STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POMEROY LIVING ROCHESTER SKILLED REHABILITATION	3500 WEST SOUTH BLVD ROCHESTER HILLS, MI 48309

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficient practice pertains to MI 291: Based on observation, interview, and record review the facility failed to prevent the development and worsening of avoidable pressure ulcers, promptly identify and obtain treatment for [REDACTED].#803 and R#805) of three residents reviewed for wounds, resulting in an Immediate Jeopardy when R#803 developed multiple facility acquired stage 3 (full thickness skin loss) pressure ulcers and R#805 developed of a stage 4 (full thickness skin and tissue loss) facility acquired pressure ulcer which required antibiotic treatment for [REDACTED]. Findings include: The Immediate Jeopardy started on 5/22/20. The Immediate Jeopardy was identified on 6/29/20. The Administrator was notified of the Immediate Jeopardy on 6/29/20 at approximately 2:20PM and a plan to remove the immediacy was requested. The immediacy was verified onsite 7/1/20 as being removed 6/29/20. Although the immediacy was removed, the facility remained out of compliance at the scope of pattern and a severity of potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. Resident #803: Review of a complaint received by the State Agency expressed, in part, that R#803 had bedsores on their bottom. On 6/25/20 at 10:36AM R#803 was observed in bed in the resident's room. R#803 was queried in regard to wounds, and explained they had wounds on their back and butt that were acquired at the facility. The resident was queried as to why they felt the wounds had developed, and explained they guessed it was from laying in urine, however they were not sure. On 6/29/20 at 1:37PM an observation was made of R#803's right buttock wound with Licensed Practical Nurse (LPN) 'A'. The resident was observed to be in bed and was observed to have their feet resting directly on the mattress. A dressing dated 6/29 was observed on the resident's right buttock. The resident's dressing was peeled back to observe the wound bed. LPN 'A' was queried as to a description of the wound, and explained the wound bed was pink with slough with a necrotic base. Review of the clinical record for R#803 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's admission minimum data set (MDS) assessment dated [DATE] it was revealed the resident scored 14 out of 15 on a brief interview for mental status exam, which indicated the resident was cognitively intact. Per this assessment R#803 required the extensive assistance of one person for bed mobility and required the total dependence of two plus persons for transfers. Also, per the assessment it was noted the resident was at risk for pressure ulcer development and had no unhealed pressure ulcers. Review of a Nursing-Admission Nursing Assessment for R#803 dated 4/21/20 documented, in part, that R#803 was cooperative with no recent memory changes, and was oriented to person, place, and time. Per the Wound Location section of the assessment, two areas were noted to the resident's skin. Bruising was noted to the resident's left arm, and an Old scar was noted to the resident's front lower left leg. No other areas were indicated on the body diagram present on the assessment. Per a Nursing-Weekly Skin Assessment-Friday form created on 4/24/20 and completed on 4/25/20 it was documented that the resident had five wound locations on the resident's skin. Per the body diagram redness was noted to the resident's front lower torso area, redness was noted to the front left chest, a bruise was noted to the left front arm, discoloration was noted to the front right arm, and redness and scabs were noted to the left lower leg. It was noted that no areas had been identified/documented on the back view of the body diagram. Review of R#803's Treatment Administration Record (TAR) for May 2020 revealed the resident was to receive skin assessments twice per week, scheduled to be completed on Tuesdays and Fridays. It was not signed off on the resident's TAR to indicate the resident's scheduled skin assessment had been completed on 4/28/20. Review of a Nursing-Weekly Skin Assessment-Friday form created 5/1/20 and completed 5/2/20 was not noted to include a body diagram. A question was left unchecked which documented, Skin Intact? If NO indicate abnormalities on diagram. The assessment indicated Yes per the comments section of the assessment to Previously identified area . Per a Weekly Skin Assessment-Friday form created 5/8/20 and completed on 5/9/20 four areas were documented to the resident's skin, including a circled area on the right buttock area on the back section of the diagram. The description of the wound documented, open area, under treatment. Per a consultation progress note written by Nurse Practitioner (NP) 'B' dated 5/8/20 at 7:03PM it was documented R#803 had a right buttock pressure ulcer. Per the consultation note was the following: Wound #1 Right Buttock is a Stage 2 Pressure Injury Pressure ulcer and has received a status of Not Healed. Initial wound encounter measurements are 7cm (centimeters) length x 4cm width x 0.01cm depth .There is a moderate amount of sero-sanguineous (yellowish with small amounts of blood) drainage noted . Also, per this consultation was the following: Wound Orders: Wound #1 Right Buttock TREATMENT RECOMMENDATIONS (Brand Name Dressing) Q3D (every three days) and PRN (as needed). Per a Nursing-Weekly Skin Assessment-Friday form dated 5/15/20 completed on 5/17/20 it was noted, in part, that one area was identified on the resident's buttocks, more towards the right side on the body diagram. The description documented was as follows: open area with dressing. No additional areas were marked on the diagram to indicate additional wounds to the buttocks. Review of a consultation progress note authored by NP 'B' dated 5/15/20 at 1:51PM documented, in part, the following: HPI (History of Present Illness) .Location: R (right) Buttock, L (left) Buttock Context: Pressure Ulcer, Deep Tissue Injury (persistent non-blanchable deep red, maroon or purple discoloration) .Wound #1 Right Buttock is a Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 9cm length x 5cm width x 0.01cm depth .There is a moderate amount of serosanguineous drainage noted .Wound #2 Left Buttock is a Deep Tissue Injury and has received a status of Not Healed .Initial wound encounter measurements are 6cm length x 2cm width .Wound bed has Dark Maroon Base [MEDICATION NAME] It was noted treatment recommendations included orders for a dressing every three days and as needed to the right and left buttock. Review of the resident's Treatment Administration Record (TAR) for May 2020 did not reveal changes to treatment orders to reflect recommendations by NP 'B'. Review of R#803's TAR for May 2020 revealed the following order with a start date of 5/11/20: Cleanse Right Buttocks with NSS (normal saline solution), and pat dry, apply (Brand Name Dressing) . This treatment was documented as having been completed on 5/11/20, 5/14/20, was not signed off as administered on 5/17/20, and was completed on 5/20/20. The resident's treatment order was noted to change on 5/22/20 to address the bilateral buttocks. Review of (Pressure Ulcer Risk) assessments for R#803 dated 4/28/20, 5/5/20, and 5/12/20 were reviewed and were all noted to have been completed on the date of 5/20/20. Scores on the assessments documented the following: 4/28/20 (completed 5/20/20): 16 Mild Risk, 5/5/20 (completed 5/20/20): 16 Mild Risk, 5/12/20 (completed 5/20/20): 15 Mild Risk. Review of a Nursing-Weekly Skin Assessment-Wednesday form dated 5/20/20 and completed on 5/21/20 documented the following in part: Per review of a back view of the body diagram on the skin assessment a circle had been drawn to include the resident's left and right buttocks. Per the description of the area it was documented, pressure sore on buttocks. This assessment indicated yes to the question as to whether the skin assessment noted a previously identified area. Review of a consultation progress note dated 5/22/20 at 3:30PM authored by NP 'B' documented, in part, the following: HPI .Location: R Buttock, L Buttock Context: Pressure Ulcer . Wound #1 Coccyx/R Buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 9.5cm length x 8 cm width x 0.2cm depth . There is a moderate amount of sero-sanguineous drainage noted which has no odor. Wound bed has Necrotic Base [MEDICATION NAME] . Wound #2 Left buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements

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 - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)

are 5.5cm length x 2cm width x 0.2cm depth . There is a moderate amount of sero-sanguineous drainage noted which has no odor. Wound bed has Necrotic (death of body tissue) Base [MEDICATION NAME] . Wound #3 Right, Proximal Buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed .Initial wound encounter measurements are 1.5cm length x 1.5 cm width x 0.2cm depth . There is a small amount of sero-sanguineous drainage noted which has no odor. Wound bed has Yellow Necrotic Base [MEDICATION NAME] . Wound #4 Right, Distal Buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2.5cm length x 0.5cm width x 0.2cm depth . There is a small amount of sero-sanguineous drainage noted which has no odor. Wound bed has Yellow Necrotic Base [MEDICATION NAME] . Wound #5 Right, Lateral Buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 5cm length x 1cm width x 0.2cm depth .There is a moderate amount of sero-sanguineous drainage noted which has no odor. Wound bed has Yellow Necrotic Base [MEDICATION