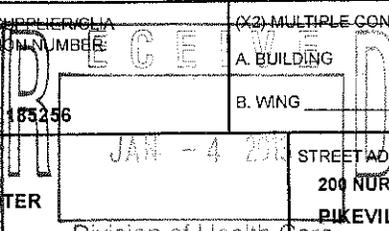


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185256	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2012
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Parkview Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction, to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care and safety of the residents. The plan of correction is submitted as a written allegation of compliance. Parkview Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the statement of deficiencies, nor does it constitute an admission that any deficiency is accurate. Further, Parkview Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies through informal dispute resolution, formal appeal, and/or any other administrative or legal proceedings.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Hall Owens TITLE: ADMINISTRATOR (X6) DATE: 1/4/2013

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, the facility failed to ensure staff consulted with the physician when there was a need to alter treatment for two of three sampled residents (Residents #1 and 2). Observation of a skin assessment conducted for Resident #2 on 11/19/12 revealed the resident had redness and excoriation to the buttock and thigh areas. A review of the medical record revealed staff failed to contact Resident #2's physician when a change occurred in the status of the resident's skin integrity. Review of Resident #1's admission skin assessment dated 08/24/12 revealed the facility identified a scabbed area to the left heel, however, there was no evidence the physician had been notified of the area.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Change in Resident Condition, dated March 2012, revealed the facility staff would recognize and appropriately intervene when a change in a resident's condition occurred. Continued review of the policy revealed the nurse would contact the resident's physician when a change in the resident's condition occurred.</p> <p>1. A review of the medical record for Resident #2 revealed the facility admitted the resident on 07/27/12. Resident #2's admission diagnoses included Morbid Obesity, Lumbar Stenosis, and Hypertension. A review of a quarterly Minimum</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> 1. Resident #1 was discharged from the facility on 9/7/12 which was prior to this survey so no corrective action could be taken. The primary physician of Resident #2 was notified of the excoriation and a treatment was ordered on 11/19/12. 2. All residents have the potential to be affected by the facility's failure to consult with the resident's physician when there was a need to alter treatment. The Nurse Unit Managers performed skin sweeps on 11/21/12 on all residents and then reviewed the residents' records to determine if the primary physician had been notified of all skin issues. Any discrepancies were addressed immediately by notification of the primary physician (see attachment #1). On 12/21/12, the Director of Nursing, Assistant Director of Nursing, Nurse Unit Manager, and other Administrative Nurses reviewed the nurses notes and physician orders on each 	1/4/13	

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F 157	<p>Continued From page 2</p> <p>Data Set assessment (MDS) dated 10/27/12 revealed facility staff assessed the resident as alert and oriented, occasionally incontinent of urine, and frequently incontinent of bowel functions. Staff also assessed Resident #2 to require extensive assistance with bed mobility, toilet use, and personal hygiene.</p> <p>A review on 11/19/12 of the weekly nursing progress notes for Resident #2, dated 11/10/12 and 11/17/12, revealed facility staff assessed the resident to have reddened and excoriated areas to the buttocks. However, a review of the medical record for Resident #2 provided no evidence facility staff had contacted the resident's physician related to the reddened or excoriated areas assessed and documented by facility staff to be present to the resident's skin.</p> <p>Observation of a skin assessment conducted by Licensed Practical Nurse (LPN) #2 on 11/19/12 at 11:40 AM, for Resident #2 revealed the resident's right inner thigh and buttock area was red and excoriated.</p> <p>An interview with Resident #2 on 11/19/12 at 11:35 AM, revealed the resident had redness on the inside of his/her legs and "butt" area. The resident stated facility staff applied medication to the red areas but could not recall how long they had administered the medication.</p> <p>Interview with Registered Nurse (RN) #2 on 11/19/12 at 5:32 PM, revealed she assessed Resident #2 on 11/17/12 and had observed the reddened areas on the resident's buttocks. RN #2 acknowledged she should have contacted the resident's physician when there was a change in</p>	F 157	<p>resident for the past 30 days looking for a change in status that included accident/incidents , a need to alter treatment, significant change in condition , and resident transfers. These changes in status were then compared to each residents' respective care plan to ensure it had been revised to include the change and interventions. Any discrepancies were addressed (see attachment #11).</p> <p>3. a. On 11/21/12, 11/22/12, 11/23/12, 11/24/12, 11/25/12, 11/26/12, 11/27/12, 11/28/12, 11/29/12, and 11/30/12, the Assistant Director of Nursing reeducated licensed nurses on the facility's policy for Change in a Resident Condition and the need to consult with the primary physician when there was a need to alter treatment. This education included a section on notification of resident/responsible party or interested family member when there was a need to alter treatment(see attachment #2).</p>		

