STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495173	A. BUILDING _____ B. WING _____	C 01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA NURSING CENTER NORFOLK	249 SOUTH NEWTOWN RD NORFOLK, VA 23502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/24/17 through 1/26/17. Six complaints were investigated during the survey. Significant Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 197 certified bed facility was 167 at the time of the survey. The survey sample consisted of 29 resident reviews; 23 current residents (Residents #1 through #23) and 6 closed record reviews (Residents #24 through #29).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		3/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2017

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F 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, family interview, facility document review, and during the course of a complaint investigation, the facility staff failed to notify the resident's emergency contact of a change in medical condition for 1 of 29 residents in the survey sample, Resident #18. The findings included:	F 157	F157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 1. Resident #18 continues to reside in the facility. The Emergency Contact has been informed of Resident #18□s Change in Condition and transfer	

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F 157	Continued From page 2 Resident #18 was admitted to the facility on 1/18/17. Diagnoses included but not limited to high blood pressure, generalized epilepsy (1) and ESRD (End-Stage Renal Disease) (2). Resident #18's Minimum Data Set (an assessment protocol) with an assessment reference date of 1/25/17, coded resident with a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognitive abilities and daily decision making skills. On 1/24/17 at 6:30 pm, an interview with Resident #18's emergency contact (a family member) was conducted by phone. The family member complained of not being notified by the facility of the resident's change in medical condition and transfer to the hospital on 1/23/17. The family member expected the facility to inform her of any changes in resident's medical condition, care and treatment. An interview was conducted on 1/26/17 at 11:10 am with the Director of Nursing (DON) and RN #2, Unit Nurse Manager. The DON stated that, "When he (Resident #18) returned from dialysis, he was having symptoms in transit. The transport team took him back to the facility and while he was still in stretcher, he was having the same symptoms of nausea, vomiting and high blood pressure. This occurred prior to arriving during transit. He was requesting to go to the ER (Emergency Room)." When asked if the Residents #18's emergency contact was notified of the resident's change in condition and transfer to the hospital, the DON	F 157	to the hospital. 2. Residents experiencing a Change in Condition have the potential to be affected. The Clinical Managers reviewed 100% of the medical records of residents who experienced a Change in Condition over the last two weeks to validate notification of RP/Emergency Contact. No other residents were affected. 3. The Staff Development Coordinator will provide education to the licensed nursing staff regarding the policy and procedure that governs the standards of practice related to Notification of Changes. The Licensed Nurses will notify the resident□s RP and/or Emergency Contact when the resident experiences a change in condition. The IDT team will review the medical record of residents who experience a change in condition during the Morning Clinical Meeting to validate notification of RP/Emergency Contact. 4. The Clinical Manager will audit 10% of the medical records of residents who experience a	

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F 157	Continued From page 3 stated that RN #3 (Nursing Supervisor) "was aware of what has occurred but he did not notify because (resident's name) was his own responsible party." The DON stated that he (RN #3) spoke with the family member (emergency contact) the following day on 1/24/17, in response to the family member's call to the DON regarding the resident's dialysis and laboratory tests. On 1/26/17 at 12:25 pm, Resident #18 was asked about his preference in regards to contacting his family member (emergency contact) when he has a change in his medical condition or transfer to a hospital. He stated that he preferred that his family member be called and notified. On 1/26/17, the DON was asked regarding her expectations from RN #18 when the resident is having a change in medical condition and being transferred to the hospital. The DON stated, "I would expect for any staff member to inform the emergency contact unless the resident preferred not to." The clinical record was reviewed and the Nurse's Progress Notes dated 1/23/17 had no documentation that the Resident #18's emergency contact was notified of change in his medical condition and transfer to the hospital. The facility policy titled "Life Care - Notification of Changes of Condition" with an original date of 10/7/1995 and revision date of 6/23/16 read, in part, as follows, "...2. The nurse on duty will notify the Practitioner and Resident/Legal Representative/Family Member when a significant change in the resident's physical, mental or psychosocial status (i.e, deterioration in health, mental or psychosocial status is either life	F 157	Change in Condition weekly for four weeks, then monthly to validate adherence to the established standards governing Notification of Changes. Findings will be reported to the QAPI Committee monthly for further review and recommendations.	

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F 157	Continued From page 4 threatening conditions or clinical complications)." The Administrator was made aware of these findings on 1/26/17 at 5:20 pm, no further information was provided. (1) ESRD (End-Stage Renal Disease) - is the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD). (Source: https://medlineplus.gov/ency/article/000500.htm) (2)Epilepsy - Epilepsy is a brain disorder that causes people to have recurring seizures. (Source: https://medlineplus.gov/epilepsy.html) COMPLAINT DEFICIENCY	F 157		
F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by:	F 242		3/6/17