NAME] .Diagnosis 1.: Pressure Ulcer Stage III Coccyx/R Buttock, R Proximal Buttock, R Distal Buttock, R Lateral Buttock, L Buttock . Per a Nursing-Weekly Skin Assessment-Friday form dated 5/22/20 completed on 5/22/20 it was noted, in part, that one circle was present on the back portion of the body diagram section of the skin assessment. This circled area included the left and right buttocks. The description documented was as follows: sore, under treatment. No additional descriptions had been documented to describe wounds present to the resident's buttocks. It was noted per NP 'B's consultation notes that staff had reported R#803 to not be compliant with repositioning. A plan of care to address Non-Adherence with receiving treatments and getting up to a chair related to shortness of breath and pain had been input in the resident's record on 5/27/20. All interventions per the plan of care were dated 5/27/20. It was noted this plan of care was in place after the development of the resident's wounds noted above. Review of a plan of care for skin for R#803 dated 4/23/20 documented, in part, the following: SKIN-at Risk for Skin Breakdown I am at risk for skin breakdown related to decreased mobility, obesity, weakness, pain, depression. Interventions per the plan of care included, in part, the following: 4/23/20- Report any signs of skin breakdown (sore, tender, red, or broken area). Notify physician as needed, 4/29/20-(Pressure Ulcer Risk Assessment) per protocol, 4/29/20-Skin assessment 2 x weekly. pay particular attention to the bony prominences. Review of an Actual skin breakdown plan of care dated 5/13/20 was noted to have the following options for etiology: admitted with Right Buttock (wound), cognitive impairment, DM (diabetes mellitus), [MEDICAL CONDITION], immobility, incontinence, use of steroid medication, [MEDICAL CONDITION] ([MEDICAL CONDITION]/PAD (peripheral artery disease) diagnosis. Marked per the
etiology on the plan of care were [MEDICAL CONDITION], immobility, and incontinence. The resident's goal per the plan of care was dated 5/13/20, and all interventions per the plan of care were also dated 5/13/20. On 6/29/20 at 10:19AM LPN 'A', who functioned as a wound care nurse at the facility, was queried in regard to wound care. LPN 'A' was queried as to what staff were to do if they identified a skin issue, and explained that they were supposed to notify the doctor and put something in place for a change in skin condition. LPN 'A' explained they would look at what was put into place to see if it would need to be changed. LPN 'A' explained that if staff observed a reddened area, they were to start a (barrier cream name) and let LPN 'A' know. When queried as to whether staff were to document a progress note if they observed an abnormal skin area, LPN 'A' acknowledged they were to do so. When queried in regard to skin assessments, LPN 'A' acknowledged they were to be completed two times per week in the computer. LPN 'A' explained that the facility had quality of life meetings weekly where wounds would be discussed. When queried as to whether there had been an increase in wounds since the pandemic, LPN 'A' acknowledged there had been an increase. LPN 'A' also explained that they attended the facility's quality assurance meetings. LPN 'A' was queried in regard to staging of wounds at the facility and explained that NP 'B' staged wounds. When queried in regard to implementation of interventions, LPN 'A' explained that they or the interdisciplinary team would address interventions on the plans of care.

R#805 On 6/25/20 at 11:22 am, R#805 was observed in their room, laying on their back in bed. The resident requested a cup of ice water and staff was notified of the resident's request. On 6/29/20 at 1:47 pm, R#805 was observed laying on their back in bed. Wound Nurse (WN) A attempted to awake R#805 with verbal and touch stimuli, however, was unsuccessful. The resident remained asleep. On 7/1/20 at 11:13 am, R#805 was observed laying on their back with oxygen administered via nasal cannula. When asked how they were doing, R#805 responded ok. A Review of the records revealed R#805 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 0 (indicating severely impaired cognition) and requiring staff assistance for all Activities of Daily Living (ADL's). A review of the resident's clinical record documented the following: An Admission Nursing assessment dated [DATE] documented four abnormal skin areas observed upon admission. Two areas were documented as discoloration to the back of the left and right lower arms. The third area was documented as redness to the coccyx/buttocks area and the fourth area documented redness to the frontal groin area. There was no documentation of the physician, wound nurse practitioner (WNP) B being notified of the redness on the coccyx/buttocks area or