STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **676185**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/16/2018**
NAME OF PROVIDER OF SUPPLIER **SENIOR CARE OF HARBOR LAKES**		STREET ADDRESS, CITY, STATE, ZIP **1300 2ND ST GRANBURY, TX 76048**	

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown or pressure ulcers for four (Residents #1, #2, #4 and #5) of four residents reviewed for pressure ulcers. 1. The facility failed to ensure weekly skin assessments were performed, a) Resident #2 was re-admitted to the facility on [DATE] and had no weekly skin assessments performed since re-admission b) Resident #1 did not receive a weekly skin assessment between 12/14/17 and 01/25/18 c) Residents #4 and #5 did not receive weekly skin assessments. 2) The DON failed to ensure weekly skin assessments were accurate, a) Resident #1's pressure ulcer was not documented on her weekly skin assessments and resulted in the ulcer going untreated from 12/13/17 until 01/26/18. b) Resident #1 was discovered to have several skin wounds upon transfer to the emergency roiagnom on [DATE] severe enough that they contacted Adult protective Services. The [MEDICAL CONDITION] were not documented on the nursing facility's weekly skin assessment sheet. 3) LVN-C failed to document Resident #2's stage II pressure ulcer and was treating the ulcer with skin prep which was not physician ordered. These failures could place 14, documented at high risk for pressure ulcers at risk of inaccurate skin assessments and undocumented and untreated pressure ulcers. Findings included: Review of Resident #1's Face Sheet dated 12/29/17 revealed she was an [AGE] year-old female who was re-admitted to the facility on [DATE], her [DIAGNOSES REDACTED]. Review of Resident #1's MDS dated [DATE] revealed the resident had moderately impaired cognition, she was able to understand and be understood. She required extensive assistance of 1-2 staff for ADL's and transfers. She was considered at risk for pressure ulcers and had no pressure ulcers on admission. She had a skin tear for which she received treatment. Review of a Progress Note dated 12/13/17 at 2:07 p.m. which was unsigned and revealed an admission report received from the transferring hospital for Resident #1 revealed skin - (L) buttocks/(R) pressure, bil (bilateral) heel breakdown Review of Resident #1's Admission Nursing Evaluation dated 12/13/17 and signed by LVN-E revealed; Skin Condition The resident had a skin tear and the dressing was intact. The skin tear was indicated on the body image as being on the left wrist. There was no documentation regarding the buttock and heel breakdown. Review of Resident #1's Weekly Skin Integrity Review revealed; 12/13/17 skin tear to left wrist 12/14/17 the resident had a skin tear to the left wrist 2 x 1cm and a stage II (pressure ulcer), had been written then a line was drawn through it and abrasion L. (left) buttock 2.5 x 1.5 x 0.1cm was documented 01/25/18 the resident had an unstageable pressure ulcer to the right heel 2.5 x 2.0cm yellow scabbed area 02/08/18 the resident had bruising, skin tears and an old unstageable pressure ulcer to the right heel described as yellow scab. There were no measurements provided. The resident did not receive skin assessments between 12/14/17 and 01/25/18 Review of Resident #1's Ulcer Surgical Site Treatment and Progress Records revealed, on one side of the sheet was documented the progress of the wound that included the measurements of the pressure ulcer and on the other side was documented the treatment for [REDACTED].>Review of Resident #1's (MONTH) Ulcer Surgical Site Treatment and Progress Records revealed; An entry dated 12/14/17 2.5cm x 1.5cm x <0.1cm (L x W X D) A treatment order dated 12/14/17 Left buttock clean with normal saline, apply bordered gauze daily and PRN. The order was discontinued 12/19/17 and changed to Laniseptic to buttocks every shift. Review of Resident #1's (MONTH) Ulcer Surgical Site Treatment and Progress Records revealed; An entry dated 01/25/18 and signed by ADON-B revealed; Unstageable 2.5L x 2.0 cm W x 0 Depth. Small (0.5 x 0.3) scabbed area with surrounding area dark yellow. A treatment order was documented for Skin prep to the right heel each shift and as needed for 14 days then re-evaluate to start 01/26/18 Review of Resident #1's (MONTH) Ulcer Surgical Site Treatment and Progress Records revealed; There was no documentation of the progress of the wound. A treatment order with a start date of 01/25/18 was documented for Skin prep to the right heel each shift and as needed for 14 days then re-evaluate to start 01/26/18 Review of Resident #1's second (MONTH) Ulcer Surgical Site Treatment and Progress Records revealed; There was no documentation of the progress of the wound. A treatment order with a start date of 02/08/18 was documented for Skin prep to the right heel each shift and as needed for 14 days then re-evaluate to start 