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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505126	A. BUILDING B. WING	C 08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON HEALTH & REHABILITATION CENTER - PASCO	2004 N 22ND AVENUE PASCO, WA 99301

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Avalon Health & Rehab Center on 08/02/12 and 08/03/12. A sample of 13 residents was selected from a census of 80. The sample included 10 current residents and the records of 3 former and/or discharged residents. The following were complaints investigated as part of this survey: #12-07-22457 #12-07-22479 #12-07-22630 Received Yakima RCS SEP 17 2012 The survey was conducted by: Rebecca Reiswig, RN The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 8/13/12 Residential Care Services Date	F 000	Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against Facility, of the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this response. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth, of any facts alleged or correctness of any conclusions set forth in the allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal, which may be filed solely because of the requirements under State and Federal law that mandate submission of the Plan of Correction with ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as an agreement with the allegations of non-compliance or admissions by the Facility. This Plan of Correction is submitted as the Facility's credible allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/13/12 8/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of a significant change in condition for 1 of 6 residents (#5) in the sample. Findings include:	F 157	F-157 Resident #5 no longer resides in the facility. Residents with status post fractures or orthopedic surgery and those with a diagnosis of peripheral vascular disease have been assessed for potential blood clots. Current facility residents with a change in condition were reviewed to assure the physician had been notified. Physician notifications have been documented. Residents admitted status post fracture or after orthopedic surgery will be assessed for the need of an anticoagulant. If one is not ordered, the physician will be contacted for clarification. Residents will be monitored for changes in condition and the physician notified when identified. Documentation of this notification will be made in the medical record. Licensed nurses will be re-educated to the signs and symptoms associated with potential blood clots, the immediate notification of the physician for condition changes, and the documentation guidelines of physician notification. An audit will be conducted of newly admitted residents by the Director of Nursing Services or designee to monitor	9/17/12 9/24/12

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F 157	Continued From page 2 Resident #5. Admitted to the facility [redacted]12 following surgical intervention for a broken left hip; additional diagnoses included peripheral vascular disease. Physician orders included physical therapy evaluation and treatment. The resident was non-weight bearing initially and gradually to begin weight bearing with physical therapy. Therapy progress notes for the week of 06/11/12 noted the resident was refusing therapy and made minimal progress with the plan of treatment. Nursing progress note, dated 06/09/12, noted the resident had "mild edema" in the left leg with no edema in the right leg. The next documentation of the left leg was on 06/14/12 and noted there was no redness or drainage present at the incision site; however, there was no documentation related to the edema in the leg. On 06/15/12 a progress note documented "swelling continues to be noted at left lower extremity. Will keep monitoring before notifying MD." Documentation of the left leg edema continued on 06/16-21/12; however, there was no evidence the physician was notified of the continuing edema. The resident was taken to the hospital by the family on [redacted]12 where he was diagnosed with a blood clot in the left leg, extending from the hip to the lower leg. Please refer to F309, the facility failed to provide care and services.	F 157	for compliance and to ensure the appropriate treatment is ordered or addressed, including anticoagulant therapy for post orthopedic surgical and fracture residents. An audit will be conducted weekly of residents with a change in condition to ensure physician notification has been accomplished. The Director of Nursing Services will ensure compliance by reporting results of audits to the QA committee monthly and as needed until a lesser frequency is deemed appropriate.	9/17/12 9/24/12

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F-225 Resident #2, and #4's care plans and assessments have been reviewed and updated as indicated following thorough investigation into the root causes of falls. Residents, who have been assessed as a "high" risk for falls, have been reassessed and the individual plan of care and fall assessment reviewed for proper corrective action. An investigation will be conducted after each fall to rule out abuse and determine the root cause of the fall. If abuse is not able to be ruled out, appropriate reporting will be conducted. The Administrator / Designee will monitor for compliance through weekly audits of Unusual Occurrences to assure appropriate investigation and reporting have been completed and documented. The Administrator will ensure compliance through the results of audits and report to the Quality Assurance committee monthly and as needed until a lesser frequency is deemed appropriate.	~~9/17/12~~ 9/24/12

