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FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 07/17/18 through 07/19/18. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census at this 90 certified bed facility was 182 at the time of the survey. The survey sample consisted of 26 current residents Resident #s 71, 43, 34, 54, 51, 45, 63, 33, 69, 66, 37, 21, 44, 48, 286, 38, 36, 35, 19, 82, 76, 131, 67, 57, 331, 184 and five closed records, Residents #s 334, 500, 81, 282 and 283.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to complete license verification for two of 25 employee records reviewed. 1. For OSM #1, (physical therapist), the facility staff failed to complete a license verification at the time of hire. 2. For CNA #1, the facility staff failed to complete a license verification at the time of hire. The findings include: 12VAC5-371-110. Management and administration. B. The nursing facility must comply with: 1. These regulations (12VAC5-371);	F 001	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. 12VAC5-371-110 Management and administration 12VAC5-371-140 Policies and procedures 1. Licenses immediately validated and placed in employee file. 2. Any resident in the care has the potential to be affected. 3. License audit of all licensed staff performed 7/24/18. Payroll coordinator educated on requirement to check the license database on 7/24/18.	8/10/18

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

Electronically Signed | 08/10/18

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F 001	Continued From page 1 2. Other applicable federal, state or local laws and regulations; and 3. Its own policies and procedures. 12VAC5-371-140. Policies and procedures. E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check A review of 25 employee records revealed the following: 1. OSM #1 (Other Staff Member) was hired on 1/15/18 as a physical therapist. There was no license verification in the employee record. 2. For CNA #1 (Certified Nursing Assistant) was hired on 8/24/16 as an NA (Nursing Assistant). The license verification was not obtained until 3/9/17, approximately 6 and a half months after hire. There was no license verification at the time of hire. On 7/18/18 at approximately 8:15 AM, ASM #2 (Administrative Staff Member) the Director of Nursing (DON) was made aware of the findings. On 7/18/18 at 8:24 AM, she stated they were not done. A review of the facility policy, "Virginia Resident Abuse Policy" documented, "1) It is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The Facility will do the following prior to hiring a	F 001	4. Audits of employee files, new and old, will be completed each week x 12. Results will be reviewed at QAPI monthly x 3 months. 5. 8/15/18 12VAC5-371-220B cross referenced to F757 F757 1. Physician notified of medication error on 08/01/18. Medication error completed 07/19/18 and licensed nurse was educated on midodrine administration. 2. All residents receiving midodrine have the potential to be affected. Audit completed on 08/03/18 by DON to ensure midodrine was given appropriately. 3. Licensed nurses educated on parameters by DON/ designee. Education will include orientation for new employees. 4. MDS nurse/ designee will review midodrine orders 5 x week x 12 weeks for accuracy. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18 12VAC5-371-220B cross referenced to F760 F760 1. Medication error was completed on 07/11/18. MD was notified of error on 07/11/18. 2. Any resident with insulin orders to hold for blood sugar below 100 has the potential to be affected. Audits of like residents have been completed by DON/ADON/UM on 08/06/18. 3. Licensed nurses were educated on following MD orders by the DON/ designee. Education will include	

