STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065219	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENTON MANOR	850 27TH AVE GREELEY, CO 80634

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure resident care was consistent with professional standards of practice, to prevent avoidable pressure ulcers for one (#5) of four residents reviewed out of seven sample residents. The facility failed to ensure Resident #5 who was admitted without pressure ulcers and dependent on staff for mobility, transfers and care did not sustain a pressure ulcer/ deep tissue injury (DTI). The facilities failures to implement a person centered care plan with appropriate interventions, monitor and carry out the interventions, document accurately and consistently in the pressure ulcer forms and Skin Weekly Non-pressure Condition Records, transcribe physician orders for heel protective booties and follow physician orders contributed to Resident # 5 sustaining an in house acquired stage 4 pressure injury with an infection to the left great toe. (see-The Skin Weekly Non-Pressure Condition Record dated 7/24/2020) Furthermore, the facility failed to document the pressure ulcer and provide the pressure reducing bed device (air mattress) in the resident's minimum (MDS) data set [DATE], and conduct a pressure ulcer assessment from 7/13/2020 through 7/23/2020. Findings include: I. Facility policies and procedures The Skin Management policy, revised July 2017, was provided by the nursing home administrator (NHA) on 8/3/2020 at 4:24 p.m. The policy revealed residents were to receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise would be identified, assessed and provided treatment to promote healing, prevent infection and prevent new ulcers from developing. Ongoing monitoring and evaluation would be provided for optimal resident outcomes. -A pressure ulcer was defined as any [MEDICAL CONDITION] caused by unrelieved pressure resulting in damage to underlying tissue. Pressure ulcers were usually over bony prominences and were staged to determine the degree of tissue damage observed. -Suspected deep tissue injury was an intact or non-intact skin with a localized area of persistent non-blanchable deep, red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood filled blister. This wound resulted from intense and/or prolonged pressure and shearing forces at the bone-muscle interface. This area may be preceded by tissue which was firm, mushy, boggy, or warmer/cooler as compared to adjacent tissue. The wound may evolve rapidly to reveal the actual extent of the tissue injury . If any necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures were visible, this would indicate a full thickness pressure ulcer (unstageable stage three or stage four). -Unstageable wound was a full-thickness skin and tissue loss where the extent of the tissue damage within the ulcer cannot be confirmed, because the depth was obscured by slough or eschar. Unstageable wounds might be covered with yellow, tan, gray, green or brown slough. -If a new pressure ulcer was identified, either upon admission, readmission or during the resident's stay, it would be assessed and documented on the weekly Pressure Ulcer Record. -A Weekly Skin Check assessment would be completed in the resident's record using the Head to Toe Skin Check. -A Situation, Background, Assessment, Recommendation (SBAR) Communication Form and a Progress Note would be completed. A new physician's order would be obtained for a new incidence of compromised skin integrity. -A nurse would initiate treatments, interventions, care plans and the appropriate skin documentation records in a timely manner according to practice guidelines. -Pressure ulcers would be measured and staged in accordance with the practice guidelines. The Comprehensive Care Plan policy, revised November 2017, was provided by the NHA on 8/3/2020 at 4:26 p.m. The policy revealed, the facility would develop a comprehensive person centered care plan that identified each resident's medical, nursing, mental and psychosocial needs within seven days after completion of a comprehensive assessment. The plan would be developed with the resident or the resident's representative. The plan would reflect the resident's goals, wishes and preferences. The plan would include measurable objectives and timetables agreed to by the resident to meet such objectives. -The purpose was to provide an effective and person centered care for each resident. -(4b) Interventions would be developed to meet both short and long term resident goals, to prevent avoidable decline in function or functional levels and to attempt to manage risk factors. -(5) The care plan would be reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change of condition. -(9) Interventions specify the frequency of the provided services. II. Resident status Resident #5, age 95, was admitted on [DATE]. According to the August 2020 computerized physician orders (CPO), [DIAGNOSES REDACTED]. The 6/7/2020 minimum data set (MDS) assessment revealed the resident had moderate impairment in cognition with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required extensive staff assistance for bed mobility, transfers, dressing, and personal hygiene. The resident was at risk for the development of pressure ulcers/injuries. The resident utilized a pressure reducing bed device and utilized hospice services. The MDS did not reveal the resident had a pressure ulcer at a stage one or higher. III. Resident observations On 7/30/2020 at 12:55 p.m., the resident laid on a regular mattress with the head of the bed elevated. The resident had covers pull to her chest. -At 1:53 p.m., the resident laid on a regular mattress with the covers pulled to her chest. Licensed practical nurse (LPN) #1 accompanied the surveyor and removed the covers off of the resident's feet. The resident was not wearing any heel protection booties, her heels were not floated and touched the mattress. The bandage on the