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F 309	Continued From page 19 consulting physician, identified any abnormalities or failure of the resident's wound to heal. Staff failed to accurately assess and consistently characterize the resident's wounds and recorded inconsistencies in wound treatments. Additionally, the clinical manager identified that the resident was admitted with the vac dressing in place. However, he/she could not attach the tubing to create a negative vacuum pressure to assist with drainage of the surgical wound to promote healing. A face-to-face interview was conducted with the Director of Nursing on February 8, 2017 at approximately 2:30 PM regarding the date the wound vac was re-applied. He/she states that the wound vac was connected on January 30, 2017. Further stated, that she/he received a phone call (on January 27, 2017) from the Employee#21 [clinical manager - registered nurse] regarding his/her inability to connect the wound vac because of "tubing issue." Employee#21 was instructed to inform the physician to get orders and document the "concern/inability to connect tubing". When queried; what made the difference in the wound vac being applied three (3) days later; he/she stated that a new wound vac kit was used. After review of the clinical record, he/she acknowledged the aforementioned findings. The clinical record was reviewed on February 8, 2017. Based on observation, record review and staff interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident's Midline	F 309		

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F 309	Continued From page 20 Inserted Catheter was flushed and monitored in accordance with the attending physician's order. Resident #221. The findings include: 1a. Facility staff failed to flush a midline catheter in accordance with the physician's orders for Resident #221. An interim physician's order dated January 24, 2017 at 6:00 PM directed: " Consent for Midline, (2) Insert a midline IV (Intravenous) Zosyn 2.25GM every 8 hourly [times] 7 days for UTI (Urinary Tract Infection) ..." According to a "Physician Progress Note" dated January 30, 2017 Resident #221's "chief complaint was "UTI"... Plan/Impression: Complete course of antibiotic..." A review of the Mid-Line Catheter Protocol dated and signed by the physician on January 25, 2017 revealed: " Flushing Protocol: Use SASH (Saline, Antibiotic, Saline, Heparin) Technique ... Intermittent Meds, 5 Ml (millimeters) NSS (Normal Saline Solution) before med, 5 ml NSS after med; Then 5 ml 100 Unit/ml Heparin Flush; Treatment Protocols: Change tubing q (every) 24 hours primary and secondary intermittent ..." The January, 2017 Central - Catheters flow sheets and the MAR [Medication Administration Records] lacked evidence (spaces left blank) that facility staff flushed the resident's mid line catheter on January 26, 27, 28 and 29, 2017.	F 309	1. Review of resident #221 was conducted and resident did not have any adverse effect. 4/6/17 2. Resident mid line was removed on Feb 8, 2017 and there is no other resident with similar order. 4/6/17 3. Licensed nurses will be re-educated on policy and procedure regarding monitoring of midline catheter according to physician order. 4/6/17 4. Audits of resident (s) with mid line will be conducted to ensure there is documentation regarding midline catheter monitoring according to physician *order*. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement. 4/6/17	

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F 309	Continued From page 21 A face-to-face interview was conducted on February 7, 2017 with Employee #10 at approximately 10:30 AM. After review of the above he/she acknowledged the findings. The record was reviewed on February 7, 2017 1b. Facility staff failed to monitor Resident #221's Midline Catheter in according to physician orders. A review of the Central-Line Catheters protocol signed by the physician on January 25, 2017 directed: "Measure Arm Circumference 27 inches above insertion site on admission, PRN (as needed) and Q (every) 7 (seven) days with dressing change, Measure external catheter length on admission, with each dressing change and PRN, Q 7 days with dressing change ...." The [external consultant's named] Vascular Access Patient Information sheet dated January 25, 2017 revealed; ".... Side: Right; Vein: Branchial- External CM (circumference measurement) -0; Arm Circumference at Site: 27 cm (centimeters) ..." A nurse's note dated January 31, 2017 at 12:33 AM revealed; "... Dressing change done for midline to right upper arm with central line kit. Resident tolerated procedure well. Area cleanse aseptically and new dressing placed, dated and initialed. Resident continues with current plan of care."	F 309		

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F 309	Continued From page 22 A review of the Central-Line Catheters monitoring flow sheets, MAR (Medication Administration Record) and Nurses Notes from January 31, 2017 through February 2, 2017 lacked any evidence of measurements of the resident's upper arm circumference or the external catheter length according to the midline catheter protocol. A face-to-face interview was conducted on February 7, 2017 with Employee # 8 at approximately 10:30 AM. After a review of the above clinical record he/she acknowledged the aforementioned findings. The record was reviewed on February 7, 2017.	F 309		
F 323 SS=D	483.25(d) (1) (2) (n) (1) - (3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		