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F 001	Continued From page 2 new employee:...ii. Check with the applicable licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their job functions and have no disciplinary action as a result of abuse or neglect...." No further information was provided by the end of the survey. 12VAC5-371-220B cross referenced to F757 12VAC5-371-220B cross referenced to F760 12VAC5-371-150 Resident Rights G. Based on staff interview it was determined the facility staff failed to enforce resident rights. The facility staff failed to register with the Department of State Police to receive notice of the registration or re-registration of any sex offender within the same or a contiguous zip code area in which the facility is located. The findings include: On 07/18/18 at approximately 10:55 a.m., a request was made to ASM (administrative staff member) # 1, administrator for evidence that the facility receives notice of the registration or re-registration of any sex offender within the same or a contiguous zip code area in which the facility is located. On 07/18/18 at approximately 11:35 a.m., ASM # 1 stated, "We are not signed up for the notification, I'm signing up today." On 07/18/18 at approximately 5:15 p.m., ASM	F 001	orientation for new employees. 4. Residents receiving insulin will be audited 3 x week by UM/ designee x 12 weeks. Results will be reviewed at QAPI monthly x 3 months. 5. 08/15/18 12VAC5-371-150 Resident Rights G 1. Administrator immediately applied for Sex Offender Registry notification and began receiving notices on 7/20/18. 2. Any resident in the care has the potential to be affected. 3. NHA educated Admissions Director and Admissions Coordinator on 8/10/18 who are a back up and also receive notices. 4. NHA/ designee will audit registry notification 3x/wk for 4 weeks and 1x/wk for 8 weeks. Results will be reviewed at QAPI monthly x 3 months. 5. 8/15/18 18VAC90-19-70 Supervision of licensed practical nurses. (SoP for wound care #71, #283) 18VAC90-19-70 Supervision of licensed practical nurses 18VAC90-19-250 Criteria for delegation (SoP for wound care #283) 1. Care plan for resident # 71 was revised on 07/19/18 by MDS director. Resident # 71 was discharged on 07/20/18. Resident # 283 was discharged on 11/08/17. 2. Any residents with a pressure ulcer have the potential to be affected. 100% skin check audit was completed by unit managers on 07/20/18 and 07/23/18.	

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F 001	Continued From page 3 (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 3, assistant director of nursing and ASM # 4, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 18VAC90-19-70. Supervision of licensed practical nurses. Based on staff interview, facility document review and clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to follow professional standards to ensure supervision of licensed practical nurses for four of 31 residents in the survey sample, Residents #71, and #283. 1. The facility staff failed to ensure a registered nurse participated/ supervised the assessment and treatment of Resident #71's pressure injury. 2. The facility staff failed to ensure a registered nurse participated/ supervised the assessment and treatment of Resident #283's pressure injury. *A pressure injury is 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 and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft	F 001	3. Licensed nurses were educated on wound protocol and documentation by DON/ designee. Education will include orientation for new employees. 4. Wound assessments will be reviewed by ADON/ designee 5x week for 12 weeks. Results will be reviewed monthly in QAPI x 3 months. 5. 08/15/18 12VAC5-371-200.B.1 Professional standards cross referenced to F658 F658 1. Resident # 58, physician's order clarified on 07/19/18 and parameters included in the order. 2. Any resident with pain medication has the potential to be affected. 100% audit of all pain medications was completed on 08/07/18 to ensure parameters are in place. 3. Licensed nurses were educated on setting parameters for pain medications by the DON/ designee. Education will include orientation for new employees. 4. New pain medication orders will be audited for parameters 5x week for 12 weeks. Results will be reviewed in QAPI monthly x 3 months. 5. 08/15/18	

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F 001	Continued From page 4 tissue. (1) The findings include: 1. Resident #71 was admitted to the facility on 6/8/18 with diagnoses that included but were not limited to: left knee replacement, high blood pressure, and gastroesophageal reflux disease (a backflow of the contents of the stomach into the esophagus) (2). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 7/6/18 coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating in which she required limited assistance of one person. In Section M - Skin Conditions, the resident was coded as having one unstageable - Deep tissue injury*. *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,	F 001		

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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. (2)

During the entrance conference, the facility was asked to provide a list of residents with pressure ulcers. A list was provided with only Resident #71's name and documented, "Left heel deep tissue injury - intact."

The "Weekly Wound Assessment" form dated 6/22/18 at 11:09 a.m. documented in part, "Wound Overview - Wound Type - "Other." Stage - n/a (not applicable), Wound location - left heel, Length - 2.3 cm (centimeters), Width - 2.3 cm. Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 6/22/18. Treatment - Pending diagnostic." A LPN (licensed practical nurse) completed this.

There was no "Weekly Wound Assessment" form for 6/29/18.

The "Weekly Wound Assessment" form dated 7/5/18 at 3:12 p.m. documented in part, "Wound Overview - Wound Type - Other. Other Wound Type - discoloration, Stage - 0, Wound location - left heel, Length - 2.0 cm (centimeters), Width - 2.5 cm., Depth - 0, Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 7/22/18 (sic). Drainage Type - None, Drainage Amount - None, Wound Bed Appearance - n/a, Odor - none, Periwound Appearance - n/a, Wound Status - improving, Treatment - Skin prep Q (every) shift." A LPN signed this.

