STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. BUILDING _____ B. WING _____	R-C 05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 revisit to the abbreviated survey conducted 4/3/18 through 4/5/18, was conducted 5/22/18 through 5/23/18. No complaints were investigated on this survey. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B report. The facility was found to be out of compliance with 42 CFR Part 483, the Federal Long Term Care requirements for two of the original five deficiencies. The census in this 77 certified bed facility was 66 at the time of the survey. The survey sample consisted of nine current Resident reviews (Residents #101 through # 109).	{F 000}	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies the plan of correction is prepared and submitted solely because of the requirements under state and federal law. This plan of correction will serve as the facility's allegation of substantial compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of nine residents in the survey sample (Resident # 107) to ensure a complete and accurate Minimum Data Set. Resident # 107 was incorrectly assessed on the most recent Annual Minimum Data Set as having an unplanned weight loss of 5% or more in 30 days, or 10% or more in 180 days. The findings were: Resident # 107 in the survey sample, an 81	F 641	1. RCA completed 5/22/18. Ad Hoc QAPI meeting was held 5/23/18. Resident #107's nutritional status/needs re-assessed by Registered Dietician (RD), 6/4/18, MDS revised to reflect resident's current status. Registered Dietician identified is no longer employed by Health Care Services Group.	

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

Exec Director 6/1/18

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 641	Continued From page 1 year-old male, was admitted to the facility on 11/3/09, and readmitted on 4/3/18 with diagnoses that included coronary artery disease, hypertension, benign prostatic hyperplasia, generalized muscle weakness, Non-Alzheimer's Dementia, and left hand contractures. According to the most recent Minimum Data Set (MDS), an Annual with an Assessment Reference Date of 4/9/18 the resident was assessed under Section C (Cognitive Patterns), as being severely cognitively impaired, with a Summary Score of 2 out of 15. Under Section K (Swallowing/Nutritional Status), at Item K0200, Height and Weight, the resident's weight was listed as 135 pounds. Under Section K at Item K0300, Weight Loss, the resident was assessed as having a weight loss of 5% or more in 30 days, or 10% or more in the last 180 days, that was not part of a prescribed weight loss regimen. According to the weights listed in the Weights/Vital Signs portion of the resident's Electronic Health Record, his weight on 4/3/18 was 135 pounds, and his weight on 3/6/18 was 132 pounds, a weight gain of three pounds in approximately 30 days. Further review of the resident's weight records revealed his weight on 4/3/18 was 135 pounds, and his weight on 10/6/17 was 142 pounds, a weight loss of seven pounds, or a 4.9% weight loss in approximately 180 days. There was no evidence to substantiate that Resident # 107 sustained a 5% or more weight loss in 30 days, or 10% or more weight loss in the	F 641	2. Quality Review of current residents MDS Section K was conducted by Regional Registered Dietician 6/4/18). Findings of Quality Review validated by Regional MDS Coordinator. Follow up based on findings. 3. Registered Dietician assigned to provide services at Envoy of Lawrenceville to receive additional orientation/demonstration by Regional Registered Dietician and Regional MDS Coordinator on completion of accurate nutrition assessments as outlined in RAI Manual/standards/regulations. 4. Regional Dietician/designee to conduct Quality Monitoring of nutritional assessments for accuracy weekly X6 weeks, every other week for 4 weeks, then monthly and PRN. Findings to be reviewed at monthly QAPI Meeting.	

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F 641	Continued From page 2 last 180 days. At 3:00 p.m. on 5/22/18, RN # 2 (Registered Nurse), one of two MDS Coordinators, was interviewed regarding the entry indicating weight loss at Item K0310 under Section K on the Annual MDS. Asked about the entry, RN # 2 said, "The RD (Registered Dietitian) enters the data for Section K." The findings were discussed with the administrative staff during a meeting with the survey team on 5/23/18 prior to the Exit Conference.	F 641	4. Regional MDS Consultant to complete random Quality Monitoring during visits for accuracy of MDS Section K. Monitoring schedule to be modified bases on findings. 5. Date of Compliance___06/12/18_	
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	{F 656}	1. Root Cause Analysis was completed on 5/23/18. Ad Hoc QAPI meeting was held 5/23/18. Resident #102's Comprehensive Care Plan was amended on 5/23/18to include Foley catheter. 2. Quality Review of current residents utilizing Foley catheters Comprehensive Care Plans was completed on 5/23/18 by MDS regional nurse and MDS facility nurse. Follow up based on findings.	

