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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE RESIDENTIAL CARE CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Unique Residential Care Center from February 01, 2017 through 8, 2017. Survey activities consisted of a review of 40 residents' clinical records during Stage 1; and review of 38 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CFU Colony Forming Unit CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram	F 000	Unique Residential Care Center make its best efforts to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Laws.	

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.

Regina Kim Administrator 3/20/17

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F 000	Continued From page 1 EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician's order sheet Prn - As needed Pt - Patient PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	F 000		
F 157	483.10(g) (14) NOTIFY OF CHANGES	F 157		

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F 157 SS=D	Continued From page 2 (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c) (1) (ii). (ii) When making notification under paragraph (g) (14) (i) of this section, the facility must ensure that all pertinent information specified in §483.15(c) (2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 157	1. Review of resident #118 was conducted and resident did not have any adverse effect. 2. Audits of residents with blood sugar monitoring were reviewed to identify other residents' blood sugar level that was not reported to physician as ordered. Any such cases if found will be corrected immediately. Follow up will be completed as indicated. 3. Nursing staff will be re-educated on physician notification of resident blood sugar level as per doctor's order and per facility policy. 4. Audits of residents MAR on blood sugar monitoring will be conducted monthly by nurse manager or designee for the next 3 months to monitor notification of physician on blood sugar level as ordered. The results of the audit will be reported to QA committee monthly to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17

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F 157	Continued From page 3 (A) A change in room or roommate assignment as specified in §483.10(e) (6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e) (10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 38 Stage 2 sampled resident's, it was determined that facility staff failed to notify the physician when the resident's blood glucose level was greater than 200 mg/dl (milligrams per deciliter). Resident #118 The findings include: Facility staff failed to notify the physician when Resident #118's blood glucose level was greater than 200mg/dl. According to the History and Physical Examination dated February 2, 2017, Resident #118's diagnoses included: "Diabetes Mellitus." A review of the Physician's Order Sheet and Plan of Care dated January 31, 2017 directed "Finger stick at ...Call MD [Medical Doctor] if BS [Blood Sugar] less than 60 or greater than 200 mg/dl". A review of the February 2017 Treatment Administration Record (TAR) revealed the following blood sugar results:	F 157		

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F 157	Continued From page 4 February 1, 2017 - 227 mg/dl February 5, 2017 - 201 mg/dl February 6, 2017 - 220 mg/dl February 7, 2017 - 273 mg/dl. The clinical record lacked evidence that the physician was notified regarding the blood sugar results. A face-to-face interview was conducted on February 7, 2017 at approximately 10:00AM with Employee #7 who acknowledged the findings. The clinical record was reviewed on February 7, 2017.	F 157		
F 253 SS=E	483.10(i) (2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations made on February 6, 2017 between 10:30 AM and 3:30 PM, it was determined that the facility failed to maintain a sanitary environment as evidenced by exhaust vents that were soiled on the inside in seven (7) of 47 resident's rooms and exhaust vents that were soiled on the outside in two (2) of 47 resident's rooms. The findings include: 1. Exhaust vents in seven (7) of 47 resident's rooms were soiled on the inside with dust particles: Rooms #122, #401, #402, #408, #417, #423 and #433.	F 253	1. From Feb. 13th – Feb. 17th the exhaust vents in rooms 122,401,402,408,417,423, and 433 were removed and the interior ducts were cleaned. The two exhaust vents in rooms 122 and 423 were removed and cleaned. 2. Inspection of all vents were conducted during the above listed time frame. Any vent meeting the deficient practice was removed for cleaning of ducts and registers. 3. The exhaust vents and ducts inspection will be added to the maintenance daily rounds inspection sheet. The maintenance personnel will conduct daily inspections of all vents on all floors. 4. The Facility Director and or Asst. Director shall monitor and conduct weekly audits. The findings shall be reported at the QA meetings monthly for the next 3 months to monitor process towards improvement.	2/20/17 4/6/17 4/6/17 4/6/17