The "Weekly Wound Assessment" form dated

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F 001	Continued From page 6 7/12/18 at 3:12 p.m. documented in part, "Wound Overview - Wound Type - Other, Other Wound Type - discoloration, Stage - 0, Wound location - left heel, Length - 2.0 cm (centimeters), Width - 2.0 cm., Depth - 0, Location Where Wound Was Acquired - In house. Was this skin impairment present on admission - No. Date wound identified - 6/22/18. Drainage Type - None, Drainage Amount - None, Wound Bed Appearance - n/a, Odor - none, Periwound Appearance - n/a, Wound Status - improving, Treatment - Skin prep each shift." A LPN signed this. The "Bi-Weekly Skin Observation" form dated, 6/25/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Left heel - discoloration 3x2x0 (length by width by depth), treatment in place." A LPN completed this. The "Bi-Weekly Skin Observation" form dated, 6/27/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - L (left) heel discoloration." A RN (registered nurse) completed this. The "Bi-Weekly Skin Observation" form dated, 7/4/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel discoloration." A LPN completed this. The "Bi-Weekly Skin Observation" form dated, 7/11/18, documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel - discoloration 2.5 x 2 x 0. Skin prep applied." A LPN completed this. The "Bi-Weekly Skin Observation" form dated, 7/16/18, documented in part, "Does the resident	F 001		

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have current Skin Issues - yes, Document current Skin Issues: Other - Left heel - discoloration." A LPN completed this.

The "Bi-Weekly Skin Observation" form dated, 7/18/18 at 10:34 a.m., documented in part, "Does the resident have current Skin Issues - yes, Document current Skin Issues: Other - Left heel - discoloration to heel 2.5 x 3 x 0. skin intact skin prep applied." A LPN completed this.

The physician order dated 6/22/18, documented, "Skin prep to left heel every shift for heel."

Observation was made of Resident #71 during the initial screening on 7/17/18 at approximately 10:15 a.m. The resident was sitting up in her wheelchair with orthopedic style shoes on both feet with thick black socks on. The resident was again observed on 7/18/18 at 9:42 a.m. sitting in her wheelchair with shoes and thick black socks on both feet.

Resident #71 was observed on 7/18/18 at 3:48 p.m. with LPN # 4. The resident was in bed with her shoes off but the black socks on. The resident had soft heel booties on both feet. Her heels were not lifted off the surface of the mattress. There was no pillow under the resident's calves. LPN #4 described the heel as "black eschar (scab or crust that forms on the skin (4)) and bogginess (an abnormal texture of tissues characterized by a feeling of sponginess, usually because of high fluid content. (5)) around the black area". When asked if that was discoloration, LPN #4 stated, "No, that's necrotic tissue (death of some or all of the cells in a tissue; usually caused by disease, inadequate blood supply to the tissue and injury (6))."

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Administrative staff member (ASM) #3, the assistant director of nursing (ADON), was asked to observe the wound on 7/18/18 at 4:00 p.m. ASM #3 stated the wound had changed, it's now hard." ASM #3 stated that it wasn't that way on Friday; the wound was still soft and was a deep tissue injury. ASM #3 verified the wound now had necrotic tissue but remained unstageable." Review of the nurse's notes failed to evidence documentation by ASM #3 that she observed the wound on Friday. The nurse's note dated, 7/18/18 at 6:18 p.m., written by ASM #3 documented, "Resident's left heel deep tissue injury assessed today and now noted unstageable with dry intact necrotic tissue to wound bed. No s/s (signs and symptoms) of infection. Tx (treatment) remains in place and appropriate. MD (medical doctor) and RP (responsible party) updated."

Review of the clinical record revealed there was no documented classification or staging of the left heel pressure ulcer until 7/18/18. On 7/18/18, after it was brought to the attention of the staff, did a registered nurse (ASM #3) assess and classify the wound as a deep tissue injury that was now noted as an unstageable wound with necrotic tissue.

The comprehensive care plan dated, 6/8/18, and revised on 6/29/18, documented in part, "Focus: At risk for skin breakdown related to: decreased mobility, weakness, recent failed total knee, episodic incontinence." The "Interventions" were dated 6/8/18. There was no documentation related to the new wound on the resident's left heel and no new interventions added to the care plan.

