STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035139	A. BUILDING _____ B. WING _____	**11/07/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SHOW LOW	**2401 EAST HUNT STREET SHOW LOW, AZ 85901**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure services provided or arranged by the facility met professional standards of quality for three residents (#181, #331, and #8). The deficient practice could result in residents having missed appointments and medication errors. Findings include: -Resident #181 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged to the hospital on (MONTH) 31, 2019. Review of the hospital discharge orders dated 5/22/19 revealed orders for [MEDICATION NAME] (antibiotic) 2 grams IV (intravenously) every 12 hours through 7/12/19, a follow up appointment with ID (Infectious Disease) prior to discontinuing the antibiotic treatment, and an EGD (esophagogastroduodenoscopy) and colonoscopy in 4 to 5 weeks. Review of the Medication Administration Records revealed [MEDICATION NAME] was administered every 12 hours from 5/23/19 through 7/12/19. However, review of the clinical record revealed no evidence the resident had a follow up appointment with ID prior to discontinuing the antibiotic treatment or that the resident had an EGD and colonoscopy. Further review of the clinical record, revealed the order was transcribed for a follow up appointment with ID (Infectious Disease) but did not include prior to discontinuing the antibiotic treatment. An interview was conducted with the medical records clerk (staff #4) on 11/07/19 at 09:08 AM. Staff #4 stated that she verifies admission orders [REDACTED]. She stated that after the review, she transcribes the orders as directed onto the MAR and sends the appointment orders to the scheduler to schedule the appointments. Staff #4 also stated that she did not understand the part of the ID appointment order that the appointment was to be scheduled before discontinuing the antibiotic, because discontinuing was scribbled d/c. The clerk stated that she contacted the Director of Nursing for clarification but was not given clarification, so she did not transcribe the part of the order regarding prior to discontinuing the antibiotic treatment. Staff #4 stated that she did send the order to the scheduler to schedule the ID and EGD/colonoscopy appointments. An interview was conducted with the Director of Nursing (DON/staff #12) on 11/07/19 at 11:56 AM. The DON stated that she was not the DON at the time the resident was admitted . She stated the proper procedure should have been to call the hospital physician for clarification of the order regarding the ID appointment. An interview was conducted with the scheduler (staff #51) on 11/07/19 on 12:22 PM. Staff #51 stated that even though she has no documentation of it, she does remember scheduling the resident for an ID appointment. She stated there was no time frame on the order and that the resident was discharged before the appointment date. Staff #51 also stated that she did receive the order to schedule the EGD/colonoscopy appointment, but that she forgot to schedule it. During an interview conducted with the administrator (staff #40) on 11/07/19 at 01:32 PM, the administrator stated transcribing order and scheduling appointments should be should be done correctly for every resident. -Resident #331 was admitted to the facility on (MONTH) 22, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 25, 2019 revealed the resident was receiving antidepressant medications. The goal was that the resident would be free from adverse reactions related to antidepressant therapy. Interventions included monitoring for antidepressant side effects which included constipation. A physician's orders [REDACTED]. During a medication pass observation conducted with a Registered Nurse (RN/staff #15) on (MONTH) 6, 2019 at 08:41 a.m., the nurse was observed to put three spoonful of [MEDICATION NAME] husk (bulk-forming laxative) into a cup of water and mix it. She then administered this mixture to the resident. Immediately following this observation an interview was conducted with the RN. The RN stated the facility was out of [MEDICATION NAME] powder so she gave the [MEDICATION NAME] husk. Staff #15 said that she had spoken with the Nurse Practitioner (NP) about being out of [MEDICATION NAME] and that the NP stated she could substitute [MEDICATION NAME] husk for [MEDICATION NAME]. The RN stated that she had administered [MEDICATION NAME] husk to the resident last night and today. She also stated that she had not written the order to substitute [MEDICATION NAME] husk for [MEDICATION NAME]. In an interview conducted on (MONTH) 7, 2019 at 10:10 a.m. with a Licensed Practical Nurse (LPN/staff #25), the LPN said it is definitely not ok to substitute a medication with another medication without a physician order. In an interview conducted with the NP on (MONTH) 7, 2019 at 10:11 a.m., the