STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted 11/04/19 through 11/05/19, was conducted on 12/10/19 through 12/11//19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. The census in this 90 certified bed facility was 78 at the time of the survey. The survey sample consisted of ten current resident reviews (Residents 101 through 110).	{F 000}		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 657		1/6/20

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

Electronically Signed | 12/19/2019

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F 657	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for the use of a foot board to the resident's wheelchair, and for pressure ulcer prevention interventions, for one of 10 residents in the survey sample (Resident #104). Findings include: Resident #104 was admitted to the facility on 11/15/19. Diagnoses for this resident included, but were not limited to: anemia, chronic pain, high blood pressure, hypothyroidism, history of DVT (deep vein thrombosis), DM (diabetes mellitus), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), diabetic ulcer to right lower extremity and pressure ulcer to left heel. The most current MDS (minimum data set) was an admission assessment dated 11/26/19. This MDS assessed the resident as having a cognitive score of 13, indicating the resident is intact for daily decision making skills. The resident was documented with one Stage 3 pressure ulcer (present upon admission) to the right lower extremity and one unstageable (present upon admission) to the left heel. The resident was assessed as requiring a wheelchair for mobility on this MDS.	F 657	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F-657 1. Resident #104□s care plan now includes all current interventions, including the foot box, and all pressure ulcer interventions recommended from the wound care clinic. MD and Responsible party have been notified. 2. All residents receiving positional and/or pressure ulcer interventions are at risk. 3. SDC or designee to educate: a. All licensed nursing staff on updating the care plan to include all pressure relieving/positional interventions. b. All nursing staff on the importance of	

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F 657	Continued From page 2 During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. Resident #104 had multipodus boots to both feet. On 12/10/19 at 12:50 PM, Resident #104 was observed again, sitting in the room, in the wheelchair in the same position, and in the same area of the room. Resident #104 was interviewed and stated she had an ulcer on her right leg and that she had and an unstageable ulcer on her left heel. Both of Resident #104's legs were wrapped with profore compression dressings that covered her feet, up to just below the knees. Resident #104 stated that she was getting therapy and that staff were changing the dressings twice a week. Resident #104 had bilateral leg rests to the wheelchair. Resident #104's right leg had moved off of the calf support pad, and the resident's foot was not touching the foot rest petal, nor the floor. The resident's left calf support pad had rotated and Resident #104's calf was laying on the top edge of the calf pad support (not flat) causing pressure to the back of the resident's calf. Resident #104 denied pain. Resident #104's current CCP (comprehensive care plan) was reviewed and documented, "...Contractures: The resident has contractures of the right lower leg...right lower leg to keep clean and prevent skin breakdown...resident has a Stage 3 pressure ulcer to her RLE (right lower extremity, and [unstageable] pressure ulcer to the left heel...devices heel float, multipodus boots to bilateral feet, foot cradle...position resident as needed...position resident for comfort...Potential	F 657	ensuring all interventions included on the care plan are in place. 4. DON or designee will audit 100% of care plans in the center to ensure inclusion of all pressure ulcer and/or positional interventions, then 50% daily for 2 weeks, then 25% five times weekly for 2 weeks, then review findings in following QA meeting. 5. Date of Compliance- 1.6.2020.	

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F 657	Continued From page 3	F 657		

for further skin impairment related to CVA...multipodus boots, and foot cradle for prevention...Pressure reduction surface to wheelchair..." The pressure reduction surface intervention listed on the CCP was not specific.

Resident #104's physician orders were reviewed and documented, "...Monitor off loading boots are in place every shift...PT (Physical Therapy) treatment order: 5-7 times/week for 6 weeks...gait training, w/c mobility..."

At approximately 2:10 PM, the above observations were reported to Resident #104's nurse, LPN (Licensed Practical Nurse) #1. Resident #104 was observed again. Resident #104's left leg calf support pad was again observed in the improper position. LPN #1 stated, "I see what you are saying." LPN #1 then began to reposition the pad and the resident's legs to the proper position. LPN #1 was asked to undress Resident #104's left leg down to the area where the calf support pad was laying on the resident's calf in the wrong position. LPN #1 undressed the left calf area and then raised the resident's left leg for observation. Resident #104's posterior calf had an indentation of approximately 4 inches long and approximately 1 inch deep. LPN #1 stated that she agreed that the resident's leg and/or the calf pad must have been improperly positioned to leave an indented area on the resident's calf. LPN #1 then stated that Resident #104 had cellulits of the legs.

