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	495178	A. BUILDING _____ B. WING _____	C 08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE HEALTH & REHABILITATION CENTER	505 WEST RIO ROAD CHARLOTTESVILLE, VA 22901

(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 abbreviated survey was conducted 08/03/2021 through 08/04/2021. One complaint was investigated during the survey. Complaint number VA00052663 was unsubstantiated with related deficient practice. Significant corrections are required for the facility to be in compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 90 certified bed facility was 89 at the time of the survey. The survey sample consisted of one (1) closed record (Resident #1) and two (2) current Resident reviews (Residents #2 and Resident #3).	F 000		
F 686 SS=G	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 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility	F 686	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with	9/14/21

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

Electronically Signed | 08/17/2021

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F 686	Continued From page 1 staff failed to ensure that two of three residents in the survey sample did not develop avoidable pressure ulcers. Resident #2 developed an avoidable facility acquired Stage III pressure ulcer on her right buttock. Resident #3 developed five avoidable facility acquired unstageable pressure ulcers, one of which was not identified by the facility until eschar (dark scab) was present over the area. This was identified as harm. Findings were: During the entrance conference on 08/03/2021 at approximately 9:15 a.m., the DON (director of nursing) was asked for a list of all residents in the facility with facility acquired pressure ulcers. The DON was asked if there was a wound nurse at the facility. She stated, "We have a nurse practitioner (NP), that has her own business (name of business). She comes in every week and sees our residents with pressure. She was here this morning around 6:30 (a.m.). She makes rounds and does all the dressing changes, she measures everything, and writes the orders." Also requested during entrance was the facility policy and procedure regarding pressure ulcers. The DON presented a list with four resident names. Two of the four, Resident #2 and Resident #3 were added to the survey sample. 1. Resident #2 was admitted to the facility on 06/23/2013 with the following diagnoses, including but not limited to: COPD (chronic obstructive pulmonary disease), hypothyroidism, bilateral foot drop, protein-calorie malnutrition, dementia without behavioral disturbances. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment	F 686	the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F686 1. Resident #□s 2 and 3 have treatment orders and preventative measures in place to prevent further pressure ulcer development. 2. All current residents will be assessed to ensure appropriate preventative measures for pressure ulcer development are in place. 3. Current licensed nursing staff will be educated on the importance of pressure ulcer prevention. Current licensed nurses will be educated on the importance of accurate weekly skin evaluations. Nursing leadership will review 10 residents weekly x 4 weeks to ensure accuracy. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 9-14-2021.	

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reference date) of 04/16/2021. Resident #2 was assessed as severely impaired in her cognitive status with a summary score of "07".

The DON was interviewed on 08/03/2021 at approximately 12:25 p.m. regarding the list of residents with facility acquired pressure ulcers. When asked about Resident #2, she stated, "She was seen for the first time today (08/03/2021) by [name of wound NP (nurse practitioner)]. The area was initially found at a Stage III."

The clinical record was reviewed. A "Weekly Skin Evaluation" dated 07/26/2021 was observed and made no mention of any areas on Resident #2's buttocks.

A progress noted dated 07/27/2021 at 19:38 [7:38 p.m.] documented: Resident w/ [with] no changes to baseline. RP [responsible party]...notified that resident remains at baseline. Resident eats very little at times but is supplemented w/ house supplement nutrition drink, which she likes a lot. Resident responds to verbal stimulation and is normally cooperative with staff providing care. Will refuse medications at times, but usually able to be redirected. Treatment to lower extremities continues..."

There was no other documentation in the clinical record regarding the resident's skin until the "Weekly Skin Evaluation" note for 07/31/2021 which documented the following regarding a new area on the gluteal fold:
"Observations:
1. Is Skin Intact without impairment? No
2. Wound(s) present: Yes
3. Are any wounds pressure related? Yes
4. Site: 55 Right gluteal fold

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Type: Pressure
Length: 2cm
Width: 2 cm
Depth: 0
Stage: NOT ANSWERED
5. Notes: open area noted to right gluteal fold, slough tissue noted in wound bed...
Wound
1. Location of wound: R [right] gluteal fold
2. Indicate whether this site was acquired during the residents stay or whether it was present on admission: Acquired
2a. Date acquired: 07/31/2021
3. Wound healed? No
4. Visible/Observation of Tissue: slough tissue present...
4b. Percentage of wound involvement (describe): NOT ANSWERED
5. Drainage present? No
6. Tunneling present? No
7. Undermining present? No
8. Description of peri-wound tissue: Pink
9. Describe wound edges and shape: Well defined
10. Surgical Wound Edges: na
11. Enter the number of sutures/staples present: 0
12. Infection suspected: No
TREATMENT
13. Current Treatment Plan: NOT ANSWERED
14. Special Equipment: NOT ANSWERED
EVALUATION
15. Wound progress: new, worsening, stalled improving- nothing documented
16. Care Plan reviewed/revised: Yes no- nothing documented
17. Comments: NONE ENTERED
18. Another wound present: No"

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Resident #2 was referred to the wound NP and seen on 08/03/2021. The progress note from the NP dated 08/03/2021 documented the following: "Wound HPI: ....[Name of Resident #2] is a 101-year-old frail appearing white female...some recent decrease in mobility, and fecal incontinence. Staff noted ulceration at buttock region 2 days ago. Patient denies pain at site...Current treatment includes: foam dressing PMHx [Past medical history/PSHx [past symptom history]: COPD, foot drop of bilateral feet, GERD [gastroesophageal reflux disease], poor mobility, dementia, fecal incontinence....Review of Systems: ...(-) [negative] lower extremity edema (+) [positive] fecal incontinence (+) urinary incontinence (+) ambulation difficulty (-) ability to self reposition...(-) weight loss...Wound (+) full thickness ulceration of the right buttock that measures 1.8 X 1.5 X 0.2 cm. Wound base 55% slough and 45% granular before debridement and 25% slough and 75% granular after. Edges adherent to wound base, moderate non-odorous serous drainage, periwound without erythema, induration, or cellulitis. Patient does not demonstrate evidence of pain when area is palpated. Plan: Stage III right buttock-contributing factors are poor mobility, fecal incontinence. Wound care to right buttock as follows:
-cleanse with normal saline or wound cleanser, pat dry
-Apply honey fiber to wound bed
-Cover with bordered foam dressing
-Change dressing QD [every day] and as needed for saturation or soilage.