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F 157	<p>Continued From page 3</p> <p>the resident's skin condition, but had failed to do so.</p> <p>An interview with LPN #2 at 11:50 AM on 11/19/12, revealed the LPN had assessed the resident's skin excoriation earlier in the shift on 11/19/12 (unaware of exact time), but had not made the physician aware of the change in Resident #2's skin condition.</p> <p>An interview with Unit Manager #1 on 11/19/12 at 6:45 PM, revealed facility staff should have contacted Resident #2's physician when the resident had been assessed to experience a change in skin condition on 11/10/12 and 11/17/12. The Unit Manager stated he conducts "spot" checks weekly to ensure skin assessments were completed appropriately; however, a "spot" check had not been conducted for Resident #2.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 11/20/12 at 11:15 AM, confirmed licensed nurses should contact the resident's physician when a change in the resident's condition occurred. The ADON stated Unit Managers were required to review the "24-hour" report daily to ensure each resident's physician had been contacted appropriately.</p> <p>2. A review of the medical record for Resident #1 revealed the facility admitted the resident on 08/24/12 with diagnoses including Hypertension, Coronary Artery Disease, and Fracture of the Left Hip. A review of Resident #1's skin assessment dated 08/24/12 revealed a scabbed area was identified on the resident's left heel. A review of the History of Present Illness document completed by the resident's physician dated</p>	F 157	<p>b. On 12/11/12, the Director of Nursing reeducated the Medical Director/primary physician of the facility and the Nurse Unit Managers on the policy for completion of the History of Present Illness form(see attachment #3).</p> <p>c. The Nurse Unit Managers will review(QA monitor) residents' skin assessment documentation weekly for any newly identified areas. If any new skin issues are found, they will review the medical record for physician notification. If they find the physician has not been notified, they will notify the physician and the Director of Nursing(see attachment#4).</p> <p>d. Prior to placing on the medical record, the Nurse Unit Manager will review the History of Prior Illness form for correct completion by the primary physician. If not completed or completed incorrectly, the Nurse Unit Manager will resubmit the</p>	

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F 157	<p>Continued From page 4</p> <p>08/28/12 revealed the form included instructions for completion and indicated a '0' was to be selected if the resident had no abnormalities and an 'X' was to be selected to indicate the resident had an abnormality, and a description of the abnormality was required. A review of the History of Present Illness document revealed a checkmark had been selected beside the area on the form labeled "skin"; however, there was no documentation of a description of the abnormality. A review of the nurse's notes dated 08/24/12 through 09/07/12 (date of discharge) revealed no evidence Resident #1's physician had been notified of the scabbed area to the left heel.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 11/19/12 at 6:05 PM, revealed the LPN did not recall Resident #1 but stated a resident's physician should be notified of scabbed areas in order for the physician to determine if a treatment was required. LPN #1 also stated facility staff should monitor scabbed areas.</p> <p>Interview with Unit Manager (UM) #1 on 11/19/12 at 7:00 PM, revealed Resident #1 did have a discolored, scabbed area to the left heel. The UM further revealed the area looked like it would heal on its own so the doctor was not contacted for a treatment order.</p> <p>Interview with the Director of Nursing (DON) on 11/20/12 at 4:15 PM, revealed the DON could not recall specific information related to Resident #1's care needs. The DON stated if a resident had a scabbed area that appeared to be drying and healing the doctor would not be contacted by the facility. Continued interview with the DON further</p>	F 157	<p>form to the physician for correction. Any discrepancies will be reported to the Director or Assistant Director of Nursing.</p> <p>e. Unit Managers will review the 24 hour report five days per week for acute changes in a resident condition to include accidents, significant change in a resident's condition, a need to alter treatment significantly, or a decision to transfer the resident. They will then review the record for physician, resident, and responsible party notification, treatment/intervention changes, and care plan revisions.</p> <p>(see attachment #5).</p> <p>Any discrepancies will be corrected immediately and reported to the Director of Nursing.</p> <p>f. On 1/1/13, 1/2/13, and 1/3/13 the Assistant Director of Nursing reeducated the licensed nurses on using the 24 hour report to document changes in a resident's</p>		

condition including accident/
incidents, significant change
in condition, need to alter
treatment, or a decision to
transfer the resident(see
attachment #6).

4. a. The Director or Assistant
Director of Nursing will QA
monitor 15 resident charts weekly
for one month then monthly for
three months for any change in
residents' condition for the past
7 days. The changes in
condition they will look for
include accident/incident,
significant change in condition,
a need to alter treatment, or a
decision to transfer a resident.
They will then review these
records for physician
notification, resident and
responsible party notification,
treatment/intervention changes,
and care plan revisions. Any
discrepancies will be addressed
immediately(attachment #7).

b. The Director of Nursing will
will provide reeducation to the
primary physician as needed on
the policy for completion of the
History of Present Illness form.

c. The Director or Assistant
Director of Nursing will
provide disciplinary follow up
and/or reeducation to
individual nurses on
notification of primary
physician, resident, and/or
responsible party for change
in condition, a need to alter
treatment significantly, or the
resident is to be transferred.

The Director or Assistant
Director of Nursing
will discuss results of the Nurse
Unit Manager's QA monitoring
and the Director or Assistant
Director of Nursing's QA
monitoring monthly for 3
months in the Quality
Assurance Meeting for
development of an action plan
as needed.