02/08/18 Review of an SBAR (Situation, Background, Appearance and Review and Notify) dated 02/11/18 revealed the resident had a change in status related to low sodium and was transferred to the emergency room . Observation 02/14/18 at 3:55 p.m. of Resident #1 at the hospital in ICU revealed the resident was supine and asleep in bed, she did not respond to voice, her face and extremities appeared relaxed and she was in no evident discomfort. Interview 02/14/18 at 4:10 p.m. with Resident #1's Hospital Case Manager. She stated she contacted Adult Protective Services on 02/14/18 to report possible neglect of the resident by the Nursing Facility due to pressure ulcers and multiple other wounds discovered in the emergency room (ER) when the resident was admitted on [DATE]. She stated ER staff took photos of the wounds. She stated the resident was transferred to the Intensive Care Unit for low blood pressure and remained there at this time. Review of the photo's reflected what appeared to be skin excoriation on the buttocks and inner thighs, an unstageable pressure ulcer to the right heel and a dark area on the left heel. Review of the nursing facility's Ulcer Surgical Site Treatment and Progress Record/EMR' which included NPUAP (National Pressure Ulcer Advisory Panel) STAGES FOR PRESSURE ULCERS revealed; Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister. Review of Resident #1's Wound assessment dated [DATE] at 4:23 p.m. and performed following admission to the hospital revealed the resident had bruising to her left breast, excoriation to her groin due to incontinence, a skin tear to her right heel, and a 1cm skin tear to her vaginal area Review of a hospital physician's History and Physical exam dated 02/12/18 revealed dark, soft area L. heel posteriorly, eschar right heel Assessment: Pressure ulcer of heel, present on admission stage I left, unstageable right.

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 0686

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
Interview 02/14/18 at 11:35 a.m. ADON-A, one of two ADON's in the facility stated she and ADON-B worked together to ensure all residents received appropriate care; however, ADON-A was in charge of the care for residents on the 200 and 300 halls which housed residents who required rehabilitation. ADON-B was responsible for the care provided to residents on halls 100 and 400 in the Long Term Care area of the facility. She stated a wound care nurse consultant provided by Medicaid, for their Long Term Care residents, visited the facility once a month, facility staff would provide the nurse consultant with a list of residents with complex skin issues they wished her to assess and recommend treatment modalities for. The facility nurses were each responsible for providing wound care for the residents.
A wound care physician visited weekly and would see specific resident's referred by the facility nurses.
In a subsequent interview with ADON-A on 02/15/18 at 09:12 a.m. she stated, when Resident #1 was re-admitted to the facility on [DATE] the resident had an abrasion to her left buttock, a skin tear to her right buttock and an unstageable pressure ulcer on her right heel that had occurred during the resident's previous admission to the facility. She stated the heel blister was dried but present upon discharge previously so she knew the heel ulcer was present upon re-admission and she did not know why it was not addressed during the initial re-admission assessment. She stated the nurses were responsible for ensuring weekly skin assessments were completed and notifying the ADON's of any new skin issues. She stated the ADON's did not provide oversight to ensure staff were actually completing weekly skin assessments. She stated all orders for wound care were written on telephone order sheets and not part of the computerized physician's orders [REDACTED].
Interview 02/15/18 at 10:20 a.m. ADON-B stated Resident #1 was admitted to the rehabilitation area on 12/13/17 and on 01/18/18 she was transferred to the Long Term Care (LTC) area. On 01/25/18 he reviewed the resident's admission skin assessment sheet and noticed a right heel ulcer she had received treatment for [REDACTED]. He went to assess the resident and found the unstageable pressure ulcer on her right heel still remained. He documented the ulcer on the Ulcer, Surgical Site Treatment and Progress Record at that time and obtained an order for [REDACTED].>He stated nurses should have seen the heel ulcer on their weekly skin assessments and documented the issue, they should then have reported the issue to ADON-A and she would have obtained a treatment order.
He stated skin prep for the heel ulcer was to harden the scab and protect the skin beneath it until the scab was ready to fall off. Without appropriate treatment the resident had the potential for the wound to worsen. If staff had started the treatment earlier the ulcer may have already been healed.