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F 242	Continued From page 5 Based on facility document review, resident interview, and staff interviews the facility staff failed to ensure that 1 of 29 residents in the survey sample was allowed to make choices about aspects of their life in the facility that were significant to the resident, Resident #19. The facility staff failed to ensure that Resident #19 was allowed to make choices about significant aspects of her daily life to include individuals allowed in her private room while in the facility. The findings included: Resident #19 was a 76 year old admitted to the facility on 8/10/16 with diagnoses to include Parkinson's Disease (1), Major Depressive Disorder (2), and Anxiety Disorder (3). The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition. The most recent Minimum Data Set (MDS) assessment was a Quarterly with an Assessment Reference Date (ARD) of 11/7/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that Resident #19 was cognitively intact and capable of daily decision making. Resident #19's Comprehensive Care Plan dated 11/15/16-Present documented in part, as follows: Problems: Is capable of independent leisure pursuits of choice.	F 242	F242 SS=D 483.10(f)(1)-(3) SELF-DETERMINATION RIGHT TO MAKE CHOICES 1. Resident #19 continues to reside in the facility. Resident #19 was assured that it is a Resident Right to make choices regarding who is allowed in her room. The Business Office Manager (BOM) received education regarding Resident□s Rights per the Staff Development Coordinator on 2/1/17 and a review of the Sentara Commitments per the Administrator on 2/1/17. The Business Office Manager verbalized understanding of Sentara□s employees commitment to promoting and maintaining Resident□s Rights. 2. All residents have the potential to be affected. No other residents were affected. 3. The Staff Development Coordinator Will provide education to the staff regarding Residents□ Rights. The staff members will promote and maintain Residents□ Rights in the provision of care and services. 4. The Social Service Director/Designee will interview ten residents weekly for four weeks, then monthly for three months to validate adherence to practices for promoting and maintaining Residents□ Rights. Findings will be submitted to the QAPI Committee for review and further recommendations.	

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Goals: Will actively engage in leisure pursuits (offered groups and/or self directed); at least 50% of the time; by next review date.

Interventions: Provide activity calendar in resident room to identify activities of interest to attend as chooses and offer/provide brief social visits as needed to initiate rapport.

Allow quality time for family, friends, staff, and/or other residents.

On 1/25/17 at approximately 10:30 a.m. a Resident Group Interview was conducted in the large dining room with 9 residents present to also include Resident #19. During the Resident Group Interview Resident #19 shared with the group an incident that had occurred on 1/24/17 in her private room.
Resident #19 stated, "Mr. (Name) was pushing me into my room into my bathroom like I asked him too. I asked him to take me to my room and sit and wait in my room for me to finish so he could wheel me back to what we were doing. My back was to the door and I heard a female voice say to Mr. (Name) you get out of there your not supposed to be in there, what is going on in there? Mr. (Name) left the room, when I came out of the bathroom he was gone. While I was in the bathroom with the door shut the lady asked me if I was alright I said why wouldn't I be Mr. (Name) has taken me to the bathroom many times. I thought our actions had gotten him in trouble but we do it all the time. When I got back to Mr. (Name) I asked him who was the lady that told him to leave my room. Mr. (Name) said it was the black lady in the business office, so he took me to the business office to point her out to me. It was (Name) the Business Office Manager

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(BOM). (Name) (BOM) said, "Why are ya'll here what is this about, how come ya'll are in here." I asked her what kind of a woman she thought I was and had I broke some rule. She said yes you did, a male cannot be in a female room. Then I went over to see the Administrator. I told him exactly what happened and how rude she was to us. The Administrator did say there was no rule that I have to keep him out of my room, no such rule."

Mr. (Name) was a male resident with a recent Minimum Data Set (MDS) assessment a Quarterly with an Assessment Reference Date (ARD) of 12/29/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated that this resident was cognitively intact and capable of daily decision making also.

On 1/26/17 at 10:00 a.m. an interview was conducted with the Business Office Manager (BOM). The BOM was asked to explain what had happened on 1/24/17 with Resident #19. The BOM stated, "It was between 10/10:30 a.m. in the morning and I was walking by her room because that is my area for daily rounds and I could see Mr. (Name) and Ms. (Name) Resident #19 in her room at the bathroom. I said is everything ok in there and said to Mr. (Name) you need to come out after you do that." Surveyor asked, "Why did you tell him he had to come out of the resident's room?" The BOM stated, "Because he is a male in a female room. Surveyor asked, "Is that a rule in the facility?" The BOM stated, "I'm used to staff members helping them, it is not our normal practice to have a male resident push a female resident into the bathroom. Surveyor asked, "Did the resident come to see you about the incident?" The BOM stated, "Yes around lunchtime the

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same day. Ms. (Name) Resident #19 said what are you trying to say about me, I can't have a male in my room. What kind of a woman do you think I am. I told her I was just making sure everything was ok, because we don't normally have males push females into the bathroom it is not our normal practice. After that part of the conversation with her I wasn't entertaining her conversation at that point anymore because it was going away from the intent."

On 1/26/17 at 10:40 a.m. an interview was conducted with the Corporate Survey Compliance Officer. The Survey Compliance Officer was given the details regarding the above stated incident on 1/24/17 and asked if there was a facility rule regarding male and females being in the same room. The Survey Compliance Officer stated, "No, as long as they are both cognitively intact and consenting adults they absolutely have the right to be in each others room and do what they want."

On 1/26/17 at 12:15 p.m. an interview was conducted with Registered Nurse (RN) #1 the Clinical Manager for Unit 3. RN #1 stated, "The CNA (Certified Nursing Assistant) assigned to (Name) Resident #19 came to me on 1/25/17 to tell me (she) Resident #19 was upset during her bath time. I went to talk to her and (she) Resident #19 was telling me about what happened with the BOM in her room the day before. She (Resident #19) asked me what was the policy with males in female rooms. I told her if both residents are alert and the person is invited I don't know of any issues with a male being in a female room."