Turn/reposition at least every 2 hours when in bed and every hour when OOB [out of bed] to chair. HOB [head of bed] at 30 degrees or less as

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able, Float heels off bed with pillows or off loading boots, minimize the number of /layers beneath patient, Pressure redistribution cushion in chair when OOB to chair and pressure redistribution mattress for bed. Limit time OOB to chair. ....Education/Instructions: Plan of care and treatment recommendation discussed with patient and nursing staff, verbalized understanding. Performed excisional Debridement of right . ttock wound consisted of: Ulceration site was prepped and conservative sharp debridement was performed. Depth of debridement was at level of subcutaneous tissue, and within wound margins. Removal of devitalized necrotic tissue with a 5mm curette. There was scant bleeding that quickly subsided with light pressure and cleansing, Patient appeared to tolerate procedure without pain or signs of discomfort."

A progress note on 08/03/2021 21:24 [8:24 p.m.] documented: "Resident seen on wound rounds by wound NP, wound changed by NP, new order placed...supplement added X 30 days, RP stated he would bring outside food for extra supplement."

On 08/04/2021 at approximately 8:30 a.m., the DON and nurse consultant were interviewed. The DON stated, "We identified an increase in pressure ulcers in July. We did education with staff in July...we had a number of new staff so we did education on turning and repositioning." The inservice information for staff was reviewed. The education included: "Subject: Pressure Ulcers and Skin breakdown, repositioning and floating heels. Objectives: Prevent Pressure Ulcers and Skin Breakdown. Summary of Content: Repositioning, turning, and floating heels, use of air mattress, Demonstrate proper use of air

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mattress." The DON stated, "All the staff were educated." Concerns were voiced to the DON and the nurse consultant regarding the number of facility acquired pressure ulcers and that after the inservice had been done, Resident #2 had developed a stage III pressure area.

On 08/04/2021 at approximately 9:00 a.m., the care plan was reviewed. The following information was observed:
"Focus: ...has an ADL self-care performance deficit r/t [related to] weakness, COPD, limited ROM [range of motion], age, impaired mobility. Interventions included but were not limited to: Assist with all ADL tasks...Resident do not get out of bed....BED MOBILITY: Extensive staff assist for bed mobility...TOILET USE: ...is incontinent and requires total/extensive staff assist. Provide peri-care after incontinent episodes... Focus: SKIN: Is at risk for skin impairment/pressure ulcer development r/t incontinence & immobility Interventions included but were not limited to: Keep skin clean and dry, pericare with incontinence episodes. Wears briefs..., Pressure reduction mattress, treatment to wounds as ordered, weekly skin assessments...Focus: The resident has a skin tear/potential for skin tear of the (right lower leg). resident with a Stage 3 to left buttock. Interventions were: Air mattress, The resident needs her nails kept short to reduce the risk of scratching or injury from picking at skin. Weekly skin assessments."

At 9:25 a.m., the NP providing wound care at the facility was interviewed. She was asked about her role at the facility. She stated, "I come every week on Tuesday mornings and provide care for the wounds in the facility." She was asked if she had seen Resident #2. She stated, "Yes, I saw her for

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the first time yesterday...I don't know her well. She hasn't had any pressure in the past. She presented with what the facility said was a Stage 2 pressure area, it was really a stage 3. I debrided the area and gave them treatment orders." The NP was asked if Resident #2's pressure ulcer had been avoidable. She stated, "Well, it's not unavoidable." She was asked to explain. She stated, "I reviewed her record, she hasn't had a significant weight loss, or a decline that would indicate the area is unavoidable...if I think an area is unavoidable I write that in my note, I didn't write that...she is totally dependant on the staff to turn and reposition her and provide incontinence care....this area was avoidable if she had been repositioned and received good incontinence care."

At approximately 10:15 a.m., RN (registered nurse) #2 was observed providing wound care to Resident #2. The old dressing was removed, the area was measured. RN #2 stated, "The whole area is 2 cm X 2.5 cm. The area of slough is 1 X 1.5 cm, the depth is about .5 cm." The wound was observed with a reddish bright pink outer area. Yellow slough was observed in the center with a small area of reddish skin in the center of the slough. The entire wound was cleaned with wound cleanser. A small piece of calcium alginate was placed over the area of slough, and a border gauze was placed over the entire area." RN #2 stated that the facility did not have the honey fiber ordered by the NP and had gotten the okay to use the calcium alginate until they could obtain it.

The facility policy "Pressure Ulcer Monitoring &Documentation" was reviewed and contained the following:
"Policy: All pressure ulcers will be monitored.

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Procedure:
1. A licensed nurse will assess patients for the presence of pressure ulcers/injuries; if a pressure ulcer/injury is present, the nurse will evaluate for complications.
2. Provide pain management prior to pressure ulcer/injury treatment as indicated.
3. The Skin Wound Evaluation will be completed weekly by a licensed nurse for any patient with pressure ulcers/injuries.
4. There will be a Wound Evaluation for each site."

The DON, the administrator, and the nurse consultant were interviewed at approximately 11:35 a.m., the above information was discussed. The DON was asked if the were any other policies regarding pressure ulcer assessment, staging, etc. She stated, "No." The nurse consultant stated, "The skin evaluation has information regarding staging." The DON was asked how wounds were identified. She stated, "If the CNA sees it they notify the charge nurse, they also have an option in their system to do a stop and watch charting. The nurse then does an assessment, a skin evaluation is done, the doctor is called, treatment is applied and the orders are initiated....it is standard nursing practice." The DON was asked how the NP who takes care of the pressure areas became involved. She stated, "[Name of Medical Director] is okay with [name of NP] evaluating the residents...all the pressure areas automatically go to [NP name]...not always the stage one but the others do..."