NP stated he was not aware that [MEDICATION NAME] husk was being substituted for [MEDICATION NAME] powder. The NP stated that he had not received any messages that he was aware of about medication substitutions for resident #331. He said the nurses should obtain an order for [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #12) on (MONTH) 7, 2019 at 10:43 a.m. The DON stated that if an over the counter medication is not available, they can purchase the medication from a store. She stated the pharmacy should be contacted to expedite sending the medication. The DON stated her expectation is that the nurse would contact the physician that a medication is not available and let the physician decide what to do. The DON also stated that the nurse should not have administered [MEDICATION NAME] husk to resident #331. -Resident #8 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the care plan initiated 8/30/2019 revealed the resident was on diuretic therapy related to [MEDICAL CONDITION] and [MEDICAL CONDITION]. Interventions included administering medication as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a score of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had no cognitive impairment. Review of the clinical record revealed a physician order [REDACTED]. Review of the Medication Administration Record for (MONTH) revealed the resident was administered the renal multivitamin from 11/2/2019 through 11/5/2019. An interview was conducted with the resident on 11/4/2019 at 12:19 PM. She stated she was started on new medications that she was not made aware of. She stated all medication changes needed to go through her kidney physician. The resident stated a staff member told her the renal multivitamin was ordered by someone in-house. She also stated that she felt she was made to take the medications. In an interview conducted with a Registered Nurse (RN/staff #15) on 11/5/2019 at 2:01 PM, the RN stated a renal multivitamin was ordered for the resident but that the facility did not have the renal multivitamin. Staff #15 stated the facility could not afford the ordered medication so she had to create a substitute. The RN stated she administered a total of 4 medications in place of the renal multivitamin: a regular multivitamin, zinc, folic acid and vitamin C. She stated she did not notify anyone of the substitution because it was handled. She stated that when the resident saw 4 new pills in her medicine cup, the resident became very upset. The RN stated that she was able to educate the resident about the change in

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) medications. She stated she was able to convince the resident to take the medications and that the resident took the 4 medications. An interview was conducted with the Director of Nursing (DON/staff #12) on 11/06/19 at 02:19 PM. She stated if a physician orders [REDACTED]. The DON stated that she was not aware of any staff members substituting medications. The DON stated that the resident should have been administered the medication as prescribed by the physician. The facility's policy titled Medication and Treatment Orders revealed medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, and policy review, the facility failed to ensure two residents (#12 and #26) received treatment and care in accordance with professional standards of practice. The deficient practice could result in residents' changes in condition not being addressed timely. Findings include: -Resident #12 was admitted on (MONTH) 12, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the care plan revealed the resident had liver disease related to alcohol [MEDICAL CONDITION] and was prescribed [MEDICATION NAME] for treatment. The goal was the resident would be free from signs and symptoms of liver complications including cognitive decline or mental status changes. Interventions included administering the medication as ordered. The Nurse Practitioner Note (NP) note dated (MONTH) 14, 2019 revealed no reports of any abusive patterns and staff did not report any incidents or events. The note included the NP had ordered labs which included checking the resident's ammonia level. A physician's orders [REDACTED]. Review of the admission MDS assessment dated (MONTH) 19, 2019, did not reveal the Brief Interview for Mental Status (BIMS) or the Staff Assessment for Mental Status was conducted. The assessment included - for the behavioral symptoms and no documentation for wandering. An admission Social Service assessment dated (MONTH) 19, 2019 revealed the resident had no behavioral concerns, no history of psychiatric treatment, and that no referrals were needed. Review of the Medication Administration Record [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] twice on (MONTH) 1, 2, 9, 15, 16, 19, and 30, and once on (MONTH) 3, 4, 5, 7, 8, 10, 17, 28, 29, and 31. Review of a nursing alert charting note dated (MONTH) 25, 2019 revealed a