ADON-B stated to ensure staff in LTC were performing weekly skin assessments he reviews the skin assessment book to ensure a weekly entry is there for each resident. He stated there was no plan in place to ensure skin assessments were being performed accurately.
Interview 02/15/18 at 11:38 a.m. LVN-F stated she had cared for Resident #1 when she transferred to the LTC area on 01/18/18. She stated she did not know Resident #1 had any skin breakdown until 01/25/17 when she was assisting a CNA to transfer the resident and she noticed a heel ulcer, it appeared to be a yellow crusty scab. The resident told her it had been there for years. No skin issues were being treated at that time. The resident was assessed on 01/25/18 by ADON-B. She stated she last saw the resident on 02/09/18 when she assisted a CNA with peri-care. She noticed no breakdown on the resident's bottom. On 02/11/18 the resident was transferred to hospital.
She stated if Resident #1's heel ulcer was not appropriately cared for it could get real bad quick, the wound was already unstageable, the pressure ulcer would have declined. She further stated Skin prep- keeps the ulcer dry, dry gauze is put around the heel for protection so it does not get caught on a sock or blanket.
Interview 02/15/18 at 12:29 p.m. with CNA-G who stated she worked in the LTC area of the facility. She stated if she found skin issues on a resident she would notify the nurse. She stated prior to Resident #1's transfer to the hospital she was staying in bed more. She performed peri-care on the resident and dressed her on 02/09/18 but she did not notice any skin issues. If she knew a resident had skin issues she would monitor those areas for worsening but she would not normally look at the heels unless the resident had known skin issues. She stated she would expect that someone who sits or lies in bed a lot may get pressure ulcers to her bottom, back and heels.
Interview 02/15/18 at 1:05 p.m. CNA-H stated she had cared for Resident #1 once when she was on the rehabilitation hall and several times on LTC hall. She stated she had performed peri-care and would dress her in the morning and put on the resident's socks and shoes, she had not noticed any skin issues. She stated she would apply Laniseptic to the resident's buttocks but she never looked at the resident's heels. She stated Resident #1 spent a lot of time in bed prior to her transfer to the hospital. She stated if a resident spent a lot of time in bed or sitting she would expect pressure ulcers to develop on the heels and bottom.
Interview on 02/15/18 at 2:19 P.M. LVN-I stated she performed Resident #1's admission assessment on 12/13/17 and documented a skin tear to the residents left wrist and documented the dressing was intact. She stated Resident #1 spent much of her time in bed and more than likely she was in bed when the assessment was performed. Review of the Progress Note dated 12/13/17 along with LVN-I, of the report received from the hospital prior to the resident's admission which indicated the resident had skin issues on her left and right buttock and both heels, LVN-I stated due to the number of assessments she performs each night, she may have got this resident mixed up with another resident. She stated she did look at the resident's heels and buttocks and she had no skin issues. She stated she performed weekly skin assessments on residents and she would have performed Resident #1's weekly skin assessments while she was in the rehabilitation area. She stated when a resident was transferred from rehabilitation to LTC she would normally tell the nurse what skin issues were present, or the nurse would look at the documentation to see what skin issues were present.
When questioned as to what could happen if a resident was admitted with a pressure ulcer that was not documented and went untreated, she stated the resident could possibly get an infection in the wound [MEDICAL CONDITION] if not addressed. She stated Skin prep protected the outer edges of the wound from bacteria that would get into the wound under the scab. Dressings were ordered to protect the skin prep, and she would treat wounds as she was told to. She stated Resident #1 was incontinent, she had a Foley catheter and required turning.
Review of CNA documentation which indicated Resident #1 had a skin issue on 12/23/17 and the Daily Skilled Nurses Notes for that date, along with LVN-I, she stated she did not know what the skin issue was because the nurse did not document the issue. She stated the CNA's would notify her if they saw any new skin issues.
Interview 02/15/18 at 3:17 p.m. the DON she reviewed the Progress Note dated 12/13/17 which the DON stated was an admission report from the hospital prior to Resident #1's admission to the facility and stated well it says there is skin breakdown left buttock and right buttock pressure ulcer and heels it looks like. She stated she was unsure which nurse had taken the report. She stated she did know Resident #1 had chronic heel issues. The DON reviewed Resident #1's admission skin assessment dated [DATE] which indicated the only skin issue was a skin tear to the resident's left wrist and stated she would think the nurse had evaluated the resident and found no issues.
