STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY CDMPLETEO
	495362	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

Ashland Nursing and Rehabilitation Facility are filing this plan of correction for purposes of regulatory compliance. The facility is submitting this plan of correction to comply with the applicable law. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.

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1. Resident #3 is no longer resides at this facility.

2. All residents have the potential to be affected by this deficient practice. The facility will conduct a 100% audit of all Care plans of residents with wounds and any areas of concern will be corrected immediately.

3. The MDS coordinators will be educated on the Policy and procedures of accurate care planning. (b) MDS coordinator will audit ten random care plans weekly x 4weeks for and then 5 random care plans weekly x 4 weeks to ensure compliance

4. All findings will be reviewed at The Quality Assurance Performance Improvement (QAPI) meeting monthly to ensure current plan is working as written.

Completion Date: 3-9-2017

LABORATORY DIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) OATE

Executive Director/Administator 2/20/17

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 280	Continued From page 1	F 280		

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to review and revised the comprehensive care plan for one of three residents in the survey sample, Resident #3.

The facility staff failed to update Resident #3's comprehensive care plan on 12/23/16 after they identified three new pressure ulcers.

The findings include;

Resident #3 was admitted to the facility on 11/17/16 with diagnoses that included, but were not limited to, cancer, anemia (low red blood cell count), coronary artery disease (heart disease), high blood pressure, kidney failure, wound infection and seizures. Resident #3 was discharged from the facility on 1/13/17.

Resident 3's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/24/16. Resident #3 was coded as a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively intact. Section M, (Skin Conditions), coded Resident #3 as having two Stage 3* pressure ulcers and three unstageable* pressure ulcers on admission.

A review of Resident #3's clinical record revealed, in part, a nurses' note that documented the following information; "Asked to evaluate residents' (L) (left) heel, measures 4.5 (centimeters) x 5.5 x < (less than) 0.1. 100 %

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(percent) darkened area (abbreviation for with) light serous (pale yellow body fluid) drainage. Left hip wound measures 1.0 X 1.0 x 0.1, 100 % slough (a yellow, creamy tissue found on the wound bed) (abbreviation for without) drainage or odor. Stage II (2) (L) buttock 1.0 x 2.9 x 0.1 100% pink tissue."

A review of Resident #3's comprehensive care plan dated 11/17/2016 revealed, in part, the following documentation; "Focus: CAA (care area assessment) 16. The resident has impaired skin integrity Scab (sic) area of right great toe, UTS (unstageable) Right inner knee, UTS left inner knee, r/t (related to) history of pressure ulcers, incontinence, fragile skin, allergies, edema. Cardiovascular disease. Impaired Mobility. Date Initiated: 11/19/2016. Revision on: 11/30/2016." There were no new revisions documented following 11/30/2016. There were no new interventions documented following 11/19/16.

On 2/2/17 at 9:55 a.m. an interview was conducted with LPN (licensed practical nurse) #2, a floor nurse. LPN #2 was asked who was responsible for updating care plans in the facility. LPN #2 stated, "The unit manager or MDS." LPN #2 was asked what she would do if a new wound was found. LPN #2 stated, "I would notify the unit manager and they update it (the care plan) or I write it on the wound sheet of the care plan. We do that for all new findings."

On 2/2/17 at 10:00 a.m. an interview was conducted with LPN #3, the unit manager. LPN #3 was asked who updated the care plans with new findings. LPN #3 stated, "The unit manager or the MDS." LPN #3 was asked what she would do if a new wound was found. LPN #3 stated, "I

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would place the new wound on the care plan with an intervention. All the care plans are on the computer so I would just go into the computer and document."

On 2/2/17 at 11:20 an interview was conducted with LPN #1, the MDS coordinator. LPN #1 was asked who was involved in updating the care plans for the residents. LPN #1 stated, "It is an IDT (interdisciplinary team) process. We (the MDS coordinators) update the care plans with the MDS assessments schedule. The DCS (director of clinical services), may update, and the floor staff may update." LPN #1 was asked how the care plans were updated. LPN #1 stated, "If there is a paper care plan they would update on that, but most are in the computer and they go on the computer and update." LPN #1 was asked to review Resident #3's care plan. LPN #1 was asked whether or not Resident #3's care plan was updated with the new wounds that were found on 12/23/16. LPN #1 stated, "No they were not updated on his (Resident #3's) care plan." LPN #1 was asked whether or not the care plan should have been updated to include the wounds found on 12/23/16. LPN #1 stated, "Yes, the person who identified the wounds should have updated the care plan."

