

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

PRINTED: 01/16/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/04/2013
NAME OF PROVIDER OR SUPPLIER  HEARTLAND VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<p>"This plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>1. The Minimum Data Set (MDS) for resident #1 was modified on 1/24/13 by the Clinical Case Manager to accurately reflect the resident's behaviors.</p> <p>2. The most recent MDS for current residents was audited by the Director of Nursing, Clinical Case Manager, the Assistant Director of Nursing and Social Services Director to determine that the MDS</p>	
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278		

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 278	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure accurate coding of the Minimum Data Set (MDS) assessments for one resident (#1,) in the select sample of three residents, related to anxiety, combativeness and exit seeking behaviors.</p> <p>Findings Include:</p> <p>Record review revealed Resident #1 was admitted to the facility, from the hospital on 12/18/12, with diagnoses to include an Anterior Myocardial Infarct, Coronary Artery Disease, Type II Diabetes, Chronic Obstructive Pulmonary Disease and Urinary Retention. A review of the admission MDS assessment, dated 12/25/12, revealed the facility assessed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and had no behaviors or wandering. The resident's mood was described as having little interest or pleasure, feeling down, tired and bad about him/herself and having trouble concentrating. The resident was not coded to be on any antipsychotic or antidepressant medications, but was coded as receiving antianxiety medications for two days of the seven day look back period.</p> <p>An observation and interview with Resident #1, on 01/02/13 at 4:38 PM, revealed the resident stated he had been at the facility "since 1955" and was "treated pretty good in this trailer park." The resident's affect was guarded and the resident was seated at bedside in a chair. The resident appeared disheveled with some food</p>	F 278	<p>accurately reflected the residents condition, including but not limited to behaviors, on 01/28/13.</p> <p>Any concerns were addressed at the time they were identified.</p> <p>3. The Administrator re-educated the Director of Nursing, Assistant Director of Nursing, the Activities Director and the Social Services Director to the requirement that the MDS be completed Accurately to reflect the residents condition, including behaviors, and that each member will validate accuracy and completion of their assessment on 1-23-13 and a post test was completed 2/4/13, to determine staff understanding of this requirement.</p> <p>4. The Administrator and/or the Director of Nursing will complete an audit to determine that the MDS accurately reflects the residents condition, on 2 MDS assessments weekly x 4 weeks, and then 1 MDS assessment</p>	

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F 278	<p>Continued From page 2</p> <p>particles on his chin and shirt and had crumpled paper towels scattered on the floor surrounding his bed.</p> <p>A record review of the nursing notes, dated 12/19/12 from 10:30 PM until 12/20/12 at 1:30 AM, revealed the resident was placed on hourly monitoring for behaviors of "door testing and exit seeking" and "acting out behaviors" of "trying to get in the floor and crawl out of the facility and asking for a gun." At 1:05 AM, the resident complained of severe chest pain and refused the prescribed Nitroglycerin (NTG) medication. He/she was transferred by ambulance to the local hospital per ambulance, at 1:30 AM and was diagnosed with a Urinary Tract Infection (UTI) and placed on antibiotics. On 12/22/12 at 2:00 AM, the resident was upset in the hallway and looking for a fire alarm to pull and attempted to call police due to wanting to leave the facility. The resident went into another resident's room and laid on the floor, grabbed a lift and refused to let go, and kicked the Certified Nurse Aide (CNA) several times. The police and the Emergency Medical Service arrived at the facility and the resident was again transferred to the hospital at 2:35 AM and returned to the facility at 5:30 AM with an order for a topical antifungal cream. Upon return, the resident was documented as "confused, angry and abusive" to staff. On 12/24/12, during the 6:00 AM until 2:00 PM shift, the resident pulled out the urinary catheter, with the bulb intact.</p> <p>An interview with CNA #1, on 01/04/13 at 2:10 PM, revealed the resident "walks around a lot and into other resident's rooms and says he/she wants to leave" and states the resident doesn't have those behaviors in the daytime.</p>	F 278	<p>weekly x 5 months. Any concerns will be addressed when identified. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations.</p>	2/5/13	