At approximately 2:20 p.m., the care plan interventions for Resident #2 were discussed with the DON, the administrator, and the nurse consultant. The DON was asked if interventions

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such as off loading boots, air mattresses, heelz up devices, floating heels, etc. were physician orders. She stated, "No, those are nursing interventions." She was asked how staff was reminded to look at those things, or the nursing staff to check to see if they were in place if they were not on the TAR (treatment administration record) to remind them. She stated, "They are on the care plan." The interventions listed for Resident #2 were read. The DON was asked where the interventions for Resident #2 regarding turning and repositioning were on the care plan. She stated, "Bed mobility...she is extensive assistance." She was asked what that meant. She stated, "Extensive assistance means she needs someone to turn and reposition her, it doesn't say turn and reposition is says extensive assistance." The administrator stated, "Extensive assistance is defined as turn and reposition." The DON stated, "That's standard nursing practice to turn the resident every 2 hours...and treat the wounds as ordered."

The DON, the nurse consultant, and the administrator were informed that based on the documentation, and the interview with the NP who stated the pressure area on Resident #2's buttocks was avoidable, harm was identified. Any additional information available was requested. The DON and the nurse consultant stated, "We identified the area, we treated it, she's 101 years old." It was reiterated that per the wound care nurse practitioner, the area was incorrectly staged by the facility as a Stage 2 when it was a Stage 3, and the area would have been avoided with "repositioning and good incontinence care."

No further information was obtained prior to the exit conference.

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2. Resident #3 was originally admitted to the facility on 09/25/2020 and readmitted on 05/25/2021. Her diagnoses included, but were not limited to: Metabolic encephalopathy, chronic congestive heart failure, urinary tract infection, cerebral vascular accident, diabetes mellitus, atrial fibrillation and right hand contracture.

The most recent completed MDS was significant change assessment with an ARD of 06/01/2021, six days after her return from the hospital. Resident #3 was assessed as severely impaired in her cognitive status with a summary score of "03". However, the electronic health record included an MDS in progress and not yet completed, with an ARD of 07/17/2021, that assessed Resident #3 as moderately impaired in her cognitive status with a summary score of "09".

When Resident #3 was readmitted from the hospital on 05/25/2021 she had a Stage III pressure area to her sacrum and DTI (deep tissue injury) to both her right and left heel. Weekly skin assessents and the wound NP notes through 06/24/2021 documented that both heels had "healed", that the sacral pressure ulcer was improving, and no additional skin issues.

Beginning on 06/28/2021, weekly skin assessment and NP wound notes documented new and worsening pressure areas as follows:

Weekly skin assessment on 06/28/202: Left ankle (outer) Pressure Length 2.1cm Width 1.3cm Depth 0.5cm Stage II...Notes: Open area right ankle...acquired, date acquired 06/27/2021, scant amount serous drainage, no tunneling or

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F 686	Continued From page 11 undermining... Weekly skin assessment on 06/30/2021: Sacrum: 0.5 x 0.7 x 0.1 Stage III Notes: R hand is contracted, Popped blister to left outer ankle healed, nitrated by wound NP. Sacrum 100 % granulation, small amount serous drainage... Wound NP note on 07/06/2021: "...pt is seen for evaluation and management of pressure injury at sacrum. Patient also with new wound at left lateral ankle. Patient hit the area on the foot pedal of her wheelchair. The area initially blistered, and now has opened...Wound: (+) Full thickness ulceration of the sacrum that measures 3.0 x 3.5 x 0.2 cm. Wound base 45% slough and 55% granular before debridement and 15% slough, 85% granular after. Edges adherent to wound base, small non-odorous serous drainage...(+) Full thickness ulceration of the left lateral ankle that measures 2.5 x 1.8 x 0.2 cm. Wound base is 10% slough and 90% granular. Edges adherent to wound base, moderate non-odorous serous drainage...Blanchable erythema noted at the left lateral heel. Plan: Stage 3 pressure injury at sacrum, abrasion at left lateral ankle, resolved DTI left heel, resolved DTI right heel-contributing factors are recent acute illness, poor mobility, recent acute illness, type 2 diabetes, incontinence...Site enlarged continue care x 1 week and if no improvement will change POC next week.... Wound care to left lateral ankle as follows: -Cleanse with normal saline or wound cleanser, pat dry -Apply calcium alginate to wound bed -Cover with gauze and kerlix -Change dressing Q 3 days and as needed for	F 686		

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saturation or soilage..."

Weekly skin assessment on 07/07/2021: "Sacrum 3.0 x 3.5 x 0.2 Stage III Left lateral ankle-abrasion- 2.5 x 1.8 x 0.2 Sacrum: 15% slough and 85% granular, moderate amount serous drainage, no tunneling or undermining, special equipment: air mattress. Wound progress: Worsening... Left lateral ankle: Acquired. 10% slough and 90% granular, moderate amount serous drainage..."

Wound NP note on 07/13/2021: "...pt is seen for evaluation and management of pressure injury at sacrum, pressure injury to left lateral ankle, left hip, and left heel. Initially the left ankle wound was defined as an abrasion last week, however, site has increased in size and patient has had increased pressure to the area now defined as a stage III pressure injury. Staff has been repositioning patient often, continues to use air mattress and offloading heels with foam boots...Wound: (+) Full thickness ulceration of the sacrum that measures 9.5 x 3.5 x 0.2 cm. Wound base 20% eschar, 50% slough and 30% granular. Edges adherent to wound base, small non-odorous serous drainage...
(+) Full thickness ulceration of the left lateral ankle that measures 5.0 x 4.5 x 0.2 cm. Wound base with some peeling skin from unroofed blister, 25% slough and 75% granular before debridement, and 100% granular after. Edges adherent to wound base, small non-odorous serous drainage...Blanchable erythema noted at the left lateral heel.
(+) Full thickness wound of the left lateral heel that measures 4.0 x 3.5 x 0.0 cm. Wound base 100% area of purple deep ecchymosis, (+) surface induration, edges adherent to wound

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base. No drainage...(+) Full thickness wound of the left hip that measures 3.0 x 3.0 x 0.0 cm. Wound base 100% area of deep purple ecchymosis. (+) surface induration, edges adherent to wound base. No drainage...

