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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid third revisit was conducted on 12/6/16 through 12/7/16. The second revisit was conducted on 11/15/16 through 11/16/16. The first revisit was conducted on 10/19/16 through 10/20/16. The standard survey was conducted on 8/30/16 through 9/1/16. Corrections are required for compliance with the 42 CFR Part 483 Federal Long-Term Care regulations. Corrected deficiencies are identified on the CMS-2567B. One complaint was investigated during the survey. The census in this 120 certified bed facility was 88 at the time of the survey. The survey sample consisted of 11 current record reviews (Residents #301 through #311) and two closed records, (Resident # 312 and Resident #313).	{F 000}	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed safely because it is required by the provision of Federal and State Laws. This plan of correction is the facility's credible allegation of compliance.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	•Residents #310 & #312 MDS's were modified for accuracy on 12/7/2016. •An audit on Section M was completed for current residents with pressure ulcers to ensure areas were coded accurately. An audit on Section O "Influenza" was completed for current residents to ensure "received dates" are coded accurately. An audit on Sections C & D was completed for residents from 11/10/2016 and ongoing to ensure areas are coded accurately. •The RNAC and the Interim DNS provided education for the IDT team on MDS accuracy. •Audits will be completed weekly x 3 months by the RNAC/Interim DNS of all new MDS's completed to ensure accuracy of sections C, D, M & O. The Interim DNS will report findings weekly to the Executive Director and provide a report monthly to the QAPI committee x 3 months.	12/8/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 12-12-16

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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subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility documentation review, clinical record review and in the course of an investigation, the facility staff failed to ensure a complete and accurate MDS (Minimum Data Set) RAI (Resident Assessment Instrument) was completed for 2 residents (Residents #310 and #312) in a survey sample of 13 residents.

1. For Resident #310 the facility staff failed to accurately complete Section C (Cognitive Patterns), Section D (Mood), Section M (Skin and Ulcer Treatments), and Section O (Influenza Vaccine), on a quarterly MDS with an ARD (Assessment Reference Date) of 11/1/16.

2. For Resident #312, the facility staff failed to accurately code Section M (Skin Conditions), Unhealed Pressure Ulcers. Resident #312 was coded for 1 pressure ulcer that was present on admission, however there was a total of four (4) pressure ulcers that were present on admission.

Findings included:

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1. Resident #310 was admitted to the facility on 4/17/13 and readmitted after hospitalization on 7/29/16. Diagnoses included: Depression, Anxiety, Psychotic Disorder, Esophageal Reflux, Hypertension, Neurogenic Bladder, Diabetes, Seizure Disorder and Morbid Obesity.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 11/1/16. Resident #310 was coded as requiring extensive to total assistance of one to two staff members for activities of daily living, except for eating in which only set-up assistance was required. Resident #310 was coded incontinent of bowel and bladder. The following sections of the MDS were incomplete or inaccurate:

a. Section C: Cognitive Patterns and Section D: Mood were not coded. These sections require the resident be interviewed for an assessment of cognition and mood. Dashes were coded in these sections.

b. Section M: Skin Conditions- Resident #310 was coded at risk for Pressure Ulcer, however " None" was coded for Skin and Ulcer Treatments provided.

c. Section O: Special Treatments, Procedures, Programs, under Influenza - Vaccine, Resident #310 was coded as having received the Influenza Vaccine on 10/6/15.

An observation and interview of Resident #310 was conducted on 12/7/16 at 9:50 a.m. The Resident was in her room, in a bariatric bed equipped with an air mattress. She was positioned on her left side and supported by a

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large foam wedge. Resident #310 was awake, alert, pleasant and immediately responded to conversation. Resident #310 stated, "Oh I am doing good here. I don't have any skin problems right now." Resident #310 further discussed her favorite television shows and her recent lack of an appetite. Resident #310 said she was able to turn and reposition herself.

Review of the clinical record was conducted on 12/6/16 and 12/7/16 during an investigation of a complaint involving Resident #310.

Review of Resident #310's electronic and hard copy clinical record revealed the following:

a. A Comprehensive Care Plan that included Resident #310's ability to express preferences and interventions for monitoring her moods. There were detailed interventions for the prevention of skin impairment to include the provision of a pressure reducing air mattress and a wedge for repositioning.

b. The electronic clinical record, under Immunization read, "Influenza-Standard Dose given 10/6/16." The MDS had the date of 10/6/15.

c. The current Physician Order Summary included orders for barrier cream to sacral area after incontinence care, and there was a physician order for an air mattress.

On 12/7/16 at 10:10 a.m., an interview was conducted with the MDS Coordinator (Admin C) who stated the dashes under the Brief Interview Memory Status (BIMS) /Cognitive Status section and the Mood section indicated that the resident

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interviews were not completed during the assessment reference period. Admin C said she did not complete the MDS but she was aware that the Resident was not interviewed during the ARD period.

On 12/7/16 at 11:45 a.m., a follow-up interview was conducted with the Assistant Director of Nursing (Admin B) and the MDS Coordinator (Admin C) regarding the incorrect date for Resident #310's Influenza Vaccine and the lack of coding for the Skin and Ulcer treatments that were in place during the ARD period. After reviewing Resident #310's clinical record, Admin. B and Admin C said the coding was incorrect. Admin B provided documentation of the correct date of the vaccination and evidence of skin protection measures that were in place during the MDS review period.