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F 253	Continued From page 5 2. Exhaust vents in two (2) of 47 resident's rooms were soiled on the outside with dust particles: Rooms #122, #423. These observations were made in the presence of Employee #3 who acknowledged the findings.	F 253		
F 254 SS=D	483.10(i) (3) CLEAN BED/BATH LINENS IN GOOD CONDITION (i)(3) Clean bed and bath linens that are in good condition; This REQUIREMENT is not met as evidenced by: Based on observations made on February 6, 2017 between 10:30 AM and 3:30 PM, it was determined that the facility failed to maintain bed linen in good condition as evidenced by a soiled comforter on top of a resident's bed in one (1) of 47 resident's rooms. The findings include: The comforter used to cover the resident's bed in room #208B was soiled with several stain marks. One (1) of 47 resident's rooms. This observation was made in the presence of Employee #3 who confirmed the finding.	F 254	1. Resident comforter in Room #208B was not soiled, however, had stain marks and was replaced immediately. 2/6/17 2. Nurse Manager/ Designee conducted an audit of resident comforters to ensure no other residents had stained comforter on their bed. None was found. 4/6/17 3. CNAs have been in-serviced on not using stained comforters on residents' bed. Laundry supervisor will discard identified stain comforters. 4/6/17 4. All Directors/Managers who enters resident rooms will report any identified stained comforters to Unit/Clinical Managers and Laundry Supervisor. Director of Nursing will report on stained comforters at QA meeting monthly for the next 3 months to monitor process towards improvement. 4/6/17	
SS=D	483.10(c) (2) (i-ii, IV, v) (3), 483.21(b) (2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to	F 280		

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F 280	Continued From page 6 be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 280	1. Resident# 175 care plan for fall was reviewed and updated with approaches. 2. Audits of residents with history of falls were reviewed to identify other residents that require updated fall care plans. Follow up will be completed as indicated. 3. Nurse Managers will be re-educated on the policy and procedures on care plan update. Nurse Manages or designee will conduct monthly audits of residents with falls to ensure care plans are updated with new interventions. 4. Audits of residents care plans with falls will be conducted monthly by Nurse Managers or designee for the next 3 months to monitor care plan updates. The results of the audit will be reported to QA committee monthly to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17

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F 280	Continued From page 7 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to review and revise one (1) resident's care who sustained multiple falls. Resident #175.	F 280		

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F 280	Continued From page 8 The findings include: The facility staff failed to review and revise a care plan for multiple falls with appropriate goals and approaches for Resident #175 . A review of the care plans last updated February 3, 2017 revealed that the care plan lacked evidenced of revision with appropriate goals and approaches for falls that occurred on October 24, 2016, November 20, 2016 and December 28, 2016 . A review of the nursing notes revealed the following: "October 24, 2016- 8:30 PM- Resident called for help ... Resident was noted on the floor lying on [his/her] left side .... November 20, 2016-2:36 PM- Resident is observed lying on the floor of the courtyard on a right lateral position at 1328 (1:28 PM) by security guard at the court yard. Resident states that [he/she] tried to push [himself/herself] back from an edge in the courtyard while sitting on the wheelchair and fell ... December 28, 2016- 3:55 AM - Resident observed lying on the floor beside [his/her] bed ...When asked what happened; resident state's "I just feel like lying down on the floor." No visible injury noted... A face-to-face interview was conducted on	F 280		

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F 280	Continued From page 9 February 1, 2017 with Employee #6 at approximately 1:00 PM. After review of the care plans, he/she acknowledged the aforementioned findings. The clinical record was reviewed on February 6, 2017.	F 280		
F 309 SS=G	483.24, 483.25(k) (l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 38 Stage 2 Sampled residents, it was determined that facility staff failed to accurately and consistently assess and/or monitor the skin	F 309		

