MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 14, 2015

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, Minnesota 55614

Re: Enclosed Reinspection Results - Project Number SL00381024

Dear Ms. Gilbertson:

On October 1, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 12, 2015. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00381	A. Building B. Wing	10/1/2015

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20230** Reg. # **MN Rule 4658.0065 Subp.** LSC	Correction Completed **10/01/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **10/01/2015**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **10/01/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/12/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

S-15
F-46

STATE OF MINNESOTA DEPARTMENT OF VETERANS AFFAIRS

SILVER BAY VETERANS HOME

★ ★ ★

45 Banks Boulevard • Silver Bay, Minnesota 55614 • (218) 226-6300
Fax (218) 226-6336 • www.mvh.state.mn.us • 1-877-729-8387

June 29, 2015

Chris Campbell, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 302-6151
Fax: (218) 723-2359

RECEIVED
JUL 02 2015
MN Dept of Health
Duluth

Re: State Nursing Home Licensing Orders – Project Number SL00381023

Dear Ms. Campbell,

Our facility was surveyed by your team on June 10, 2015 through June 12, 2015. As always we look forward to a review by your team. We know that your team works hard to identify areas of concern to promote quality for the people we serve.

The citations will be corrected as follows:

a) MN Rule 4658.0065 Subp. 1 Resident Safety and Disaster Planning.
   - Revision of current Water Outage policy to include a procedure for a procedure for calculating estimated potable and non-potable water needs for residents use per day including appropriate staff education,

b) MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care: Use.
   - Review of current repositioning and plan of care policies. Update these policies as appropriate. Provide education to appropriate staff on policies and monitor using a QAPI team approach.

c) MN Rule 4658. 0525 Subp. 4 Rehab Positioning.
   - Review of current repositioning and plan of care policies. Update these policies as appropriate. Provide education to appropriate staff on policies and monitor using a QAPI team approach.

All citations will be corrected on July 17, 2015. If you have any questions you may contact Pat Smedstad, DON or me @ 877-729-8387 or email us at one of our State of Minnesota email addresses.

Respectfully,

Carol Gilbertson, LNHA – Silver Bay Veterans Home
Carol.gilbertson@state.mn.us or 218-353-8684

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5988

June 23, 2015

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, Minnesota 55614

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00381023

Dear Ms. Gilbertson:

The above facility was surveyed on June 10, 2015 through June 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Chris Campbell at the phone or email listed above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

Minnesota Department of Health

RECEIVED
JUL 02 2015
MN Dept of Health
Duluth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING: _____ B. WING _____	06/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/10/2015, through 6/12/2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 230	MN Rule 4658.0065 Subp. 1 Resident Safety and Disaster Planning; Subpart 1. Safety program. A nursing home must develop and implement an organized safety program in accordance with a written safety plan. The written plan must be included in the orientation and in-service training programs of all employees and volunteers to ensure safety of residents at all times.	2 230		

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2 230	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure potable and non-potable water needs for resident use in the facility were estimated should loss of normal water supply occur. This had the potential to affect all 78 residents residing in the facility. Findings include: The facility policy on Water Outage dated 6/14, directed to supply water for the entire building it would require one water tanker a day, or 5,666 gallons a day, with 50 gallons a day for makeup water for the boiler. The policy lacked a procedure for calculating estimated potable and non-potable water needs for resident use per day. On 6/12/15, at 1:30 p.m. the Environmental Services Director (ES)-A was interviewed and verified the Water Outage policy lacked a procedure for calculating estimated potable and non-potable water needs for resident use per day. SUGGESTED METHOD FOR CORRECTION: The Environmental Services Director or designee could develop, review, and/or revise policies and procedures to ensure the Water Outage policy includes a procedure for calculating estimated potable and non-potable water needs for resident use per day. The Environmental Service Director or designee could educate all the appropriate staff on the policy. The Environmental Services Director or designee could monitor and adjust needs as facility requirements change. TIME PERIOD FOR CORRECTION: Twenty-one	2 230		

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2 230	Continued From page 3 (21) Days.	2 230		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all resident Care Plans address each resident's repositioning needs. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days. Based on observation, interview and document review, the facility failed to provide timely repositioning as directed by the care plan for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2 had a recently healed coccyx pressure ulcer reopen on 6/9/15. R2 was under continuous observation on 6/10/15, from 5:30 p.m. until 7:27 p.m. when R2 transferred himself from the wheelchair to an easy chair in the lobby. R2 was not provided every one hour repositioning and	2 565		