change of condition summary. The resident was found outside the building for a second time that day, was out at the far driveway, and was very combative towards the Certified Nursing Assistant (CNA). The note included the resident was brought back into the building and a wander guard was applied to the resident's right ankle. A nursing alert charting note dated (MONTH) 30, 2019 revealed another change of condition summary that the resident was upset because the roommate was yelling at her and being mean. The note included the resident was so upset she pulled the fire alarm in the hallway near the dining room. The note also included the resident calmed down when she was moved to another room and that she was adjusting well to the room and the new roommate. However, review of the clinical record revealed no evidence the practitioner was notified the resident was refusing the [MEDICATION NAME] and that the resident had a change in behavior. A NP note dated (MONTH) 1, 2019 revealed the staff had not reported any incidents or events. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] twice on (MONTH) 4 and 7, and once on (MONTH) 1, 2, 6, 8, 12, 13, 15, 20, and 30. A nursing alert charting note dated (MONTH) 30, 2019 revealed the resident was adjusting well to the room change, was still angry and refusing medications, and was making angry remarks to the staff. A nursing medication administration note dated (MONTH) 30, 2019 revealed the resident was ignoring staff and that the NP was aware of the behavioral issues. However, the NP note dated (MONTH) 3, 2019 revealed the resident slept well over the weekend without difficulties or problems per staff and that staff did not report any incidents or events. The note included the resident continues to do well in the facility and appears happy. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] once on (MONTH) 3, 4, 27, and 30. Review of the care plan dated (MONTH) 10, 2019 revealed the resident exhibited exit-seeking behavior as evidence by trying to exit secure facility exits and wandering. The goal was the exit-seeking behaviors will be reduced to less than daily. Interventions included monitoring the resident for tailgating when staff or visitors come and go from the facility and referring to Social Services as needed. A quarterly Social Service Review dated (MONTH) 12, 2019 revealed the resident's cognitive status, behavioral symptoms, and mental health was the same as the prior assessment on (MONTH) 16, 2019. Review of the laboratory report dated (MONTH) 17, 2019 revealed the resident's ammonia level was 255 ug/dL (micrograms/deciliter). Normal reference interval is 19 - 87 ug/dL. The report also included a handwritten note that the NP was notified on (MONTH) 20, 2019 at 8:35 a.m. Review of a nursing alert charting note dated (MONTH) 18, 2019 revealed a change of condition summary. The resident started cussing at a CNA and kicked the CNA in the jaw while the CNA was trying to provide incontinent care to the resident. The note included the CNA left the room so that the resident could calm down. The quarterly MDS assessment dated (MONTH) 19, 2019 revealed a score of 6 on the BIMS which indicated the resident had severely impaired cognition. The assessment include the resident exhibited wandering behavior 1 to 3 days out of the 7 day look-back period but did not exhibit any physical or verbal behaviors. A nursing alert charting note dated (MONTH) 20, 2019 revealed nursing sent a message to the NP regarding the elevated ammonia level of 255. The NP progress note dated (MONTH) 20, 2019 revealed the resident was not overly lethargic, no reports of fever/chills/nausea/vomiting/diarrhea, and that staff had not reported any incidents or events. The note included the ammonia level is elevated, the resident is asymptomatic and will be watched for now. The note also included the labs would be rechecked next week to ensure this was normal for the resident. However, further review of the clinical record did not reveal follow up labs were ordered or that the resident's behaviors had been reported to the practitioner. Review of a NP progress note dated (MONTH) 1, 2019 revealed the resident frequently refused [MEDICATION NAME] and complained of diarrhea. The note included the [MEDICATION NAME] is needed to keep the ammonia level as low as it is which is high compared to the normal population. The note also included the staff did not report any incidents or events. An alert nursing note dated (MONTH) 10, 2019 revealed resident #12 went into another resident's room and was messing with the bed controls. The note included resident #12 had also thrown all of her bedding (which was not wet) into the hall and purposely run over a CNA's leg with her wheelchair. An alert nursing note dated (MONTH) 23, 2019 revealed the resident had hit and cussed at a CN[NAME] The note included the resident had been violent and verbally abusive with this CNA on one other occasion. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] once on (MONTH) 4, 6, 7, 8, 9, 11, 12, 26, 28, and 30 and twice on (MONTH) 10, 13, 14, 15, 16, 17, 18, 21, 22, 23, 24, 27, 29, and 31. A NP progress note dated (MONTH) 1, 2019 revealed the resident has a little bit of an attitude about her medications and refuses to take them but that she does fairly well. The note included staff does not report any significant incidents or events. The note also included no recommendation to change the medications. Review of an Incident Note dated (MONTH) 6, 2019 revealed the resident was in her room with her back to the door sitting in her wheelchair talking to another woman. The resident was visibly upset. The resident was observed holding a butter knife

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) and motioning to cut her wrist. Staff approached the resident cautiously and gently took her hand. The resident then stuck the butter knife under her leg. After 10 minutes of calming the resident and getting the resident to say what was upsetting her, staff were able to take the butter knife from the resident. Review of an alert nursing note dated (MONTH) 6, 2019 revealed the resident had been found with a butter knife and was threatening to cut her wrists. The note included the resident was distraught over family issues and was being sent to the hospital for evaluation of suicidal ideation. Review of the hospital lab report dated (MONTH) 6, 2019 revealed the ammonia level was 36. The normal reference interval is 9 - 30 umol/L (micromole/liter). During an interview conducted with the Medical Records Manager (staff #4) on (MONTH) 7, 2019 at 8:40 a.m., staff #4 stated that other than the laboratory report dated (MONTH) 20, 2019; there were no other laboratory reports for resident #12. An interview was conducted with a Registered Nurse (RN/staff #5) on (MONTH) 7, 2019 at 8:46 a.m. The RN stated that when a resident refuses a medication frequently, the process would be to document an alert progress note and contact the practitioner. The RN also stated that he had not reported resident #12 refusing [MEDICATION NAME] to the practitioner. He said the resident is usually in good spirits, but when she's not feeling well you can tell by her behavior. On (MONTH) 7, 2019 at 9:24 a.m., an interview was conducted with the Nurse Practitioner (NP/staff #49). The NP stated that it was not reported to him that the resident refused [MEDICATION NAME] on a regular basis. He stated it was reported the resident refuses [MEDICATION NAME] sometimes. The NP also stated that he was not aware the resident had assaulted staff. He stated that he would expect staff to notify him of a change in condition and if a resident was frequently refusing medications. He said symptoms of high ammonia levels would include lethargy and increased confusion. The NP stated he ordered the laboratory test to recheck the ammonia level but that he does not remember seeing the laboratory report. On (MONTH) 7, 2019 at 11:00 a.m., an interview was conducted with the DON (staff #12). She stated her expectation is for nursing to notify the practitioner if a resident is refusing medications and if a resident has a change of condition related to behaviors. The DON stated a practitioner writing about an order in the progress note is not the same as writing the order. The DON also stated that the practitioner can write the order or alert staff to write the order. The facility's policy titled Change in a Resident's Condition or Status revised (MONTH) (YEAR), revealed staff shall promptly notify the resident's attending physician of changes in the resident's medical/mental status. The nurse will notify the resident's attending physician when there has been a significant change in the resident's physical/emotional/mental condition and refusal of medications two (2) or more consecutive times. The policy stated that a significant change of condition is a major decline in the resident's status that requires interdisciplinary review and/or revision of the care plan and will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. The policy also revealed that except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical mental condition or status. The facility's policy regarding Lab and Diagnostic Test Results - Clinical Protocol revised (MONTH) 2012, revealed the physician will identify and order lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. Nursing staff shall promptly notify the physician if the result is something that should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). -Resident #26 was admitted to the facility on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. Review of the weights summary report for 2019 revealed weights were obtained monthly from (MONTH) to August. Review of a physician progress notes [REDACTED]. The note included they will continue to monitor the resident's weight