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{F 656}	Continued From page 3 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan (CCP) for one of 9 residents in the survey sample: Resident # 102. Findings include: Resident # 102 was admitted to the facility 2/15/14 with a readmission date of 4/19/18. Diagnoses for Resident # 102 included, but were not limited to: diabetes, dysphasia, bipolar disorder, dementia, difficulty walking, and history of stroke. The most recent MDS (minimum data set) was a Medicaid 14 day assessment dated 5/2/18. This assessment had Resident # 102 coded with severe impairment in cognition with a total	{F 656}	3. Regional MDS nurse provided re-education to MDS coordinator and Licensed Nurses regarding Comprehensive Care Planning process/standard/regulation. 4. Regional MDS nurse / designee to complete Quality Improvement Monitoring of residents with newly acquired Foley catheters utilizing Morning Clinical Meeting and Weekly Standards of Care (SOC) Meeting Process weekly X6 weeks, every other week x 4 weeks, and then monthly and PRN. Findings to be reviewed at monthly QAPI Meeting. Monitoring schedule to be modified bases on findings. 5. Date of Compliance___06/12/18_	

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{F 656}	Continued From page 4 summary score of 03 out of 15. The electronic medical record (EMR) was reviewed 5/22/18 at 2:15 p.m. It was noted on the current POS (physician order summary) an order for "Foley Catheter 16 FR (size of catheter) Diagnoses: Stage 3 Sacral Wound." The order also included care and treatment for the catheter. The order was dated 5/9/18. Review of the CCP was then conducted and noted there was no CCP to address the resident's foley catheter. On 5/23/18 at 7:55 a.m. RN (registered nurse) # 2, an MDS coordinator, was interviewed about the CCP. The regional MDS coordinator was also present. They were asked who was responsible for updating/developing a CCP for a new area identified. The regional MDS coordinator stated "The nurse taking the order off should update the care plan at that time; if not, then in the morning meetings the 24 hour reports are reviewed and the order would be noted then. At that point, MDS, the DON (director of nursing), or the unit manager could update it. It should be done within 24 hours preferably." On 5/23/18 at 8:50 a.m. LPN (licensed practical nurse) # 1, the unit manager for Resident # 102's hall, was interviewed about the CCP. LPN # 1 stated "The nurse taking off the order can update the CCP at that time.." LPN # 1 was asked who took the order off for Resident # 102's catheter. She stated "I did." LPN # 1 was asked why the CCP wasn't updated at that time. She replied "I don't know; I think I called [RN #2]...I didn't do it." On 5/23/18 at 9:15 a.m. RN # 2 was interviewed again. She was asked if the catheter was an update to a current intervention, or a new CCP.	{F 656}		

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{F 656}	Continued From page 5 RN # 2 stated it would be a new CCP since the resident did not previously have a catheter. RN # 2 further stated "I didn't know [name of resident] even had a catheter until yesterday when the medical records staff told me about it." RN # 2 was then asked about the morning meetings, and the 24 hour report, and how the order was missed. RN # 2 stated "I have no idea about that; the DON and unit manager fill those out; you would need to ask one of them." On 5/23/18 at 9:45 a.m. the DON was asked about the morning meetings, and the order for Resident # 102's catheter. The DON stated "I'm not sure why it didn't make it to morning meeting. Maybe it just got dropped for some reason." At 11:23 a.m. the DON came to the conference room. She told this surveyor "Here is the 24 hour report form; the foley was identified and discussed in the morning meeting, but it got dropped." The DON was then asked what was meant by "It got dropped." The DON stated "It didn't get done; I have no idea why." The administrator, executive director, director of direct care services, DON, and two corporate staff were informed of the above findings during a meeting 5/23/18 beginning at 3:00 p.m. No further information was provided prior to the exit conference.	{F 656}		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677	1. RCA completed 5/23/18. Ad hoc QAPI meeting was held on 5/23/18.	

