #15, L (Left) heel, is chronic Stage 2 Pressure Ulcer and has a status of not healed, measurements 2 cm length x 1 cm width x 1 cm depth. Small amount of Serous Drainage. 2) Wound #16, Left Lateral Foot is Chronic Necrotic Tissue (unstageable) Pressure Ulcer and received a status of not healed, measurements 1.2 cm length x 5.5 cm width x 0.1 cm depth, no drainage. Wound is 76%-100% black eschar, none granulation. 3) Wound #17, Right Anterior Ankle is chronic stage II Pressure Ulcer and has received status of not healed. Measurements are 1 cm length x 0.8 cm width x 0.1 cm depth. Small amount of serous drainage. Wound bed is 26-50% adherent yellow slough. 26-50% bright red granulation. 4) Wound #18 Right Medial Heel is a chronic Stage II Pressure Ulcer and has received a status of not healed. Measurements are 0.3 cm length x 0.3 cm width x 0.3 cm depth. Small amount of serous drainage. The wound bed is 76-100% bright red granulation. 5) Wound #19 Right Lateral Heel is a chronic Stage II Pressure Ulcer and has received a status of not healed. Measurements are 0.2 cm length x 0.3 cm width x 0.1 cm depth. There is a small amount of serous drainage. The wound bed is 76-100% bright red granulation. 6) Wound #20 Right Lateral Foot is a chronic Stage II Pressure Ulcer and has received a status of not healed. The Measurements are 2 cm length x 4.7 cm width x 0.8 cm depth. The margin is thickened, the wound bed is 26-50% adherent yellow slough and 26-50% bright red granulation. 7) Wound #21 Right Lateral Lower Leg is a chronic Stage II Pressure Ulcer and has received a status of not healed. The Measurements are 1.5 cm length x 1.5 cm width x 0.2 cm depth. The wound margin is undefined, the wound bed is 51-75% adherent yellow slough. 1-25% bright red granulation. 8) Wound #22 Left Buttocks is a chronic Stage III Pressure Ulcer and has received status of not healed. The wound margin is thickened, the wound bed is 51-75% adherent yellow slough with 1-25% bright red granulation. 9) Wound #23 Right Buttocks is a chronic Stage IV Pressure Ulcer and has received status of not healed. The Measurements are 1 cm length x 1 cm width x 0.1 cm depth. There is a small amount of serous drainage. The wound bed is 51-75% adherent yellow slough with 1-25% bright red granulation. 10) Wound #24 is a chronic Stage II Pressure Ulcer and has received the status of not healed. The measurements are 1.0 cm length x 1.5 cm width x 0.1 cm depth. There is a moderate amount of serous drainage. The wound bed is 26-50% adherent yellow slough with 26-50% pink granulation. 11) Wound #25 Sacral is a chronic Stage II Pressure Ulcer and has received a status of not healed. There is small amount of serous drainage. The wound bed is 76-100% bright red granulation. 12) Wound #22 Left Buttocks, The ulcer base is biofilm. There was an incisional debridement preformed. Post abridgement measurements 8 cm length, x 6.5 cm width x