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F 157	Continued From page 5 revealed if the resident was admitted to the facility with the scabbed area on the left heel, the resident's physician should have been aware of the area.	F 157			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 1. Resident #1 was discharged from the facility on 9/7/12, prior to this survey so no corrective action could be taken. 2. All residents have the potential to be affected by the facility's failure to ensure a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity was completed. The Director of Nursing, Nurse Unit Managers, and the Minimum Data Set Coordinator compared skin issues from the sweeps performed by the Nurse Unit Managers on 11/21/12 to each resident's last MDS to ensure all skin issues had been coded. All skin issues had been coded correctly (see attachment #1). On 12/30/12, 1/1/13, 1/2/13,	1/4/13	

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F 272	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument User Manual (Version 3.0) the facility failed to ensure a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity was initially conducted for one of three sampled residents (Resident #1). A review of the medical record revealed the facility admitted Resident #1 on 08/24/12. Documentation on the admission skin assessment dated 08/24/12 revealed Resident #1 had a scabbed area on the left heel. However, a review of the initial comprehensive Minimum Data Set (MDS) dated 09/06/12 revealed facility staff failed to document the scabbed area to Resident #1's left heel on the MDS.</p> <p>The findings include:</p> <p>Review of the Resident Assessment Instrument User Manual (Version 3.0) revealed eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color and may appear scab-like) should be coded as an unstageable pressure ulcer on the MDS.</p> <p>Review of the medical record of Resident #1 revealed the facility admitted the resident on 08/24/12 with diagnoses including Hypertension;</p>	F 272	<p>and 1/3/13 the Minimum Data Set Coordinators reviewed each resident's last comprehensive assessment to ensure it is an accurate, standardized reproducible assessment of each resident's functional capacity. For any discrepancies found an attestation to the comprehensive assessment was completed (see attachment #8).</p> <p>3. a. On 12/4/12, the Regional MDS consultant reeducated the Minimum Data Set Coordinator on the Resident Assessment Instrument User Manual (Version 3.0) coding instructions for eschar and to record documented skin issues on the MDS to ensure an accurate assessment for each resident(see attachment #9).</p> <p>b. On 11/21/12, 11/22/12, 11/23/12, 11/24/12, 11/25/12, 11/26/12, 11/27/12, 11/28/12, 11/29/12, and 11/30/12, the Assistant Director of Nursing reeducated the licensed nurses to document any skin issue on the skin assessment documentation form(s) to include size and/or description</p>	

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F 272	<p>Continued From page 7</p> <p>Coronary Artery Disease, and Fracture of the Left Hip. A review of Resident #1's admission skin assessment dated 08/24/12 revealed staff assessed the resident to have a scabbed area on the left heel; however, staff failed to document the size of the area or a description of the appearance of the area. A review of Resident #1's admission Minimum Data Set (MDS) dated 09/06/12 revealed facility staff assessed the resident to be at risk for the development of pressure ulcers but failed to document the scabbed area on the assessment. In addition, a review of the care plan revealed although facility staff identified the resident was "At Risk for Pressure Ulcer related to Decrease Mobility," facility staff failed to identify the scabbed the area on Resident #1's left heel and failed to put interventions in place for monitoring the area. Further review of the care plan revealed Resident #1 had the facility's standardized pressure prevention intervention, a HeelZup cushion, in place.</p> <p>Interview with Unit Manager (UM) #1 on 11/19/12 at 7:00 PM, revealed Resident #1 had a discolored, scabbed area to the left heel at the time of admission. The UM further revealed the area looked like it would heal on its own, so the physician was not notified about the area. The interview further revealed there was not a physician's order to monitor or treat the area.</p> <p>Interview on 11/20/12 at 4:12 PM, with MDS Coordinator #1 revealed the information for the MDS assessment was obtained from each resident's medical record from "skin sweeps" (skin assessment documentation), medication administration record, treatment administration</p>	F 272	<p>of the area(see attachment #2).</p> <p>c. The Nurse Unit Managers will review (QA monitor) residents' skin assessment documentation weekly for any newly identified areas to ensure the size and/or description is documented. Any discrepancies will be corrected and reported to the Director or Assistant Director of Nursing(see attachment #4).</p> <p>d. The facility hired another Minimum Data Set Coordinator for a total of 2 to provide a check and balance system for that department. On 1/2/13, the Administrator educated the new MDS coordinator on the Resident Assessment Instrument User Manual (Version 3.0) coding instructions for eschar and to record documented skin issues on the MDS to ensure an accurate assessment for each resident. She educated both Minimum Data Set Coordinators that they must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity(see attachment #10).</p>	

4. The Director or Assistant Director of Nursing will provide disciplinary follow up and reeducation to individual nurses as needed. Each MDS coordinator will QA review 5 resident's comprehensive assessments that have been conducted by the other MDS coordinator weekly for one month and then monthly for 2 months to ensure an accurate, standardized reproducible assessment of each resident's functional capacity has been completed. They will initial and date each MDS as they review them. Any discrepancies will be corrected and reported to the Administrator for reeducation and disciplinary follow up as needed.

The Director or Assistant Director of Nursing will report the results of the Unit Manager monitoring and the MDS coordinators will report the results of their monitoring monthly for three months to the Quality Assurance committee for development of an action plan as needed.