treatment being started. An Admission Braden Scale (assessment tool for predicting the risk of pressure ulcer) documented a total score of 18 Mild Risk. A review of March 2020 Treatment Administration Record documented no treatments for the coccyx/buttock area. A physician order [REDACTED]. Further review of the records revealed no documentation that a skin assessment was completed on the dates of May 8th, 15th, 19th, 22nd or June 2nd and 26th. The Director of Nursing (DON) was queried on the missing skin assessments and asked to provide the assessments for review, however no further assessments were provided by the end of survey. Additional skin assessments dated April 1st, 7th, 8th, 10th and 17th documented redness on the buttock/coccyx area, however no notification was documented of the physician, WNP B or WN A being notified. A Nursing note dated 4/24/20 at 7:42am, documented Observed the resident's buttocks redness developed. Treatment order in place. Sent msg (message) to unit manager and wound care nurse. A wound care consultation report dated 4/24/20 at 2:58 pm, documented in part Context: Pressure Ulcer . Wound #1 Coccyx/ L Buttock is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 4 cm length x 1.5 cm width x 0.2 cm depth, with an area of 6 sq. (square) cm and a volume of 1.2 cubic cm. There is a moderate amount of sero-sanguineous drainage (yellowish with small amounts of blood) noted which has no odor. Wound bed has Necrotic Base [MEDICATION NAME] . TREATMENT
RECOMMENDATIONS- [MEDICATION NAME] (THIN LAYER) DAILY AND PRN - Coccyx/ L Buttock . Additional Orders . LOW AIR LOSS
MATTRESS OR LOW AIR LOSS BED, FREQUENTLY REPOSITION . PRESSURE RELIEF / OFFLOADING RECOMMENDATIONS DISCUSSED WITH NURSING
STAFF . The DON was asked to provide documentation of the start/delivery of the low air loss mattress or low air loss bed, however, was unable to provide documentation of the start or delivery of the ordered mattress. A review of the April 2020 Resident Treatment Administration Record revealed the following: Reposition patient side to side- no signature of completion for the following dates and times: 25th - 6 pm & 10 pm, 26th - 2 am, 6 am & 2pm, 28th- 2 am, 6 am, 10 am and 2 pm. Cleanse Left Buttock with wound cleanser, pat dry and apply [MEDICATION NAME] on 4x4, and cover with dry dressing- no signature of completion for the 28th. A wound care consultation report dated 5/15/20 at 1:24 pm, documented in part . There is a moderate amount of sero-sanguineous drainage noted which has a strong odor . TREATMENT RECOMMENDATIONS- CRUSHED [MEDICATION NAME] (500 MG milligram) + HYDROGEL DAILY AND PRN X 14 DAYS . Review of the nursing notes revealed no
documentation of the WNP B or a physician being notified of the wound having a strong odor prior to this consultation. A Nursing note dated 5/21/20 at 8:37 pm, documented in part wound needed addressed <sic> foul odor noted with yellow exudate. Treatment done as ordered. Wound consult ordered. A Nursing note dated 5/23/20 at 4:23 pm, documented in part wound is 9.1 cm x 4.8 cm x 0, irregular edges, black soft filled base, mild odor, moderate serosanguineous drainage. Wound cleaned with NSS (normal saline solution), applied [MEDICATION NAME] and Solosite covered with gauze and secured with Bordered gauze . Further review of the progress notes revealed no documentation to the physician or WNP B of the worsening of the wound. A wound care consultation report dated 5/29/20 at 6:36 pm, documented in part Wound #1 Coccyx/ L Buttock is a Stage 4 Pressure injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 9cm length x 6cm width x 3.5cm depth, with an area of 54 sq. cm and a volume of 189 cubic cm. Undermining has been noted at 11:00 and ends at 2:00 with a maximum distance of 3.5cm . Diagnosis 1. Pressure Ulcer Stage IV Coccyx/ L Buttock . Please note change in diagnosis . TREATMENT RECOMMENDATIONS- HYDROGEL IMPREGNATED GAUZE DAILY AND PRN . Review of the residents
clinical record revealed no prior documented notification to the physician or WNP B of the worsening of the Coccyx/ Buttock wound before this consultation. A review of the skin assessment documentation revealed no documented assessments for the dates of May 19th & 22nd. The May 26th skin assessment did not identify any worsening of the wound or any documented notification to the physician. The DON was asked to provide documentation of the skin assessments for May 19th and 22nd and no further documentation was provided by the end of survey. A review of the May 2020 Resident Treatment Administration Record revealed the following: Reposition patient side to side- no signature of completion for the following dates and