The facility policy titled "Resident Rights and

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Responsibilities" last revised on 11/10/15 documented in part, as follows:

Policy Statement: Prior to, or upon admission to the facility, the Resident/Patient will be informed of his/her rights, grievance procedures, and the rules and regulations governing his/her conduct and responsibilities while a resident in the facility.

Monitoring:

*A written copy of the Resident's rights, grievance procedures, and responsibilities will be provided to the resident and/or his/her resident representative. The Resident/Patient, or his/her resident representative, will be required to sign a statement certifying that such rights and responsibilities have been reviewed with his/her and that they have been explained to his/her satisfaction.

*Residents are entitled to exercise their rights and privileges to the fullest extent possible.

*The facility will make every effort to assist the resident in exercising his/her rights and ensure that the Resident/Patient is always treated with respect, kindness, and dignity.

The facility "Resident Orientation Handbook" last revised 2/2016 documented in part, as follows:

Resident's Bill of Rights for Long Term Care Facilities: VIRGINIA RESIDENT BILL OF RIGHTS, pages 16-25.

I. Privacy and Respect

*When you enter a nursing facility, you must be

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treated as a person with respect, dignity, and consideration.

III. Freedom from Abuse and Restraint

*You cannot be abused, scowled at, or punished at any time in the nursing facility.

IV. Freedom of Association and Communication in Privacy

You have a right to be visited by, and the facility must provide immediate access to:

*Others who want to visit you with your consent.

*You have a right to meet with other residents and resident groups in or out of the nursing facility.

V. Activities

*You have a right to plan your own daily activities.

On 1/26/17 at approximately 8:30 p.m. a pre-exit interview was conducted with the Administrator, the Director of Nursing, the Director of Clinical Services, and the Survey Compliance Officer where the above information was shared.

Prior to exit no further information was shared by the facility.

(1) Parkinson's Disease: a slowly progressive degenerative neurologic disorder characterized by resting tremor, pill rolling of the fingers, a masklike facies, shuffling gait, forward flexion of the trunk, loss of postural reflexes, and muscle rigidity and weakness.

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F 242	Continued From page 11 (2) Major Depressive Disorder: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality. (3) Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal. The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 242		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on general observations of the facility, the facility staff failed to ensure resident equipment was maintained in a sanitary manner on 1 of 4 nursing units (South 2). The findings include: On 1/25/17 at 2:30 p.m., during general observations on the South 2 unit's shower room, a shower chair was observed heavily soiled with brown material. The Housekeeping Supervisor and the Maintenance Director were both present	F 253	F253 SS=D 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1. The shower chair was disinfected per the staff during the survey. 2. Residents who utilize equipment have the potential to be affected. No residents were affected. 3. The Staff Development Coordinator will provide education to the staff regarding	3/6/17

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F 253	Continued From page 12 during the inspection. Both stated it was the nursing staff's responsibility to maintain the shower chairs in a sanitary manner. The South 2 Registered Nurse (RN) entered the shower room, examined the shower chair and stated, "The day shift showers have been completed for this unit and this shower chair should have been cleaned after resident use because it was stored in with the other clean shower chairs. It is one of our routinely used shower chairs." The Maintenance Director stated the shower chairs are power washed on a routine quarterly basis to maintain on going plan to deep clean resident equipment. He stated it was a line listed item on the Preventative Maintenance (PM) Weekly Check Off List. The PM Weekly Check Off List dated 1/12/17 to 1/20/17 did not evidence that shower chairs were on the list for inspection and routine power washing. The RN disinfected the shower chair and removed all material which she indicated was fecal material. On 1/25/17 at approximately 8:00 p.m., the aforementioned information was shared with the Administrator and Director of Nursing (DON). No further information was provided prior to survey exit. The facility's policy and procedure titled "Geri/Wheelchair/Other Resident Equipment-Disinfecting and Cleaning" dated 1/14/14 indicated resident equipment would be cleaned according to established schedules and as needed, clean each chair with cleaning agent, rinse and thoroughly between resident use and as needed.	F 253	the established Infection Control protocol for maintaining a sanitary, orderly and comfortable environment of care. The nursing staff will disinfect the shower equipment after each use. The Environmental Service Department will provide deep cleaning of the shower equipment weekly. 4. Members of the Safety Committee will conduct environmental rounds weekly to validate that the environment of care is maintained in an sanitary and orderly fashion; this includes adherence to Infection Control standards in maintaining shower equipment. Findings will be reported to the QAPI Committee monthly for further review and recommendations.	
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		3/6/17

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F 314	Continued From page 13 CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility document review the facility staff failed to provide the necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing for 1 of 29 residents in the survey sample, Resident #9. The facility staff failed to provide appropriate monitoring for Resident #9 who was at risk for pressure ulcer development. The facility staff failed to identify the resident had developed a right ischial (the lower portion of the hip bone) pressure ulcer until it had advanced to a stage III. Furthermore, the prevention intervention of weekly skin assessments conducted on 12/8/16, 12/29/16, 1/5/17, 1/12/17 and 1/19/17 were not thorough and were inaccurate.	F 314	F314 SS=G 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 1. Resident #9 continues to reside in the facility. The resident was readmitted to the facility on 12/06/2016. The Licensed Nurse Identified the presence of a Stage II pressure injury to the right ischium upon readmission; treatment orders were obtained and implemented along with an Interim Plan of Care to address the identified pressure injury; members of the Wound Care Team monitored the wound during Weekly Wound Rounds; treatment	