Plan: Stage 3 pressure injury at sacrum, stage 3 pressure injury to left lateral ankle, recurrent DTI left heel, DTI at left hip, resolved DTI right heel, contributing factors are recent acute illness, poor mobility, recent acute illness, type 2 diabetes, incontinence, neuropathy.

Site enlarged CHANGE care-
Wound care to sacrum as follows:
-Cleanse wound with normal saline or wound cleanser
-Apply calcium alginate to wound bed
-Cover with bordered foam dressing
-Change dressing daily and as needed for saturation or soilage

Site enlarged CHANGE care-
Wound care to left lateral ankle as follows:
-Cleanse with normal saline or wound cleanser, pat dry
-Apply xeroform to wound bed
-Cover with gauze and Kerlix
-Change dressing daily and as needed for saturation or soilage

Wound care to left hip and left heel as follows:
-Cleanse with normal saline or wound cleanser, pat dry.
-Apply skin prep/barrier film to wound bed
-Provide this care daily.

Apply resta cream to bilateral feet/heels daily to prevent xerosis

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Assist to-
Turn/reposition at least every 2 hours when in bed and every hour when OOB [out of bed] to chair. HOB [head of bed] at 30 degrees or less as able, Float heels off bed with pillows or off loading boots, minimize the number of layers beneath patient, Pressure redistribution cushion in chair when OOB to chair and pressure redistribution mattress for bed. Limit time OOB to chair.
....Education/Instructions: Plan of care and treatment recommendation discussed with patient and nursing staff, verbalized understanding..."

Weekly skin assessment on 07/14/2021:
"Sacrum: 9.5 x 3.5 x 0.2 Stage III; Left hip Pressure 3 x 3 0 Suspected DTI; Lt [left] lateral heel Pressure 4 x 3.5 x 0 Suspected DTI; Left lateral ankle Pressure 5 x 4.5 x 0.2 Stage III
Sacrum: Wound base 20% eschar 50% slough and 30% granular, moderate amount serous drainage- cleanse with wound cleanser, pat dry, apply calcium alginate to wound bed, cover with bordered foam dressing. Wound progress: Worsening
Left lateral ankle: Acquired (NO DATE), wound base with some peeling skin from unroofed blister 25% slough and 75% granular before debridement and 100% granular after. Small amount serous drainage. Treatment: Cleanse, apply xerform to wound bed and cover with gauze wrap with kerlix. Wound Progress: New
Left hip: Date acquired 07/13/2021, 100% purple ecchymosis, no drainage. Treatment: Skin Prep. Wound Progress: New
Left lateral heel: Date acquired 07/13/2021, wound base 100% area of purple deep ecchymosis, no drainage. Treatment: Skin prep. Wound Progress: New."

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Wound NP note on 07/20/2021: "Patient is seen for evaluation and management of pressure injury to sacrum, pressure injury at left lateral ankle, right and left hip, left medial great toe, and left heel. Patient continues to deny complaints, states she is very comfortable. Appetite has been good, intake is good. Staff has been repositioning her frequently and patient has air mattress and foam boots. Wound: (+) Full thickness ulceration of the sacrum that measures 8.2 x 3.5 x 0.2 cm. Wound base 75% slough and 25% granular before debridement and 65% granular and 35% slough after. Edges adherent to wound base, moderate non-odorous serous drainage...
(+) Full thickness ulceration of the left lateral ankle that measures 4.0 x 2.5 x 0.0 cm. Wound base 5% slough and 95% slightly moist eschar. Edges adherent to wound base, scant non-odorous serous drainage...
(+) Full thickness wound of the left lateral heel that measures 3.0 x 2.5 x 0.0 cm. Wound base 100% area of purple deep ecchymosis, (+) surface induration, edges adherent to wound base. No drainage...
(+) Full thickness wound of the left hip that measures 2.5 x 3.8 x 0.2 cm. Wound base 100% slightly moist eschar, edges adherent to wound base. Scant serous drainage.
(+) Full thickness ulceration of the right hip measures 7.0 x 3.0 x 0.0 cm. Wound base 100% slightly moist eschar. edges adherent to wound base, scant non-odorous serous drainage...
(+) Full thickness wound of the left medial great toe that measures 2.0 x 1.5 x 0.0 cm. Wound base 100% stable eschar, edges adherent to the wound base. No drainage.
Plan: Stage 3 pressure injury at sacrum, unstageable pressure injury to left lateral ankle,

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recurrent DTI left heel, unstageable pressure injury to left hip, unstageable pressure injury at right hip, unstageable pressure injury to left medial great toe, resolved DTI right heel, contributing factors are recent acute illness, poor mobility, recent acute illness, type 2 diabetes, incontinence, neuropathy.
Site Improved Continue Care- Wound Care to Sacrum... (Dressing change described is unchanged from previous note)
Wound Care to Left lateral ankle and left hip: Apply alginate and coversite Q3days in an attempt to keep the site dry and help it stabilize.
Wound Care to left medial foot and left heel as follows: (Dressing change described is unchanged from previous note)"
(NOTE: There was no mention of treatment for the right hip)

Weekly skin assessment on 07/21/2021:
"Sacrum Pressure 8.2 x 3.5 x 0.2 Stage III; Left Hip Pressure 2.5 x 3.8 x 0.2 Unstageable; Lt great toe Pressure 2 x 1.5 x 0 Unstageable; Lt lateral heel Pressure 3 x 2.5 x 0 Suspected DTI; Left lateral ankle Pressure 4 x 2.5 x 0 Unstageable; Right hip Pressure 7 x 3 X 0 unstageable.
Sacrum: wound base 75% slough, 25% granular before debridement and 65% granular 35% slough after, Moderate amount serous drainage. Wound edges adherent to base. Wound progress: Improving
Left lateral Ankle: Acquired, (NO DATE), wound base with 5% slough and 95% slightly moist eschar, Scant serous drainage, wound edges adherent, Treatment: Cleanse, apply calcium alginate to wound bed and cover with coversite dressing. Wound progress: New.
Left hip: Date acquired: 07/13/2021 100% slightly

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moist eschar, scant amount serous drainage, Wound Progress: worsening
Left lateral heel: Date acquired 07/13/2021 Wound base 100% area of deep purple ecchymosis; Wound Progress: Improving
Right hip: Date Acquired: 07/20/2021 100% slightly moist eschar, scant amount serous drainage, wound edges adherent to base. Treatment: Cleanse with wound cleanser, pat dry, and apply silicone border. Wound Progress: New.
Left Great Toe: Date acquired: 07/20/2021 100% stable eschar, no drainage. Treatment: Cleanse,Apply Skin prep. Wound Progress: New."