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F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) times: 6th - 10 am and 2 pm, 7th - 10 am, 2 pm, 6 pm & 10 pm, 10th - 10 pm, 16th 2 am and 6 am, 18th- 2pm, 20th- 2pm, 22nd - 2 pm and 30th- 10 am and 2 pm. Cleanse Left Buttock with wound cleanser, pat dry and apply [MEDICATION NAME] on 4x4, and cover with dry dressing- no signature of completion for the May 6th treatment. A Hospice note dated 6/15/20 at 1:13 pm, documented in part . Wound has progressively worsened since last visit (5/27/20), called placed to MD (medical doctor) for new orders and awaiting call back. The facility's skin assessments completed by the nursing staff was reviewed for the dates of May 29th, June 2nd-none, 5th, 9th, 12th and 16th revealed no documentation of worsening of the wound or notification to the physician, until the above hospice nurse note. Further review noted no documentation of the physician returning the nurses phone call regarding the worsening of the wound or further treatment implemented. A Hospice note dated 6/18/20 at 11:02 am, documented in part . wound on coccyx assessed, (Doctor's name redacted) notified, new order to place Foley catheter for wound progression . A wound care consultation report dated 6/19/20 at 1:54 pm, documented in part . Wound #1 Sacrococcyx/ Bilateral Buttock is a Stage 4 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 9cm length x 7.7cm width x 3.2cm depth, with an area of 69.3 sq. cm and a volume of 221.76 cubic cm. Bone is exposed. Undermining has been noted at 11:00 and ends at 2:00 with a maximum distance of 4.6cm. There is a large amount of sero-sanguineous drainage noted which has a strong odor. Wound bed has Necrotic Base [MEDICATION NAME]. The wound is deteriorating . Please note change in wound site . TREATMENT RECOMMENDATIONS- DAKINS SOLUTION STRENGTH BID (twice a day) AND PRN X14 DAYS - (lightly packed), SECONDARY DRESSING- COVER WITH SECONDARY DRESSING . ORAL ANTIBIOTIC - [MEDICATION NAME] 100mg PO (by mouth) BID X 14 DAYS A review of June's skin assessments and nursing notes revealed no identification or documentation of the worsening of the wound by the facility's nursing staff and no notification to the physician or WNP B until the hospice nurse attempted to notify the physician on 6/15/20 and on 6/18/20 when the hospice nurse obtained a foley catheter placement for wound progression. A review of the June 2020 Resident Treatment Administration Record revealed the following: Reposition patient side to side- no signature of completion for the following dates and times: 4th - 10 am & 2 pm, 6th- 6 pm & 10 pm, 7th- 2 am, 6 am, 6 pm & 10 pm, 8th - 2 am & 6 am, 11th- 6 pm, 17th- 2 pm, 6 pm & 10 pm. Cleanse Left Buttock with wound cleanser, pat dry, apply Hydrogel Impregnated gauze, cover with 4x4, dry dressing- no signature of completion for the 2nd, 8th or 17th. A care plan titled SKIN- At Risk for Skin Breakdown dated 3/13/20 documented in part . Report any signs of skin breakdown (sore, tender, red, or broken area). Notify physician as needed . Skin assessment 2 x weekly. Pay particular attention to the bony prominences . A care plan titled Actual skin breakdown, Etiology: I have a stage 4 on coccyx . dated 4/24/20 documented in part, . Assess the pressure ulcer location, stage, size (length, width, depth), presence/absence of granulation tissue and epithelization per protocol, Apply treatment as ordered, Wound care consult and follow up as ordered/ needed, Weekly wound round and measurements and prn . A care plan titled INFECTION- infected non healing wound (dated 6/22/20) documented in part . Assess the site for a decrease of redness, swelling . Document and report abnormals . A review of the care plans revealed no interventions for the resident's air mattress or turning and repositioning directive. On 6/29/20 at 10:17 am, WN A was queried on if a resident is admitted with redness on their skin what are the nurses expected to do? WN A replied They would notify the doctor and put something in place. They will notify me, and we would start a topical for prevention . If the nurse discovers any skin issues, they should do a progress note . When asked how often skin assessments were completed, WN A stated in part .Twice a week . When asked how often the residents were seen by the wound nurse practitioner, WN A stated in part, . I keep a list of any concerns and have a list ready every Friday when the wound nurse practitioner comes. Hospice residents are seen once a month, if it worsens, we see them before that . When asked about the monitoring of the worsening of the residents' wounds and the follow up wound care of residents with wounds, WN A explained that staff should be notifying them and the doctor. Any concerns they observed or that was reported would require a resident to be added to the list for the wound NP to assess when they returned to the facility. When asked if they noted an increase in the facility acquired pressure ulcers