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F 314	Continued From page 14 On 12/23/16 an advanced stage III (1) pressure ulcer (2) to the right ischial was initially identified by the wound care specialist during a routine wound care assessment. The ischial pressure ulcer measured 4.5 cm (centimeters) x 1.5 cm x 0.2 cm. with light sero-sanguinous drainage, and presented with 15% yellow necrotic (dead) tissue that required surgical excisional debridement (3). The findings included: Resident #9 was admitted to the facility on 6/15/11 and a current readmission on 12/6/16. Diagnoses included quadriplegia (paralysis of all four extremities; legs and arms) and a chronic stage III pressure ulcer to the left outer ankle. The current MDS (Minimum Data Set) an annual with an assessment reference date of 12/13/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. The resident required extensive assistance of one staff for bed mobility, and personal hygiene. The resident was dependent on staff for transfers and bathing. Under Section M. Skin Condition the resident was assessed as having a stage III pressure ulcer and a stage II pressure ulcer. The resident was incontinent of bowel and had an indwelling Foley catheter (a tube placed into the bladder to drain urine). A hospital skin sheet for Resident #9 with a diagram of a body dated 12/5/16 was reviewed. The skin sheet annotated the resident had an open "wound" on the left outer ankle with nonblanchable redness, and an open "area" with	F 314	Orders and the plan of care were revised as indicated; resulting in resolution of the wound within 30 days. The wound was resolved prior to the time of the survey. 2. Residents with actual or risk for alterations in skin integrity have the potential to be affected. No other residents were affected. 3. The Staff Development Coordinator/ Designee has provided education to the nursing staff regarding the established practice standards that govern promoting and maintaining Skin Integrity, Wound Prevention and Wound Management. The Licensed Nurse will conduct a Skin Assessment/Evaluation upon admission, Quarterly and with a Significant Change in Condition. The Licensed Nurse will obtain and implement appropriate treatment orders for residents identified as having alterations in skin integrity. The IDT team will develop and implement an individualized, resident-centered plan of care to address the residents identified actual and/or risk factors for alterations in skin integrity. The Licensed Nurse will conduct weekly Head-to-To Skin Inspections in all residents. The Wound Care Team will evaluate progression of Wounds during Weekly Wound Rounds. The	

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F 314	Continued From page 15 nonblanchable redness around on the residents sacrum/coccyx area (based on the picture). The registered nurse (RN) unit manager for 2 South was interviewed on 1/25/17 at 10:15 a.m. She documented on 12/7/16, "Resident noted with a stage 2 ulcer to right ischium with excoriation and reddened areas. tx (treatment) implemented...Resident has Triad ordered for excoriated areas..." The RN unit manager was asked if the resident had a stage 2 pressure ulcer to the right ischium as there were no Weekly Skin Assessment Progress Reports found in the clinical record from 12/6/16 through 1/25/17 for this ulcer. She stated, "I'm not sure it was a stage 2 pressure ulcer, he came back from the hospital with MASD (4), it was probably MASD (Moisture Associated Skin Damage)." She further stated that she had requested the wound care specialist to assess the area on 12/9/16. She stated the wound care specialist assessed the resident's skin and verbalized to her that there was no pressure ulcer on the right ischium/ buttocks. A stage II should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD). National Pressure Ulcer Advisory Panel (NPUAP) The wound care specialist physical exam dated 12/9/16 indicated the resident's buttock area was "normal". The RN unit manager was asked about the stage III pressure ulcer to the right ischium on 1/25/17 at 10:15 a.m.. She stated, "It was discovered during wound rounds with (name of wound care specialist)". The RN unit manager stated she	F 314	Licensed Nurse will complete the Weekly Wound Progress Report for residents with alterations in skin integrity. 4. The Clinical Manager will review 100% of the Medical records for residents with alterations in Skin Integrity weekly for four weeks, then monthly to Validate adherence to the established practice standards for Skin Integrity. Findings will be submitted to the QAPI for review and further recommendations.	

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would have expected the wound to have been identified by the certified nurse aides who provide daily baths and incontinent care or during the weekly skin assessments.

The Braden Scale Pressure Ulcer Risk Assessment dated 12/23/16 evidenced the resident scored a 12. This indicated the resident was at high risk for pressure ulcer development.

The comprehensive plan of care effective 12/22/2016 to present identified the resident was at risk for further developing pressure ulcers.
The goal was the resident will remain free of further developing pressure ulcer(s) over the next 90 days, target date 2/22/17.
Interventions listed to achieve the goal included the following; check skin for redness, skin tears, swelling, or pressure areas. report any signs of skin breakdown, use pillows, pads, or wedges to reduce pressure on heals and pressure points, turn/reposition...

The Wound Care Specialist Evaluation dated 12/23/16 read, in part: "At the request of (name of attending physician), this (age and gender) was seen and evaluated today....presents with a stage 3 pressure wound of the right ischium of at least 1 days duration. Etiology: Pressure. The wound measured 4.5 cm (centimeters) x 1.5 cm x 0.2 cm. with light sero-sanguinous drainage, 15% yellow necrotic (dead) tissue (5), 50% granulation tissue (6), skin 35%. Procedure: Surgical excisional debridement of subcutaneous tissue. Dressing: Santyl (a debriding ointment) and calcium alginate dressing (a type of dressing that forms into a gel when it comes into contact with liquid) once a day.