resident's great toe area was dated 7/29/2020. IV. Wound dressing observation and interview On 7/30/2020 at 3:18 p.m., the resident laid on a regular mattress and was not wearing heel protection booties on either foot. Her heels were not floated and they touched the mattress. The LPN #1 said the resident did have a pair of heel protection booties, but they were soiled and she sent them to the laundry. She said the resident did not have a second set of booties. -Another method to offload the residents heels was not appropriate to relieve pressure from her feet and the pillow that was placed by staff at this time was positioned under the residents knees. LPN #1 said the wound dressing was changed daily and the resident had been followed by a wound clinic. She said due to the resident's decline, the resident was not followed by the clinic at this time. She said the wound resulted from a bad bunion on the resident's left foot. LPN #1 said the wound was measured each Friday with a nurse practitioner and the measurements were sent to her primary care physician and to hospice. LPN #1 removed the bandage dated 7/29/2020 and cleaned the wound with a spray wound cleanser. The wound appeared to be black in color with no visible open area in the middle and drainage. She then applied silver alginate to the wound bed and covered it with a dry dressing. V. Record review The Care Plan (CP) initiated on 3/23/2020 for the potential for impaired skin integrity had interventions to refer to the skin care team as needed, ensure the proper positioning with each encounter, turn/reposition as needed to decrease pressure, complete skin checks weekly per the facility protocol, document findings, provide wound care/preventative skin care per physician orders, observe wound healing and notify the physician of changes in the wound or emerging wounds. -The CP did not mention the resident had a pressure ulcer on her left great toe (bunion) or specific interventions for the resolution of the pressure ulcer. -The preventative interventions initiated on 7/1/2020 and revised on 7/31/2020 included an air mattress and soft floating booties. The Wound Care Clinic (WCC) progress note by a Nurse Practitioner (NP) dated 4/24/2020 revealed the resident received a telemedicine visit. The information was obtained from the resident, caregiver and the clinical record. The resident had a deep tissue injury (DTI) on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The initial wound encounter measurements were 2.5 centimeters (cm) length by 3.0 cm width with no measurable depth.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)

The area of the wound was 7.5 square cm. The wound was 100% [MEDICATION NAME]. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The WCC progress note by a NP dated 5/1/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 0.5 cm length by 1.0 cm width with no measurable depth. The area of the wound was 0.5 square cm. There was no drainage and the wound was 100% [MEDICATION NAME].

There was no change in the wound progression. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. There was no WCC progress note for 5/8/2020 for the wound to the left great toe being assessed weekly. The WCC progress not by a NP dated 5/15/2020 revealed the information was obtained from the resident, caregiver and chart. The resident verbally gave consent to receive telemedicine services. The pressure ulcer received a status of not healed. The subsequently wound measurements of 0.5 cm length by 0.5 cm width with no measurable depth. The wound had an area measurement of 0.3 square cm. The wound was 100% [MEDICATION NAME] with no change noted in the wound progression. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The WCC progress not by the NP dated 5/22/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 0.5 cm length by 0.6 cm width with no measurable depth. The area of the wound was 0.3 square cm. There was no drainage and the wound was 100% [MEDICATION NAME]. There was no change in the wound progression. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The WCC progress note by a NP dated 5/29/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 1.5 cm length by 1.2 cm width with no measurable depth. The area of the wound was 1.8 square cm. There was no drainage and the wound was 100% [MEDICATION NAME]. There was no change in the wound progression. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The Braden Scale for Predicting Pressure Sore Risk dated 6/1/2020 at 9:26 a.m., revealed a score of 13 or moderate risk. The resident's sensory perception was slightly limited in response to verbal commands. The resident could not always communicate discomfort or the need to be turned related to the possibility of sensory impairment which limited the ability to feel pain or discomfort in one or two extremities. The resident was confined to the bed and was completely immoble. The resident did not make even the slightest changes in body or extremity position without assistance. The resident's meal intake was adequate. The resident had the potential problem of friction and shear. The resident moved feebly or required minimum assistance. During a move the skin probably slid to some extent against sheets, chairs, restraints or other devices. The resident maintained a relatively good position in a chair or the bed most of the time, but occasionally slid down. The WCC progress note by a NP dated 6/5/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 0.8 cm length by 1.2 cm width with no measurable depth. The area of the wound was 0.96 square cm. There was no drainage. There was no change in the wound progression. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The WCC progress note by a NP dated 6/12/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 0.5 cm length by 1.0 cm width with no measurable depth. The area of the wound was 0.5 square cm. There was no drainage and the wound was 100% [MEDICATION NAME]. The wound was improving.