loss. However, further review of the weights summary for 2019 revealed no weight was obtained for (MONTH) and October. Review of the clinical record revealed no documentation that the resident had refused to be weighed in (MONTH) or October. A monthly Nursing Summary dated (MONTH) 22, 2019 revealed the resident's most recent weight was on (MONTH) 22, 2019. Review of the dietary WINS (weight intervention nutrition skin) list dated (MONTH) 6, 2019 revealed no weight since (MONTH) and that a new weight was needed. Further review of the clinical record revealed a weight was obtained on (MONTH) 6, 2019. An interview was conducted on (MONTH) 6, 2019 at 1:01 p.m. with the Dietary Manager (staff #32), who stated that the only reason a resident would not be on monthly weights is if the resident was on hospice or was too fragile to move. The dietary manager stated that they have been requesting weights for this resident from nursing. During an interview conducted with the Registered Dietician on (MONTH) 6, 2019 at 1:06 p.m., she stated that at the WINS meeting she makes a list of all the residents who have nutritional concerns. She stated resident #26 is on this list and that they requested a weight be obtained for this resident on September18 and (MONTH) 8, 2019. In an interview conducted with a Restorative Nursing Aide (RNA/staff #35) on (MONTH) 6, 2019 at 1:57 p.m., staff #35 stated that the RNAs and the CNAs are the ones that weigh residents. Staff #35 also stated that she did not know why resident 26 was not weighed monthly. An interview was conducted with the Director of Nursing (DON/Staff #12) on (MONTH) 7, 2019 at 10:43 a.m. The DON stated that her expectations for weights are a resident is weighed when admitted , once for 4 weeks following admission, and then weighed monthly. She stated that this resident refuses care and that if the resident had refused to be weighed, it would be documented. A review of the facility's policy for Nutrition Management Program dated (YEAR), revealed all residents are weighed within 24 hours of admission and for the following four weeks or until stable. Residents that demonstrate a significant weight loss will be placed on weekly weights until weight is stabilized. The policy also revealed all other residents will be weighed monthly.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on closed clinical record review, staff interviews, and policy review, the facility failed to ensure one (#180) of four sampled residents was provided care and services to prevent the development of pressure sores. The deficient practice could result in residents developing pressure sores. Findings include: Resident #180 was admitted to the facility on (MONTH) 27, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 27, 2019 revealed the resident had impairment to skin integrity related to the right hip surgical incision. The goal was that the resident would have no complications related to skin injury. Interventions included pressure relieving/reducing mattress, pillows, sheepskin padding etc. to protect the skin while in bed. The care plan did not include skin concerns to the heels. Review of the clinical record revealed a physician order [REDACTED]. A care plan initiated on (MONTH) 27, 2019 revealed the resident had activities of daily living self-care performance deficit related to activity intolerance. Interventions included the resident required the assistance of one staff for repositioning and turning in bed, and transfers. Review of the Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 27, 2019, revealed a score of 16, indicating the resident was at low risk for developing pressure sores. Review of a nursing wound progress note dated (MONTH) 28, 2019 revealed the resident's heels were blanching with bogginess. The note included the resident was encouraged and educated about frequent activity/repositioning while in bed and in the wheelchair. The note also included the resident was repositioned using a pillow and that heel boots were placed on the resident's feet. The note did not include any description or other assessment of the heels. Additional review of the care plan revealed the care plan was not revised to reflect the heels with bogginess nor was there an intervention for heel boots on the care plan. The Certified Nursing Assistant (CNA) documentation for turning, repositioning, floating the heels when in bed, and wearing heel protective boots consisted of a Yes to indicate it was completed but did not include if some or all of the interventions were completed and how often. Per the documentation on the form from (MONTH) 28 through (MONTH) 2, 2019, Yes was documented three times on (MONTH) 28 and (MONTH) 2, two times on (MONTH) 29 through 31, and one time on (MONTH) 1. Further review of the clinical record revealed no additional documentation to indicate preventative measures were consistently implemented from (MONTH) 28 through (MONTH) 2, 2019.