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F 677	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide nail care for one of nine residents in the survey sample. Resident #105 was observed with long toenails on his left foot. The findings include: Resident#105 was admitted to the facility on 5/10/18 with a re-admission on 5/19/18. Diagnoses for Resident #105 included liver cirrhosis, encephalopathy, benign prostatic hypertrophy and left heel pressure ulcer. A nursing assessment dated 5/21/18 assessed Resident #105 as alert and oriented and to require the assistance of one person for activities of daily living (bathing, grooming, dressing, ambulation). On 5/23/18 at 10:20 a.m., accompanied by licensed practical nurse (LPN) #2 and the director of nursing (DON), a dressing change to Resident #105's left heel was observed. The toenails on the resident's left foot were thick and long, extending beyond the end of his toes. The nails on the third, fourth and little toe were curled over the end of the toes. Resident #105 was asked at the time of the observation about the long nails. The resident stated he would appreciate if someone would cut the nails as they were long. The nails on the right foot were trim. Resident #105's re-admission assessment dated 5/19/18 documented the resident was assessed with long, thick nails on both feet. The resident's baseline care plan documented the resident required the supervision of one person for	F 677	1. On 5/23/18 Certified Nursing Assistant provided nail care to identified foot. Resident # 105 receives nail care as indicated. 2. Quality Review of current residents to ensure toe nail care/podiatry service needs identified/complete. Follow up based on findings. 3. Director of Nursing/designee provided re-education to nursing staff regarding identifying/providing podiatry services/toe nail care. 4. DON/Designee to conduct Quality Improvement Monitoring of residents for receipt of toe nail care/podiatry services weekly X6 weeks, every other week for 4 weeks, then monthly and PRN. Findings to be reviewed at monthly QAPI Meeting. Monitoring schedule to be modified bases on findings 5. Date of Compliance___06/12/18_	

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F 677	Continued From page 7 grooming/hygiene. The clinical record made no mention of the resident refusing nail care. There was no explanation in the clinical record indicating why the left foot nails were not trimmed. On 5/23/18 at 10:35 a.m., LPN #2 was interviewed about Resident #105's long toenails. LPN #2 stated, "I'll do it [cut nails] since he said he wanted them done." LPN #2 stated the aides routinely cut nails when showers were given. LPN #2 stated Resident #105 was scheduled to have a shower on the last evening shift (5/22/18). LPN #2 stated that sometimes the resident refused care. On 5/23/18 at 10:45 a.m., the certified nurses' aide (CNA #1) assigned to Resident #105 was interviewed about the long toenails. CNA #1 stated she did not give Resident #105 a shower as he was assigned to get a shower on the evening shift. CNA #1 stated nails were usually cut during shower time. CNA #1 stated she thought Resident #105's nails were cut by therapy or podiatry. CNA #1 stated the resident was "already up" when she got here today and she was not aware of his long toenails. On 5/23/18 at 10:40 a.m., Resident #105 was interviewed again about the long nails on his left foot. Resident #105 stated the nails "need attention. They [long nails] are not good." Resident #105 stated he was assisted with a shower last evening (5/22/18) but his nails were not trimmed. The resident denied refusing any care regarding his nails. Resident #105 stated, "They just did not get around to it yet." This finding was reviewed with the administrator	F 677		

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F 677	Continued From page 8 and director of nursing during a review meeting on 5/23/18 at 3:00 p.m. {F 686} Treatment/Svcs to Prevent/Heal Pressure Ulcer SS=D CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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, facility document review and clinical record review, the facility staff failed to follow infection control practices during a dressing change to pressure ulcers for one of nine residents in the survey sample. A nurse failed to perform proper hand hygiene during a dressing change to Resident #104's pressure ulcers. The nurse also applied prescribed ointment medication to pressure ulcers without use of an applicator, touching the end of the multi-dose tube directly on the wound. In addition, the nurse applied a debriding ointment (Santyl) to a healed ulcer area on the resident's foot when the ointment was prescribed for application to the open pressure ulcer wound	F 677 {F 686}	1. RCA completed 5/23/18. Ad Hoc QAPI meeting was held on 5/23/18. Resident #104 wound was re-assessed (5/24/18) by DON and exhibited no decline in progress related to technique observed during treatment application. Santyl utilized discarded. Resident #104 receives treatments utilizing infection control practices per standard/regulation by Director of Nursing with LPN#2 observing. DON provided individual re-education for LPN#2. Understanding of education verification of LPN #2 competency completed via observation/demonstration. 2. Quality Review conducted by DON/Designee to ensure that residents receiving wound care treatment services completed utilizing infection control practices pre standard/regulation. Follow up based on findings.	