Weekly skin assessment on 07/29/2021: "Sacrum Pressure 7 x 3.5 x 0.2 Stage III; Left hip Pressure 2.5 x 2.8 X 0.2 Unstageable; Left great toe Pressure 2 x 1.5 x 0 Unstageable; Left lateral heel Pressure 3 x 2.5 x 0 Suspected DTI; Left lateral ankle Pressure 4 x 2.5 x 0 Unstageable; Right hip Pressure 7 x 3 x 0 Unstageable." The rest of the skin evaluation was identical to the weekly skin evaluation completed on 07/21/2021.

Wound NP note on 08/03/2021: "Patient is seen for evaluation and management of pressure injury to sacrum, left lateral ankle, right and left hip, left medial great toe, and left heel. Patient denies complaints, appetite and intake are good. Patient has air mattress and is using foam boots to offload heels. Review of Systems: (-) ability to self-reposition, (+) poor bed mobility, (+) intermittent appetite loss, (-) weight loss. Besides meals, drinks ensure daily.
Wound: (+) Full thickness ulceration of the sacrum that measures 3.1 x 3.6 x 0.2cm x 3.5 x 0.2 cm. Wound base 85% slough and 15% granular before debridement and 60% granular

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F 686	Continued From page 18 and 40% slough after. Edges adherent to wound base, moderate non-odorous serous drainage... (+) Full thickness ulceration of the left lateral ankle that measures 4.0 x 2.6 x 0.2 cm. Wound base 5% slough- this is the only area of depth, and 95% slightly moist eschar. Edges adherent to wound base, scant non-odorous serous drainage... (+) Full thickness wound of the left lateral heel that measures 1.0 x 0.8 x 0.0 cm. Wound base 100% stable eschar,edges adherent to wound base. No drainage... (+) Full thickness wound of the left hip that measures 2.5 x 3.2 x 0.2 cm. Wound base 100% slightly moist eschar, edges adherent to wound base. Scant serous drainage. (+) Full thickness ulceration of the right hip measures 6.6 x 3.4 x 0.0 cm. Wound base 100% slightly moist eschar. Edges adherent to wound base, scant non-odorous serous drainage... (+) Full thickness wound of the left medial great toe that measures 1.0 x 1.0 x 0.0 cm. Wound base 100% stable eschar, edges adherent to the wound base. No drainage. Plan: Stage 3 pressure injury at sacrum, unstageable pressure injury to left lateral ankle, now unstageable pressure injury with stable eschar at the left heel, unstageable pressure injury at left hip, unstageable pressure injury at right hip, unstageable pressure injury to left medial great toe, resolved DTI right heel, contributing factors are recent acute illness, poor mobility, recent acute illness, type 2 diabetes, incontinence, neuropathy. Site Improved Continue Care- Wound Care to Sacrum..." (Dressing change described is unchanged from previous note) "Site Stable/Improved, continue care- Wound care to left lateral ankle and left hip, and	F 686		

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F 686	Continued From page 19 right hip: -Cleanse with NS or wound cleanser, pat dry -Apply alginate Then apply coversite OR border foam dressing Provide this care q 3 days, and as needed for saturation or soilage. Site improved, continue care- Wound Care to left medial foot and left heel as follows: ..." (Dressing change described is unchanged from previous note) Weekly skin assessment on 08/03/2021: "Sacrum: 3.1 x 3.6 x 0.2 Stage III; Lt lateral heel Pressure 1 x 0.8 x 0 Unstageable; Left great toe: Pressure 1 x 1 x 0 Unstageable; Left hip pressure 2.5 x 3.2 x 0.2 Unstageable; Left lateral ankle Pressure 4 x 2.6 x 0.2 Unstageable; Right hip pressure: 6.6 x 3.4 x 0 Unstageable. Sacrum: Wound base 85% slough and 15% granular before debridement and 60% granular and 40% slough after. Moderate amount serous drainage. Wound edges adherent to base. Wound Progress: Improving. Left lateral ankle: Acquired (NO DATE), wound base with 5% slough and 95% slightly moist eschar, scant amount serous drainage. Treatment: Cleanse, apply calcium alginate to wound bed and cover with coversite. Wound Progress: (NOT ANSWERED) Left hip: Date acquired 07/13/2021, 100% slightly moist eschar, scant amount serous drainage. Wound edges adherent to base. Treatment: Cleanse with wound cleanser, pat dry and apply calcium alginate to wound bed and cover with coversite dressing Q3D and prn. Wound Progress: Improving Left lateral heel: Date acquired 07/13/2021, Wound base 100% stable eschar, no drainage, Wound Progress: Improving	F 686		

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Right hip: Date Acquired: 07/20/2021 100% slightly moist eschar, scant amount serous drainage, wound edges adherent to base. Wound Progress: Improving.
Left Great Toe: Date acquired: 07/20/2021 100% stable eschar, no drainage. Wound Progress: (NOT ANSWERED)."

At approximately 12:15 p.m., Resident #3 was observed sitting up in a chair in her room. She was interviewed about her care at the facility including her wounds. She stated, "I don't know how I got them but I got them." She was asked if she was able to move herself from side to side in the bed. She stated, "No, I can't turn myself. They do it for me...sometimes it's a long time between times." She was asked to clarify "a long time". She stated, "I don't know about the time on the clock, but sometimes it's two hours before they come...I call and call and they don't come. They are busy, I know." Resident #3 was asked about her diet. She stated, "My food is pureed...I don't like it. My daughter brings me chicken and greens, I like that." She was asked if she had difficulty swallowing. She stated, "No."

Resident #3's bed was observed with an air mattress in place. A pump for the mattress was hanging on the foot of her bed. A green light was lit up on the side. There were no lights illuminated on the display screen on top of the pump.