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The Wound Care Specialist Evaluation dated 1/6/17 read, in part: Stage 3 pressure wound of the right ischium resolved on 1/6/17.

Further investigation evidenced the prevention intervention of weekly skin assessments conducted on 12/8/16, 12/29/16, 1/5/17, 1/12/17 and 1/19/17 were not thorough and or inaccurate as follows:
1. On 12/8/16, two days after readmission, the skin assessment identified the resident had one pressure ulcer located on the left ankle. Under other skin lesions, other wounds, or other skin problems the nurse checked, "No". The clinical record evidenced the resident had been assessed with excoriation and was receiving treatment.
2. The 12/29/16 skin assessment identified the resident had one pressure ulcer to the right ischium. The assessment failed to capture the left ankle pressure ulcer that was still present.
3. The 1/5/17 skin assessment identified the resident had one pressure ulcer to the right ischium. The assessment failed to capture the left ankle pressure ulcer that was still present.
4. The 1/12/17 skin assessment identified the resident had one pressure ulcer to the right ischium. The right ischium pressure ulcer had resolved on 1/6/17. The assessment failed to capture the left ankle pressure ulcer that was still present.
5. The 1/19/17 skin assessment identified the resident had one pressure ulcer to the right ankle, this was incorrect, the ulcer was on the left ankle.

The failure to provide a thorough and accurate assessment as evidenced by the above weekly skin assessments was presented to the RN 2 South unit manager on 1/25/17 at 10:15 a.m.

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The following morning on 1/26/17 at 10:10 a.m., the RN 2 South unit manager stated she had spoken with the night shift nurse (licensed practical nurse #10) who had conducted the weekly skin assessments for Resident #9. The nurses response was that she must have been "sleepy" and made "mistakes". The unit manager stated the nurse was provided education this morning on wound care and skin assessment. She stated the nurse was receptive to the education. Following this education, the RN unit manager had the nurse perform a head to toe skin assessment on a resident. The RN unit manager stated the nurse had made a "couple" of mistakes during the assessment.

An attempt to contact and interview LPN #10 was made on 1/26/17 at 1:50 p.m., a message was left. The nurse did not make a return phone call.

A dressing change observation of the left ankle and inspection of the resident's sacral/ buttock area was conducted on 1/26/17 at 12:45 p.m. The RN unit manager assisted the licensed practical nurse. The resident was observed to have a diffuse area of erythema (redness) and discoloration with three small areas of broken skin which appeared to be MASD. The nurse cleansed the area with dermal wound cleanser, applied Solosite gel (a hydrogel wound dressing with preservatives) to the open areas, applied skin prep to surrounding skin and covered with an Allevyn dressing. This treatment was started 1/25/17.

The above findings was shared with the Director of Nursing (DON) on 1/26/17 at 4:45 p.m. The DON stated she would have expected the stage

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III ischial pressure ulcer to have been identified during daily skin care or during the weekly skin inspections by the licensed nurse. She further stated that, "this is one of the areas that we are definitely working on...filling out the weekly skin assessments is one of them...".

At approximately 6:00 p.m., the DON provided additional information. An Ad Hoc QAPI (Quality Assurance Performance Improvement) plan dated 12/12/16. One of two Identified Opportunity for Improvement/ Deficient Practice was F 314. It read, in part: The IDT (Interdisciplinary) team has identified an opportunity to promote the highest quality of care and services by validating adherence to the established practice standards for Skin Integrity and Wound Management.
The DON/Designee will provide education to the nursing staff regarding the established practice standards that govern promoting and maintaining Skin Integrity, Wound Prevention and Wound Management. Education will be conducted during Dec TEA Time. One of the sign in sheets evidenced the night shift nurse (LPN#10's) signature of attendance for this education on 1/12/17.
According to the DON all education would be completed by 2/2/17.

The Ad Hoc QAPI plan did not include a date of compliance. When asked by two inspectors on speaker phone at approximately 6:45 p.m. the date of compliance, the DON stated, February 24, 2017. Shortly after this during a meeting with the survey team, the DON signed page 2 of the Ad Hoc QAPI with the date of compliance as 1/26/17.

No additional information was provided prior to exit.

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F 314	Continued From page 20 A complete assessment is essential to an effective pressure ulcer prevention & treatment program. A comprehensive individual evaluation helps the facility to: o Identify the resident at risk of developing pressure ulcers, the level & nature of risk(s); & o Identify the presence of pressure ulcers. It is, therefore, important for clinical staff to regularly conduct thorough skin assessments on each resident who is at risk for developing pressure ulcers. *Policies & Definitions: The facility policy titled Pressure Ulcer Prevention, revision date 6/23/16 read, in part: Policy Statement-To prevent development of pressure ulcers. Weekly skin inspections are conducted and documented on all residents by licensed staff. *Monitoring - At least daily, staff should remain alert to potential changes in the skin condition & should evaluate & document identified changes. NPUAP (National Pressure Ulcer Advisory Panel). COMPLAINT DEFICIENCY (1) Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. (NPUAP)	F 314		