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{F 686}	Continued From page 9 bed. The findings include: Resident #104 was admitted to the facility on 8/14/17 with a re-admission on 10/27/17. Diagnoses for Resident #104 included COPD (chronic obstructive pulmonary disease), high blood pressure, dysphagia, pressure ulcers, diabetes and obesity. The minimum data set (MDS) dated 3/27/18 assessed Resident #104 as cognitively intact. Resident #104's clinical record documented the resident was receiving care and treatment for three pressure ulcers. Pressure ulcer assessment records dated 5/21/18 documented the following pressure ulcers for Resident #104. Left heel - unstageable ulcer measuring 7.0 x 6.0 x 0.2 cm (length by width by depth in centimeters) Right heel - healing stage IV ulcer measuring 2.0 x 2.0 x 0.1 cm Sacrum - healing stage IV ulcer measuring 7.0 x 6.5 x 0 cm The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as, "...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer...injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." This reference defines an unstageable ulcer as, "Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by	{F 686}	3. Director of Nursing/Designee provided individual education for LPN#2 (5/24/18). Director of Nursing/Designee provided re-education to Licensed Nurses regarding wound care treatment services provided utilizing infection control practices per standard/regulation; including competency observation/demonstration. 4. DON/Designee to conduct random Quality Improvement Monitoring of wound care treatment services provided utilizing infection control services per standard/regulation weekly X6 weeks, every other week x 4 weeks, then monthly and PRN. Findings to be reviewed at monthly QAPI Meeting. Monitoring schedule to be modified based on findings 5. Date of compliance 06/12/18_.	

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{F 686}	Continued From page 10 slough or eschar..." This reference defines a stage IV pressure injury as, "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..." (1) a) A nurse failed to perform proper hand hygiene during a dressing change to Resident #104's pressure ulcers. The nurse also applied prescribed ointment medication to pressure ulcers without use of an applicator, touching the end of the multi-dose tube directly on the wound. Resident #104's clinical record documented the following physician orders for care and treatment of pressure ulcers. 4/29/18 - Clean sacral wound with wound cleanser, pat dry, apply wet/dry dressing and cover with 4 x 4 (gauze) dressing daily 5/2/18 - Clean right heel wound with wound cleanser, pat dry, apply Santyl ointment to wound bed and cover with 4 x 4 dressing daily 5/22/18 - Clean left heel with wound cleanser, pat dry, apply Santyl ointment to wound bed and cover with 4 x 4 daily On 5/23/18 at 1:30 p.m., accompanied by licensed practical nurse (LPN #2), dressing changes to Resident #104's pressure ulcers were observed. During dressing changes to Resident #104's left heel and right heel, LPN #2 failed to change gloves and perform hand hygiene after removing the soiled dressings and prior to cleansing the wounds. For the left heel, LPN #2 washed her hands, put on gloves and removed the old, soiled dressings. Without changing gloves or performing hand hygiene, LPN #2	{F 686}		

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	495192	A. BUILDING _____ B. WING _____	R-C 05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

(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 686}	Continued From page 11 sprayed the wound with cleanser and wiped the wound dry with a gauze. LPN #2 then changed gloves and washed her hands prior to applying the prescribed Santyl ointment and covering the wound with gauze. LPN #2 repeated the same process for the right heel and did not change gloves and perform hand hygiene after removing the old, soiled dressing and prior to cleansing the wound. In addition, on the right heel, LPN #2 did not use an applicator to apply the Santyl ointment to the wound. LPN #2 applied the Santyl ointment directly from the tube, touching the wound with the tip of the tube opening. LPN #2 put the top back on the tube and stored it with the resident's other wound care supplies. On 5/23/18 at 2:10 p.m., LPN #2 was interviewed about hand hygiene during the dressing changes. LPN #2 stated she was supposed to change gloves and wash hands after removing the soiled dressings and prior to cleansing the wounds. LPN #2 stated the tube of Santyl ointment was a multi-dose tube used only for Resident #104. LPN #2 stated she should have used Q-tip applicators for the ointment. LPN #2 stated she did not bring applicators in with her wound care supplies. LPN #2 stated she touched the tip of the ointment tube on the wound because the ulcer on the resident's right heel was difficult to reach. On 5/23/18 at 2:15 p.m., the director of nursing (DON) was interviewed about infection control practices related to the dressing change observation. The DON stated nurses were supposed to change gloves and perform hand hygiene immediately after removing/discarding the soiled dressing and prior to cleansing the wound. The DON stated cotton-tipped	{F 686}		