No information was found in the clinical record to evidence Resident #104 had a diagnoses of cellulits.

Resident #104 was asked how long she had been

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F 657	Continued From page 4	F 657		

up in the wheelchair. Resident #104 stated that she had been up in the wheelchair since around 6:00 AM and had not been put back to bed. Resident #104 was asked if anyone had been to check on her since lunch and the resident stated, "No." Resident #104 stated that she had gone to therapy that morning and that therapy had taken something out from under her legs this morning. Resident #104 stated that she didn't know what it was, but it wasn't a pillow, but did state that it was some type of support for her legs.

The therapy department staff, including the OT (occupational therapist), the PTA and the director of therapy services (OT #2) were interviewed on 12/10/19 and 12/11/19. According the the interviews, a foot box was implemented 3 days after admission and was in place until early morning on 12/11/19.

On 12/10/19 at 2:45 PM, the PTA was interviewed about documentation of foot box being implemented in any of the therapy notes and the PTA stated there was no documentation in the system about this device. The PTA had the foot box support device in her hand and stated that she was taking it back down to Resident #104 at this time to put it back in place.

On 12/10/19 at 2:55 PM, the OT was interviewed. The OT stated that the resident had been working with OT to advance ambulation and that therapy took the box off. The OT stated that the box was implemented on day number three, after the resident's admission and stated that the box got removed today (12/10/19).

There were no orders, therapy progress notes or care plan information for this device. On 12/11/19

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at 10:44 AM, the therapy director was interviewed. The therapy director was asked if that device should have been documented for Resident #104, since therapy staff were saying that it was implemented on day 3. The therapy director stated that it should have been documented and should have been on the resident's CCP.

On 12/10/19 at approximately 4:00 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware in a meeting with the survey team that the resident's CCP was not specific to the pressure relieving device and did not include the foot box. The DON stated that the foot box was actually for proper alignment and would not have been in the resident's CCP for pressure relief. The DON was asked for the resident's wound care orders, notes and information from the wound care clinic, as this information was not located in the resident's clinical record.

On 12/11/19 at 7:30 AM, Resident #104's wound records were reviewed and documented that the resident was originally seen on 11/21/19 and was each week following. The wound physician orders documented, "...profore lite multilayer compression dressing- bilateral. Avoid standing for long periods of time. Elevate legs to the level of the heart or above for 30 minutes 3 times daily and/or when sitting. Other - Use your compression pump twice a day, prop leg up, place pillow under knee to relieve pressure on the calf..."

On 12/11/19 at 10:30 AM, the DON and corporate nurse met with the survey team and were asked why the resident's wound care orders and

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F 657	Continued From page 6 progress note information was not in the resident's clinical record and was asked where this information came from. The DON stated that she had it faxed and that some of the information was in her office. The DON was made aware that the orders and interventions were not included in the resident's CCP. The DON stated that those are original orders from the [name] wound clinic and stated that the nurses will take off orders and put in the record and care plan. The DON and corporate nurse were made aware that this information was not anywhere in the resident's medical record and was not sure how that information could be put on the resident's care plan if the information was in the DON's office. The corporate nurse stated that the information on the wound physician's orders from the wound care clinic should have been included in the resident's care plan. No further information and/or documentation was presented prior to the exit conference on 12/11/19 to evidence the CCP was reviewed and revised to include interventions for the care and prevention of pressure ulcers for Resident #104.	F 657		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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	{F 686}		1/6/20