On 2/2/17 ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional director of clinical services were made aware of the above findings. A policy for updating care plans was requested at this time and none was provided prior to the end of the survey process.

No further documentation was provided prior to the end of the survey process.

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* This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/
Pressure Ulcer Stages/Categories
Category/Stage I: Non-blanchable erythema
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.
Category/Stage II: Partial thickness
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
*Bruising indicates deep tissue injury.
Category/Stage III: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose)

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subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
Category/Stage IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.
Additional Categories/Stages for the USA
Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.
Suspected Deep Tissue Injury - depth unknown
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as

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F 280	Continued From page 7 compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (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 interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide wound care in a manner to minimize infections and promote healing for one of three residents in the survey sample, Resident #2. During observed wound care the facility staff	F 314	F314D 1. Resident #2 wounds were re-dressed during the survey following infection control practice. 2. All residents with wounds have the potential to be affected by this deficient practice. The DCS observed wound care for other residents with wounds and did not identify any deficient practice. 3. Education has been provided to nursing staff on infection control practices and how to perform wound care. The DCS or designee will do wound rounds twice a week to ensure compliance with infection control practices and identification of any new areas. The DCS or designee will audit wound documentation 5x a week for three months to ensure accuracy in documentation. 4. All findings will be reviewed at The Quality Assurance Performance Improvement (QAPI) meeting monthly to ensure current plan is working as written. Completion Date 3-9-2017	

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failed to ensure that Resident #3's open wounds did not come in contact with dirty materials.

The findings include;

Resident #2 was admitted to the facility on 9/12/16 with a readmission on 11/4/16 with diagnoses that included, but were not limited to, anemia (low red blood cell count), high blood pressure, diabetes, aphasia (difficulty with speaking), pressure ulcers, quadriplegia (inability to move below the chest).

Resident 2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/16. Resident #2 was unable to respond to questions on the Brief Interview for Mental Status (BIMS), the staff assessment coded Resident #2 as a "2 (two), indicating that Resident #2 was severely impaired cognitively. Section M, (Skin Conditions), coded Resident #2 as having one Stage 4* pressure ulcers and one unstageable * pressure ulcer acquired.

On 2/1/17 at 09:30 LPN (licensed practical nurse) #4, the wound care nurse, was observed providing wound care to Resident #2. LPN #4 gathered her supplies, cleaned the bedside table in Resident #2's room with a bleach wipe, placed an absorbent paper towel on the table and laid the supplies on top of the towel. LPN #4 poured 1/4/ strength Dakins ** (a brand name solution used to prevent and treat tissue infections) into three separate medicine cups and placed gauze into each cup to absorb the Dakins solution. LPN #4 stated that the order for the wounds was to dress with a "wet to dry" dressing using the Dakins solution. Three wound dressings were

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scheduled to be changed; the left hip, right hip and sacrum. LPN #4 with the assistance of an aide turned Resident #2 over onto his left side, the chuck beneath Resident #2 was observed to be soiled by a red/brown substance in the area directly beneath Resident #2's hip. The chuck was not changed prior to the wound dressing change. The dressing on the right hip was removed the wound was cleaned using a Dakins soaked gauze. LPN #4 measured the wound as 8.5 cm (centimeters) x 8.1 cm x 1.7 cm with undermining and tunneling present at 8 o'clock and 12 o'clock (the clock face is used to orient care givers to the location of the tunneling). The wound bed was described by LPN #4 as a stage III (three) wound with the edges defined and the wound bed as "beefy red with necrotic tissue present at 12 o'clock and slough present." After LPN #4 had finished cleansing the wound with the Dakins soaked gauze, LPN #4 removed her gloves, washed her hands and put on a clean pair of gloves. While LPN #4 washed her hands, the CNA (certified nursing assistant) who was helping with turning Resident #2 took the sheet that had been covering Resident #2 and placed it over the open wound. LPN #4 returned to the patient's right side and the CNA pulled the sheet back exposing Resident #2's open wound area. LPN #4 took clean Dakins soaked gauze and proceeded to pack the gauze into the wound, being sure to pack the gauze under the edge of the wound edge. As LPN #4 packed the open wound the bottom edge of the soaked gauze strip touched the chuck beneath Resident #2. LPN #4 continued to pack the gauze into the wound. LPN #4 covered Resident #2's right hip wound with a dry dressing, securing it into place. LPN #4 then proceeded to remove the dressing on the sacrum exposing a small open wound measuring 0.7 cm