P. 8A

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F 272	Continued From page 8 record (TAR), therapy notes, and interviews with Registered Nurses (RNs) and Certified Nursing Assistants (CNAs). The interview further revealed a scab would not be coded on an MDS assessment because there is no guidance or recommendation for coding a scab on an MDS assessment. MDS Coordinator #1 further revealed the scabbed area identified on Resident #1's left heel was not coded on the MDS and, as a result, not coded on the care plan, because Resident #1's scabbed area was not documented on the skin sweep paper and there was no treatment in place on the TAR. Interview on 11/20/12 at 4:15 PM, with the DON revealed the DON was unable to remember specific information about Resident #1. The DON stated if a scabbed area was drying and appeared to be healing the doctor would not be notified for treatment. The interview further revealed the DON would have to assess an area to determine if the area required monitoring.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	F279 1. Resident #1 was discharged from the facility on 9/7/12 which was prior to this survey so no corrective action could be taken. 2. All residents have the potential to be affected by the facility's failure to ensure a comprehensive care plan was developed.	1/4/13

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F 279	<p>Continued From page 9</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to ensure a comprehensive plan of care was developed for one of three sampled residents (Resident #1). Facility staff assessed Resident #1 upon admission and noted the resident had a scabbed area to the left heel; however, the facility failed to develop a plan of care to ensure the area was monitored and/or treatment provided.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Care Plan, dated March, 2012, revealed a plan of care would be established for every facility resident and all identified needs of the residents would be addressed.</p> <p>Review of the Resident Assessment Instrument User Manual (Version 3.0) revealed eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color and may appear scab-like) should be coded as an unstageable pressure ulcer.</p> <p>Based on documentation in the medical record, the facility admitted Resident #1 on 08/24/12 with</p>	F 279	<p>On 11/21/12, the Nurse Unit Managers performed skin sweeps on all residents. They compared these skin sweeps to the medical record to ensure a plan of care was developed to ensure the area(s) were monitored and/or a treatment was provided(see attachment #1). On 12/30/12, 1/1/13, 1/2/13, and 1/3/13 the MDS coordinators compared the last comprehensive assessment for each resident to their current care plan to ensure the results of the assessment were used to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Any discrepancies were corrected by the MDS coordinators with the</p>	

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F 279	<p>Continued From page 10</p> <p>diagnoses that included Hypertension, Coronary Artery Disease, and Fracture of the Left Hip. A review of Resident #1's admission skin assessment dated 08/24/12 revealed a scabbed area was identified on the resident's left heel but there was no evidence of the size of the area or a description of the appearance of the area. A review of Resident #1's admission Minimum Data Set (MDS) dated 09/06/12 revealed the resident was at risk for the development of pressure ulcers; however, facility staff failed to document the scabbed area on the resident's left heel on the MDS. A review of Resident #1's care plan revealed facility staff identified the resident to be "At Risk for Pressure Ulcer related to Decrease Mobility" and had the facility's standard intervention in place for the utilization of a HeelZup cushion on an as needed basis; however, facility staff failed to document the scabbed the area on Resident #1's left heel or develop specific interventions related to the scabbed area on the care plan.</p> <p>Interview with LPN #1 on 11/19/12 at 6:05 PM, revealed the LPN did not remember Resident #1 but stated if a scabbed area was found on a resident's heel the doctor should be notified and the area should be monitored and possibly treatment ordered. The interview further revealed a scabbed area should be placed on the plan of care by the staff that identified the area with interventions to monitor and/or treat.</p> <p>Interview with Unit Manager (UM) #1 on 11/19/12 at 7:00 PM, revealed Resident #1 did have a discolored, scabbed area to the left heel. The RN further revealed the area looked like it would heal on its own and the area, or interventions related</p>	F 279	<p>development of a comprehensive care plan based on the comprehensive assessment (see attachment #8).</p> <p>3. a. On 11/21/12, 11/22/12, 11/23/12, 11/24/12, 11/25/12, 11/26/12, 11/27/12, 11/28/12, 11/29/12, and 11/30/12 the Assistant Director of Nursing reeducated the licensed nurses, including the Minimum Data Set Coordinator, on development of a comprehensive plan of care for all identified skin issues to ensure monitoring and/or treatment is provided. This training included development/revision of a care plan for new physician orders and/or diagnoses (see attachment #2).</p> <p>b. On 12/4/12, the Regional MDS consultant reeducated the Minimum Data Set Coordinator on the Resident Assessment Instrument User Manual (Version 3.0) coding instructions for eschar and to record</p>		

documented skin issues on the MDS to ensure an accurate assessment for each resident (see attachment #9).

c. The Nurse Unit Managers will review(QA monitor) skin assessment documentation weekly for newly identified areas. If any new issues, they will review the resident's record to ensure a plan of care has been developed. Any discrepancies will be corrected immediately and reported to the Director or Assistant Director of Nursing (see attachment #4).

d. The facility hired another MDS coordinator, for a total of 2, to provide a check and balance system for that department. On 1/2/13, the

Administrator educated the new MDS coordinator on the Resident Assessment Instrument User Manual(Version 3.0) coding instructions for eschar and to record documented skin issues on the MDS to ensure an accurate assessment for each resident. She educated both MDS coordinators to use the results of the comprehensive assessment to develop a comprehensive care plan for each resident that include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment(see attachment #10).