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2 565	Continued From page 4 offloading as assessed and directed by the care plan. R2's skin integrity care plan revised on 5/1/15, indicated R2 was at risk for skin breakdown related to edema of the lower extremities, wrist fracture, pressure ulcers and immobility. Care plan interventions included; Mepilex border dressing to bilateral coccyx ulcers, pressure relieving cushion in the chair, a pressure relieving stage two mattress on the the bed and reposition R2 every one hour while up in the wheelchair. The care plan further directed staff to assist R2 to stand for at least one full minute to offload. The closet care guide dated 5/10/15, directed staff to reposition R2 every one hour while up in the wheelchair. Attempt to assist R2 to stand for at least one full minute to offload every hour. On 6/10/15, at 7:45 p.m. human service technician (HST)-A stated, "I guess he repositioned himself because now he's in the easy chair." The HST did not know when R2 was previously positioned and stated R2 was to be repositioned every hour. On 6/12/15, at 9:50 a.m. the DON was interviewed and was informed of the open area on R2's right buttock. The DON verified the care plan and the care guide directed staff to reposition R2 every hour and staff should have followed the plan of care. The facility's Skin Integrity Management policy and procedure revised 5/14, indicated repositioning would be done according to individual resident assessment as documented in the care plan.	2 565		

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2 905	Continued From page 5	2 905		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents are repositioned according to their plan of care. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days. Based on observation, interview and document review, the facility failed to provide accurate assessment with corresponding care planning and timely repositioning to promote the healing and prevent the development of new pressure ulcers for 1 of 3 residents (R2) reviewed for pressure ulcers. Findings include: R2 had a recently healed coccyx pressure ulcer reopen on 6/9/15. R2 was under constant observation on 6/10/15, from 5:30 p.m. until 7:27	2 905		

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2 905	Continued From page 6 p.m. when R2 transferred himself from the wheelchair to an easy chair in the lobby. R2 and was not provided hourly repositioning and offloading as assessed and directed by the care plan. In addition, R2's skin assessments, wound documentation, and care planning were inconsistent with determining the etiology and type of the wounds. Appropriate, individualized care plans can then be developed based on consistent documentation and assessments. An Admission Record dated 6/12/15, indicated R2's diagnoses included Alzheimer's disease, dementia with behavioral disturbances, depression, anxiety, chronic pain, type two diabetes and chronic kidney disease. R2's skin integrity care plan revised on 5/1/15, indicated R2 was at risk for skin breakdown related to edema of the lower extremities, wrist fracture, pressure ulcers and immobility. Care plan interventions included; Mepilex border dressing to bilateral coccyx ulcers, pressure relieving cushion in the chair, a pressure relieving stage two mattress on the the bed and reposition R2 every one hour while up in the wheelchair. The care plan further directed staff to assist R2 to stand for at least one full minute to offload every hour. The significant change Minimum Data Set (MDS) dated 4/9/15, indicated R2 had moderately impaired cognition with no behaviors or rejection of cares. The MDS further indicated R2 was independent with bed mobility and transfers. R2 needed the extensive assistance of one staff to use the toilet. R2 was at risk for pressure ulcers and had no unhealed pressure ulcers. A Care Area Assessment (CAA) dated 4/9/15,	2 905		

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2 905	Continued From page 7 indicated R2 was at risk for developing pressure ulcers. R2 did not have a history of pressure ulcers. R2 had a decline in ambulation since the last review and preferred to use a wheelchair for mobility. This increased the risk for skin impairment. Other risk factors included R2's refusals to allow bathing. Staff assist R2 as they are able with skin care and observation of his skin condition. R2's goal was to not have any impaired skin integrity through the review. Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguineous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage III: Full thickness skin loss Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. Assessments of R2's skin from 4/17/15 through 6/12/15, were inconsistent with determining the type of wound it was and were assessed as follows: On 4/17/15, R2 has two stage III ulcers noted that day located over the coccyx just left and right of the gluteal cleft. The left ulcer measured 0.8 centimeters (cm) x 0.5 cm x 0.2 cm in depth. The right ulcer measured 1.0 cm x 0.7 cm x 0.2 cm. Interventions included staff was to ask R2 to use	2 905		

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2 905	Continued From page 8 the toilet every two hours and offload R2 every one hour when up in the wheelchair. On 4/20/15, a Tissue Tolerance Assessment (the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) was completed for sitting in the wheelchair. The assessment summary concluded R2 was at risk for skin impairment. The assessment directed staff to reposition R2 every one hour when up in the wheelchair and assist R2 to stand for at least one full minute to offload every hour. A Wound Assessment to the right coccyx dated 4/20/15, indicated R2 had an active stage III pressure ulcer that was facility acquired. The pressure ulcer measured 1.0 cm x 0.7 cm x 0.2 cm. Another Wound Assessment to the right coccyx dated 4/20/15, indicated R2 had an active stage III pressure ulcer that was facility acquired. The pressure ulcer measured 0.5 cm x 0.5 cm x 0.1 cm. A rehabilitation therapy progress note dated 4/20/15, indicated R2 was provided a honeycomb style wheelchair cushion for pressure relief related to a nursing request for a cushion assessment. A progress note dated 4/27/15, the director of nursing (DON) made an addendum to the medical record indicating the wound was a stage II. A Wound Assessment to the right coccyx dated 4/29/15, indicated R2's stage III pressure ulcer was closed.	2 905		