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x 0.6 cm x 0.5 cm. LPN #4 cleansed the area with a Dakins soaked gauze and then stepped away to remove her gloves and wash her hands. As LPN #4 was at the sink, the CNA pulled the dirty chuck beneath Resident #2 up and over his buttocks, covering the open sacral wound. When LPN #4 returned to the bedside the CNA let the dirty chuck fall back to the bed. LPN #4 packed the sacral wound with the Dakins soaked gauze, placed and secured a dry dressing to the area. Resident #2 was turned over onto his right side so that LPN #4 could address Resident #2's left hip wound. The chuck beneath Resident #2's left hip was noted to have an area that was soiled. The dressing on the left hip was cleansed and dressed without incident.

Following the wound care LPN #4 was asked why she prepared a clean area prior to changing Resident #2's wound dressings. LPN #4 stated, "To be sure that we do not introduce anything into the wound that could cause an infection." LPN #4 was asked whether or not the chuck beneath Resident #2 was considered clean. LPN #4 stated, "No it looks like it has drainage from his (Resident #2's) wounds. It is not clean." LPN #4 was asked whether or not the chuck should have been changed prior to changing the wound dressings. LPN #4 stated, "It is not a sterile technique but we should make sure that the area is clean." LPN #4 was asked if she was aware that the CNA assisting her had pulled the dirty sheet over Resident #2's exposed right hip wound and pulled the soiled chuck beneath Resident #2 over the open sacral wound, while she washed her hands. LPN #4 stated that she hadn't really noticed. LPN #4 was asked whether or not there was a concern with the CNA making contact with open wounds with items that were soiled. LPN #4

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stated that the wound should not come into contact with anything while open. LPN #4 was asked whether or not she had noticed that the gauze she used to pack Resident #2's left hip wound had come into contact with the soiled chuck beneath the resident. LPN #4 stated that she had not noticed that the gauze touched the chuck. LPN #4 further stated, "If the gauze touched the soiled chuck there is potential for bacteria to get into the open wound."

A meeting was held with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, on 2/1/17 at 5:15 p.m. ASM #1 and ASM #2 were made aware of the above findings. A policy regarding infection control during wound care was requested.

No further information was provided prior to the end of the survey process.

* This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/
Pressure Ulcer Stages/Categories
Category/Stage I: Non-blanchable erythema
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.
Category/Stage II: Partial thickness
Partial thickness loss of dermis presenting as a

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	495362	A. BUILDING _____ B. WING _____	C 02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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
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shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
*Bruising indicates deep tissue injury.
Category/Stage III: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
Category/Stage IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.
Additional Categories/Stages for the USA
Unstageable/Unclassified: Full thickness skin or

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F 314	Continued From page 13 tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. Suspected Deep Tissue Injury - depth unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. ** This information was obtained from the following website; http://www.webmd.com/drugs/2/drug-62261/dakin"s-solution/details,	F 314		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F 514		

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are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical document review and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a complete and accurate record for one of three residents in the survey sample, Resident #3.

The facility staff failed to clearly and consistently identify the location of a wound that was found on

1. Resident #3 no longer resides in this facility. Resident #2 treatment record has been updated and corrected.
2. All residents who reside in this facility have the potential to be affected by this deficient practice. Records of residents with wounds will be audited and any concerns will be corrected.
3. Education was provided to staff on infection control and wound care dressing to ensure compliance. An audit of wound care notes from licensed staff and the Wound care M.D. was done to ensure compliance and cohesiveness. The DCS or designee will do wound rounds twice a week to ensure accuracy in documentation. The DCS or designee will audit wound documentation 5x a week for three months to ensure accuracy in documentation..
4. All findings will be reviewed at The Quality Assurance Performance Improvement (QAPI) meeting monthly to ensure current plan is working as written
Completion Date: 3-9-2017

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Resident #3 on 12/23/16. A wound discovered on Resident #3 on 12/23/16 was described as a sacral wound, a left buttock wound and a right buttock wound. The treatments and discussion of the wound used the three areas interchangeably.