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{F 686}	Continued From page 7 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, resident interview, staff interview, and clinical record review, the facility staff failed to implement care and services for the prevention of pressure ulcers for one of 10 residents in the survey sample, Resident #104. The facility staff failed to ensure pressure relief interventions were implemented on the resident's wheelchair. Findings include: Resident #104 was admitted to the facility on 11/15/19. Diagnoses for this resident included, but were not limited to: anemia, chronic pain, high blood pressure, hypothyroidism, history of DVT (deep vein thrombosis), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), DM (diabetes mellitus), diabetic ulcer to right lower extremity and pressure ulcer to left heel. The most current MDS (minimum data set) was an admission assessment dated 11/26/19. This MDS assessed the resident as having a cognitive score of 13, indicating the resident is intact for daily decision making skills. The resident was documented with one Stage 3 pressure ulcer (present upon admission) to the right lower leg and one unstageable (present upon admission) to the left heel. During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her	{F 686}	F-686 1. Resident #104□s foot box has been returned to resident□s wheelchair to maintain proper chair positioning, and recommended pressure relief interventions are now being completed per recommendation. MD and Responsible party have been notified. 2. All residents utilizing a wheelchair as a device are at risk. 3. SDC or designee will educate: a. All nursing staff on identifying potential pressure that may require intervention, pressure relief interventions, and communicating with therapy on changes with devices/interventions. b. All Therapy staff on communicating with nursing team when interventions are being placed, trialed, adjusted, or removed. 4. DON or designee will audit 100% of resident□s wheelchairs for any potential pressure points, then validate on rounds 3x daily for 2 weeks, the 2x daily for 2 weeks, then review findings in following QA meeting.	

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{F 686}	Continued From page 8 room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. On 12/10/19 at 12:50 PM, Resident #104 was observed again, sitting in the room, in the wheelchair in the same position, and in the same area of the room. Resident #104 was interviewed and stated she had an ulcer on her right leg and that she had and an unstageable ulcer on her left heel. Both of Resident #104's legs were wrapped with profore compression dressings that covered her feet, up to just below the knees. Resident #104 stated that she was getting therapy and that staff were changing the dressings twice a week. Resident #104 had bilateral leg rests to the wheelchair. Resident #104's right leg had moved off of the calf support pad, and the resident's foot was not touching the foot rest petal, nor the floor. The resident's left calf support pad had rotated and Resident #104's calf was laying on the top edge of the calf pad support (not flat) causing pressure to the back of the resident's calf. Resident #104 denied pain. Resident #104's current CCP (comprehensive care plan) was reviewed and documented, "...Contractures: The resident has contractures of the right lower leg...right lower leg to keep clean and prevent skin breakdown...resident has a Stage 3 pressure ulcer to her RLE (right lower extremity, and [unstageable] pressure ulcer to the left heel...devices heel float, multipodus boots to bilateral feet, foot cradle...position resident as needed...position resident for comfort...Potential for further skin impairment related to CVA...multipodus boots, and foot cradle for prevention...Pressure reduction surface to wheelchair..." The pressure reduction surface	{F 686}	5. Date of Compliance: 1.6.2020.	

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{F 686}	Continued From page 9	{F 686}		

intervention listed on the CCP was not specific.

Resident #104's physician's orders were reviewed and documented, "...Monitor off loading boots are in place every shift...PT (Physical Therapy) treatment order: 5-7 times/week for 6 weeks...gait training, w/c mobility..."

At approximately 2:10 PM, the above observations were reported to Resident #104's nurse, LPN (Licensed Practical Nurse) #1. Resident #104 was then observed again. Resident #104's left leg calf support pad was again observed in the improper position. LPN #1 stated, "I see what you are saying." LPN #1 then began to reposition the pad and the resident's legs to the proper position. LPN #1 was asked to undress Resident #104's left leg down to the area where the calf support pad was laying on the resident's calf in the wrong position. LPN #1 undressed the left calf area and then raised the resident's left leg for observation. Resident #104's posterior calf had an indentation of approximately 4 inches long and approximately 1 inch deep. LPN #1 stated that she agreed that the resident's leg and/or the calf pad must have been improperly positioned to leave an indented area on the resident's calf.

Resident #104 was asked how long she had been up in the wheelchair. Resident #104 stated that she had been up in the wheelchair since around 6:00 AM and had not been put back to bed. Resident #104 was asked if anyone had been to check on her since lunch and the resident stated, "No." Resident #104 stated that she had gone to therapy that morning and that therapy had taken something out from under her legs. Resident #104 stated that she didn't know what it was, but

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{F 686}	Continued From page 10	{F 686}		

it wasn't a pillow, but did state that it was some type of support for her legs.