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F 314	Continued From page 21 (2) Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). National Pressure Ulcer Advisory Panel (NPUAP) (3) Debridement - Debridement is the removal of devitalized/necrotic tissue & foreign matter from a wound to improve or facilitate the healing process. Various debridement methods include: Sharp or surgical debridement refers to removal of foreign material or devitalized tissue by a surgical instrument. (NPUAP) (4) MASD-Moisture Associated Skin Damage is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate (drainage) and perspiration. RAI (Resident Assessment Instrument) Manual. (5) Necrotic (dead) or devitalized tissue that has lost its usual physical properties & biological activity. NPUAP (6) Granulation tissue is the pink-red moist tissue that fills an open wound, when it starts to heal. It contains new blood vessels, collagen, fibroblasts, & inflammatory cells. NPUAP	F 314		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		3/6/17

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F 323	Continued From page 22 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on general observations of the facility, the facility failed to ensure the environment remained as free from accident hazards as possible. 1. The facility's patio areas (3) had several raised edges along it's parameter, 1/4 to 1/2 inch high. One sunken paving stone was also observed in one of the patio areas. These environmental hazards posed a potential trip or fall accident for ambulatory residents. 2. The facility staff failed to ensure resident shower bed mats were in good repair, without rips and tears to prevent skin integrity problems. The findings include:	F 323	F323 SS=E 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISON DEVICES 1a. Resident #20 continues to reside in the facility. Resident #20 has had no untoward affects from ambulating in the courtyard. The courtyard was immediately taken out of access for renovations. Residents were informed of the opportunity to utilize alternative outside areas as desired. b. Residents who ambulate in the courtyard with or without assistive devices have the potential	

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F 323	Continued From page 23 1. On 1/25/17 at 3:45 p.m., several raised edges of the three sectional patio 1/4 to 1/2 inch, and a sunken paving stone in one patio area were identified during general observations. The Maintenance Director was present during this observation and stated because of the water that settled on the paving stones, it caused sinking of the stones and recessing from edges of the patio. The Administrator joined the Maintenance Director and observed the hazards in the patio areas and stated they try to watch and observe closely the residents that ambulate with and without assistive devices until they can fix or replace all patio sections. He stated it was on the to do list, but probably need to move it up high on the list before someone tripped and "Get it done." Three ambulatory residents were identified that frequented the 3 sectional patio. Resident #20 was one of the residents that was observed ambulating throughout the patios on 1/24/17 at 3:40 p.m. The resident was admitted 9/10/14. The most recent Minimum Data Set (MDS) was a quarterly dated 12/29/16 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a total possible score of 15, which indicated the resident was fully intact with the skills needed for daily decision making. He stated he was careful when out on the patio. The facility's policy titled "Risk Management-Hazard Surveillance" dated 5/12/15 indicated the Administrator would ensure hazards are addressed and corrective action is taken if necessary. 2. The facility staff failed to ensure resident	F 323	to be affected. No residents have been affected. c. The courtyard is scheduled for repair to begin February 8, 2014. total renovations will include re-constructing of walking surfaces. Expected completion date is March 1, 2017. d. The Maintenance Director/Designee will conduct Environment of Safety Checklist Hazard Surveillance Rounds Weekly for four weeks, then monthly to validate that the environment is free of accidental hazards. Findings will be reported to the Safety Committee and QAPI Committee for review and further Recommendations. F323 SS=E 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISON DEVICES 2a. The facility staff removed the identified shower mat from the shower bed and properly disposed of the mat. The shower mat has been replaced. b. Residents who utilize the shower bed have the potential to be affected. No residents were affected. c. The Staff Development Coordinator will provide education to the staff regarding the process for ensuring that the resident care environment remains free from accidental hazards; to include ensuring that equipment is maintained in proper operational	

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F 323	Continued From page 24 shower bed mats were in good repair, without rips and tears to prevent skin integrity problems. On 1/25/17 at 1:45 p.m., during general observations of the facility and inspection of South 1's shower/bathing room, the shower bed mat exhibited numerous rips and tears. During the aforementioned inspection, the Maintenance Director stated the nursing staff should electronically send him work orders for repairs or replacements, but he had none related to damaged shower bed mats. The Maintenance Director stated he would take the damaged shower bed mattress off the shower bed, put it out of commission and order a new mat. The Maintenance Director also stated he conducted Preventative Maintenance (PM) rounds daily and weekly, to include all equipment in shower rooms, but had not seen the damaged shower mat. The most recent PM weekly check off list dated 1/20/17 did not indicate there were any problems or damages to shower bed mats. On 1/25/17 at 2:00 p.m., the South 1 Registered Nurse (RN) Unit Manager stated the mat needed to have been replaced and she was unaware of the rips/tears which had the potential to cause skin integrity issues. On 1/25/17 at approximately 8:00 p.m., the aforementioned information was shared with the Administrator and Director of Nursing (DON). No further information was provided prior to survey exit.	F 323	order. d. The Maintenance Director/Designee will conduct Environment of Safety Checklist Hazard Surveillance Rounds Weekly for four weeks, then monthly to validate that the environment is free of accidental hazards. Findings will be reported to the Safety Committee and QAPI Committee for review and further recommendations.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		3/6/17