An interview was conducted with ASM (administrative staff member) #3, ASM #2, the

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director of nursing (DON), RN (registered nurse) # 5, the unit manager, and ASM #1, the administrator on 7/19/18 at 8:32 a.m. When asked about the process staff follows for newly identified wounds, ASM #3 stated, "When it is initially found the nurse does a change in condition form. We notify the doctor. Get orders for treatment and notify the responsible party." When asked when measurements of the wound are taken, ASM #3 stated, "They should be done when the new area is found and weekly measurements until healed." When asked if weekly wound rounds are made at the facility, ASM #2 stated, "No, the nurses do the treatments and notify the unit manager of any changes in the wound." When asked who oversees the LPNs that are doing the measurements and treatments, ASM #2 stated, "The unit managers and the ADON." When asked who stages the wounds, ASM #2 stated, "The unit managers, the ADON and myself, the DON. Whenever there is a new wound, we all go and look at it." When asked where this is documented, ASM #3 stated, "In the chart." When asked who oversees the wound program, ASM #2 stated, "The unit manager is aware of any changes in the wounds by the nurses on the unit. The RN will step in when there is no progression of healing of the wounds." When asked if the LPNs have received any training on wound care, ASM #3 stated, "They get training on hire and in nursing school. And there are standing orders." When asked if the nurses get specific training on the assessment of wounds and the treatment of wounds, ASM #3 stated, "There is no formal training, we have no process for that here."

The facility policy, "Wound Management" documented in part, "A resident with pressure ulcers receives necessary treatment and

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F 001	Continued From page 10 services, consistent with professional standards of practice, to promote healing, prevent infections, and prevent new ulcers from developing...3. When assessing the ulcer: a. Differentiate the type of ulcer (pressure-related versus non pressure-related). (Pressure ulcers are usually located over a bony prominence, such as the sacrum, heel, the greater trochanter, ischial tuberosity, fibular head, scapula and ankle). b. Determine the ulcer's stage. c. Describe and monitor the ulcer's characteristics. d. Monitor the progress toward healing and for potential complications. e. Assess, treat and monitor pain, if present. f. Monitor dressing and treatments. 4. An evaluation of the pressure ulcer wound should be documented at least weekly to include a. location and stage, b. Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth, and the presence, location and extent of any undermining or tunneling/sinus tract. c. exudate, if present; type (such as purulent/serous), color, odor and appropriate amount, d. pain, if present; nature and frequency, e. Wound bed: color and type of tissue/character including evidence of healing (e.g., granulation tissue or maceration) as appropriate. f. Appearance of surrounding tissue, g. Any evidence of infection...7. If a pressure ulcer does not show evidence of progress toward healing within 2-4 weeks, the physician will be notified and the residents overall condition will be reassessed for any changes needed in the treatment plan. Monitoring: 1. Should evaluate and document when there are identified changes. 2. Residents will be monitored every shift to ensure that measures are in place as specified on the care plan to prevent/promote skin breakdown. 3. Twice weekly, on bath/shower days, the nursing assistant will look at the	F 001		

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resident's skin and place the identified area on the shower sheet. The nursing assistant will report any reddened and/or areas of concern to the licensed nurse. 4. The licensed nurses will complete a head to toe body review twice a week as well. This head to toe body review is in addition to the nursing assistant's skin review...6. The interdisciplinary team will review residents with pressure ulcers during the weekly NAR (Nutritional at Risk) committee/resident review committee."

18VAC90-19-70. Supervision of licensed practical nurses.
Licensed practical nursing shall be performed under the direction or supervision of a licensed medical practitioner, a registered nurse, or a licensed dentist.

18VAC90-19-250. Criteria for delegation. 3. Establishment of organizational standards to provide for sufficient supervision that assures safe nursing care to meet the needs of the clients in their specific settings.

2. The delegating nurse retains responsibility and accountability for nursing care of the client, including nursing assessment, planning, evaluation, documentation, and supervision.(6)

Administrative staff member (ASM) #2, the director of nursing, ASM #3, the assistant director of nursing and ASM #4, the regional director of clinical services were made aware of the above findings on 7/18/18 at 5:20 p.m.