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MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

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2 905	Continued From page 9 A progress note dated 5/1/15, indicated R2 continued to have excoriated areas on the buttocks. A Tissue Tolerance Assessment for sitting in the wheelchair dated 5/1/15, indicated R2 was at risk for skin impairment. The assessment directed staff to reposition R2 every one hour when up in the wheelchair and assist R2 to stand for at least one full minute to offload every hour. A progress note dated 5/3/15, indicated the wounds on R2's buttocks were healing well. The wound was closed and pink in color and to continue repositioning every hour. A Tissue Tolerance Assessment dated 5/7/15, indicated the sore on R2's buttock was resolved. R2 was tolerating every two hour repositioning and the care guide and the care plan would be updated. A Wound Assessment to the right coccyx dated 5/9/15, indicated R2's stage III pressure ulcer was healed. A Wound Assessment to the right inner buttock dated 6/9/15, indicated R2 had an active facility acquired superficial abrasion from trauma that measured 2.2 cm x 1.0 cm. A progress note dated 6/12/15, indicated R2's right buttock was noted to have a small amount of clear drainage when the dressing was removed. The area continued to be reddened and measured 0.4 cm x 0.5 cm. A progress note dated 6/12/15, indicated R2 continued to have excoriations bilaterally on the	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING: _____ B. WING _____	06/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 905	Continued From page 10 buttocks. A wound care progress note dated 6/12/15, indicated R2 refused a skin check at 3:30 p.m. but did allow his skin to be checked at 4:45 p.m. putting R2 at 3.25 hours of sitting in the wheelchair. The note indicated there was no redness and R2's coccyx and left buttock skin was intact. R2's right buttock had a round superficial open area with a pink wound base. R2 had mild pain with palpitation. R2 was provided education to offload (stand up) every two hours and try to spend more time in bed to promote healing. A Wound Assessment to the right inner buttock dated 6/12/15, indicated R2 had an active facility acquired superficial abrasion from trauma that measured 0.5 cm x 0.5 cm x 0.0 cm in depth. On 6/12/15, at 8:25 a.m. R2's coccyx area was observed with registered nurse (RN)-B. RN-B removed an adhesive border type dressing from R2's right buttock. R2 was observed to have a circular open area on the buttock to the right of the coccyx that appeared moist and was red. RN-B measured the area and stated it measured 0.5 cm x 0.4 cm. On 6/10/15, at 7:45 p.m. human service technician (HST)-A stated, "I guess he repositioned himself because now he's in the easy chair." The HST did not know when R2 was previously repositioned and stated R2 was to be repositioned every hour. On 6/11/15, at 9:25 a.m. R2 stated he transferred himself into the easy chair last night because he had a "growth on his butt" and it was sore.	2 905		

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2 905	Continued From page 11 On 6/12/15, at 9:50 a.m. the DON was interviewed and was informed of the open area on R2's right buttock. The DON verified the care plan and the care guide directed staff to reposition R2 every hour and staff should have repositioned R2 every hour. The DON stated she had three wound certified nurses and wounds were assessed weekly. On 6/12/15, at 2:00 p.m. RN-A stated she was wound certified. The RN stated when R2's skin healed a tissue tolerance assessment was done and R2 was changed to every two hour repositioning. The RN verified the care plan still directed staff to reposition R2 every one hour while up in the wheelchair and to assist R2 to stand for at least one full minute to offload every hour. The RN updated the care plan on 6/11/15. The RN stated the open areas on R2's buttocks were not pressure related but were from shearing (an applied force or pressure exerted against a surface and layers of skin as tissues slide in opposite but parallel planes, Moseby's Medical Dictionary) because of the way R2 transfers and sits with his feet up. The facility's Skin Integrity Management policy and procedure revised 5/14, included a pressure ulcer definition as any lesion caused by unrelieved pressure that resulted in damage to underlying tissue. Although friction and shear were not primary causes of pressure ulcers they were important contributing factors in the development of pressure ulcers. The policy further stated repositioning would be done according to individual resident assessment as documented in the care plan.	2 905		