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F 323	Continued From page 23 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. 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 resident's environment free of accident hazards as evidenced by a surge protector that was observed in use and unmounted in one (1) of 47 resident's rooms and a surge protector that was stored on top of the resident's dresser and did not have the lens cover to the on/off switch. The findings include: 1. A surge protector was observed in use, on the floor of room #315B and needed to be mounted. 2. A surge protector was observed in use, on top of a resident's dresser in room #219B and was missing the lens cover to the on/off switch. These observations were made in the presence of Employee #3 who acknowledged the findings	F 323	1. The cited surge protectors in rooms 315B and 219B were replaced on 2/7/17 and installed with facility approved surged protectors. 2. Inspections conducted on 2/7/2017 of all the rooms in the facility did not find any other similar cases as cited. 3. The admission and nursing staff will continue to remind family members that the facility will provide and install all surge protectors in the building. And they will be discouraged from bringing their own units into the facility. Nursing and Housekeeping staff will report to Engineering if any unmounted surge protector is observed. 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.	2/7/17 2/7/17 4/6/17 4/6/17
F 325 SS=D	483.25(g) (1) (3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 325		

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F 325	Continued From page 24 comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 verify a significant weight change for Resident #255 who was assessed with a potential significant weight loss in a period of 7 days. The findings include: The facility's policy titled, "Weighing Residents", Policy No: 103, page 1 of 1, Issued 02/17 stipulated: "Weights will be recorded by a Certified Nursing Assistant upon admission, return from hospital, monthly, and more frequently as needed. II. Procedure: 4. Notify Clinical Nurse Manager of any significant weight loss or gain ...5. The Clinical Nurse Manager will report to the dietitian if resident loses or gains weight in excess of normal range and/or five pounds or more gain or loss in one month ..." Resident #255 was admitted to the facility on November 30, 2016 with diagnoses which	F 325	1. Resident # 255 was not effected since the admission weight was false and all subsequent weekly weights were within the 5 pounds guideline. 2. An audit was conducted by the Dieticians/ Designee on all new admissions and residents who had significant variance. Weights were verified to ensure accuracy and no deficient practice was found. 3. Dietician, Nurse Managers, and CNAs will be re-educated on Weight loss/Weight gain policy and procedures. 4. Dietician/ designee will conduct monthly audits verifying significant weight changes. The result will be reported at the QA meetings for the next 3 months to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17

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F 325	Continued From page 25 included: Gait Disorder, Bilateral Lower Limb Weakness, Abnormal Weight Loss, Altered Mental Status most likely secondary to Alzheimer's Disease and Vitamin B12 Deficiency. An "Admission Order Sheet and Physician Plan of Care" dated November 30, 2016 directed; "Weight upon Admission, then weekly x (times) 4 on Wednesday. Then monthly and PRN (as needed) ..." A review of the facility's weight log book revealed the following weights for Resident #255: November 30, 2016- 135 lbs. (pounds) December 7, 2016- 115 lbs. December 14, 2016- 115 lbs. December 21, 2016- 117.8 lbs. December 28, 2016- 112.6 lbs. January 5, 2017- 115.4 lbs. February 2, 2017- 119.2 lbs. Resident had a 20-pound weight loss from November 30, 2016 to December 7, 2016, which was indicative of a 14.8% weight loss within 7 days. Clinical record and facility policy lacked evidence that a system to verify the weight loss of 20 pounds was in place to ensure accuracy. The dietician's notes revealed the following: "December 2, 2016- 3:45 PM- Initial contact; [resident] seen in bed to review food [preferences]; meal plan updated; NKFA (No known food allergies); Regular diet ordered; Ht	F 325		

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F 325	Continued From page 26 (Height) 60"; has upper denture; own lower teeth w/some missing in the middle; can feed self; full assessment to follow. January 3, 2017- 11:52 AM- Weekly wts (weights); 11/30- 135.8, 12/7- 115, 12/21-117.8, 12/28-112.6; initial wt likely an error as res (resident) has been consuming ~ (approximately) 75% regular diet since admission; seen ambulating w/ walker (with walker) in PT (Physical Therapy); transferred 2 North to 3 South on 12/30/16; continue to monitor wts(weights) intake." There was no documentation of the weight variance in the dietitian's note prior to January 3, 2017. Also, the clinical record lacked evidence that the clinical manager was made aware of Resident #255's weight loss in accordance to facility's policy. . A face-to-face interview was conducted with Employee #9 on February 7, 2017 at approximately 1:00 PM regarding the weight variance. He/she stated the resident was on another floor when first admitted. However, a baseline weight was obtained from the hospital discharge summary and the admission weight of 135 was inaccurate. A face-to-face interview was conducted with Employee #13 on February 7, 2017 at approximately 1:26 PM regarding the resident's weight variance. He/she stated that they monitor weekly weights to get a baseline. The clinical record was reviewed on February 7, 2017.	F 325		