(1) This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-

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clinical-resources/npuap-pressure-injury-stages/.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
(3) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 207.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 394.
(6) This information was obtained from the following website: https://www.dhp.virginia.gov/nursing/nursing_laws_regs.htm#reg

2. The facility staff failed to follow professional standards of practice for the treatment and care of a pressure injury, not having a registered nurse participate in the assessment and treatment of the pressure injury for Resident #283.

Resident #283 was admitted to the facility on 10/5/17 with diagnoses that included but were not limited to: spinal stenosis (spinal stenosis, is when the spine is narrowed in one or more areas: The space at the center of the spine. The canals where nerves branch out from the spine. The space between the bones of the spine. This narrowing puts pressure on the spinal cord and nerves and can cause pain.) (1), compression fracture of lumbar vertebra, atherosclerotic heart disease of native coronary artery (atherosclerosis is a common disorder of the arteries in which plaques and lipids form on the inner arterial wall. As a result, the vessels become non-elastic and

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the lumen is narrowed, leading to decreased blood flow.) (2), high blood pressure, edema, depression, glaucoma, atherosclerosis of native arteries of the left leg with ulceration of the heel and peripheral vascular disease (any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart (3).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, prior to his transfer from the hospital, with an assessment reference date of 11/2/17, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score, indicating the resident had moderate difficulty in making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of his activities of daily living; moving in the bed, transfers, toileting and personal hygiene. In Section M - Skin Condition, the resident was coded as having one stage 1 pressure ulcer. No other pressure ulcers were coded.

The admission MDS assessment, with an assessment reference date of 10/12/18 coded the resident in Section M - Skin Conditions, with one stage 1 pressure ulcer and one unstageable wound * that measured 4.0 cm (centimeters) in length, 4.0 cm in width and 0 cm in depth. The wound was coded as having slough (a yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) Definition obtained directly from the MDS assessment. Under, "Number of Venous or Arterial Ulcers" it was coded as the resident not having any ulcers of this nature.

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

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F 001	Continued From page 14 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 the heel or ischemic limb should not be softened or removed. (4) The "Admission Assessment" dated, 10/5/18 at 2:30 p.m. documented in part, "Resident is a 93 year old male who arrived from (Name of inpatient rehab center) at 2:20 p.m. The "Bi-Weekly Skin Observation" dated, 10/5/18 at 2:30 p.m. documented, "1. Does the resident have current Skin Issues?" A "Yes" was documented. Under "Site and Description: edema to ankles, left heel ulcer and bruising to left knee." The nurse who documented this assessment was no longer employed at the facility and was not available for interview. The physician order dated, 10/5/18 at 11:49 p.m. documented, "Cleanse left heel with wound cleanser and apply Santyl* and cover with foam dressing." *Santyl is a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue. (5) The clinical record was reviewed. There was no documented evidence of the staging or measurements of the heel wound until 10/18/17. The "Weekly Wound Assessment" dated, 10/18/17 documented, "Wound type - pressure. Stage - UTD (unstageable). Wound location: left heel. Length: 3.7 cm (centimeters) x (by) Width 4	F 001		

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cm. Depth: na. Location Where Wound Was Acquired - Community acquired. Was the skin impairment present on admission - yes. Date Wound Identified - 10/5/17. Drainage - serosanguinous. Drainage amount - small. Wound Bed Appearance - slough, red and black. Wound status - unchanged. Treatment: Santyl and Foam."

The comprehensive care plan dated, 10/5/17, documented in part, "Focus: Resident is frequently incontinent of bowel and bladder and has a bed mobility problem. Has a non-blanchable area of redness on his coccyx and an unable to stage area on his left heel, which was present on admission. At risk for worsening of skin integrity." The following interventions were dated 10/5/17: Air mattress to bed as ordered. Immediately report any skin redness or skin breakdown to charge nurse. Provide incontinent care as needed." The following interventions were dated 10/18/17: Apply tx (treatment) as ordered. Assist with toileting upon risking, AC (before meals) PC (after meals) HS (hours of sleep) and PRN (as needed). Assist with turning and positioning routinely as needed. Follow facility skin protocol. Notify MD (medical doctor) of changes in skin as needed."