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) Review of the Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 3, 2019, revealed a score of 18, indicating the resident was at low risk for developing pressure sores despite skin issues being identified to the resident's heels on (MONTH) 27, 2019. Review of the weekly skin check dated (MONTH) 3, 2019, now revealed the resident had pressure sores to the right and left heel and included a recommendation for foam booties to prevent further breakdown. The admission Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019 revealed a score of 15 on the Brief Interview Mental Status which indicated the resident had intact cognition. The assessment included the resident had two unstageable pressure sores with suspected deep tissue injury (DTI) in evolution that were not present at the time of admission. The assessment also included a pressure reducing device was in place for the chair and bed but did not include a turning/repositioning program had been implemented. The assessment also revealed the resident required extensive assistance of two+ staff for bed mobility and transfers, and did not use a wheelchair as a mobility device. Review of the wound physician's note dated (MONTH) 3, 2019, revealed the resident had DTI to the mid-lateral right heel and to the medial left heel. The right heel measured 3.5 centimeters (cm) x 4.5 cm with an area of 12.37 square cm. The left heel measured 2 cm x 3 cm with an area of 4.712 square cm. The right and left heel wound bed had 76-100% [MEDICATION NAME] and the peri-wound skin did not exhibit signs or symptoms of infection. Apply skin prep to the right and left heel and cover with a dry protective dressing daily. Recommendations included floating the heels when in bed, offloading the wound, offloading mattress, and repositioning per facility protocol. Physician orders [REDACTED]. Review of the Pressure Ulcer Documentation and Assessment form dated (MONTH) 3, 2019, revealed the onset of the DTI to the mid-lateral right heel and to the medial left heel was on (MONTH) 3, 2019. The right DTI measured 3.5 cm x 4.5 cm. x 0 and the left DTI measured 3.2 cm x 3.3 cm x 0. Both heels were non-blanchable, deep red and purple in discoloration with epithelization with no drainage or induration noted. Skin prep was applied to the heels and the heels were covered with a dry protective dressing. Interventions included floating the heels while in bed and offloading the wound. The documentation also included the resident was encouraged and educated about frequent activity/repositioning while in the bed and wheelchair and that the resident was repositioned and heel boots were placed on the resident's feet. The care plan regarding skin integrity was revised on (MONTH) 4, 2019, to include the deep tissue injuries to the right and left heel. Further review of the clinical record revealed skin and wound assessments, and pressure sore treatments were provided. The discharge MDS assessment dated (MONTH) 3, 2019, revealed the resident was discharged to the hospital on (MONTH) 3, 2019 with two unstageable DTI sores. An interview was conducted on (MONTH) 6, 2019 at 12:23 p.m. with the wound nurse (staff #17), who said their policy states that residents are to be repositioned every two hours or more. Staff #17 stated that the CNAs are responsible for repositioning residents. She stated the CNAs document the repositioning in the data system every shift and that there is no place for the CNAs to document how often a resident was repositioned each shift. She said there have been times when there was only one CNA on the day shift and that the CNAs have told her that they did not have time to reposition residents every two hours. She also stated that the size and shape of the pressure sores on the resident's heels, is the type of pressure sores a resident gets when the resident uses a wheelchair. Review of the facility's wound management policy dated 2013, revealed the goal of their comprehensive wound management program is to promote the highest level of functioning and well-being of their residents and to minimize the number of residents that develop in-house acquired pressure sores. A thorough head to toe assessment of each resident's skin will be completed on admission and at least weekly thereafter. The skin check will be completed by the wound care team which consists of the wound care nurse and the wound care assistant. A pressure ulcer risk assessment (Braden) will be completed upon admission, the following 4 weeks and quarterly thereafter. Residents with a Braden score less than 12 will have interventions placed to prevent pressure sore development. Skin impairment care plan and goals will be initiated, updated, and reviewed as applicable by the Interdisciplinary team. This is to include all residents at risk as well as those with actual skin impairments.