At approximately 1:00 p.m., the DON was asked about the multiple new wounds that had been identified on Resident #3. She stated that Resident #3 was turned every two hours, and she had an air mattress in place. She stated, "She has a wound on her sacrum, she's been positioned on her sides to off load the pressure

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on her sacrum and she developed deep tissue injuries on her hips. Concerns were voiced that per the documentation the wound on the right hip was not discovered until it was 100% eschar. The DON was asked about staffing. She stated, "Like everyone in the area we have staffing challenges, we have open positions, we have PRN staff, and we are covering the facility at appropriate staffing levels." Copies of the July as worked schedule for Resident #3's unit were requested.

At 2:35 p.m., Resident #3 was observed lying in bed on the right side. The air mattress pump on the footboard of her bed was observed. The green light on the side of the pump was lit up, but there were no lights illuminated on top of the pump. There was no sound of air moving through the mattress.

LPN (licensed practical nurse) #2 was at the nurse's station and was asked to come look at the pump. She came to Resident #3's room, looked at the pump, and stated, "These are new...I don't know anything about them." She pushed the power button on top of the pump, nothing happened. She stated, "Let me see if I can find someone."

She left the room and spoke with LPN #1. LPN #1 came to the room. She also pushed the power button on top of the pump, nothing happened. She turned the switch off on the side of the pump and turned it back on. The top of the pump still did not illuminate any settings, or indication that the pump was on and functioning.

At approximately 2:40 p.m., OS (Other Staff) #2 from the maintenance department came to the

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room. He stated, "I just put this air mattress on the bed the other day...the lights on top were working then." He was asked what lights had been working. He stated, "When I set it up I get the weight from the nurses and set that, and I put it on alternate pressure, I don't mess with the cycle time." He then unplugged the pump from the wall, disconnected the air hose, pushed the buttons on the top of the pump, turned the switch on the side off and on. LPN #3 came to the room. She stated, "It was on this morning because I checked it."

At 2:45 p.m., the maintenance director came to the room. He stated, "We just started putting the mattresses on the beds." A pump like the one on Resident #3's bed was located in the room next door. It was observed with the maintenance director. The top of the pump was illuminated with the resident's weight range, cycle time and alternating pressure. The sound of air moving in the mattress could be heard. The maintenance director pushed the power button on top of the pump. The screen was no longer illuminated, but the green light on the side remained on. He stated, "The switch on the side tells you the pump box is getting power, the switch on top tells you the pump is on to the mattress." He was asked if he could hear the air going through the mattress. He stated, "Yes." He was told that the sound had not been heard at Resident #3's mattress. He stated, "I didn't hear it either."

At approximately 3:05 p.m., a new pump was placed on Resident #3's bed. The top of the pump illuminated and air was heard moving in the mattress. OS #2 programmed the pump for Resident #3's weight and for an alternating cycle. CNA (certified nursing assistant) #1 was in the

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room. She was asked if she was caring for Resident #3. She stated, "Yes." She was asked if she had looked at the lights on the pump. She stated, "Yes, it turned off earlier, but it came back on...then it was blinking and it came back on. I thought that was normal...it didn't alarm or anything." She was asked if she told the nurses. She stated, "No, it came back on, I thought it was normal."

At 3:20 p.m., Resident#3's air mattress was discussed with the DON and the nurse consultant. The nurse consultant stated, "We need to do some education."

On 08/04/2021 at approximately 8:30 a.m. the DON and the corporate nurse consultant were interviewed. The DON stated, "We identified an increase in pressure ulcers in July. We did education with staff ...we had a number of new staff so we did education on turning and repositioning." The inservice information was presented. The education included: "Subject: Pressure Ulcers and Skin breakdown, repositioning and floating heels. Objectives: Prevent Pressure Ulcers and Skin Breakdown. Summary of Content: Repositioning, turning, and floating heels, use of air mattress, Demonstrate proper use of air mattress." The DON stated, "All the staff were educated." Concerns were voiced to the DON and the nurse consultant regarding the number of facility acquired pressure ulcers and the level of skin involvement present when they were identified. Resident #3's pressure ulcer on her right hip was first identified as a wound with 100% eschar.

At 9:25 a.m., the NP providing wound care at the facility was interviewed over the telephone. She

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CHARLOTTESVILLE HEALTH & REHABILITATION CENTER	505 WEST RIO ROAD CHARLOTTESVILLE, VA 22901

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was asked about the care she was providing to Resident #3 and the history on her pressure ulcers. She stated, "She came back to us after a hospital admission with pressure on her sacrum which we were treating and it was improving. She had deep tissue injuries to both heels and they both resolved quickly. Everything was going well. Then about a month ago I came in to check her sacral wound and she had a new ulceration on her left ankle. The staff thought maybe she had hit it. We added some foam boots to protect her. Then the next week the ankle was worse and she had an area on her left hip that was a deep tissue injury. An ulceration can go from deep tissue injury to eschar in a couple of hours, they can quickly evolve. I talked to the manager and said I was concerned that she was on her left side for more than a couple of hours, I questioned about the boot positioning. I stressed the importance of turning here more often. The next week I came and now she had an area on her right hip. I think that repositioning was the issue and maybe they were overcompensating by turning her to get her off her left side and that hip, for too long. I'm not sure if they were just letting her lay for an extended period of time on one side or it was the positioning. I stressed that she needed to be turned in degrees, not all the way over each time but in degrees to distribute her weight and off load those areas. An area can become unstageable in a short time, just a couple of hours." She was asked if she had been aware of the new wounds before she came in to see the resident. She stated, "Well that day the ankle was wrapped, I knew about that, but no one contacted me before I got there about the new wound on either hip. If you have a deep tissue injury the goal is to give it time to heal...let it resolve from the inside to the outside, so you dont have a big