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F 441	Continued From page 25 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 26 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to: #1. For Resident #2, the facility staff failed to ensure infection control measures were maintained during wound care. #2. The facility staff failed to ensure resident shower bed mats were in good repair, without rips and tears to prevent chances of cross	F 441	F441 SS=D 483.80(a)(1)(2)(4)¿(f) INFECTION CONTROL, PREVENT SPREAD, LINENS 1a. Resident #2 continues to reside in the facility. Resident #2 is receiving dressing changes in accordance with physician□s orders and established infection control practices. Employee #1 was re-educated by the Staff Development Coordinator	

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F 441	Continued From page 27 contamination and infection. The findings included: 1. Resident #2 was admitted to the facility on 7/17/15 with a readmission on 10/6//15. Diagnoses for Resident #2 included but are not limited to Quadriplegia (inability to move 4 extremities) related to fracture of (Cervical 5 through Cervical 7 vertebrae - fracture of neck), iron deficiency anemia, and Unstageable sacral Pressure Ulcer (1). Resident #2' s Annual Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/9/16 coded Resident #2 with a BIMS (Brief Interview for Mental Status) score of 14 of 15 indicating no cognition impairment. In addition, the Annual Minimum Data Set coded Resident #2 requiring total dependence with two staff persons for bed mobility, transfers and locomotion on and off the unit. In addition, the Annual Minimum Data Set coded Resident #2 as requiring total dependence with dressing, eating, toilet use and bathing. Resident #2's 6/30/15 Nursing Assessment clinical record documented, "No" for the question, "Does the patient have a Pressure Ulcer?" An 8/4/15 Physician progress note documented a Pressure Ulcer first identified as Unstageable Pressure Ulcer of the sacrum (tail bone area) measuring 4.5 centimeters (cm) long by 8.5 cm width 60 % eschar; 20 % yellow necrotic (4) tissue and 20 % granulation (5).	F 441	on 1/26/17 with return demonstration for competency with performing a clean dressing change. 1b. Residents with orders for dressing changes have the potential to be affected. The Clinical Managers have completed TX Observations with Licensed Nurses three times per week. No other residents were affected. 1c. The Staff Development Coordinator will provide education to the staff regarding the established Infection Control Guidelines; to include maintaining infection control during dressing changes. The Licensed Nurse will perform treatments in accordance with the physicians orders and the established infection control practices. 1d. The Staff Development Coordinator/ Designee will conduct Treatment Observations with three Licensed Nurses weekly for four weeks, then monthly to validate adherence to established Infection Control Practice standards. Findings will be submitted to QAPI Committee for review and further recommendations. F441 SS=D 483.80(a)(1)(2)(4)¿(f)	

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F 441	Continued From page 28 Physician orders documented the following: 8/3/15 Turn and reposition resident every 2 hours if unable to reposition self 8/3/15 Pressure relief surface for chair 10/26/15 Consult with wound Medical Doctor for Wound Care 4/6/16 P500 Mattress for pressure relief and aide with wound healing Resident #2's 11/7/16 Braden Scale for Predicting Pressure Sore Risk included the following predisposing factors: Limited Sensory Perception Skin constantly moist Bedfast, inability to walk Completely immobile Problem with friction and shearing of skin surface Resident #2 was hospitalized 10/2/15 through 10/6/15 with a diagnosis of Urinary Retention and a Foley Catheter was inserted. Resident #2's Current (effective date 11/29/16) Care Plan documented the following problem: Pressure ulcer related to immobility Stage IV (6) to sacrum (wound Vac Therapy began 2/1/16). 6/10/16 Chemical cauterization of hypergranulation to facilitate healing. Wound Vac Therapy discontinued 8/12/16. 11/4/16 Medical Doctor cauterized Stage IV sacral pressure ulcer due to hypergranulation. Goal Date 2/22/17 for goal of "...size of ulcer will decrease with evidence of healing over the next 90 days. Interventions included: First step mattress Upgrade to P500 air mattress 4/14/16 Weekly wound rounds by (wound specialists) consultant for assessment and treatment	F 441	INFECTION CONTROL, PREVENT SPREAD, LINENS 2a. The facility staff removed the identified shower mat from the shower bed and properly disposed of the mat. The shower mat has been replaced. 2b. Residents who utilize the shower bed have the potential to be affected. No residents were affected. 2c. The Staff Development Coordinator will provide education to the staff regarding the process for ensuring that the resident care environment remains free from accidental hazards; to include ensuring that equipment is maintained in proper operational order. 2d. The Maintenance Director/Designee will conduct Environment of Safety Checklist Hazard Surveillance Rounds Weekly for four weeks, then monthly to validate that the environment is free of accidental hazards. Findings will be reported to the Safety Committee and QAPI Committee for review and further recommendations.	

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Nutritional Screening. Adjust diet/supplements as indicated to reduce the risk of skin breakdown.

12/14/16 Weekly Skin Assessment documents Sacrum Pressure Ulcer Stage "Unstageable (7), DTI (8) (Deep Tissue Injury) with measurements of:
Length 1.5 centimeter (cm)
Width 1.3 cm
Depth 0.3 cm
Exudate amount moderate
Exudate color: Straw/Red without odor
Surrounding Skin: Macerated

8/3/15 Physician Order documented: "Pressure Relief Surface for chair"

4/6/16 Physician Order documented: "P500* mattress for pressure relief and aide with wound healing" for Stage IV pressure ulcer of sacral region.