The DON reviewed the Care Plan conference summary dated 12/15/17 which indicated Stage II PU (pressure ulcer) to buttocks & ST (skin tear) to lower arm. The DON stated it looked like the MDS nurse wrote the information.
The DON reviewed Interim Plan of Care dated12/13/17 which documented a stage II PU L. buttocks and ST to wrist
Upon advising the DON that ADON-B had assessed Resident#1 on 01/25/18 as he believed she would still have the unstageable pressure ulcer on her right heel, she stated I find it hard to believe that it would go through that many people and no-one had seen it if it was there. She stated she would not speculate on how that could have happened.
She stated she would expect the CNA's to assess the resident's skin during showers and getting them dressed, that is part of their responsibilities .my concern would be the system is broken if someone can be admitted and pressure ulcers are not documented and I need to get it fixed immediately.
She stated, regarding Resident #'s ulcer not being treated, the ulcer could heal on it's own or it could get worse.
Resident's with documented pressure ulcers get a dietary consultation, the dietitian received a copy of the skin assessment sheets every week.
Review of Resident #2's Face Sheet dated 04/07/17, revealed he was a [AGE] year-old-male who was re-admitted to the facility on [DATE], his [DIAGNOSES REDACTED].
Resident #2's MDS assessment dated [DATE] revealed he had moderately impaired cognition, he had difficulty hearing and speaking and his understanding was limited. He had limited mobility on one side, of both his upper and lower extremities. He was totally dependent on two staff for ALD's. He was incontinent of both bowel and bladder and had a Foley catheter for urinary drainage. He was considered at risk of developing pressure ulcers, he had no pressure ulcers but had skin problems for which he received treatment.

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F 0686

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 2)
Review of Resident #2's Care Plan updated 11/07/17, reflected;
Problem Onset: 11/07/17 Open area to (R) lat (lateral) lower leg
Goal & Target Date: wound will lessen in size without s/s (signs/symptoms) of infection over the next 90 days
Approaches included .wound care as ordered; cleanse w/wound cleanser, pat dry, apply [MEDICATION NAME], cover w (with)/4x4 gauze, wrap w/kling Q (every) day x 30 days, then re-assess. Wound measurements/characteristics weekly and document .
The resident was at risk for alteration in skin integrity as evidenced by history of pressure ulcers, nutrition via [DEVICE], [MEDICAL CONDITION] and stays in bed except for getting up for showers
Goal & Target Date: (name of Resident) will not suffer complications resulting from pressure ulcers over the next 90 days
Problem Onset: 04/10/17
Approaches included .Weekly and PRN skin assessment by nurse .
Review of Resident #2's Physician's Telephone Orders revealed;
Date Ordered: 10/07/17 cleanse with Normal Saline, pat dry, apply [MEDICATION NAME] and cover with [MEDICATION NAME]. Cover
with [MEDICATION NAME] and tape for 10 days, each day and PRN (as needed), then re-assess. Indication/Dx (Diagnosis) R. ankle stage II
Date Ordered: 01/19/18 Cleanse right outer calf with normal saline product, pat dry, apply Dakin's soaked 4 x 4 cover with stack of 4 x 4 and Kling daily and PRN. Indication/Dx: was blank
Date Ordered: 01/27/18 Cleanse right outer calf with normal saline, pat dry, apply santyl and cover with 4 x 4 and Kling each day and PRN. Indication/Dx: wound
Date Ordered: 01/29/18
1) D'c (discontinue) wound care cleanse and apply Dakins
2) Start wound care, cleanse with normal saline, pat dry, apply . (illegible) , change every 3 days and PRN
Indication/Dx: Dx L. leg
Review of Resident #2's Weekly Skin Integrity Review dated 01/10/18 and signed by LVN-D revealed ankle, calf, and left knee skin issues, but did not reflect any other skin problems.