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open area." She was asked if the staff had been aware of the areas before she saw them, specifically the right hip that was first identified as covered in eschar. She stated, "I don't know, the actual manager was off when I came in and she had the area on her right hip...if I had been notified I would done a drill down to try to see what was going on, is she being repositioned often, repositioned in degrees. I have reemphasized to the staff that when finding new wounds to be proactive to keep them dry and stable...it's really very confusing. I have been pretty pleased that the facility does what I ask, the residents are clean and not soiled when I get there. There must have been a period of time when something happened. They are likely being more vigilant now with turning her because her wounds are improving." She was asked if it was unusual for a wound to be identified with 100% eschar as Resident #3's right hip had. She stated, "It is not common to find a wound at the level of eschar, that is not the initial presentation. It may have been a deep tissue injury initially but eschar is not the initial presentation." She was asked if she had been the first to identify the area. She stated, "I guess so, I don't remember if there was a foam dressing on it or not, I really can't remember...again it is strange that she developed the areas. I went back to look and see if she had COVID in the past. There are some studies about that, but she hadn't. She was not at nutritional risk, her diabetes was under control, there were no other issues, there was no physical reason for them. She is improving now. I do think it was all possibly related to repositioning. It could have been as short as one shift where she wasn't repositioned correctly. She was not actively dying, her intake was okay." She was asked if Resident #3's wounds other than the sacral ulcer that was

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present on readmission were avoidable. She stated, "Yes, they were. Repositioning was the issue. If I see a wound and it is unavoidable I write that in my note, I didn't write that."

At 10:40 a.m., LPN #1 and LPN #2 were observed providing wound care to Resident #3. RN (registered nurse) #1 (staff development) was also in the room. The sacral wound was observed and identified by LPN #2 as a Stage III, with healing tissue, marbled slough, no odor or drainage. Wound care was then provided to the left hip. LPN #2 identified the area as a deep tissue injury with healing skin, eschar in place, slough on one side of the eschar. Wound care was then provided to the left ankle. The area was covered in eschar which was not completely attached to the wound bed. Slough present on the attached side. Wound care was then provided to the left lateral heel. The area was identified as a deep tissue injury. The skin was peeling back around the a deep red area, purple area in center. Wound care was then provided to the left great toe. This was identified as an unstageable area with eschar present. Wound care was then provided to the right hip. Wound cleanser was used to remove the old dressing that was attached to the wound bed. The wound was identified as eschar which was not completely attached to the wound bed. Slough was present around the eschar. All wound care was provided to each area as ordered. During the dressing change Resident #3 spoke with RN #1 and stated, "At night when I wet it stings and burns, I call and I call and nobody comes."

At approximately 11:35 a.m., the above conerns were discussed with the DON, the administrator, and the corporate nurse consultant. The as

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worked schedule was reviewed. On 07/12/2021 two CNAs were scheduled for dayshift on the Resident #3's unit. The DON stated, "It is census based staffing." The administrator left the room and returned with the census of Resident #3's unit on 07/12/2021. She stated, "There were 26 residents." The DON stated, "That's 13 for each CNA. Ideally we staff at 3 but two is appropriate." The dressing change observations and Resident #3's wounds were discussed. The DON stated, "We started educating when it started (the increase in pressure wounds)."

At approximately 2:20 p.m., the care plan interventions for Resident #3 were discussed with the DON, the administrator, and the nurse consultant. The DON was asked if interventions such as off loading boots, air mattresses, heelz up devices, floating heels, etc were physician orders. She stated, "No, those are nursing interventions." She was asked how staff was reminded to look at those things, or the nursing staff to check to see if they were in place if they were not on the TAR (treatment administration record) to remind them. She stated, "They are on the care plan." The interventions listed for Resident #3 were read. The DON was asked where the interventions for Resident #3 regarding turning and repositioning were on the care plan. She stated, "Bed mobility...she is extensive assistance." She was asked what that meant. She stated, "Extensive assistance means she needs someone to turn and reposition her, it doesn't say turn and reposition is says extensive assistance." The administrator stated, "Extensive assistance is defined as turn and reposition." The DON stated, "That's standard nursing practice to turn the resident every 2 hours...and treat the wounds as ordered."

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F 686	Continued From page 28 The conversation with the NP was discussed. The DON, the nurse consultant, and the administrator were informed that based on the documentation, and the interview with the NP who stated the five pressure areas that Resident #3 had developed while in the facility were all avoidable, harm was identified. The DON stated, "(Name of Wound NP) is scheduled to give an inservice here for the staff...she has never discussed turning in degrees with me, I was not aware of that... we provided education to staff here when we identified the increase in pressure areas." No further information was obtained prior to the exit conference.	F 686		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure that an air mattress was working properly and that staff was knowledgable about the device for one of three residents, Resident #3. Resident #3's air mattress pump was not functioning properly, the direct care staff did not know how to correct the problem, nor did one staff member recognize that the system was not working properly. Findings were: Resident #3 was originally admitted to the facility	F 908	F908 1. The pump on resident #3s air mattress was replaced. 2. All air mattress pumps currently in use will be observed to ensure the lights are functioning according to manufacturers recommendation. 3. All current staff will be educated on the use of our air mattresses. Maintenance Director or designee will review 5 air mattresses weekly x 4 weeks to ensure they are functioning properly.	9/14/21

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F 908	Continued From page 29 on 09/25/2020 and readmitted on 05/25/2021. Her diagnoses included, but were not limited to: Metabolic encephalopathy, chronic congestive heart failure, urinary tract infection, cerebral vascular accident, diabetes mellitus, atrial fibrillation and right hand contracture. The most recent completed MDS was significant change assessment with an ARD of 06/01/2021, six days after her return from the hospital. Resident #3 was assessed as severely impaired in her cognitive status with a summary score of "03". However, the electronic health record included an MDS in progress and not yet completed, with an ARD of 07/17/2021, that assessed Resident #3 as moderately impaired in her cognitive status with a summary score of "09". Review of the clinical record throughout the morning of 08/03/2021, indicated that Resident #3 had an air mattress in place due to multiple pressure areas. At approximately 12:15 p.m., Resident #3 was observed sitting up in a chair in her room. Resident #3's bed was observed with an air mattress in place. A pump for the mattress was located on the footboard of the bed. The left side of the pump had a switch with a green light that was lit up. The display on top of the pump was not illuminated. At 2:35 p.m., Resident #3 was observed lying in bed on her right side. The air mattress pump on the footboard of her bed was observed. The green light on the side of the pump was lit; however, the display on top of the pump was not illuminated. The settings on the display panel	F 908	Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 9-14-2021.	