The findings include;

Resident #3 was admitted to the facility on 11/17/16 with diagnoses that included, but were not limited to, cancer, anemia (low red blood cell count), coronary artery disease (heart disease), high blood pressure, kidney failure, wound infection and seizures. Resident #3 was discharged from the facility on 1/13/17.

Resident 3's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/24/16. Resident #3 was coded as a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating that the resident was cognitively intact. Section M, (Skin Conditions), coded Resident #3 as having two Stage 3* pressure ulcers and three unstageable * pressure ulcers on admission.

A review of Resident #3's clinical record revealed, in part, the following nurse's notes written by LPN (licensed practical nurse) #4, the wound care nurse;

"12/23/16 Asked to evaluate residents (sic) .....
Stage II (two) (L) buttock 1.0 x 2.1 x 0.1 (measurements in centimeters)."
"12/29/16 Clarification Buttock wound area on right side as previously documented as left."

Further review of Resident #3's clinical record

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revealed, in part, the following telephone orders entered by LPN #4;
"12/23/16 Cleanse (L) buttock wounds with NS (normal saline) apply santyl * (a brand name product used for pressure ulcer wounds), cover with dry dressing, change QD (each day) and PRN (as needed).

A review of Resident #3's pressure ulcer record revealed, in part, the following entry for 12/23/16;
"Present on Admission (check marked "no") 12/23/16. Location: (R) right medial sacrum."

A review of Resident #3's wound physician notes dated 1/2/17 revealed, in part, the following entry for 12/23/16;
"Stage 3 ** Pressure Wound of the Medial Sacrum"

A review of Resident #3's TAR (treatment administration record) dated 1/1/17 - 1/31/17 revealed, in part, the following treatment entry for nursing staff to sign off as being completed each day;
"Cleanse (L) (left) buttock wound with NS. Apply santyl, cover with dry dressing. Change QD and PRN."

On 2/2/17 at 11:25 a.m. an interview was conducted with LPN #4, the wound care nurse. LPN #4 was asked to review her notes and describe where the wounds that were discovered on 12/23/16 were located on Resident #3. LPN #4 stated, "I clarified in my notes that he (Resident #2) had a wound on his left buttock that was a stage 2. I don't know why my pressure ulcer record states the medial sacrum; I just try to make sure that my notes match the wound doctor's notes." LPN #4 was asked if the wound

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doctor saw Resident #2 on 12/23/16, LPN #4 stated he did not, he (the wound doctor) saw Resident #2 on 1/2/17. LPN #4 was asked if Resident #2 had a wound on both his sacrum and his buttock, LPN #4 stated he did not. LPN #4 was asked to explain the discrepancy with the nurse's notes, the wound sheets and the pressure ulcer record. LPN #4 stated that she must have just used different descriptors for the same site in an effort to be "on the same page" as the wound doctor. LPN #4 further stated, "There was only one wound and it was on his bottom (buttocks) and that's what we were treating and charting on."

On 2/2/17 at approximately 11:45 a.m. ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #4, the regional director of clinical services were made aware of the discrepancy in the documentation. ASM #4 stated that based on their research into Resident #2's wounds it appeared that LPN #4 had erroneously documented the buttock wound as a sacral wound, and that Resident #2 only had a buttock wound and not a sacral wound.

No further information was provided prior to the end of this survey process.

* This information was obtained from the following website;
http://reference.medscape.com/drug/santyl-collagenase-343561

** The information for wound staging was obtained from the following website;
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagesca

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tegories/
Pressure Ulcer Stages/Categories
Category/Stage I: Non-blanchable erythema
Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.
Category/Stage II: Partial thickness
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
*Bruising indicates deep tissue injury.
Category/Stage III: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.
Category/Stage IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone,

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tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.
Additional Categories/Stages for the USA
Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.
Suspected Deep Tissue Injury - depth unknown
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

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