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F 309	Continued From page 10 integrity [surgical site] for Resident #262, which resulted in harm. The resident was admitted on 1/27/17, there was no evidence that the nursing facility identified and/or acted on any abnormalities with the wound; the resident was evaluated by an outside consultant during a routine follow-up appointment approximately 10 days post admission wherein the wound was determined to have deteriorated and required emergency management. The nursing facility's failure to assess the wound resulted in the wound deterioration requiring transfer to a local emergency department and same day "urgent" surgical intervention of the surgical wound. The findings include: Res #262 was admitted to the facility on January 27, 2017 status post-surgery of the lumbar spine. He/she was admitted with a surgical wound of the lower back for which a wound vac (negative-pressure wound therapy using a vacuum assisted drainage technique to remove blood or serous fluid from a wound or operation site) was administered for management of drainage from the lumbar surgical site during his/her hospital stay. During an evaluation of the resident's surgical site by an outside-of-the-facility consultant on Feb 6, 2017 (10 days' post admission to the nursing facility) the resident was assessed with "foul-smelling pus" draining from the surgical site and transferred to an acute care hospital for emergency surgical intervention for wound washout and debridement. A review of the facility's assessments of the resident's altered skin lacked evidence of deterioration or lack of healing. Additionally, the documented assessments reviewed in the resident's medical record lacked evidence of accuracy,	F 309	1. Resident # 262 was sent from facility for pre-scheduled appointment with surgeon on February 6, 2017. As per facility assessment, there were no complication from wound noted before and during the transfer to appointment. 2. All residents with wounds will be assessed to ensure accurate comprehensive assessment and accurate documentation of wounds as per policy and procedure. Follow up will be completed as indicated. 3. Licensed nurses will be re-educated on policy and procedure regarding accurate/consistent assessment and documentation of wounds. 4. Audits of resident skin sheets and corresponding nurses' note will be done on residents with wounds to ensure there is accurate and consistent assessment and documentation of wounds. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement. This 309 deficiency will be discussed at next medical staff meeting.	4/6/17 4/6/17 4/6/17 4/6/17

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F 309	Continued From page 11 completeness and consistency as follows: According to the "Discharge/Transfer Summary" from the hospital dated January 27, 2017 15:48 (3:48 PM), the resident's discharge diagnoses included "Acute postoperative pain, Morbid Obesity, [status post] spinal fusion [of the vertebral column thoracic through sacral region] for scoliosis and Anemia ...Hospital Course... POD (Post-op day) #13 (1/25/17); The inferior aspect of [his/her] incision began to leak. [His/Her] incision was partially reopened at bedside, and a wound vac was placed. POD #15; ...Subsequently deemed medically stable, and discharged to subacute rehab. [His/her] current wound vac was placed on 1/25. It will be clamped for transport to the facility. [His/her] wound vac should be changed twice weekly with small black granulofoam. Please keep [his/her] bulk off the lily pad. Decision can be made by wound care team at facility regarding when they feel it is appropriate to change to wet to dry dressings." The nursing admission note dated January 27, 2017 at 7:12 PM revealed "Resident admitted to [skilled facility named] from [acute hospital named] at this time; resident arrived BIBA (brought in by ambulance) from [name hospital] this pm; resident has a medical history significant for respiratory failure post op; anemia due to acute blood loss; acute post-operative pain; history of spinal fusion for scoliosis; morbid obesity; presently resident presents as alert and oriented x [times] 3; ... integumentary inspection reveals s/p (status post) surgical site to back extending from cervical to sacral spine with staples in place wound closure; s/p surgical site to abdomen measuring 16cm in length.. MD (Medical Doctor) notified and verified all orders...	F 309		

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F 309	Continued From page 12 MD gave wound care orders until wound vac to be implemented ..." The physician prescribed a wound vac to manage Resident #262's surgical wound as noted in the following admission order: January 27, 2017 "1/27/17 (no documented per physician) ....Turn and position every 2 hours, chart by shift, OOB (Out of bed) with assistance, Reverse Trendelenburg when in bed, do not flex, OK to sit upright in chair, Current wound vac (negative-pressure wound therapy using a vacuum assisted drainage technique to remove blood or serous fluid from a wound or operation site) placed on 1/25/17, wound vac to be changed twice weekly with small black granulofoam, keep bulk off lily pad, wound care team to decide when appropriate to change to wet-dry dressing ..." The physician prescribed an alternate treatment to manage the resident's surgical wound after licensed nursing staff advised him/her of their inability to carry out the aforementioned order for the wound vac: January 27, 2017 (1/27/17) - 7:30 PM directed; " ... Wound care to back - Cleanse [with] DWC (Dermal Wound Cleaner), Apply Xerofoam to surgical site, cover with Bordered Foam Dressing until wound vac placed ... The physician's history and physical examination ["Admission Assessment form"] dated January 29, 2017 revealed; "Chief Compliant/Reason for Admission: Rehab (Rehabilitation) and 24-hour care ... male/female with morbid obesity, Recent medical course ... S/P (Status Post) Laminectomy (surgery that creates space by	F 309		