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct a thorough investigation of falls in accordance with CFR 483.13(c)(2)(3) for 2 of 3 residents (#2,4) in the sample to determine potential causes and attempt to prevent further falls. Findings include: Resident #4. Multiple diagnoses included muscle weakness and personal history of falls. The transfer form from the hospital on the date the resident admitted to the nursing home, [redacted]12, noted the resident fell from his bed from potential over medication at home. The resident had physician orders for pain medication and sleeping medications. On 06/13/12 a Fall Risk Assessment noted the resident scored 15, or high risk, for falls. On 06/28/12 he scored 18, also high risk for falls. The plan of care noted a potential for falls and the resident required two assist for transferring. Interventions included to encourage the use of proper footwear and assistive devices and were to monitor his bed position frequently. On 07/28/12 at 7:50 a.m. a progress note documented that an aide notified the nurse that the resident was "found on the floor next to his bed." At that time the resident stated he had rolled in his bed and fell out onto the floor. He had bleeding from a small cut above his left eyebrow. His pupils were "tiny and non-reactive" (indicating a possible brain injury) and the	F 225		

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F 225	Continued From page 5 resident stated he could not move his arms or his legs. The resident was transported per ambulance to the Emergency Department. Review of the facility's investigation noted the resident fell out of bed and had a head injury. He was transferred to the hospital approximately 55 minutes after the fall. Interventions implemented following the fall included mats on the floor next to his bed and to have a low bed and a mattress with built-up edges. On 08/03/12 at approximately 3:40 p.m. the Director of Nursing stated that while the resident was in the facility he was not assessed to need a low bed, in spite of a prior fall out of bed. The investigation included statements from staff and included "causal contributing factors" to be his limited mobility and history of falls. However, it did not include when or where he was last seen; when he was last toileted, when he was last repositioned or what he was attempting to do when he fell. Resident #2. Review of the facility's investigation revealed the resident was found on the floor in her room on 07/23/12 at 2:30 p.m. The resident stated "I don't know what happened." The investigation noted the resident was impulsive and would get up without help. Interventions were to remind the resident to ask for help before standing. However, the investigation did not identify when the resident was last toileted, when she was last seen, or other possible causes of her fall.	F 225		
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

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F 241 SS=D	Continued From page 6 INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and review of Resident Council minutes, the facility failed to ensure the dignity of 3 of 6 residents (#7,8,9) in the sample who were interviewed and stated their requests for assistance were delayed. Findings include: Review of the May 29, 2012, Resident Council Meeting minutes noted that residents were concerned with call light times "getting bad again." They complained that it was bad during the weekend evenings and was at least a half hour to forty minutes to get call lights answered over the holiday weekend. The next meeting minutes, June 26 2012, also noted discussion regarding resident's concerns and the facility's "expectations for call light wait times." The residents were informed that all staff were "responsible for acknowledging call lights and that the time of acknowledgement should be no longer than 5 minutes". Resident #7. On 08/02/12 at approximately 11:00 a.m. the resident was seated in his wheelchair by his bed. He stated he required some assistance to transfer to the toilet, but "they wait til your hind end is just about numb before they get you up." Resident #8. On 08/02/12 at approximately 11:30	F 241	F-241 Residents #7, #8, and #9 were assessed for concerns related to call light response times. Care Plans have been updated as indicated.. Ingterviewable residents in the facility have been interviewed regarding call light response time. Concerns have been addressed for residents stating wait times are prolonged. Staff will be re-educated on the importance of call light response. Call light audits will be conducted in the facility three (3) times a week by the Administrator and or designee to monitor for compliance. Results will be reported to the Quality Assurance committee monthly and as needed until a lesser frequency is deemed appropriate by the Administrator to ensure compliance.	~~9/17/12~~ 9/24/12

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F 241	Continued From page 7 a.m. the resident was lying in bed. He stated he sometimes waited 45 minutes for help. He stated he used a urinal frequently, about every 10-15 minutes. If the urinal was full when he needed it he would "get wet" and that it happened just that morning. Resident #9. On 08/02/12 at approximately 10:45 a.m. the resident stated she sometimes waited for 20-25 minutes to get help.	F 241		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide appropriate care and services to assist 1 of 6 residents (#5) in the sample to reach his highest physical potential following surgical intervention for a fractured hip. Due to the facility's failure to recognize and appropriately evaluate swelling in the left leg, a deep vein thrombosis (clot) developed and emergency treatment was delayed for Resident #5. Findings include: Resident #5. Admitted [redacted]12 for care following repair of a fractured hip. Other diagnoses included dementia and peripheral	F 309		