On 12/7/16 at 12:50 p.m., the Administrator was informed of the inaccuracies identified in Resident #310's MDS. The Administrator said the facility had been without a full-time MDS Coordinator for a while and a new Coordinator had been recently hired for the position

Guidance was provided in "Long Term Care Facility Resident Assessment User's Manual 3.0 Version 1.14, October 2016:

a. Regarding completion of the Section C. page C-16. "Direct or performance-based testing of cognitive function using the BIMS is preferred as it decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium. However, a minority of residents are unable or unwilling to participate in the BIMS..... When cognitive impairment is

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incorrectly diagnosed or missed, appropriate communication, activities, and therapies may not be offered."

b. Regarding the need for accurate MDS completion, page 2-14. "The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI process, which includes the Federally-mandated MDS, is the basis for an accurate assessment of nursing home residents."

On 12/7/16 at approximately 1:45 p.m., during the end of day debriefing, the Administrator and the Assistant Director of Nursing (Admin B) were informed of the findings. No additional information was provided.

2. For Resident #312, the facility staff failed to accurately code Section M (Skin Conditions), Unhealed Pressure Ulcers. Resident #312 was coded for 1 pressure ulcer that was present on admission, however there was a total of four (4) pressure ulcers that were present on admission.

Resident #312 was admitted to the facility on 6/15/16 and readmitted after hospitalization on 10/21/16. Diagnoses included: Anemia, Diabetes, Hyperlipidemia, Seizure Disorder, Schizophrenia, Asthma, and Atrial Fibrillation.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/28/16. Resident #312 was coded as having short and long term memory problems and as having modified

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independence in daily decision making. He was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living. In Section M, under Unhealed Pressure Ulcer, Resident #312 was coded as having 1 Stage 4 that was present upon admission. The MDS described a stage 4 as, "Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed."

Wound staging information was accessed at the The National Pressure Ulcer Advisory Panel website:
www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ >:
"Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.?Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture

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associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss.?Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to

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reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions."

Review of the clinical record was conducted on 12/6/16 and 12/7/16 during the investigation of a complaint involving Resident #312. Resident #312 was discharged from the facility to the hospital on 12/5/16, therefore a closed record review was conducted.

Resident #312's clinical record contained the following information regarding his pressures:

a. A Comprehensive Care Plan included preventive and treatment measures for multiple pressure ulcers that were present on admission.

b. A Wound Care Specialist Evaluation dated 10/5/16 provided a Focused Wound Exam for a Stage 4 Pressure Wound of the Right, Lateral Hip, a Stage 4 Pressure Wound of the Left Ischium, an Unstageable (Due to Necrosis) of the Left Medial Heel and a Shear Wound of the Left, Lower Buttock.

c. A Readmission Assessment dated 10/21/16 listed the following pressure ulcers: 1. Right (R) hip Stage IV. 2. Left (L) Ischium Stage IV. 3. L Heel Unstagable (Necrotic). 4. R. Buttock Stage II. 5. R. Foot Stage II, 6. Scrotum Redness.

d. The October 2016 Physician Order Summary included orders that were initiated on 10/21/16 for

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wound care treatment to Resident #312's L. heel, sacrum, R. lateral hip, and L. ischium.

e. Review of the Treatment Administration Records (TAR) for October 2016 revealed treatments to Resident #312's four pressure ulcers was administered per physician orders.

f. A Wound Evaluation Flow Sheet dated 10/26/16 (two days prior to the ARD) identified and described Resident #312's wounds. There was a flowsheet for the R. Hip, L. Ischium, L Heel and R. Buttock.

g. Review of the October and November Progress Notes revealed consistent documentation of Resident #312's wounds, "Bilateral hips, sacrum and heel".

On 12/7/16 at 11:45 a.m., an interview was conducted with the Assistant Director of Nursing (Admin B) and the MDS Coordinator (Admin C) regarding the coding of Resident #312's pressure ulcers on the MDS. After reviewing the clinical record, Admin C said it looked as if only one of the four pressure ulcers was coded on the MDS. Admin C said she did not know why all of the wounds weren't coded on the MDS. Admin B stated, "I know this Resident and he had four pressure ulcers and he was admitted initially (6/15/16) from the hospital with them."

Documentation of Resident #312's wound tracking flow sheets, admission and re-admission skin assessments were provided and substantiated that each of the wounds were present on initial or on re-admission to the facility. Only one of the four pressure wounds was coded on the MDS as being present on admission.

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Guidance was provided in "Long Term Care Facility Resident Assessment User's Manual 3.0 Version 1.14, October 2016, page M-7.

"If a resident who has a pressure ulcer that was " present on admission " (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as "present on admission " because it was originally acquired outside the facility and has not changed in stage."

On 12/7/16 at approximately 1:45 p.m., during the end of day debriefing, the Administrator and the Assistant Director of Nursing (Admin B) were informed of the findings. No additional information was provided.