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F 309	Continued From page 13 removing the lamina- the back part of the vertebra that covers your spinal canal) and Spinal Fusion..." A written statement dated February 8, 2017 [no time indicated] written by Employee#21 [clinical manager - registered nurse] revealed; "Resident arrived to [named skilled nursing facility] on 1/27/17 with wound vac dressing in place. I was informed by Director of Admissions that day that I was only to attach the wound vac device to the dressing on the resident. However, the wound vac device would not attach to the dressing due to differing connections/attachments. I then notified the Director of Nursing who instructed me to call the Medical Director. I then called the Medical director who gave wound care orders [wet-to-dry dressing until wound vac available]." A review of Resident#262's clinical record revealed inconsistencies regarding the implementation of the wound vac. Licensed nursing staff recorded that the wound vac was initiated on January 27, 2017. However, according to interview and record review, the wound vac was not implemented until January 30, 2017 as evidenced by the following: Wound/skin sheet dated January 27, 2017: "Date of Onset/Origin: January 27, 2017- Site/Location: Lower Back (Lumbar); Type of Wound: Surgical; Exudate Type: Serious; Odor: None; Exudate amount: Large; Wound Bed: Pink/Beefy Red, Comments: Wound vac applied ... Nurse's entry:	F 309		

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F 309	Continued From page 14 "January 30, 2017- 04:31 PM- ... Resident's wound vac in place and draining. Staples and surgical site intact with no sign of infection..." Wound/skin sheet dated January 30, 2017: January 30, 2017 - Site/Location: Lower Back (open area); Type of Wound: Other: Surgical (wound vac); Size: 4cm x 2cm; Depth: 1 cm; Exudate Type: Serosanguineous; Odor: None; Exudate: Amount: Moderate; Wound Bed: Pink/Beefy Red, Date notified physician: 1/30/17, Comments: wound vac applied, functioning and draining well. The history and physical examination documented by the physician on January 29, 2017 revealed the following under the section labeled skin: "surgical wound lumbar area ...sacral wound ..." There was no evidence of a comprehensive assessment regarding the characteristics of the resident's wound(s). Additionally, there were no successive notes recorded by the primary care physician. Subsequent to the physician's visit of January 29, 2017, the prescribed wound treatment orders were modified to include the use of a highly absorbent dressing as noted below: January 29, 2017 (1/29/17) - 5:00 PM- ... "(1) Please clean lower back (Lumbar) surgical wound [with] normal saline- Apply Maxorb Extra Alginate (highly absorbent dressing used for moderate to heavily drainage wounds) on wound area cover [with] Derma rite daily [times] 10 days ... As noted above, the wound vac was applied on January 30, 2017 and according to nurse's notes,	F 309		

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F 309	Continued From page 15 was draining as noted in the following nurse's entry: February 2, 2017 at 10:56 PM "... wound vac in place draining serosanguinous, Staples and surgical site intact ..." The wound vac was 'dislodged' on February 3, 2017 (4 days post implementation of the wound vac) as noted by the following nurse's entry: February 3, 2017 at 6:49 PM "While resident was having x-ray AP (Anterior-Posterior) lateral, T-spine (Thoracic Spine) and L-spine (Lumbar Spine). Wound vac became dislodged. [MD named] notified, new order to D/C (Discontinue) wound vac and restart previous dressing changes until wound Vac replacement arrives. Dressing applied as ordered ..." The nurses' notes lacked consistent documentation depicting the characteristics of the resident's surgical wound at the time of dislodgement, there was no information regarding the type of exudate as evidenced by the following wound/skin sheet dated February 3, 2017: February 3, 2017: Site/Location: Lower back (open area) surgical wound; Type of Wound: Other: Surgical; Size: 4 cm x 2cm; "0" depth; Exudate Type: no assessment recorded (space was blank); Odor: None; Exudate amount: Small; Wound Bed: Pink/Beefy Red; Plan of Care Updated: Wound vac dislodged when doing X-ray- 45 staples intact ..." Physician's wound treatment order post wound vac dislodgement:	F 309		