Observation 02/14/18 at 2:19 p.m. of Resident #2, along with LVN-C who stated the resident had two unstageable, due to scabs, pressure ulcers on his right leg/calf. Observation of the resident revealed he had contractures of his arm, right hand, leg and foot. There was a pillow beneath the resident's right knee and a rolled blanket beneath the resident's right distal foot. The lateral aspect of the Resident's foot was resting on the bed. He had a [MEDICAL CONDITION] of his left leg. LVN-C removed the right leg dressing, there was a small amount of fresh blood evident on the dressing. Beneath the dressing was a reddened non-blanchable, pressure ulcer approximately (Length x Width) 10.16cm x 5.08cm, within the reddened area were two pressure ulcers (ulcers #1 and #2). Ulcer #1 was located on the proximal lateral calf and measured approximately 2.54cm x 3.81cm, the scab had partially lifted from the skin and a small amount of fresh blood was coming from the wound. Ulcer #2 located on the distal lateral calf measured approximately 2.54cm x 2.54cm, there was no scab covering the wound. The wound bed was deep red and a small amount of blood was coming from the wound.
Interview 02/14/18 at 2:22 p.m. LVN-C stated she had performed wound care on Resident #2 today and had measured his wounds. She stated the resident's scabs must have come off after she had provided wound care because the wounds were dry and scabbed when she last saw them. She stated the wound care nurse consultant saw the resident each month and recommended treatment but the consultant did not document the visits.
Review of Resident #2's Ulcers, Surgical Site Treatment and Progress Record entries dated 02/14/18 and signed by LVN- C, reflected;
NPUAP (National Pressure Ulcer Advisory Panel) STAGES FOR PRESSURE ULCERS
Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister
Stage 1: Intact skin. Non-blanchable redness .
Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough .
Stage 3: Broken skin, deep tissue involvement. Full thickness wound
Stage 4: Broken skin through all layers of tissue, including muscle, tendon or bone .
Unstageable: Full thickness loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed .
L (length) 2.8cm, W (width) 1.7cm
Additional Documentation: black area 2.0cm x 0.6cm, green slough area 0.8cm x 1.1cm surrounding area pink
Length: 0.7cm/0.2cm, Width: 0.5cm/0.2cm
Additional Documentation: Both area dry and scabbed, no drg (drainage), no redness
Observation of Resident #2 on 02/15/18 at 1:45 p.m. along with ADON-B. The resident was supine in bed, there was a pillow beneath his right knee and upper leg, the resident's right foot, which was contracted inwards, was lying on a folded blanket. The lateral aspect of the right foot was visible and there were two circular pressure ulcers approximately 0.5cm x 0.5cm each, the top layers of skin were not present and the wound beds were deep red and moist.
Interview 02/15/18 at 2:0 p.m. with LVN-C and ADON-B revealed they reviewed Resident #2's Ulcer, Surgical Site Treatment and Progress Record revealed the two stage II pressure ulcers on the lateral aspect of the resident's right foot were not documented on the treatment record. When asked why the sites were not documented for treatment LVN-C stated she was just doing skin prep to the areas. When questioned as to where the order for the skin prep was, she stated there was no order for the skin prep, she stated the areas would never go away. She stated the resident had had them for a long time. She stated she would classify the areas as stage I or II, and that she would only document the areas if they got worse than a stage I. ADON-B stated all pressure areas needed to be documented and the treatment should be documented on the EMR (Electronic Medical Records -Ulcers, Surgical Site Treatment and Progress Record) He stated all treatments required a physician's orders [REDACTED].>Interview 02/15/18 at 3:17 p.m. the DON she stated regarding the undocumented right lateral foot ulcers, Resident #2's physician had said the resident had pressure ulcers that had healed but would always remain red and staff should reposition him to try to keep the skin intact. She stated she would expect the nurse to document the location and measurement of those wounds on the monthly summary report along with what the physician had said. The DON provided a monthly summary dated 12/29/17. Under skin conditions, Ulcers and Other skin conditions the nurse had checked the area that indicated None. There was no documentation in the notes area of the report. The DON then stated the physician had told her, just a few weeks ago that the resident had scar tissue on his foot that would not heal but she had no documentation to show this. She stated the physician had no treatments ordered for those areas but the facility protocol for a stage I - II pressure ulcers was a barrier cream. Skin prep was used as a barrier to toughen the skin. She stated the nurse should have documented the treatments on the TAR (Treatment Administration Record/ Ulcers, Surgical Site Treatment and Progress Record) and should have had a treatment order before doing treatments on those areas. She stated the nurse told her she did not have the treatment documented on the TAR. She stated the nurse had intended to write a physician's orders [REDACTED]. She stated if a nurse discovered a new skin issue they were to call the DON after hours. If the issue was discovered during business hours they were to tell the DON or ADON.