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F 431	Continued From page 27	F 431		
F 431 SS=D	483.45(b) (2) (3) (g) (h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals.	F 431	1. All units' treatment carts were checked to ensure proper locking system is in place. Treatments carts were locked, no resident was effected. 2/1/17 2. Audits of all treatment carts will be conducted to ensure staff are locking carts per facility policy. 4/6/17 3. Nursing staff will be re-educated on making sure all treatment carts are locked when not in use as per facility policy. 4/6/17 4. Audits of all treatment carts will be conducted weekly to ensure carts are locked. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement. 4/6/17	

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F 431	Continued From page 28 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, of two (2) of eight (8) nursing unit wound treatment carts, it was determined that facility staff failed to ensure all resident biologicals were stored in a locked compartment. Units 2 North and 2 South. The findings include: 1. During the inspection of the 2 South and 2 North treatment carts conducted on February 1, 2017 at approximately 10:15 AM, multiple tubes of resident ointments, creams and shampoos were observed stored unlocked in the treatment carts. There was no evidence that the resident biologicals were adequately secured. A face-to-face interview was conducted with Employees #7 and #17. Both employees	F 431		

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F 431	Continued From page 29 acknowledged the findings. The observation was made on February 1, 2017.	F 431		
F 441 SS=D	483.80(a) (1) (2) (4) (e) (f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441	1. Employee walking on the floor mat did not result in resident adverse effect. — 4/6/17 2. No other staff member was observed walking on floor mat. — 4/6/17 3. Nursing staff will be in-serviced not to walk on the floor mat. — 4/6/17 4. Audits will be conducted monthly to monitor staff not walking on floor mats. The result of the audit will be reported to QA committee for the next 3 months to monitor process towards improvement. — 4/6/17 1. Sharp container was immediately emptied, and did not result in any resident adverse effect. — 2/7/17 2. Audits on all sharp containers was conducted to ensure no other sharp container was full. Identified sharp containers were changed immediately. — 4/6/17 3. Nursing staff will be in-serviced to make sure sharp containers are changed when full per policy. — 4/6/17 4. Audits of all sharp containers will be conducted monthly to ensure sharp containers are changed timely when full. The result of the audits will be reported to QA committee for the next 3 months to monitor process towards improvement. — 4/6/17	

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F 441	Continued From page 30 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on an observation, and staff interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to practice in a manner to prevent potential contamination/spread of infection as evidenced by an observation of an employee walking on the bedside floor mat; and two (2) sharps containers were filled above the full line	F 441	1. Employee # 12 is no longer an employee. 4/6/17 2. Director of HR conducted an audit on new employees to identify anyone who requires TST for baseline or initial testing. 4/6/17 3. Director of HR and HR assistant will be re-educated on policy and procedure on administration of Two-step testing (TST) for new hires. 4/6/17 4. HR Director will conduct a monthly audit for provisions of TST for new hires. The result of each of the audits will be reported to QA committee for the next 3 months to monitor process towards improvement. 4/6/17	

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F 441	Continued From page 31 located on the 3 south Unit, and to ensure that one (1) employee was pre- screened for communicable disease prior to employment; Resident #72. The findings include: 1. Facility staff failed to practice in a manner to prevent potential contamination/spread of infection as evidenced by an observation of an employee walking on Resident #72's floor mat. During the initial tour of the facility at approximately 10:00 AM on February 1, 2017 Employee #16 was observed walking across the floor mat on the right side of Resident #72's bed. A face-to-face interview was conducted on with Employees #16 and Employee #7 at the time of the observation, The employees acknowledged the finding. 2. Facility staff failed to decrease the spread of infection as evidenced by two (2) sharps containers filled beyond the full line on the 3 South Unit.	F 441		