The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The WCC progress note by a NP dated 6/19/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 1.5 cm length by 0.9 cm width with no measurable depth. The area of the wound was 0.27 square cm. There was no drainage and the wound was 100% [MEDICATION NAME]. The wound was improving. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The WCC progress note by a NP dated 6/26/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 0.3 cm length by 0.9 cm width with no measurable depth. The area of the wound was 0.27 square cm. There was no drainage and the wound was 100% [MEDICATION NAME]. There was no change in the wound progression. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. The Treatment Administration Record (TAR) dated 7/1/2020 revealed the resident received four ounces of house supplement twice a day for wound healing. The resident had 62 opportunities to consume the supplement for the month. The resident consumed 0% a total of 19 times, 25% a total of 3 times, 50% a total of 7 times, 75% a total of 1 time, 100% a total of 30 times and not documented a total of 2 times. The Skin Weekly Non-Pressure Condition Record dated 7/3/2020 revealed an assessment of the great toe with an onset date of 4/24/2020. The resident had a DTI measuring 1.0 cm length by 1.5 width by 0.1 depth. The periwound was red and the wound bed was dark. There was a small amount of serosanguineous (blood and clear yellow liquid) drainage. The specialty interventions were air mattress and floating boots. The physician was notified. The WCC progress note by a NP dated 7/10/2020 revealed the information was obtained from the resident, caregiver and the clinical record. The resident was seen today for a follow up and management of the resident's wound. The resident had a DTI on the left great toe, persistent with a non-blanchable deep red, maroon or purple discoloration pressure ulcer and received a status of not healed. The subsequent wound encounter measurements were 2.5 cm length by 4.0 cm width with no measurable depth. The area of the wound was 10.0 square cm. There was no drainage and the wound was 100% slough. The wound was deteriorating. The periwound skin texture was normal, the periwound skin moisture was normal and the periwound skin color was normal. The resident reported a wound pain level of 0 out of 10. A review of the resident's physician orders revealed the following: -7/11/2020: cleanse the left great toe with a wound cleanser, apply silver alginate to the wound bed and cover with a dry dressing. -7/31/2020: apply Santyl Ointment 250 unit/gram to the left great toe topically every day shift. This was related to an unspecified open wound of the left great toe without damage to the nail. -7/31/2020: cleanse the left great toe with a wound cleanser, apply Santyl to the wound bed, and cover with a dry dressing on every day shift. The Skin Weekly Non-Pressure Condition Record dated 7/12/2020 revealed an assessment of the great toe with an onset date of 4/24/2020. The resident had a DTI measuring 2.5 cm length by 4.0 cm width by 0.1 cm depth. The wound was not staged. The peri-wound was macerated (soft and breaking down of skin due to prolonged exposure to moisture) and red. The wound bed was 100% slough (dead tissue cream or yellow in color) with moderate drainage and visible muscle and bone to the left great toe. There was moderate serosanguineous drainage. Specialty interventions were air mattress and floating booties. The wound had deteriorated. The physician was notified. -The resident's clinical record did not contain a Skin Weekly Non-Pressure Condition Record or a WCC progress note by the NP from 7/13/2020 through 7/23/2020. The Skin Weekly Non-Pressure Condition Record dated 7/24/2020 revealed an assessment of the great toe with an onset date of 4/24/2020. The resident had a DTI measuring 4.0 cm length by 5.0 cm width by 0.3 cm deep. The wound was a stage 4 pressure ulcer (full thickness skin loss with exposed muscle, tendon or bone). The wound bed was 80% beefy red granulation and 20% slough. The peri-wound was pink and non-blanchable. The wound has increased in size and depth. There was moderate purulent (milky in color and possibly due to infection) drainage with visible bone. There was an increase in drainage. The physician was notified on 7/24/2020.