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F 278	<p>Continued From page 3</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/04/13 at 1:38 PM, revealed she was aware of the resident trying to exit the facility, but unaware of the combative behaviors and witnessed the resident attempting to throw a walker through a window and exit, when one of the CNAs was able to intervene and distract the resident. The LPN stated the MDS coordinator creates the care plan for wandering and behaviors. The nurses on the floor update the care plan when new physician orders are received but the MDS Coordinator usually completes and updates the care plans.</p> <p>An interview with the MDS Coordinator, on 01/04/13 at 1:58 PM, revealed she was aware of the resident's combative and wandering behaviors, but stated the Social Services Director (SSD) was responsible for the behavior and wandering part of the MDS assessment. She stated this part of the MDS assessment was not accurate and should have been completed to include these behaviors, so the resident would have triggered for this and a care plan would have been implemented.</p> <p>An interview with the SSD, on 01/04/13 at 10:00 AM, revealed he was responsible for the mood and behaviors part of the MDS. His interview with the resident, prior to the admission MDS, revealed the resident was depressed due to the loss of independence and having to leave his/her home and stay at the nursing home. The SSD was not aware of the resident's exit seeking behaviors or acting out behaviors and did not review the nursing notes or interview the staff regarding the resident's behaviors or exit seeking.</p>	F 278			

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F 278	Continued From page 4 He stated the Elopement /Wandering Risk Evaluation Form, dated 12/19/12, was completed by the nurses and he had not included this record in his assessment of the resident and MDS assessment. The form stated the resident experienced "aimless/random wandering , observable anxiety and frustration, exit seeking behaviors and had entered other resident's rooms.  An interview with the Director of Nursing (DON), on 01/04/13 at 2:42 PM, revealed the resident was not on any behavioral monitoring sheets to target the resident's behaviors because the sheets are only implemented when the resident's are on psychiatric medications and was unaware the resident was not accurately assessed for wandering and behaviors on the MDS or care plans.	F 278			
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 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	1. The care plan for Resident #1 was revised and updated by a licensed nurse on 1/4/13, to reflect the residents skin conditions and behaviors.  2. An audit of the care plans for current residents was completed on 1/28/13 by the Director of Nursing and Registered Nurses to determine that the care plans accurately reflected the residents condition, including but not limited to skin conditions and behavior.		

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F 279	<p>Continued From page 5</p> <p>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 observation, interview, record review and policy review, it was determined the facility failed to develop a comprehensive care plan, for one resident (#1), in the selected sample of three residents, related to exit seeking and combative behaviors, skin rashes and excoriations.</p> <p>Findings include:</p> <p>A review of the "Summary of Manual Update Changes to the Care plan," dated January 2008 and revised August 2011, revealed it was the policy of the center to develop an individualized care plan for each resident, utilizing the information during each assessment. The licensed nurse initiates a care plan addressing the resident's most immediate needs. The Interdisciplinary Team (IDT) develops care plans addressing the resident's most acute problems and has measurable objectives and timetables to meet the residents medical, nursing, mental and psychosocial needs.</p> <p>A record review revealed Resident #1 was admitted to the facility, from the hospital on 12/18/12, with diagnosis to include Coronary Artery Disease, Diabetes, Chronic Obstructive Pulmonary Disease and Urinary Retention. A review of the admission MDS assessment, dated 12/25/12, revealed the facility assessed the</p>	F 279	<p>Any concerns were addressed when identified.</p> <p>3. The Clinical Case Manager, Social Services, Activities and licensed nurses were re-educated by the Director of Nursing and Assistant Director of Nursing to develop a comprehensive care plan that will reflect the residents condition, including but not limited to skin conditions and behaviors as of 1/24/13, and a post test was completed 2/4/13, to determine staff understanding of this requirement.</p> <p>4. The Administrator and/or the Director of Nursing will complete an audit to determine that a comprehensive care plan is developed and revised to accurately reflect the residents condition by reviewing 2 resident care plans weekly x 4 weeks, and then 1 resident care plan weekly x 5 months. Any concerns will be addressed when identified. The Director of Nursing will submit a</p>		