*P500 a specialized air mattress

12/15/16 Physician Order documented: "Cleanse area with DWC (dermal wound cleanser), pack with aquacel and cover with allevyn bid (twice daily) until resolved.

Resident #2's 8/4/15 Wound Care Specialist Physician's note documented the following: "He presents with an unstageable (due to necrosis) of the sacrum ... There is light sero - sanquinous exudate. There is no indication of pain associated with this condition." The

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Physician documented: "Factors complicating wound healing: Anemia (9) - unspecified. HGB (hemoglobin) (10) 10.1 on 8/7/15."

Resident #2's 11/7/16 Braden Scale for Predicting Pressure Sore Risk scored Resident #2, "Very High Risk".

Observations for Resident #2 included:

1/24/17 at approximately 7:20 a.m.: Resident lying in bed, air mattress inflated. The Call light was a device that Resident blows into to call for nurse, was in place.

1/25/17 at approximately 11:20 a.m.: Wound Care Observation done of LPN (Licensed Practical Nurse) #1 who was accompanied by the Unit's RN Clinical Manager #4.
LPN #1 was observed placing her supplies on Resident #2's over the bed table without sanitizing the surface. The LPN was observed with gloves on, turning Resident #2, cleansing fecal (bowel movement) material from his sacral pressure ulcer and then was observed removing her gloves and placed a new pair of gloves on without washing her hands. LPN #1 was observed taking scissors and proceeded to cut aquacel dressing when the RN Clinical Manager stopped her and instructed her to sanitize the scissors before continuing. The LPN left the room and returned with sanitizer. The LPN washed her hands approximately 10 seconds. The LPN proceeded to sanitize the scissors, cut the aquacel dressing and then packed the wound. The LPN was observed picking up the marker and dated the outer dressing without hand washing. The LPN then covered the wound with

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Allevyn dressing. The LPN measured the sacral wound at: Length 1.1 centimeters (cm); Width 0.9 cm and depth 1.0 cm. After LPN #1 had taken the soiled dressings and brief out of the room, she placed the bag on top of the wound cart's trash compartment while she returned the bag of dressings that had been on top of Resident #2's bedside table back to the wound cart drawer. LPN stated she was done and did not sanitize the over bed table until cues provided by the surveyor to do so.

The RN Clinical Manager on 1/26/17 at approximately 11:10 a.m., stated: "She truly compromised infection control." The RN Clinical Manager stated that infection control was compromised related to handwashing and sanitizing of surface and scissors. The RN Clinical Manager stated that inservices had been completed with the LPN involved.

The Policy and Procedure with 6/12/15 revision date, titled: "Life Care - Hand Hygiene" documented the following:
Purpose: Guidelines are provided for proper and effective hand hygiene to prevent transmission of infections.
Appropriate 20 second handwashing must be performed under the following conditions:
Before performing resident care
After handling soiled items"

The Policy and Procedure with 6/23/16 revision date, titled: "Life Care - Wound Care" documented the following:
Purpose: To provide aseptic wound care in accordance with Physician's orders.
Required Action steps:
4. Set up clean area with supplies.

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5. Wash hands thoroughly and put on gloves
7. Discard Equipment and Wash hands

The facility administration was informed of the findings during a meeting on 1/26/17 at approximately 2:30 p.m. The facility did not present any further information about the findings.

(1) Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough (2) or eschar (3). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(S) should not be removed (The National Pressure Ulcer Advisory Panel)

(2) Slough: dead tissue separated from living tissue (Medline Plus)

(3) Eschar: dead tissue, a thick hardened black crust or scab (Medline Plus)

(4) necrotic- dead tissue (Medline Plus)

(5) granulation- soft pink fleshy tissue during the healing process of a wound (Mosby's 4th edition Medical, Nursing, and Allied Health Dictionary)

(6) Stage IV Stage 4 Pressure Injury:
Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur.

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Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (The National Pressure Ulcer Advisory Panel)

(7) Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(S) should not be removed. (The National Pressure Ulcer Advisory Panel)

(8) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

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(9) If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. (Medline Plus)

(10) Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body. (Medline Plus)

2. The facility staff failed to ensure resident shower bed mats were in good repair, without rips and tears to prevent chances of cross contamination and infection.

On 1/25/17 at 1:45 p.m., during general observations of the facility and inspection of South 1's shower/bathing room, the shower bed mat exhibited numerous rips and tears.

During the aforementioned inspection, the Maintenance Director stated the nursing staff should electronically send him work orders for repairs or replacements, but he had none related to damaged shower bed mats. The Maintenance Director stated he would take the damaged shower bed mattress off the shower bed, put it out of commission and order a new mat. The Maintenance Director also stated he conducted Preventative Maintenance (PM) rounds daily and weekly, to include all equipment in shower rooms, but had not seen the the damaged shower mat. The most recent PM weekly check off list dated 1/20/17 did not indicate there were any problems or damages to shower bed mats.

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F 441	Continued From page 35 On 1/25/17 at 2:00 p.m., the South 1 Registered Nurse (RN) Unit Manager stated the mat needed to have been replaced and she was unaware of the rips/tears which had the potential to house germs between resident to resident use and cause skin integrity problems. On 1/25/17 at approximately 8:00 p.m., the aforementioned information was shared with the Administrator and Director of Nursing (DON). No further information was provided prior to survey exit.	F 441		