since the pandemic, WN A stated yes. On 6/29/20 at 10:35 am, WN A and the DON were queried on the skin assessments not found for the dates of April 28th , May 8th, 15th, 19th & 22nd and June 2nd and 26th and why the resident's care plans were not modified to reflect the current interventions. The DON stated they would follow up and get back to the surveyors. The DON was able to provide further documentation, however, none of the information was relevant to the requested information. On 6/29/20 at 5:39 pm the Administrator documented in part (Resident #805's name redacted) wound care plan has been reviewed and deemed appropriate with no changes needed . On 7/1/20 at 12:28 pm, the DON provided an updated/modified wound care plan for R#805. On 7/1/20 at 11:30 am, WNP B was queried on if staff observed a wound worsening between their visits what should the nurses do and replied in part . If they have concerns before that they call me or one of my team members. Yes, they should contact me if it worsens . When asked how they follow up with the resident's wound care they stated in part, . the weekly visits is based off the roster that (WN A name redacted) gives to me . A facility policy titled Pressure Ulcer & Skin Care Management dated May 2015 documented in part, A resident who enters the facility without pressure ulcers does not develop pressure ulcers . A licensed nurse checks the resident's body for the presence of pressure ulcers, wounds, and other skin conditions . The licensed nurse documents that the body check was completed on the resident's weekly head to toe skin record. The presence of any pressure ulcer, wound, or other skin condition is documented weekly on pressure ulcer or skin report forms . The interdisciplinary team will develop a care plan addressing risk factors and periodically review and update the care plan as needed to minimize risk and promote healing . A licensed nurse completes a Wound/skin healing record or a Non pressure skin report: When a pressure ulcer, wound or other skin condition is identified, and Weekly until healed. The interdisciplinary team will review residents with skin conditions regularly to monitor treatment and support effectiveness and recommend changes as needed . Documentation on the weekly head to toe skin check for the presence of pressure ulcers, wounds, and other skin conditions. Record the description of ulcers on the Wound/skin healing record or the Non pressure skin report. Assessment of risk for pressure ulcers is documented. Document approaches and interventions to prevent and/or treat pressure ulcers in the care plan. The Quality of Life meeting is documented in the nurse's notes. A facility policy titled Braden Scale with Interventions dated 5/13 documented in part, . A Braden Scale evaluation must be completed on each new patient upon admission and if it has been determined that the patient is moderate or low risk a Braden Scale will be completed at least weekly for the first month following admission . Daily skin check by CENA (CENA to report any changes in resident's skin. Nurse to document if more redness, pain, or drainage is noted with a current wound. Or if a new pressure ulcer is found . Turning schedule (if not being done with CENA rounds) to meet the patient's needs if unable to move independently . Elevate heels off bed if partially or totally immobile. Heel and sacrum checks daily (CENA to notify nurse of any breakdown, redness, or tenderness . The facility submitted the following accepted plan of removal: Plan for IJ Removal F686 Failure to Prevent Pressure Ulcers 1. Residents 805 and 803 remain in the facility and continue to receive care and treatment as ordered. Both residents continue to be followed by wound care physician and wound care Nurse Practitioner. 2. Resident 805's wound care plan has been reviewed and deemed appropriate with no changes needed. 3. Resident 803's wound care plan has been reviewed and updated with minor changes. 4. 6 of 6 residents with pressure ulcers have had their wound care plans reviewed. 3 of 6 required minor changes. 5. A facility-wide completion of skin assessments was done 6/29/20 to ensure all residents have current skin assessments. 6. Facility-side (Pressure Ulcer Risk Assessment) scales were completed 6/29/20 to ensure all residents have a current (Pressure Ulcer Risk Assessment) scale documented. 7. The Skin Management policy has been reviewed and deemed appropriate. 8. Beginning 6/29/2020 nurses are being educated on skin assessment and {Pressure Ulcer Risk Assessment) process and frequency to ensure compliance with the Skin Management Policy. Effective 6/30/2020 nurses are not being allowed to provide care until the education is received. Effective 6/29/2020 the facility has validated that no residents are at risk for harm related to the alleged deficient practices.