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F 279	<p>Continued From page 6</p> <p>resident was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and had no behaviors or wandering. The resident's mood was described as having little interest or pleasure, feeling down, tired and bad about him/herself and having trouble concentrating. The resident had no pressure areas or other ulcers, wounds or moisture associated skin problems. A review of the comprehensive care plan for skin breakdown, dated 12/18/12, revealed the resident had non-specific "redness and itching." Interventions were to apply a protective barrier cream and complete weekly skin assessments. There was no care plan to monitor for the need for Diabetic foot care. An intervention was added on 12/22/12, for an antifungal cream topically to the peri area for redness and itching. There was no care plan for exit seeking and combative behaviors. The resident was admitted with an indwelling urinary catheter, that was discontinued on 12/24/12, after the resident pulled the catheter out, with the bulb intact.</p> <p>An observation and interview with Resident #1, on 01/02/13 at 4:38 PM, revealed the resident stated he had been at the facility "since 1955" and was "treated pretty good in this trailer park." The resident's affect was guarded and the resident was seated at the bedside in a chair. The resident appeared to be disheveled with some food particles on his chin and shirt and had crumpled paper towels scattered on the floor surrounding his bed. An observation of a skin assessment, on 01/03/13 at 11:35 AM, revealed the resident had reddened areas to the anterior and posterior peri-anal areas, sacrum and right ankle and was missing all but one toe on the right</p>	F 279	summary of findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations.	2/5/13	

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F 279	<p>Continued From page 7</p> <p>foot due to the resident's statement of having "ingrown toenails," and a scabbed area to the right lateral foot.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 01/04/13 at 2:10 PM, revealed the CNA stated the resident's peri area was "blood red" on admission to the facility, on 12/18/12, especially the area around the urinary catheter, that was "red and swollen." The CNA stated the resident usually acted out, attempting to leave the facility and striking out at staff, on the night shift. The CNAs did not fill out any behavioral monitoring sheets but verbally passed this on in report, to the CNAs on the next shift, when the behavior occurred.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/03/13 at 11:43 AM, revealed the resident's redness and excoriation that were noted on the admission skin observation, should have been documented on the Non-Pressure Skin Assessment sheets, that were to be completed weekly. The Treatment Records for December 2012 and January 2013 showed the skin assessments were completed and the skin was intact, with no further documentation.</p> <p>An interview with LPN #2, on 01/03/13 at 2:05 PM, revealed the resident's buttocks and groin area were slightly reddened on admission and a protective ointment was applied. The LPN was unable to state why the resident was missing all but one toe on the right foot but stated this should have been monitored and care planned to be observed and the non-pressure sheets should have been utilized to indicate the areas of excoriation and redness and how they were</p>	F 279			

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F 279	Continued From page 8 improving or worsening. The resident was placed on a "one-to-one observation" on 12/19/12, when exit seeking and combative. However, these behaviors were not care planned and interventions were not put into place.  An interview with the MDS Coordinator, on 01/04/13 at 2:05 PM, revealed she "missed" the evaluation of the resident's wandering behaviors and stated the resident should have had a care plan for this. She was unaware the resident had any skin issues.  An interview with the Director of Nursing (DON), on 01/03/13 at 2:20 PM, revealed hourly documentation for the one-to-one observation of the resident, after the exit seeking behavior, on 12/19/12 from 10:30 PM until 12/20/12 at 1:30 AM, when the resident had to be transported to the hospital for anxiety and chest pain. The DON stated there was no other documentation to show the resident was monitored and no policy for one-to-one observations as the need for this was based on nursing judgement and stated every fifteen minute checks were not done at the facility, due to having 14 minutes where the resident could be in danger. She was unsure why the wandering risk was not picked up on the care plan as well as the behaviors that proceeded this. When asked about root causes for the behaviors, the DON stated the UTI and urinary catheter could have been the problem as the resident has not been combative since the catheter was removed by the resident. She stated the rashes, excoriation, and problems with the residents missing toes should have also been assessed and care planned.	F 279			
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309			

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F 309 SS=D	<p>Continued From page 9 HIGHEST WELL BEING</p> <p>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 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure for Preventing Pressure Ulcers, it was determined the facility failed to provide care and services to maintain the highest practicable well-being for one resident (#1), in the selected sample of three residents. An observation of a skin assessment for Resident #1, revealed excoriated and reddened areas to the groin and peri-areas, redness to the sacral area and the right lateral ankle and a scabbed area to the right lateral foot, that had not been noted in the previous weekly assessment and was not addressed or documented by the facility since admission.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure for "Putting the Plan Into Action", dated January 2008, revealed a licensed nurse performs head-to-toe skin checks of the resident and documents the findings on the Treatment Administration Record (TAR.) The licensed nurse documents the following notations: "Y" for skin</p>	F 309	<p>1. A Non-Pressure Wound and Skin Condition Document was completed by a licensed nurse for resident #1 to reflect and monitor the residents skin conditions including the reddened peri area and scabbed areas to the foot on 1/3/13. The care plan for resident #1 was revised to reflect the residents current conditions and further risk of skin breakdown due to the residents history by a licensed nurse on 1/3/13.</p> <p>2. A skin assessment was completed of current residents by the Director of Nursing Services and the Assistant Director of Nursing Services on 1/3/13, and medical records reviewed to determine that a skin condition document was in place as appropriate for all skin conditions identified. The medical records for current residents were audited by the Director of Nursing and the Assistant Director of Nursing on 1/28/13 to determine that each resident is receiving the</p>		