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F 309	Continued From page 8 vascular disease. Admission physician orders included Physical and Occupational Therapy evaluations and treatment, head to toe skin assessment every week on Friday and orders for pain medications as needed. Review of the hospital documentation noted the resident had received Lovenox (an anticoagulant medication used to prevent deep vein thrombosis, or clots) daily while in the hospital. The transfer orders from the hospital had no order for that medication or any other anticoagulation medication. The Admission Nursing Assessment, dated [redacted]12, noted the resident had pain with movement and had a lengthy incision to the left hip which had no redness or drainage at the time. There was no documentation related to the appearance of the lower leg. Review of the interdisciplinary assessment tool, dated 06/15/12, noted the resident required extensive assistance for bed mobility and transfers and was totallly dependent for toileting. Physical Therapy (PT) was started by 06/04/12; however, documentation by PT, dated 06/11/12 noted "making minimal progress secondary to consistent refusals of PT and inability to comply." Progress notes, dated 06/08/12 at 1:44 p.m., noted the resident "regularly has been refusing his therapies...". On 06/09/12 at 1:03 p.m. progress notes documented "mild edema noted in left leg as compared to the right leg with 0. Good nerve and circulation check." On 06/14/12 there was no redness or drainage present. On 06/15/12 at 10:50 p.m. "Swelling continues to be	F 309	F-309 Resident #5 no longer resides in the facility. Residents with status post fractures or orthopedic surgery as well as those with a diagnosis of peripheral vascular disease have been assessed for signs and symptoms of a blood clot. No other residents were noted. Residents admitted status post fracture or after orthopedic surgery will be assessed for potential blood clots, and the need of an anticoagulant therapy during the initial, clinical assessment. Physicians of residents without an order will be contacted to ascertain if they would like one ordered. This will be documented in the medical record. Licensed nurses will be re-educated to the signs and symptoms associated with potential blood clots, the immediate notification of the physician for condition changes, and the documentation guidelines of physician notification. An audit of the nursing assessments of those residents post orthopedic surgery or post fracture will be conducted by the Director of Nursing Services or designee weekly to monitor for compliance, and to assure any signs of blood clots have been reported to the physician.	~~9/17/12~~ 9/24/12

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F 309	Continued From page 9 noted at left lower extremity. Will keep monitoring before notifying MD." On 06/16/12 at 6:16 p.m. "Swelling continues to be noted at left lower extremity. Resident encouraged to have both legs elevated at bed time to manage edema." Although staff recognized the left leg was swelling, they failed to assess for tenderness, pain, warmth and discoloration of the leg (all symptoms of a blood clot). On 06/17/12 at 6:47 p.m. "Left lower extremity swelling noted." On 06/18/12 at 9:06 p.m. "Swelling continues to be noted at left foot. Left foot elevated on the pillow at all times to manage edema." On 06/19/12 at 8:51 p.m. "Left foot encouraged to elevate on pillow at bed time to manage edema." On 06/20/12 at 9:24 p.m. "Left leg elevated at bed time to manage edema." On 06/21/12 at 5:57 p.m. "Left lower leg elevated at bed time to manage edema." The resident's temperature at that time was 99 degrees Fahrenheit. At 11:35 p.m. an "addendum" was noted which documented "skin to left leg warmer than right one. Swelling continues to be noted at left lower extremity. Tylenol given for high temperature with good result. Temperature rechecked 98.0. Will give report to wound care nurse for further evaluation." In spite of the resident experiencing edema to the left lower extremity and frequent documentation of edema, or swelling, since 06/09/12 (12 days), there was no assessment of the left leg for tenderness, pain, warmth or discoloration. The physician saw the resident on 06/08 and 20/12; however, there was no documentation related to the resident's leg. There was no documented evidence that staff informed the primary physician	F 309	Results of these audits will be reported to the Quality Assurance committee monthly and as needed until a lesser frequency is deemed appropriate by the Director of Nursing Services to ensure compliance.	~~9/17/12~~ 9/24/12

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F 309	Continued From page 10 or the surgeon of the increased inflammation in the leg. On 06/21/12 the resident was taken to the hospital by the family. Interview with a family member on 08/02/12 at approximately 8:30 a.m. revealed that the resident had begun complaining about the left leg around his 10th day [redacted]12) in the facility. Family requested the physician see the resident; however, the physician was "more concerned with pain management" than the appearance of the leg. The family member stated the leg was so swollen the resident could not bend it and the leg was red and hot. In addition, the family member stated the therapist suggested that the family member massage the leg. (If a blood clot was present, massaging the extremity could dislodge the clot and it could damage the heart or lungs.) Review of the ultrasound study of the left leg at the hospital on 06/22/12 noted "deep vein thrombosis from the posterior tibial vein up through the external iliac vein" (extensive leg involvement). A deep vein blood clot is potentially life threatening. The facility failed to recognize the resident's increased risk of developing a blood clot which included his history of vascular disease, the lack of anticoagulation medication, and decreased activity due to his refusals for walk. And, once the swelling in the leg developed (a sign of potential blood clot) the facility failed to recognize that a blood clot may be present for 12 days, thus emergency treatment was delayed.	F 309		