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4. The Director or Assistant Director of Nursing will provide disciplinary follow up and reeducation to individual licensed nurses as needed. They will report the results of the Nurse Unit Managers' QA monitoring monthly for three months to the Quality Assurance Committee for development of an action plan as needed. Each MDS coordinator will QA review 5 resident comprehensive assessments completed by the other MDS coordinator weekly for one month and monthly for 2 months and compare to the comprehensive care plan to ensure the assessment was used to develop a care plan that includes measurable objectives and timetables to meet each resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. They will initial and date each MDS as they review. Any discrepancies will be corrected and reported to the Administrator for reeducation and/or disciplinary follow up. The MDS coordinators will report the results of their QA audits monthly for 3 months to the Quality Assurance Committee for development of an action plan as needed.

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F 279	Continued From page 11	F 279		1/4/13	
F 280 SS=D	<p>to the area, were not added to the care plan.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to evaluate and revise the care plan when a change in status occurred for one of three sampled residents (Resident #2). Observation of a skin assessment conducted by facility staff on 11/19/12 for Resident #2 revealed the resident had</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> Resident #2's plan of care was revised by the Nurse Unit Manager on 11/19/12 to include the excoriation and the treatment the primary physician ordered for the excoriation. All residents have the potential to be affected by the facility's failure to revise the care plan when a change in status occurs. On 11/21/12, the Nurse Unit Managers performed skin sweeps on all residents and compared the results with each residents' plan of care to ensure all skin impairments had been documented (see attachment #1). On 12/21/12, the Director of Nursing, Assistant Director of Nursing, Nurse Unit Manager, and other Administrative Nurses reviewed the nurses notes and physician orders on each resident for the past 30 days looking for a change in status that included accident/incidents, a need to 		

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F 280	<p>Continued From page 12</p> <p>red/excoriated areas to the buttock and thigh areas. Interviews on 11/19/12 revealed staff provided treatment to the red/excoriated areas on the resident's buttock and thigh areas. However, a review of the care plan for Resident #2 revealed facility staff failed to revise the resident's care plan related to the resident's impaired skin integrity.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Care Plan, dated March 2012, revealed a plan of care would be established for every facility resident and all identified needs of the residents would be addressed.</p> <p>A review of the medical record for Resident #2 revealed the facility admitted the resident on 07/27/12 with diagnoses that included Morbid Obesity, Lumbar Stenosis, and Hypertension. A review of a quarterly Minimum Data Set assessment (MDS) dated 10/27/12 revealed Resident #2 required extensive assistance with bed mobility, toilet use, and personal hygiene. Further review of the MDS revealed the resident was interviewable, occasionally incontinent of urine, and frequently incontinent of bowel functions.</p> <p>A review of the weekly nursing progress notes conducted on 11/19/12 revealed facility staff assessed Resident #2 on 11/10/12 and 11/17/12 and documented the resident's buttocks were reddened or excoriated. A review of the care plan for Resident #2 revealed facility staff failed to revise the resident's care plan related to the resident's skin integrity impairment on 11/10/12 or</p>	F 280	<p>alter treatment, significant change in condition, and resident transfers. These changes in status were then compared to each residents' respective care plan to ensure it had been revised to include the change and interventions. Any discrepancies were addressed (see attachment #11). On 12/30/12, 1/1/13, 1/2/13, and 1/3/13 the MDS coordinators reviewed each resident's last comprehensive assessment and compared it to each resident's respective care plan to ensure all needed evaluations and revisions have been implemented. Any discrepancies were addressed by the MDS coordinators as a care plan revision (see attachment #8).</p> <p>3. a. On 11/21/12, 11/22/12, 11/23/12, 11/24/12, 11/25/12, 11/26/12, 11/27/12, 11/28/12, 11/29/12, and 11/30/12 the Assistant Director of Nursing reeducated the licensed nurses, including the Minimum Data Set Coordinator to evaluate and revise a resident's care plan</p>	

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F 280	<p>Continued From page 13 11/17/12.</p> <p>Observation of a skin assessment conducted by Licensed Practical Nurse (LPN) #2 on 11/19/12 at 11:40 AM, for Resident #2 revealed the resident's right inner thigh and buttocks were red and excoriated.</p> <p>Resident #2 acknowledged in interview conducted on 11/19/12 at 11:35 AM, that the inner areas of the resident's leg and buttock area were red and stated staff applied medication (unsure of type or name of medication) to the area. Resident #2 could not recall the length of time staff had applied the medication to the reddened areas.</p> <p>An interview with Certified Nursing Assistant (CNA) #2 on 11/19/12 at 3:45 PM, revealed Resident #2's "bottom had been red for weeks." CNA #2 stated she had reported the redness to Unit Manager #1 but was unable to recall the exact date.</p> <p>An interview with CNA #3 on 11/19/12 at 4:15 PM, revealed she observed Resident #2's buttocks to be red on 11/15/12, and had reported the reddened areas to nursing staff but was unable to recall which facility nurse had been notified.</p> <p>Interview with Registered Nurse (RN) #2 on 11/19/12 at 5:32 PM, revealed the RN assessed Resident #2's buttocks to be reddened on 11/17/12. The RN stated care plans should be updated when there was a change in condition, and acknowledged she failed to update Resident #2's care plan on 11/17/12 when she assessed the reddened areas on the resident's buttock and</p>	F 280	<p>when a change in status occurs, including a new skin impairment (see attachment #2).</p> <p>b. The Nurse Unit Managers will review (QA monitor) skin assessment documentation weekly and compare the findings to the residents' plan of care to ensure all skin impairments are care planned. Any discrepancies will be corrected and reported to the Director or Assistant Director of Nursing (see attachment #4).</p> <p>c. On 1/1/13, 1/2/13, and 1/3/13 the Assistant Director of Nursing reeducated the licensed nurses on using the 24 hour report to document changes in a resident condition including accident/ incidents, significant change in a resident's condition, a need to alter treatment, or a decision to transfer a resident (see attachment #6)</p>	