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Specialty interventions were air mattress and floating booties. The Skin Weekly Non-Pressure Condition Record dated 7/31/2020 revealed an assessment of the great toe with an onset date of 4/24/2020. The resident had a DTI measuring 3.8 cm length by 3.0 wide with no depth. The wound was a stage 3 pressure ulcer. The area was 50% slough and 50% granulation. The wound had moderate green purulent drainage with no odor. The wound bed appeared red and yellow. The positioning intervention was to float the heels. The wound had decreased in diameter and had an increase of healthy beefy red granulation. The physician was notified on 7/31/2020. -This indicated the resident had the ability to heal even though she was receiving hospice services. DTI was avoidable and treatable. The resident's Meal Percentage Intake (MPI) records were provided by the director of nursing (DON) on 8/5/2020 at 10:34 a.m. The records revealed: -The resident had 90 meal opportunities from 6/1/2020 through 6/30/2020. The resident consumed 0-25% a total of 7 times, 26-50% a total of 8 times, 51-75% a total of 17 times, 76-100% a total of 42 times and not documented 16 times. -The resident had 93 meals opportunities from 7/1/2020 through 7/31/2020. The resident consumed 0-25% a total of 15 times, 26-50% a total of 16 times, 51-75% a total of 14 times, 76-100% a total of 37 times and not documented 11 times. VI. Interviews The DON was interviewed on 8/3/2020 at 9:15 a.m. She said the resident was on hospice services when she was admitted to the facility on [DATE]. She said the resident did not have a pressure ulcer to her left great toe area when admitted . She said the great toe pressure ulcer was facility acquired on 4/24/2020. She said this pressure ulcer was staged at a 4. She said wound measurements were conducted by LPN #1 and the NP. She said if the NP was not in the facility the wound measurements were conducted by the LPN #1 via telemedicine with the NP. She said the resident had leveled out from her recent decline that started the second week of July 2020. She said the resident's family and physician were notified about the resident's condition. She said hospice called each week to check on the resident. The DON said the wound had improved, but now it was some worse because the resident stopped eating for about one week and declined to the point that end of life services was considered. She said the resident had an admission weight of 131 pounds and she had a weight of 127 pounds on 7/31/2020 and 8/3/2020. She said the resident averaged eating 25 to 50% of her meals. She said she usually ate one large daily meal and then ate smaller meals for the other two daily meals. She said the resident was provided a dietary supplement twice a day between meals. She said sometimes the resident drank the supplement and sometimes she refused. The DON said the wound had improved some on the 7/31/2020 assessment and the resident would be placed back on wound rounds by the service provider NP every Friday. She said the resident's family and physician were notified weekly on the wound assessments. The DON said the resident was on a regular mattress and there was no physician order for [REDACTED]. The DON said the resident did not have a physician's order for bilateral heel protection booties. She said the resident did have booties and on 7/30/2020, they were sent to the laundry. She said a second pair of booties were provided to the resident on 7/31/2020. She said the resident should have the booties on while in bed and with the heels floated. LPN #2 was interviewed on 8/3/2020 at 11:15 a.m. She said hospice ordered an air mattress and it was delivered to the facility on [DATE]. She said previously the resident was on a regular mattress. She said the resident had a pressure ulcer on her left great toe area. She said the resident was unable to use the call light, staff checked and repositioned her every two hours. She said the resident sometimes did not eat much and slept a lot. She said the resident utilized bilateral booties while the resident was in bed The DON was interviewed with the NHA in attendance a second time on 8/3/2020 at 3:00 p.m. She said the resident had bilateral boggy heels with stage 2 pressure ulcers on admission. She said the heel ulcers resolved quickly. She said the pressure ulcer on the resident's left big toe (bunion) started on 4/24/2020 as a DTI with a red or purple color. She said the skin opened on 7/3/2020 and was a stage II or III. She said as of 7/30/2020, the pressure ulcer was covered with slough and the wound