On 12/10/19 at 2:20 PM the PTA (physical therapist assistant) was interviewed. The PTA stated that she had worked with Resident #104 that morning between 7:00 and 8:00 AM. The PTA stated that the resident had her "puff boots" on to prevent pressure. The PTA was asked if Resident #104 had anything else in place. The PTA stated that the resident had a "little box" that therapy was using for support and to keep Resident #104 in alignment and that therapy had been doing trials without it. The PTA stated that she thought the resident had the device since admission and that Resident #104 had it all day yesterday, then it was removed. The PTA stated that Resident #104 didn't have it today. The PTA was asked if she had put pillows under the resident's legs. The PTA stated that may be something nursing does, but not therapy. The PTA stated that someone from OT (occupational therapy) sees the resident in afternoon to ask how she is doing and if she is comfortable. The PTA stated that it can be anytime after lunch, but didn't know if anyone had seen her today after lunch. The PTA was asked for assistance in locating information regarding the foot box support to determine if there was an order for this device and to determine when it was implemented and when it was removed.

On 12/10/19 at 2:45 PM, the PTA was interviewed. The PTA stated, "There is no original order to have [the foot box] or to discontinue this [foot box], period." The PTA was asked about documentation of the foot box being implemented in any of the therapy notes. The PTA stated there was no documentation in the

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{F 686}	Continued From page 11	{F 686}		

system about the foot box. The PTA had the foot box support device in her hand and stated that she was taking it back down to the resident at this time to put it back in place.

On 12/10/19 at 2:55 PM, the OT was interviewed. The OT stated that Resident #104 had been working with OT to advance ambulation and that therapy took the foot box off. The OT stated that the box was implemented on day number three after the resident's admission, and stated that the box got removed today. The OT stated that she saw Resident #104 between 10:00 and 11:00 AM. The OT stated that the box was becoming an impediment for Resident #104 and that is why it was taken off. The OT was made aware of the observations of Resident #104's left leg calf pad putting pressure on the back of the resident's calf. The OT stated that she saw Resident #104 today around 1:00 PM and stated that she "poked" her head in the door and asked the resident how she was doing. The OT stated that Resident #104 denied pain and that she didn't see Resident #104 or the wheelchair in an abnormal position when she did the walk by. The OT was asked where that was documented. The OT stated that was just something therapy does; they don't document that and it isn't a facility requirement to document that.

On 12/10/19 at 3:50 PM, Resident #104 was interviewed again and asked if anyone from therapy checked on her, specifically anytime after lunch (besides the PTA putting the box back in place at approximately 2:45 PM) and the resident stated, "No."

The resident's PT and OT therapy progress notes were reviewed from admission to present and did

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LOUISA HEALTH & REHABILITATION CENTER	210 ELM STREET LOUISA, VA 23093

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{F 686}	Continued From page 12	{F 686}		

not reveal any orders or any documentation of the foot box support for Resident #104's legs and feet.

On 12/10/19 at approximately 4:00 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware of the above information in a meeting with the survey team.

On 12/11/19 at approximately 8:15 AM, Resident #104 was observed in her room, sitting in her wheelchair with the foot box support device in place. Resident #104 was asked if that device was better for her, and she stated, "Yes Ma'am, thank you."

On 12/11/19 at 9:30 AM, the DON and corporate nurse met with the survey team and stated that the per their interviews with therapy, the positioning foot box for Resident #104 was removed on 12/10/19 at 8:00 AM and that the resident was monitored through out the day and was last seen by the OT at 1:56 PM.

The DON and corporate nurse were made aware of discrepancies regarding the above information as far as observations, and interviews with the resident and therapy staff. The DON and corporate nurse were made aware that there was no documentation to evidence that Resident #104 was checked on at all and no documentation regarding the foot box at all.

On 12/10/19 at approximately 4:00 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware in a meeting with the survey team of the above observations. The DON stated that the foot box was actually for proper alignment and would not have been in

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Resident #104's CCP for pressure relief. The DON was asked for the resident's wound care orders, notes and information from the wound care clinic for the management of the resident's wounds, as this information was not located in the resident's chart.

On 12/11/19 at 7:30 AM, Resident #104's wound records were reviewed and documented that the resident was originally seen on 11/21/19 and was seen each week following. The wound physician orders documented, "...profore lite multilayer compression dressing - bilateral. Avoid standing for long periods of time. Elevate legs to the level of the heart or above for 30 minutes 3 times daily and/or when sitting. Other - Use your compression pump twice a day, prop leg up, place pillow under knee to relieve pressure on the calf..."