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F 309	Continued From page 16 February 3, 2017 (no time indicated) - - Telephone order: D/C (Discontinue) wound vac- Clean surgical wound on lower back [with] NSS (Normal Saline Solution), Apply Maxorb Exra Alginate on wound Area-cover with Derma rite daily and PRN (as needed) ..." The medical record lacked evidence that the physician assessed and reevaluated the resident's wound(s) after the dislodgment of the wound vac. There was no evidence that staff consistently monitored the status of Resident #262's surgical site post dislodgement. Nurse's notes revealed wound treatments were performed daily, however; there was no evidence of comprehensive assessments of the characteristics of the surgical wound subsequent to the dislodgment of the wound vac. Nurse's notes read as follows: 2/3/2017- 11:18 PM "... wound dressing intact. X-ray result was received no evidence of fracture reported ..." 2/4/2017- 06:54 AM "... wound dressing intact ..." 2/4/2017-04:15PM "... Tolerated dressing change to back surgical wound with minimal discomfort. 2/4/2017-11:27 PM "... wound dressing intact ... 02/5/2017- 06:41 AM " ... Spinal incision dressing intact with no drainage or odor ..." 02/5/2017-05:24 PM - "Wound dressing intact. Serosanguineous drainage noted"	F 309		

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F 309	Continued From page 17 02/06/2017- 12:05 AM "... wound dressing intact with Serosanguinous drainage noted ..." 02/06/2017-06:40 AM- "... spinal incision dressing is drained. Dressing is cleaned with normal saline and dressed. Resident is cleaned and made ready for [his/her] appointment this AM. SIC (written as documented)" A review of the treatment administration record [TAR] for February 2017 revealed the nurse's initials in the slot for February 6, 2017 indicative that the wound treatment was performed prior to the resident's departure for an appointment outside to the facility. Note, as per physician's order dated February 1, 2017 "f/u [follow up] with Neurosurgeon [named] for staple removal on Monday, February 6, 2017 at 9:00 AM." An assessment conducted by an out-of-facility consulting physician at approximately 10:48 AM on February 6, 2017 (within hours of leaving the facility) characterized Resident #262's wound as "actively draining foul smelling purulence [exudate]." The Neurosurgery (outside consulting physician) note dated February 6, 2017 read: "... discharged from [hospital named] on 1/27/17 presenting to [MD named] clinic today for a postop check with signs and symptoms concerning for wound breakdown including a ~ 10 cm segment of wound breakdown in the lumbar and sacral region with actively draining foul-smelling purulence. [He/she] was sent to the ED (Emergency Department) for wound washout	F 309		

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F 309	Continued From page 18 in the OR (Operating Room) today ... Physical Exam ... Incision with ~10cm region of wound breakdown in the lower lumbar and sacral area with actively draining foul-smelling purulence ... Plan: Patient going to OR today as an add-on for wound washout and debridement ..." A review of the ED (Emergency Department) dated February 6, 2017 at 11:52 AM revealed; "Pt (Patient) presented to ED ...Pt reports [he/she] had back surgery in January 2017 ... Pt unable to stand independently. Pt arrived in w/c (wheelchair); 4 staff members [plus] [patient's relative named], assisted patient to the bed from wheelchair. Serousanguinous fluid (large amount dripped on the floor. Patient wound is approx. (approximately) 10 cm (centimeters) in length, width unable to determine ... Pt was transferred to OR (Operating Room) for wound vac placement." According to an "Operative Report" dated 2/6/2017 - 12:48 AM; "Pre-operative diagnosis: Lumbar wound; Post-operative diagnosis: Wound Dehiscence ..." In summary, Resident #262 was admitted to the facility with an intent for management of his/her post-operative surgical wound with a wound vac. The wound vac was applied for a period of 4 out of 10 days that the resident resided in the facility. On the 10th day post admission, the resident was assessed by an outside consultant who identified the surgical wound as deteriorated and sent the resident to the hospital for emergency management and surgical intervention. There was no evidence that facility staff, who observed the resident's wound hours prior to the outside	F 309		