d. Nurse Unit Managers will review the 24 hour report five days per week for acute changes in a resident condition to include accidents/incidents, significant change in a resident's condition, a need to alter treatment significantly, or a decision to transfer the resident. They will then review the record for physician, resident, and responsible party notification, treatment/ intervention changes, and care plan revisions (see attachment #5). Any discrepancies will be corrected immediately and reported to the Director of Nursing.

4. The Director or Assistant Director of Nursing will QA monitor 15 resident charts weekly for one month then monthly for three months for any change in residents' condition to include physician notification, resident and responsible party notification, treatment/intervention changes, and care plan evaluation and revisions (see attachment #7). The Director or Assistant Director of Nursing will provide disciplinary follow up and reeducation to individual nurses as needed. They will report on theirs and the Nurse Unit Manager QA monthly for three months to the Quality Assurance Committee for development of an action plan as needed.

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F 280	Continued From page 14 change in the resident's skin condition. An interview with LPN #2 at 11:50 AM on 11/19/12, revealed the LPN had observed the resident's skin excoriation earlier in the shift on 11/19/12. A second interview with LPN #2 on 11/19/12 at 6:10 PM, revealed staff nurses were not responsible to update the resident's care plan when a change in a resident's condition occurred. The LPN stated she had not been made aware whose responsibility it was to update the resident's care plan when a change in the resident's condition occurred. An interview with Unit Manager #1 on 11/19/12 at 6:45 PM, revealed facility staff should have updated the resident's care plan when the resident was assessed to experience a change in status on 11/10/12. The Unit Manager stated that "spot" checks were conducted weekly to ensure skin assessments were completed appropriately; however, a spot check had not been conducted for Resident #2. An interview with the Assistant Director of Nursing (ADON) on 11/20/12 at 11:15 AM, confirmed facility staff was responsible to update the resident's care plan when a change in the resident's condition had occurred.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	F309 1. Resident #2's primary physician was notified on 11/19/12 by the Nurse Unit Manager and an order for treatment for the excoriation was obtained.	1/4/13	

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F 309	<p>Continued From page 15</p> <p>accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care were provided for one of three sampled residents (Resident #2). Observation of a skin assessment conducted by facility staff on 11/19/12 revealed Resident #2 had red/excoriated areas to the buttock and thigh areas. Interviews with facility staff on 11/19/12 revealed the resident required treatment to the red/excoriated areas. However, a review of the medical record for Resident #2 provided no evidence facility staff had contacted the resident's physician and obtained treatment related to the resident's impaired skin integrity.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Change in Resident Condition, dated March 2012, revealed the nurse was responsible to complete an assessment and notify the resident's physician when a change occurred in the resident's status.</p> <p>A review of the medical record revealed the facility admitted Resident #2 on 07/27/12 with diagnoses of Morbid Obesity, Lumbar Stenosis,</p>	F 309	<p>2. All residents have the potential to be affected by the facility's failure to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care (see attachment #1). On 11/21/12, the Nurse Unit Managers performed skin sweeps on all residents then reviewed the treatment record to ensure any skin impairments were receiving a corresponding treatment as needed. Any discrepancies were corrected. On 12/21/12, the Director of Nursing, Assistant Director of Nursing, Nurse Unit Manager, and other Administrative Nurses reviewed all current residents' physician orders</p>		

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F 309	<p>Continued From page 16</p> <p>and Hypertension. A review of a quarterly Minimum Data Set (MDS) assessment dated 10/27/12 revealed facility staff assessed Resident #2 to require extensive assistance with bed mobility, toilet use, and personal hygiene. Further review of the MDS revealed facility staff assessed the resident to have a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated Resident #2 was interviewable, and also assessed the resident to be occasionally incontinent of urine and frequently incontinent of bowel functions.</p> <p>Continued review of Resident #2's medical record revealed weekly nursing progress notes dated 11/10/12 and 11/17/12 that the resident's buttocks were reddened or excoriated. However, there was no documentation in the medical record that facility staff had notified Resident #2's physician of the reddened/excoriated areas on the resident's buttocks or to obtain treatment for the resident's impaired skin integrity. A review of the Comprehensive Care Plan dated 08/04/12 revealed facility staff failed to revise Resident #2's care plan when a change in the resident's skin integrity occurred on 11/10/12 and 11/17/12.</p> <p>Observation of a skin assessment conducted by Licensed Practical Nurse (LPN) #2 on 11/19/12 at 11:40 AM, for Resident #2 revealed the resident's right inner thigh and buttocks were red and excoriated.</p> <p>An interview with Resident #2 on 11/19/12 at 11:35 AM, revealed the resident had redness on the inner aspect of the legs and "butt" areas. The resident stated staff had applied medication to the red areas "today" (11/19/12), however, Resident</p>	F 309	<p>and nurses notes for the past 30 days looking for a change in status that included accident/incidents, a need to alter treatment, a significant change in a resident's condition, or a resident transfer. These changes in status were then compared to each residents' respective care plan to ensure it had been revised to include the change and the interventions so that the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care is provided. Any discrepancies were addressed (see attachment #11). On 12/30/12, 1/1/13, 1/2/13, and 1/3/13 the MDS coordinators reviewed each resident's last comprehensive assessment and care plan to ensure each resident is receiving</p>		