On 12/11/19 at 10:25 AM, the therapy director [also known as OT #2] was interviewed and stated that any device or implementation of a device should be documented in the therapy progress notes.

On 12/11/19 at 10:30 AM, the DON and corporate nurse met with the survey team and were asked why Resident #104's wound care orders and progress note information were not in the resident's clinical record and asked where this information came from. The DON stated that she had it faxed to ensure that she had all of the information from each visit and further stated that she had some information originals in her office. The DON was asked why this information was not in the resident's clinical record anywhere. The DON was made aware that the orders were not found in the resident's clinical record. The DON

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stated that those orders are from the [name] wound clinic and stated that the nurses at the facility will take off orders and put in the record and care plan. The DON was asked how they were supposed to do that if the records were in her office. The DON stated that the facility staff were backed up and that it had not been scanned into the system by medical records. The DON and corporate nurse were made aware that Resident #104 had been going to the wound clinic since 11/21/19 and those orders were listed from the very first visit. The corporate nurse stated that the information on the physician's orders from the wound care clinic should have been put on Resident #104's care plan, but stated that that information did not specifically need to be on the resident's current order sheet.

12/11/19 at 10:44 AM, the therapy director was again interviewed. The therapy director stated that each resident is individualized and that the therapy department trials things all the time and they will communicate verbally with nursing to assist in the process. The therapy director stated that therapy staff will check on resident's every so often and they don't document on a daily basis, but document every 10 visits in the progress notes and that it is more of a summary. The therapy director was asked if that device should have been documented for Resident #104, since therapy staff were saying that it was implemented on day 3. The therapy director stated that it should have been documented and should have been on the resident's CCP (comprehensive care plan). The therapy director stated, "...skin break down can happen at any time and the progress notes are supposed to encompass anything done during the therapy visits..."

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{F 686}	Continued From page 15 No further information and/or documentation was presented prior to the exit conference on 12/11/19 to evidence that the facility staff implemented care interventions for the prevention of pressure ulcers for Resident #104.	{F 686}		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		1/6/20

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F 842	Continued From page 16 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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 observation, resident interview, staff interview, and clinical record review, the facility staff failed to maintain and complete and accurate clinical record for one of 10 residents in	F 842	F-842 1. Resident #104□s wound clinic records have now been uploaded into the patient	

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F 842	Continued From page 17 the survey sample (Resident #104). The resident's wound clinic records, which included orders and interventions, were not part of the resident's medical record. Findings include: Resident #104 was admitted to the facility on 11/15/19. Diagnoses for this resident included, but were not limited to: anemia, chronic pain, high blood pressure, hypothyroidism, history of DVT (deep vein thrombosis), DM (diabetes mellitus), diabetic ulcer to right lower extremity and pressure ulcer to left heel. The most current MDS (minimum data set) was an admission assessment dated 11/26/19. This MDS assessed the resident as having a cognitive score of 13, indicating the resident is intact for daily decision making skills. The resident was assessed as requiring extensive assistance of 2 staff for transfers, dressing, and toileting. Resident #104 was documented with one Stage 3 pressure ulcer (present upon admission) and one unstageable (present upon admission). During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. Resident #104 had multipodus boots to both feet. On 12/10/19 at 12:50 PM, Resident #104 was observed again, sitting in the room, in the wheelchair in the same position, and in the same area of the room. Resident #104 was interviewed and stated she had an ulcer on her right leg and that she had and an unstageable ulcer on her left	F 842	electronic record. 2. All residents receiving medical services outside the center are at risk. 3. Regional Consultant will educate administrator or designee on ensuring that clinical documents are uploaded into the electronic record to maintain record accuracy. 4. Administrator or designee will audit 100% of all patients returning from receiving medical services outside the center for provided documentation being uploaded in the electronic record 5 times weekly for 4 weeks, then review findings in the following QA. 5. Date of Compliance: 1.6.2020.	

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heel. Both of Resident #104's legs were wrapped with profore compression dressings that covered her feet, up to just below the knees. Resident #104 stated that she was getting therapy and that staff were changing the dressings twice a week. Resident #104 had bilateral leg rests to the wheelchair. Resident #104's right leg had moved off of the calf support pad, and the resident's foot was not touching the foot rest petal, nor the floor. The resident's left calf support pad had rotated and Resident #104's calf was laying on the top edge of the calf pad support (not flat) causing pressure to the back of the resident's calf.