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(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 441	Continued From page 32 During a tour of the 3 South Unit conducted on February 7, 2017 at approximately 2:30 PM with Employees #8, #19, and #20, it was observed that the sharps containers in rooms 309 and 311 were filled and stored for use beyond the full line. Employees #8, #19, and #20 acknowledged the finding during the observation. 3. Facility staff failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection as evidenced by: a failure to ensure that one (1) of 9 (nine) newly hired employee was screened for communicable disease such as, Mycobacterium Tuberculosis (TB) upon hire and prior to providing direct care to resident's in the facility. Employee #12. Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates: "Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection. "	F 441		

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	095036	A. BUILDING _____ B. WING _____	02/08/2017

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F 441	Continued From page 33 <https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm> "TB Screening Procedures... all HCWs (health care workers) should receive baseline screening upon hire ...HCWs should receive TB screening annually (i.e., symptom screen) for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results...HCWs with a baseline positive or newly positive...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually". The facility staff failed to ensure that Employee #12 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #12's personnel file revealed the following: Job Title: Registered Nurse Date of Hire: December 6, 2016 There was no evidence that Employee #12 was offered or received the two-step Purified Protein Derivative (PPD) skin test [a test that determines if you suffer from tuberculosis], a chest x-ray or the Tuberculosis Symptom Screening Questionnaire prior to or upon employment. The file was reviewed on February 7, 2017.	F 441		
F 463 SS=D	483.90(f) (2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

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F 463	Continued From page 34 (f) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. 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 resident's call bell in good working condition as evidenced by a non-functioning call bell that failed to emit an alarm when tested in resident's room #417A. The findings include: The call bell in resident room #417A failed to initiate an alarm when tested, one (1) of 47 resident's rooms. This observation was made in the presence of Employee #3 who acknowledged the finding.	F 463	1. The defective call bell module in room 417A was replaced immediately after it was discovered. Resident was not affected. 2. Call bells in the other rooms were tested the same day and no other defective units were discovered. 3. The maintenance staff will continue to do daily audits so they could immediately repair/replace any defective call bell accessories. Nursing and Housekeeping staff will be re-educated to report any defective call bell to engineering immediately. 4. The facilities director and or his Assistant 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.	2/6/17 2/7/17 4/6/17 4/6/17
F 514 SS=D	483.70(i) (1) (5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		

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F 514	Continued From page 35 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 document one (1) resident's skin assessment on admission. Resident #68. The findings include: A physician's progress notes dated January 18, 2017, revealed Resident #68 was re-admitted to	F 514	1. Resident #68 was readmitted to facility on January 17, 2017 with wounds to right and left heels. There was no wound on the sacrum. — 4/6/17 2. Audits of all residents admitted to facility in the last 3months will be conducted to ensure accurate documentation of skin assessment — 4/6/17 3. Nursing staff will be re-educated on the policy and procedure on resident wound assessment on admission and accurate documentation. — 4/6/17 4. Audits of new admissions will be done including nurses note to ensure accurate documentation of skin assessment. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement. — 4/6/17	

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F 514	Continued From page 36 the facility on January 17, 2017 with chief complaints of: "... Right/Left heel ulcers (detected on admission); ROS (Review of Systems): B/L (Bilateral heel eschars- Unstageable; Float/Monitor ..." The electronic nurses' notes revealed the following: "1/17/17 [January 17, 2017] - 6:37 PM- Resident returned from [hospital named] at 5:30 PM ... Resident returned with PEG (Percutaneous endoscopic gastrostomy) -Tube in left abdomen. Chronic heel ulcer to bilateral heels and sacral ulcer -both were hospital acquired.... 1/17/17- 11:24 PM- ... head to toe assessment done. Deep tissue injury noted on both heel measuring; RT (right) heel 4cm by 4cm and left heel 8 by 5cm ...both heels in both and leg floated ..." A review of the "Weekly Wound Healing Record" included documentation signed by the licensed nurse which revealed: "Date of Onset: January 17, 2017-Site/Location: Left Heel (medial); Type of Wound: DTI (Deep Tissue Injury), Stage: Unstageable ... Date of Onset: January 17, 2017- Site/Location: R (Right) heel (medial); Type of Wound- DTI; Stage: Unstageable ..."	F 514		

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F 514	Continued From page 37 The clinical record lacked evidence that the resident had a sacral pressure ulcer as documented on the nurse's admission note. A face-to- face interview was conducted with Employee #10 on February 6, 2017 at approximately 11:15 AM regarding the aforementioned findings. He/she acknowledged that the resident did not have a sacral pressure ulcer and that the admission documentation was inaccurate. The clinical record was reviewed on February 6, 2017.	F 514		