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F 309	<p>Continued From page 17</p> <p>#2 was unsure how long the areas had required treatment.</p> <p>An interview with Certified Nursing Assistant (CNA) #2 on 11/19/12 at 3:45 PM, revealed Resident #2's "bottom had been red for weeks." CNA #2 was unable to recall when she had observed the redness to the resident's buttocks and stated she had reported the redness to Unit Manager #1 (unable to recall date).</p> <p>An interview with CNA #3 on 11/19/12 at 4:15 PM, revealed Resident #2's buttocks had been red on 11/15/12, and she had reported the reddened areas to nursing staff but was unable to recall which facility nurse had been notified.</p> <p>Interview with Registered Nurse (RN) #2 on 11/19/12 at 5:32 PM, revealed the RN assessed Resident #2 to have reddened areas to the buttocks on 11/17/12. The RN stated she had not contacted the resident's physician to obtain a treatment for the reddened areas and had not updated the resident's care plan. RN #2 acknowledged the resident's physician should have been contacted and the resident's care plan should have been updated when the change was observed in the resident's skin integrity on 11/17/12.</p> <p>An interview with LPN #2 at 11:50 AM on 11/19/12, revealed she had observed the excoriation to the resident's skin on 11/19/12; however, LPN #2 acknowledged the resident's physician had not been contacted, and the resident's care plan had not been updated as a result of the change in the resident's skin integrity.</p>	F 309	<p>the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care is provided. Any discrepancies were addressed by the MDS coordinators as a care plan revision (see attachment #8).</p> <p>3. a. On 11/21/12, 11/22/12, 11/23/12, 11/24/12, 11/25/12, 11/26/12, 11/27/12, 11/28/12, 11/29/12, and 11/30/12 the Assistant Director of Nursing reeducated the licensed nurses to contact the primary physician for any change in resident condition, including any new skin impairment, and to evaluate and revise the care plan for each new order and/or diagnosis to ensure each resident will receive the necessary care and services to attain or</p>		

maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care (see attachment #2).

b. The Nurse Unit Managers will review(QA) skin assessment documentation weekly on all residents. They will compare this documentation with each resident's record to ensure the primary physician has been notified and a corresponding treatment has been obtained if needed. Any discrepancies will be reported to the primary physician for orders and the Director or Assistant Director of Nursing (see attachment #4).

c. On 1/1/13, 1/2/13, and 1/3/13 the

Assistant Director of Nursing reeducated the licensed nurses on using the 24 hour report to document changes in a resident conditions that include accident/ incidents, a significant change in a resident's condition, a need to alter treatment or a decision to transfer the resident (see attachment #6).

d. The Nurse Unit Managers will review the 24 hour report five days per week for acute changes in a resident's condition to include accidents/incidents, a significant change in a resident's condition, a need to alter treatment significantly or a decision to transfer the resident. They will then review the record for physician, resident and responsible party notification, treatment/intervention changes, and care plan revisions (see attachment #5). Any discrepancies will be corrected immediately and reported to the Director of Nursing.

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4.

The Director or Assistant Director of Nursing will QA monitor 15 resident charts weekly for one month then 15 charts monthly for 3 months for resident change in status to include physician notification, resident/family notification, intervention implementation and effectiveness and care plan revisions to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for each resident (see attachment #7). The Director or Assistant Director of Nursing will provide disciplinary follow up and reeducation to individual licensed nurses as needed. They will report the results of their QA and the Nurse Unit Managers QA monthly for three months to the Quality Assurance Committee for development of an action plan as needed.

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F 309	Continued From page 18 An interview with Unit Manager #1 on 11/19/12 at 6:45 PM, revealed licensed nursing staff was responsible to call the resident's physician to obtain any treatment needed and to update the resident's care plan at the time the resident was assessed to experience a change in condition. The Unit Manager stated he had not been made aware Resident #2's inner thighs and buttock area were reddened. An interview with the Assistant Director of Nursing (ADON) on 11/20/12 at 11:15 AM, revealed facility staff was responsible to contact the resident's physician and obtain needed treatment when a change in the resident's condition occurred. The ADON stated facility staff was also responsible to update/revise the resident's care plan to reflect when a change in the resident's condition occurred.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy the facility failed to ensure one	F 314	F314 1. Resident #1 was discharged from the facility on 9/7/12 which was prior to this survey so no corrective action could be taken. 2. All residents have the potential to be affected by the facility's failure to provide necessary treatment and services to promote healing of a pressure sore.	1/4/13	