Resident #104's current CCP (comprehensive care plan) was reviewed and documented, "...Contractures: The resident has contractures of the right lower leg...right lower leg to keep clean and prevent skin breakdown...resident has a Stage 3 pressure ulcer to her RLE (right lower extremity, and [unstageable] pressure ulcer to the left heel...devices heel float, multipodus boots to bilateral feet, foot cradle...position resident as needed...position resident for comfort...Potential for further skin impairment related to CVA...multipodus boots, and foot cradle for prevention...Pressure reduction surface to wheelchair..." The pressure reduction surface was not specific, no other interventions were found related the resident's pressure ulcer.

The resident's physician's orders were reviewed and documented, "...Monitor off loading boots are in place every shift...PT (Physical Therapy) treatment order: 5-7 times/week for 6 weeks...gait training, w/c mobility...profore lite multilayer compression dressing to RLE [right lower extremity]...left calcaneus...profore lite multilayer compression dressing..."

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At approximately 2:10 PM, the above observations were reported to Resident #104's nurse, LPN (Licensed Practical Nurse) #1. Resident #104 was observed again. Resident #104's left leg calf support pad was again observed in the improper position. LPN #1 stated, "I see what you are saying." LPN #1 then began to reposition the pad and the resident's legs to the proper position. LPN #1 was asked to undress Resident #104's left leg down to the area where the calf support pad was laying on the resident's calf in the wrong position. LPN #1 undressed the left calf area and then raised the resident's left leg for observation. Resident #104's posterior calf had an indentation of approximately 4 inches long and approximately 1 inch deep. LPN #1 stated that she agreed that the resident's leg and/or the calf pad must have been improperly positioned to leave an indented area on the resident's calf. LPN #1 then stated that Resident #104 had cellulits of the legs.

Resident #104 was asked how long she had been up in the wheelchair. Resident #104 stated that she had been up in the wheelchair since around 6:00 AM and had not been put back to bed. Resident #104 was asked if anyone had been to check on her since lunch and the resident stated, "No." Resident #104 stated that she had gone to therapy that morning and that therapy had taken something out from under her legs this morning. Resident #104 stated that she didn't know what it was, but it wasn't a pillow, but did state that it was some type of support for her legs.

On 12/10/19 at approximately 4:00 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware in a meeting

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with the survey team of the above observations. The DON was asked for Resident #104's wound care orders, notes and information from the wound care clinic for the management of the resident's wounds, as this information was not found in the resident's clinical record.

On 12/11/19 at 7:30 AM, Resident #104's wound records were reviewed and documented that the resident was originally seen on 11/21/19 and was seen each week following. The wound physician orders documented, "...profore lite multilayer compression dressing - bilateral. Avoid standing for long periods of time. Elevate legs to the level of the heart or above for 30 minutes 3 times daily and/or when sitting. Other - Use your compression pump twice a day, prop leg up, place pillow under knee to relieve pressure on the calf..."

On 12/11/19 at 10:30 AM, the DON and corporate nurse met with the survey team and were asked why Resident #104's wound care orders and progress note information were not in the resident's clinical record and asked where this information came from. The DON stated that she had it faxed to ensure that she had all of the information from each visit and further stated that she had some information originals in her office. The DON was asked why this information was not in the resident's clinical record anywhere. The DON was made aware that the orders were not found in the resident's clinical record. The DON stated that those orders are from the [name] wound clinic and stated that the nurses at the facility will take off orders and put in the record and care plan. The DON was asked how they were supposed to do that if the records were in her office. The DON stated that the facility staff

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F 842	Continued From page 21 were backed up and that it had not been scanned into the system by medical records. The DON and corporate nurse were made aware that Resident #104 had been going to the wound clinic since 11/21/19 and those orders were listed from the very first visit. The corporate nurse stated that the information on the physician's orders from the wound care clinic should have been put on Resident #104's care plan, but stated that that information did not specifically need to be on the resident's current order sheet. No further information and/or documentation was presented prior to the exit conference on 12/11/19 to evidence Resident #104's clinical records were complete and accurate to include interventions and orders for the pressure ulcer care and prevention. No further information and/or documentation was presented prior to the exit conference on 12/11/19.	F 842		