A request was made to ASM #3, the assistant director of nursing (ADON), on 7/18/18 at approximately 1:45 p.m. for all the wound assessments and measurements for Resident # 283. ASM #3 returned on 7/18/18 at 2:00 p.m., to this surveyor, and stated, "We don't have any weekly wound measurements prior to 10/18/17."

An interview was conducted with LPN (licensed practical nurse) #6 on 7/18/18 at 3:06 p.m. When

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asked about the process staff follows for a resident's skin upon admission to the facility, LPN #6 stated, "I go in with a CNA (certified nursing assistant) and we undress the resident. We look at every crevice and measure any open area, surgical sites that we see. We count the stitches or staples if they have any." When asked about the process staff follows if a resident is admitted with a heel wound, LPN #6 stated, "We go assess, measure, and put appropriate treatment in place. We document the size, and odor description." When asked if assessing, measuring and treating wounds is in her scope of practice, LPN #6 stated, "Yes." LPN #6 stated, "If we are uncertain of what the wound is, we grab (name of unit manager) or (name of ASM #3)." When asked how often wounds are measured. LPN #6 stated they are measured weekly. When asked where the measurements are documented, LPN #6 stated, "On the "Weekly Wound Assessment."

An interview was conducted with LPN #4 on 7/18/18 at 3:10 p.m. When asked how often wounds are measured, LPN #4 stated they are measured weekly. When asked where the measurements are documented, LPN #4 stated, on the 'Weekly Wound Assessment.' When asked if it is in his scope of practice to assess and make decisions about a wound, classify the wound, i.e., stage 1 or stage 2, LPN #4 stated, "No, I don't think so." When asked who stages or classifies the wounds, LPN #4 stated, "The RN (registered nurse) does that after we do the initial assessment."

An interview was conducted with RN #5, the unit manager, on 7/18/18 at 3:25 p.m. When asked if the LPN's can do the initial assessment of wounds, RN #5 stated, "Yes and they can

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F 001	Continued From page 17 implement treatment." When asked if there is anything an RN would have to do, RN #5 stated, "Measurements and staging." when asked how often wounds are measured, RN #5 stated, "Weekly." When asked where the measurements are documented, RN #5 stated, "On the 'Weekly Wound Assessment Form." An interview was conducted with ASM #3, ASM #2, the director of nursing (DON), RN # 5, the unit manager, and ASM #1, the administrator on 7/19/18 at 8:32 a.m. When asked about the process staff follows for new wounds, ASM #3 stated, "When it is initially found the nurse does a change in condition form. We notify the doctor. Get orders for treatment and notify the responsible party." When asked when measurements of the wound are taken, ASM #3 stated, "They should be done when the new area is found and weekly measurements until healed." When asked if weekly wound rounds are made at the facility, ASM #2 stated, "No, the nurses do the treatments and notify the unit manager of any changes in the wound." When asked who oversees the LPNs that are doing the measurements and treatments, ASM #2 stated, "The unit managers and the ADON." When asked who stages the wounds, ASM #2 stated, "The unit managers, the ADON and myself, the DON. Whenever there is a new wound, we all go and look at it." When asked where that is documented, ASM #3 stated, "In the chart." When asked who oversees the wound program, ASM #2 stated, "The unit manager is aware of any changes in the wounds by the nurses on the unit. The RN will step in when there is no progression of healing of the wounds." When asked where the measurements and documentation was located, for Resident #283's	F 001		

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F 001	Continued From page 18 heel wound, identified on admission, ASM #2 stated, "They weren't done." When asked if the LPNs have received any training on wound care, ASM #3 stated, "They get training on hire and in nursing school, and there are standing orders." When asked if the nurses get specific training on the assessment of wounds and the treatment of wounds, ASM #3 stated, "There is no formal training, we have no process for that here." ASM #1, ASM #2, ASM #3 and RN #5 were made aware of the above concern on 7/19/18 at 8:45 a.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.niams.nih.gov/health-topics/spinal-stenosis. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 53. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (5) This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm. 12VAC5-371-200.B.1 Professional Standards. Cross reference to F658	F 001		