Review of Skin Prep Indications, obtained 02/28/18 from http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/, reflected Skin Prep could be used for the following purposes:
oApply as a coating to prepare the skin for adhesives.
oProvides a protective interface that may reduce friction during the removal of tape.
oFor skin attachment sites: drainage tubes, external catheters, surrounding ostomy sites and other adhesive dressings.
oFor use in sensitive stoma areas as a skin protectant.
oMay reduce irritation from contact with body wastes and stoma fluid.
oForms a protective film on skin which may reduce exposure to urine and feces.
oSKIN-PREP should only be used on intact skin.
The precautions for Skin Prep included, Do not apply directly to open wounds or in deep puncture wounds. Should redness or other signs of irritation appear, discontinue use.
Observation 02/15/18 at 1:43 p.m. along with ADON-B, Resident #4, on the 400 hall, was lying on her side, there was no pillow between the residents knees and ankles. ADON-B stated the resident should have a pillow between her legs to protect pressure areas. No redness noted.

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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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) Review of Resident #4's Face sheet revealed she was a [AGE] year-old female, who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's MDS dated [DATE] revealed she was severely cognitively impaired, she required extensive assistance of two staff with ADL's including bed mobility. She was at risk for pressure ulcers, she had no ulcers but had other skin problems for which she received treatment. Observation 02/15/18 at Observed along with ADON-B Resident #5 on 400 hall, the resident was in a motorized wheelchair, his heels were resting directly on a pillow. The resident stated he has staff elevate his heels when he is in bed because it feels better. ADON-B removed the pillow, folded it and placed it behind the resident's calves so his heels floated above the foot rest on the WC and the resident said that felt better. No redness noted to heels. Review of Resident #5's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's MDS dated [DATE] revealed, he was cognitively intact. He required extensive assistance of two staff with ADL's including bed mobility. He was at risk for pressure ulcers, he had no ulcers. The resident had other skin problems for which he received treatment. Interview on 02/16/18 at 10:02 a.m. with the Administrator, Medical Director (MD), the VP of clinical operations, and the DON. Upon questioning the MD as to what could happen if a resident who had an unstageable ulcer to her heel went without appropriate care and treatment he stated he would not comment on this. When asked if he would expect that the nurse would call him if his patient developed a new skin ulcer or wound, he stated No he would expect the nurse would notify him when he made his rounds on Monday's and Friday's. Upon questioning the MD if he was involved in reviewing and approving the facility's Policies and Procedures he said he was. The VP of Clinical Operations then stated, she would expect the nurses to perform a complete head to toe assessment of each resident on a weekly basis and she would expect them to document any [MEDICAL CONDITION] including measurements, location and type of wound. She stated it was the facility policy that the nurse contact the physician immediately if a resident had a new pressure ulcer and obtain an order for [REDACTED]. Interview 02/16/18 at 12:35 p.m. the DON she stated wounds should be documented as to location and type of wound with each wound documented on a separate form. Interview 02/16/18 at 2:01 p.m. with ADON-B revealed when questioned as to where the missing skin integrity review sheets were for Resident #1, he stated they weren't done. ADON-B stated he was only able to find one weekly skin integrity review for Resident #2 from 12/01/17 through the current date and it was dated 01/10/18. When questioned as to if there was anywhere else the skin assessments could have been documented he stated No, they were not done. He stated he had performed a skin sweep of the resident's on his halls and would provide an updated assessment for Resident #2. Review of Resident #2's updated skin integrity review sheet dated 02/15/18 and completed by ADON-B, revealed the resident had a stage II pressure ulcer to the lateral aspect of his right foot that measured 0.5cm x 0.5cm, it was dry, red and open. He also had an unstageable pressure ulcer to the lateral aspect of his right calf. Review of the facility's Skin Management System Policy and Procedure revised 03/16 reflected; 1. A head to toe body evaluation will be completed on every resident upon admission or readmission and weekly thereafter. These evaluations will be documented on the 'Weekly Skin Integrity Review' form or EMR. .If skin is compromised, proceed to the appropriate form below. .A. Pressure Ulcers .will be documented on the 'Ulcer, Surgical Site Treatment and Progress Record' form or EMR. Use one form per wound. Wound progress is to be documented each week with measurements and wound descriptions. Daily treatments are also documented on the same form . .8. Facility DONs are responsible to establish a system to monitor and assure Skin Management System Compliance Review of CMS Form 802 dated 02/14/18 revealed 14 residents were at High Risk for Pressure Ulcers.