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{F 686}	Continued From page 12 applicators were supposed to be used for application of the Santyl ointment. The facility's policy titled Dressing Change (revised 12/6/17) stated, "A clean dressing will [be] applied by a nurse to a wound as ordered to promote healing..." The procedure included the following steps for a dressing change, "...Assemble equipment...place supplies on prepped work surface...Perform hand hygiene...Apply gloves...Remove and dispose of soiled dressing...Remove gloves...Perform hand hygiene...Apply gloves...Cleanse wound as ordered..." This procedure also included applicators in the list of supplies to assemble prior to the dressing change. b) A nurse applied a debriding ointment (Santyl) to a healed ulcer area on the resident's foot when the ointment was prescribed only for application to the open pressure ulcer wound bed. On 5/23/18 at 1:30 p.m., accompanied by licensed practical nurse (LPN #2), dressing changes to Resident #104's pressure ulcers were observed. During the dressing change to the resident's right heel, LPN #2 stated the resident had "two places" on the right heel. The resident had a circular, dime size area of dry skin on the inside edge of her right heel. This area was not open and was white in color. The resident also had an open pressure ulcer on the base of the right heel approximately the size of a quarter. During the wound care, LPN #2 applied Santyl ointment to the white dried skin area on the inside of the heel and to the open pressure ulcer at the base of the heel. Resident #104's clinical record documented a	{F 686}		

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{F 686}	Continued From page 13 physician's order dated 5/2/18 with instructions to clean the right heel wound with cleanser, pat dry and to apply Santyl ointment (250 units/gram) to the wound bed and cover with a gauze dressing each day. The clinical record documented no treatment orders for the white, dried skin area on the inside of the right heel. On 5/23/18 at 2:10 p.m., LPN #2 was interviewed about applying Santyl to both the open pressure ulcer and the closed skin area on the resident's right heel. LPN #2 stated the resident had two areas of skin impairment on the right heel and the order was to apply Santyl to the right heel. On 5/23/18 at 2:15 p.m., the director of nursing (DON) was interviewed about treatment to Resident #104's right heel. The DON stated the small white dried skin area on the inside of the resident's right heel was no longer being treated. The DON stated the white area was from a previous pressure ulcer that had healed. The DON stated the white area was no longer open and that treatment had been discontinued. The DON stated Santyl ointment was supposed to be applied to the open pressure ulcer at the base of the heel and not to the white area of dried skin. On 5/23/18 at 2:25 p.m., LPN #2 was interviewed again, about why she applied Santyl to the dried, closed skin area on the resident's right heel. LPN #2 stated there was only one order for treatment to the right heel and she was not aware the white, dried skin area was not treated. LPN #2 stated she did not routinely perform dressing changes and the "regular" nurse for Resident #104 probably knew the treatment for the dried skin area was discontinued.	{F 686}		

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{F 686}	Continued From page 14 Santyl ointment is a prescription medication indicated for debriding chronic dermal ulcers and severely burned skin. The manufacturer's safety information states, "Use of Santyl Ointment should be terminated when debridement is complete and granulation tissue is well established." (2) These findings were reviewed with the administrator and DON during a meeting on 5/23/18 at 3:00 p.m. (1) NPUAP Pressure Injury Stages. 2016. National Pressure Ulcer Advisory Panel. 5/24/18. www.npuap.org. (2) How to Apply Collagenase Santyl Ointment. 2018. Smith & Nephew, Inc. Fort Worth, Texas. 5/24/18. www.santyl.com.	{F 686}		