bed was not visible, it should be staged as a IV. She said she did not know how the wound started. She said she thought it was more due to the internal pressure that pressed the tissue on the bone. The DON said the resident's co-morbidities included [MEDICAL CONDITION], left side [MEDICAL CONDITION], hypertension, [MEDICAL CONDITION] with a pacemaker, [MEDICAL CONDITION], and dementia. She said [MEDICATION NAME] (diuretic) was the only medication the resident was administered that might prevent wound healing. The DON said the pressure ulcer was not documented on the MDS dated [DATE] because the skin assessment was documented on a non-pressure skin form and it should have been documented on a pressure ulcer form. She said it should have always been documented as the pressure ulcer. The DON said there was no physician's order for bilateral booties on the computerized physician orders (CPO) dated 8/1/2020. She said an order had been written for the booties but it was not transcribed onto the monthly CPOs. She said a new physician order for [REDACTED]. She said since there was no order on the CPO for the booties, the TAR would not have a place to document the monitoring of the booties. The DON said hospice provided an air mattress on 8/1/2020. She said previously the resident had not been on an air mattress. She said staff were to float the residents heels when in bed so that they did not touch the mattress. The DON said there was no care plan for the resident's left great toe (bunion) pressure ulcer. She said a care plan should have been developed by the wound nurse, LPN #1. She said the plan should have included the location of the pressure ulcer and the resident specific interventions such as an air mattress and bilateral booties. The DON said there were no laboratory results for this resident. She said no laboratory tests had been ordered by her physician. She said the physician ordered specific laboratory tests on 7/31/2020. The DON said the resident's pressure ulcer wound was monitored during daily wound dressing changes and on the weekly wound assessment. If any changes were observed in the wound, the resident's provider would be notified. The weekly wound assessment was conducted in conjunction with the NP either in person or by telemedicine. The DON said the resident was unable to use the call light and staff went into the room every two hours to reposition the resident, if the resident allowed. The hospice nurse practitioner (HNP) was interviewed via a conference call with the NHA and DON on 8/3/2020 at 4:00 p.m. She said the resident had a wound on her left great toe (bunion) area. She said the wound started on 4/24/2020 as a DTI that was not measurable at this time. The HNP said the wound became a pressure ulcer on 7/3/2020 when it opened and had some depth. She said she did not stage the ulcer on this date. She said she did not know how the DTI started. She said the resident did have a little contracture in her feet, multiple comorbidities, and a variable nutritional status, which could promote the development of a wound. The HNP said on 7/10/2020 the resident was deteriorating and was not engaging with staff. The pressure ulcer was unstageable. She said on 7/30/2020 via telemedicine, the pressure ulcer was unstageable and contained slough. She said since the wound bed was covered with slough, it was unknown what was under the slough. The HNP said the resident's primary care physician (PCP) could review her notes in the computerized clinical record and write orders as necessary. She said the resident's PCP had not contacted her. VII. Observations and follow-up 8/3/2020 On 8/3/2020 at 11:15 a.m., the resident laid on an air mattress. She had covers pulled to her chest. LPN #2 accompanied the surveyor and removed the covers off of the resident's feet. The resident had heel protection booties on both her feet and the heels were floated off of the mattress. The following physician orders were subsequently added: -8/3/2020: heel protection booties applied to both feet while in bed on every shift for skin treatment and prevention. -8/3/2020: monitor specialty air mattress for proper function on every shift and as needed for mattress function. -8/3/2020: monitor the left great toe and surrounding area for pain, maceration, increased warmth, swelling, drainage, or other abnormalities on every shift for skin treatment and prevention. Document all observed abnormalities or changes noted in progress notes and alert the physician.