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F 314	<p>Continued From page 19 of three sampled residents (Resident #1) received necessary treatment and services to promote healing of a pressure area. Resident #1 was admitted to the facility on 08/24/12 and was identified to have a scabbed area on the left heel on the admission skin assessment. However, the facility failed to ensure Resident #1's physician had been notified of the scabbed area on the resident's left heel in order to obtain treatment orders and failed to ensure an area on the resident's heel was monitored for changes.</p> <p>The findings include:</p> <p>Review of the facility's policy, Wound Care Prevention and Treatment Objectives (dated 03/12), revealed the facility would accurately identify existing pressure ulcers and the appropriate stages to optimize healing by utilizing consistent, standardized treatment.</p> <p>Review of the Resident Assessment Instrument User Manual (Version 3.0) revealed eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color and may appear scab-like) should be coded as an unstageable pressure ulcer.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 08/24/12 with diagnoses to include Hypertension, Coronary Artery Disease, and status-post Left Hip Fracture. The medical record also revealed the resident was discharged on 09/07/12 and was to receive continued care provided by home health services. A review of Resident #1's admission skin assessment dated 08/24/12 revealed a scabbed area was identified on the resident's left</p>	F 314	<p>The Nurse Unit Managers performed skin sweeps on all residents on 11/21/12. No residents were noted to have a pressure sore without a corresponding treatment to promote healing.</p> <p>3. a. On 11/21/12, 11/22/12, 11/23/12, 11/24/12, 11/25/12, 11/26/12, 11/27/12, 11/28/12, 11/29/12, and 11/30/12 the Assistant Director of Nursing reeducated licensed nurses that all skin issues are to be documented on residents' individual skin assessment documentation and reported to their primary physician so an order for treatment can be obtained and transcribed to the treatment record.</p> <p>b. Nurse Unit Managers will review(QA monitor) skin assessment documentation</p>		

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F 314	<p>Continued From page 20</p> <p>heel but there was no evidence of the size of the area or a description of the appearance of the area. A review of Resident #1's admission Minimum Data Set (MDS) dated 09/06/12 revealed the resident was at risk for the development of pressure ulcers. A review of skin assessments dated 08/28/12 and 09/04/12, and a review of the treatment administration record (TAR) for August 2012 and September 2012, revealed no evidence the scabbed area on Resident #1's heel had been monitored by staff. A review of Resident #2's care plan revealed a problem area identified by staff as "At Risk for Pressure Ulcer related to Decrease Mobility" with a facility standard intervention of a HeelZup cushion; however, facility staff failed to identify the scabbed area on Resident #1's left heel and develop interventions to monitor the area.</p> <p>Resident #1's home health record was obtained and a review of the admission home health note dated 09/10/12 revealed the resident had an area to the left heel that appeared to be soft, black eschar that was documented to measure 1.4 centimeters (cm) in length and was 0.5 cm in width.</p> <p>Interview with CNA #1 on 11/19/12 at 6:15 PM, revealed the CNA did not remember any areas on Resident #1's heels but stated staff utilized "HeelZup cushions" for the resident's feet. CNA #1 stated the cushions were not used "very" often for Resident #1.</p> <p>Interview with Unit Manager (UM) #1 on 11/19/12 at 7:00 PM, revealed Resident #1 had a discolored, scabbed area to the left heel upon admission. The UM further revealed the area</p>	F 314	<p>weekly for all residents. They will compare these skin assessments with the medical record for each resident that has a pressure sore to ensure there is a treatment ordered that is promoting healing. Any discrepancies will be reported to the primary physician to obtain orders for wound healing and the Director or Assistant Director of Nursing.</p> <p>4. The Director or Assistant Director of Nursing will provide disciplinary follow up and reeducation to individual nurses as needed. They will report the results of the Nurse Unit Manager's QA monthly for three months to the Quality Assurance Committee for development of an action plan as needed.</p>		

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F 314	<p>Continued From page 21</p> <p>looked like it would heal on its own and a treatment order was not obtained.</p> <p>Interview on 11/20/12 at 4:12 PM, with MDS Coordinator #1 revealed the information for the MDS assessment was obtained from each resident's medical record from "skin sweeps" (skin assessment documentation), medication administration record, treatment administration record (TAR), therapy notes, and interviews with Registered Nurses (RNs) and Certified Nursing Assistants (CNAs). The interview further revealed a scab would not be coded on an MDS assessment because there is no guidance or recommendation for coding a scab on an MDS assessment. MDS Coordinator #1 further revealed the scabbed area identified on Resident #1's left heel was not coded on the MDS and as a result not coded on the care plan, because Resident #1's scabbed area was not documented on the skin sweep paper and there was no treatment in place on the TAR.</p> <p>Interview with the Director of Nursing (DON) on 11/20/12 at 4:15 PM, revealed the DON was not familiar with Resident #1's care needs. However, according to the DON, if a resident had an area that was scabbed, drying, and appeared to be healing, the resident's physician would not be notified and a treatment would not be put in place.</p>	F 314			