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F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to perform ongoing assessments and monitoring of skin for breakdown and/or to ensure appropriate interventions were in place for 2 of 3 residents (#1,3) in the sample who developed pressure sores. Findings include: Resident #1. Admitted on [redacted]12 with multiple diagnoses including cirrhosis of the liver. The admitting progress note identified both heels were "pink and spongy", indicating damage from pressure. On 06/30/12 the Pressure Sore Risk Assessment noted a score of 15, which did not place the resident at high risk of developing a pressure sore. (A score of 12 or less would indicate high risk.) There was no further assessment of the heels in the medical record. On 07/02/12 at 3:25 a.m. progress notes documented the resident complained of pain on the coccyx. She was turned to her side to sleep and a "small area on coccyx observed." A topical	F 314	F-314 Resident #1 no longer resides in the facility. Resident #3's wound treatment regime and plan of care have been reviewed with the physician, and revised as needed. An audit of skin assessments has been completed for residents in the facility. No other discrepancies were noted. Licensed nurses have been re-educated on skin assessments and the importance of accurate documentation of these assessments. The Director of Nursing or designee will conduct an audit three (3) times a week to monitor for compliance assuring skin assessments are completed and accurately documented. Results will be reported to the Quality Assurance committee by the Director of Nursing Services monthly and as needed until a lesser frequency is deemed appropriate to ensure compliance.	~~9/17/12~~ 9/24/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505126	A. BUILDING B. WING	C 08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 12 treatment was started at that time. On 07/05/12 the Wound Summary noted "late note from Monday 07/02/12" and documented the resident had an open sore (Stage II) to her coccyx when admitted. However, there was no documentation of the coccyx area upon admission, thus it was unknown whether the resident admitted with the pressure sore or developed it while in the facility. The Nutritional Risk Assessment, not dated, did not identify any skin issues for the resident. Facility staff was to perform a weekly head to toe skin check; however, review of the treatment record for July 2012 revealed no assessments were done. The resident was no longer in the facility, thus no observation was made of the current condition of the resident's heels or coccyx. Resident #3. Admitted to the facility on [redacted]12 with diagnoses which included aftercare for traumatic hip fracture. The Admission Nursing Assessment, dated [redacted]12, noted the resident had "some redness to R(ight) lateral heel." The pressure sore risk assessment on that date did not identify the resident as a high risk for the development of pressure sores. Neither was there documentation in the medical record related to the right heel until 03/13/12, which noted a new pressure sore was found on 03/01/12 on the side of the right foot, measuring 1.1 x 1.3 x 1.0 centimeters (approximately 1 inch in diameter). It was noted to be a Stage II ulcer (partial thickness loss of skin).	F 314		

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F 314	Continued From page 13	F 314		

The plan of care, dated 01/26/12, noted a problem for potential impaired skin integrity and staff was to encourage the resident to float his heels when in bed and use heel protectors when in bed. Staff was also to do a weekly head to toe skin check. Review of the Weekly Skin Integrity Action Tool for April 2012 noted the only head to toe check was on 04/21/12 with "no new skin issues." In May the weekly skin check was done twice, on 05/22,29/12, and noted "no new skin issues." In June the skin check was done on 06/05,13,20/12. Although there was a weekly skin integrity action plan, the documentation was incomplete and did not reflect an accurate assessment of the condition of the skin.

On 04/09/12 the pressure area on the right foot was noted to have progressively worsened to a Stage IV, a full thickness tissue loss with exposed bone, tendon or muscle.

A progress note, dated 04/12/12 noted the resident was admitted [redacted]12) for treatment of a pressure ulcer to the lateral aspect of the right foot; yet there was no documentation of the right foot until 03/13/12, almost two months later. On 03/14/12 a culture of the wound was taken and the resident was started on antibiotic therapy for infection.

Progress notes, dated 06/26/12, noted an aide reported an open wound on the left buttock below the coccyx, "appears to be pressure ulcer." The next documentation related to the pressure ulcer on the buttocks was dated 07/12/12 (16 days later) and noted it was 2.3 x 2.8 centimeters, less than one inch in diameter. There was no odor,

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F 314	Continued From page 14 tunneling or undermining noted. There was no further description or documentation of the buttock wound until 07/30/12 when progress notes documented "almost totally resolved." On 08/03/12 at approximately 10:50 a.m. the resident was observed in bed with a heel protector on his right foot. His heels were not floated off the mattress. Interview with the Nursing Assistant providing care (Staff A) stated a pillow was used between his legs, but his heels had never been floated off the bed to his knowledge.	F 314		