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included but were not limited to: alarms, power, lock, weight, cycle time, and how the air was to be in the mattress (i.e. alternating, etc.). There was no sound of air moving through the mattress.

LPN (licensed practical nurse) #2 was at the nurse's station and was asked to come look at the pump. She came to Resident#3's room, looked at the pump, and stated, "These are new...I don't know anything about them." She pushed the power button on top of the pump, nothing happened. She stated, "Let me see if I can find someone." She left the room and spoke with LPN #1. LPN #1 came to the room. She also pushed the power button on top of the pump, nothing happened. She turned the switch off on the side of the pump and turned it back on. The top of the pump still did not illuminate any settings, or indication that the pump was on and functioning.

At approximately 2:40 p.m., OS (Other Staff) #2 from the maintenance department came to the room. He stated, "I just put this air mattress on the bed the other day...the lights on top were working then." He was asked what lights had been working. He stated, "When I set it up I get the weight from the nurses and set that, and I put it on alternate pressure, I don't mess with the cycle time." He unplugged the pump from the wall, disconnected the air hose, pushed the buttons on the top of the pump, turned the switch on the side off and on. LPN #3 came to the room. She stated, "It was on this morning because I checked it."

At 2:45 p.m., the maintenance director came to the room. He stated, "We just started putting the mattresses on the beds." He asked OS #2 if the

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pump was a rental or one that the facility owned. OS #2 stated, "I think it's a rental, I can't remember, I've put so many of these things on in the past week." A pump like the one on Resident #3's bed was located in the room next door. It was observed with the maintenance director. The top of the pump was illuminated with the resident's weight range, cycle time and alternating pressure. The sound of air moving in the mattress could be heard. The maintenance director pushed the power button on top of the pump. The screen was no longer illuminated, but the green light on the side remained on. He stated, "The switch on the side tells you the pump box is getting power, the switch on top tells you the pump is on to the mattress." He was asked if he could hear the air going through the mattress. He stated, "Yes." He was told that the sound had not been heard at Resident #3's mattress. He stated, "I didn't hear it either."

At approximately 3:05 p.m., a new pump was placed on Resident #3's bed by OS #2. The top of the pump illuminated and air was heard moving in the mattress. OS #2 programmed the pump for Resident #3's weight and for an alternating cycle. CNA (certified nursing assistant) #1 was in the room. She was asked if she was caring for Resident #3. She stated, "Yes." She was asked if she had looked at the lights on the pump. She stated, "Yes, it turned off earlier, but it came back on..then it was blinking and it came back on. I thought that was normal...it didn't alarm or anything." She was asked if she told the nurses. She stated, "No, it came back on, I thought it was normal."

The maintenance director was interviewed regarding the pump at approximately 3:10 p.m.

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He stated, "This is new, we have just started putting the air mattresses on the beds...we use to rent all the pumps. This new company wants us to buy them...(Name of OS #4) is in central supply, she gets pumps for us. We just put them on there, then we are done with it. They are the nurse's responsibility after that." He was asked if he had been inserviced on the new pump for the air mattress. He stated, "No." He was asked who inserviced/educated the staff. He stated, "Not me...I guess (name of OS #4) does that."

LPN #1, LPN #2, and LPN #3 were all asked if they had been educated on the new air mattress pump on Resident #3's bed. All three stated, "No."

CNA #1 was asked if she had been inserviced. She stated, "Yes." She was asked who had inserviced her. She stated, "(Name of the Maintenance Director)." She was asked that since she had been inserviced why did she not notify someone when the lights were blinking on the pump's display screen earlier in the day and when it had gone off and come back on. She stated, "I thought that was normal."

At 3:20 p.m., the above information was discussed with the DON and the nurse consultant. The nurse consultant stated, "We need to do some education."

On 08/04/2021 at approximately 11:15 a.m., the maintenance director was interviewed. He stated, "I called customer service yesterday and they said they would send another one. I told them I wanted to know what was wrong with this one. Of course, customer service couldn't help me with that and tech support wasn't available. I figured if

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they were sending me another one I could take this one apart and see what was wrong with it. When I did, I saw the cord to the digital display had come undone and wasn't making good contact." He was asked if that was why the pump display had blinked and gone off. He stated, "Yes, that is what was happening. I saw a hoyer lift in there, maybe they hit it with that, maybe it came loose in transit...when I reconnected it and plugged it in, the display lit right up...I think it was pumping air all along." The maintenance director was reminded of the conversation the day before when the air was heard moving through the mattress with the use of the pump with the lit display screen, but not with the one that was not working.

At approximately 2:25 p.m., the above information was discussed with the DON, the administrator, and the corporate nurse consultant. OS #4 from central supply came to the room and was interviewed about the pumps for the air mattress. She was asked how the staff was educated on the use of the new pumps. She stated, "There is a manual that comes with the pump. The unit managers are aware we have the manuals." She was asked if something happened and the pump wasn't working, what was the staff supposed to do to troubleshoot the device, and would she be the person to help. She stated, "Not me, there is a manual available to the staff. (Name of Maintenance Director) has it. She was asked if the maintenance director was at the facility 24/7. She stated, "The unit mangers have a key to his office." She was asked if there was a specific place for the manuals in his office. The administrator stated, "We have access to (Name of Maintenance Director) 24/7, if he is not here we can call him...he will handle the problem." OS

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F 908	Continued From page 34 #4 stated, "We rent the pumps at first until we can get one here that we have purchased, once we own it is our responsibility." The DON was also in the room, she stated, "Usually we have an inservice. Standard practice is we inservice on how to use the equipment." The administrator stated that the maintenance director had been onsite the previous day and the pump had been replaced. Concerns were voiced that although he was onsite and the problem was corrected after being identified by the survey team, earlier in the day CNA #1 had observed the pump display malfunction, when it was turning on and off and blinking. She was not aware that those were not normal functions for the pump and had therefore had not notified anyone of the problem. The administrator nodded her head. No further information was obtained prior to the exit conference on 08/04/2021.	F 908		