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F 309	<p>Continued From page 10</p> <p>Intact and "N" for skin not intact. If "N" was documented, the nurse writes a narrative in the TAR describing the area. The process then moves into the wound management phase and the physician and responsible party are notified, a progress note is completed and the care plan is updated. A Non-Pressure Wound and Skin Condition Documentation Form is to be utilized for venous/arterial ulcers, abrasion, discolorations, bruises, rashes, etc.</p> <p>Record review revealed Resident #1 was admitted to the facility from the hospital on 12/18/12 with diagnoses to include Diabetes, Chronic Obstructive Pulmonary Disease and Urinary Retention. A review of the admission MDS assessment, dated 12/25/12, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and had no behaviors or wandering. The resident had no pressure areas or other ulcers, wounds or moisture associated skin problems. A review of the comprehensive care plan for skin breakdown, dated 12/18/12, revealed the resident had non-specific "redness and itching." Interventions were to apply a protective barrier cream and complete weekly skin assessments. There was no care plan to monitor for the need for Diabetic foot care. An intervention was added on 12/22/12, for an antifungal cream topically to the peri area for redness and itching. There was no care plan for exit seeking and combative behaviors. The resident was admitted with an indwelling urinary catheter, that was discontinued on 12/24/12.</p> <p>An observation of a skin assessment, on 01/03/13 at 11:35 AM, revealed the resident had</p>	F 309	<p>necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and care plan. Any concerns were addressed when identified.</p> <p>3. Licensed nurses were re-educated by the Assistant Director of Nurses on 1/10/13, regarding assessing, documenting, and monitoring conditions (including the use of Skin Condition Monitoring Document, developing and revising care plans) to meet the requirement that each resident receive 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 care plan and a post test was completed 02/04/13, to determine staff understanding of this requirement.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 01/04/2013
NAME OF PROVIDER OR SUPPLIER  HEARTLAND VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8006 US HWY 60 WEST LEWISPORT, KY 42351		
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F 309	<p>Continued From page 11</p> <p>reddened areas to the anterior and posterior peri-anal areas, sacrum and right ankle and was missing all but one toe on the right foot due to the resident's statement of having "ingrown toenails," and a scabbed area to the right lateral foot.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 01/04/13 at 2:10 PM, revealed the CNA stated the resident's peri area was "blood red" on admission to the facility, on 12/18/12, especially the area around the urinary catheter, that was "red and swollen."</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 01/03/13 at 11:43 AM, revealed the resident's redness and excoriation that were noted on the admission skin observation, should have been documented on the Non-Pressure Skin Assessment sheets, that were to be completed weekly. The Treatment Records for December 2012 and January 2013 showed the skin assessments were completed and the skin was intact, with no further documentation.</p> <p>An interview with LPN #2, on 01/03/13 at 2:05 PM, revealed the resident's buttocks and groin area were slightly reddened on admission and a protective ointment was applied. The LPN was unable to state why the resident was missing all but one toe on the right foot but stated this should have been monitored and care planned to be observed and the non-pressure sheets should have been utilized to indicate the areas of excoriation and redness and how they were improving or worsening.</p> <p>An interview with the MDS Coordinator, on 01/04/13 at 2:05 PM, revealed she was unaware</p>	F 309	<p>4. The Director of Nursing or Assistant Director of Nursing will complete an audit of the medical record of newly admitted residents weekly x 24 weeks to determine that appropriate documentation and monitoring tools are in place to reflect 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 care plan. Any concerns will be addressed when identified. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x 6 months for further review and recommendations.</p>	2/5/13	

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NAME OF PROVIDER OR SUPPLIER  HEARTLAND VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 12 the resident had any skin issues.  An interview with the Director of Nursing (DON), on 01/03/13 at 2:20 PM, revealed the rashes, excoriation and problems with the resident's missing toes should have also been assessed and care planned and the Non- Pressure Skin Assessments should have been utilized.	F 309			