STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING _____ B. WING _____	C 09/24/2020

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 09/22/2020 through 09/24/2020. Five complaints (VA00048306 and VA 00048023 substantiated with deficiencies, VA00047843, and VA00048368 unsubstantiated with no deficiencies, and VA00048390- substantiated with no deficiencies) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 125 certified bed facility was 101 at the time of the survey. The survey sample consisted of seven current resident reviews (Residents #5 through #10 and #13) and seven closed record reviews (Residents #1, #2, #3, #4 #11, #12 and #14).	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		10/19/20

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

Electronically Signed | 10/12/2020

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to develop a comprehensive care plan to address the identified and assessed risk of falls for one of 14 residents in the survey sample, Resident #2. The findings include: Resident #2 was admitted to the facility on 11/13/2019 with diagnoses that included but were not limited to: paraplegia (1), osteomyelitis (2), pressure ulcer (injury) (3), stage IV (four) (3),	F 656	1. During Complaint Survey, 1 of 14 Residents did not have comprehensive care plan developed and implemented. Resident #2 has been discharged from facility no additional corrective actions were indicated. 2. All Residents have the risk to be affected. All Care Plans have been reviewed and revised as indicated by Director of Nursing. 3. Education by Regional to DON and DON/ADON to 100% to IDT regarding	

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F 656	Continued From page 2 diabetes, high blood pressure, malnutrition (4), and atrial fibrillation (5). The most recent complete MDS (minimum data set) assessment, a Medicare five day/admission assessment, with an assessment reference date of 11/20/2019, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or two staff members for all of her activities of daily living except eating in which the residents was coded as only requiring supervision. For transfers the resident was coded as requiring extensive assistance of two staff members. In Section V - Care Area Assessment, the resident was coded as triggering the care area for falls. An "X" was documented under that column. The column for Care Planning Decision, documented an "X" next to falls. Indicating the resident should be care planned for falls. The comprehensive care plan dated 11/13/2020 failed to evidence documentation addressing the identified risk of falls for Resident #2. The care plan dated 11/14/2020, documented in part, "Focus: ADL (activities of daily living) - Self-care deficit related to functional quadriplegia impaired mobility, paraplegia." The "Goal" documented in part, "Will not develop complications related to decreased mobility." The "Interventions" documented occupational therapy and physical therapy evaluation and treatment per physician's orders. The resident "Care Card" with no date documented, documented, "Mobility: Ambulation - assist of two persons. Bed Mobility - assist of two	F 656	developing, implementing, and updating Care Plans; and Clinical Morning Meetings will review, and revise Care Plans as indicated by Changes and/or Admissions initiated on 10/12/2020. 4. Director of Nursing will complete audits on care plans for new admissions and changes in conditions weekly X 4 weeks and Monthly X 2 starting on 10/12/2020. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Clinical morning meeting will review orders for completion beginning 10/12/2020. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved.	

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persons. Transfer with Mechanical Lift. Transfer - Assist of two persons."

The SBAR (situation, background, assessment and review) dated 12/2/2019 at 11:44 a.m. documented in part, "Change in condition noted related to lowered to the floor."

The "Fall Investigation" dated 12/2/2019, documented in part, Equipment - Weight chair and bed were checked. Activity - transferring to weight chair. Resident diagnosis - a check mark was placed next to paralysis (lower extremity). Description of incident - Resident was being transferred from her bed to the weight chair and was lowered to the floor by the CNA (certified nursing assistant). Additional comments - education was provided to the CNA.

An interview was conducted with LPN (licensed practical nurse) #2, on 9/28/2020 at 12:35 p.m. When asked who develops and updates the care plans, LPN #2 stated the unit managers, any nurse and MDS. LPN #2 was asked if a resident fall or being lowered to the floor should be on the care plan. LPN #2 stated that if it is something new for the resident it should be put on the care plan. When asked if a resident with paraplegia would be considered a fall risk, LPN #2 stated, yes, they have no lower body control and that puts them at risk for falls.

The CNA above was no longer employed by the facility and was unavailable for interview. The nurse that documented the 12/12/19 SBAR was no long employed by the facility and was unavailable for interview.

An interview was conducted with ASM

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(administrative staff member) #2, the director of nursing, on 9/23/2020 at 2:54 p.m. ASM #2 was asked to review the fall (lowering to the floor) investigation for Resident #2 on 12/2/2019. ASM #2 was asked if the CNA transferred the resident by himself, ASM #2 stated, "Yes, he did." When asked if a resident's fall risk and the actual fall should be care planned, ASM #2 stated, yes. ASM #2 was asked to review the resident's care plan. Once reviewed, ASM #2 was asked if Resident #2's care plan addressed her risk for falls or the actual fall on 12/2/2019. ASM #2 stated that there was nothing about falls on the care plan. When asked if there should be, ASM #2 stated, yes there should be, she is at risk.

The facility policy, "Care Plans, Comprehensive Person-Centered" documented in part, "A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment...Receive the services and/or items included in the plan of care...Incorporate risk factors associated with identified problems...The comprehensive, person-centered care plan is developed within seven days of the completed of the required comprehensive assessment (MDS)."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77

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documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 9/23/2020 at 4:15 p.m.

No further information was provided prior to exit.

(1) Paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435

(2) Osteomyelitis, an infection of bone and bone marrow usually caused by bacteria Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423.

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft

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F 656	Continued From page 6 tissue." Stage 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf (4) Malnutrition is state of poor nutrition, resulting from an insufficient, excessive or unbalanced diet. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 349. (5) Atrial fibrillation a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/19/20

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F 684	Continued From page 7 by: Based on clinical record review, resident interview, staff interview, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to administer prescribed treatments as ordered by the physician for three of 14 residents in the survey sample, Residents #1, #5, and #12. The findings include: 1. The facility staff failed to administer prescribed treatments as ordered by the physician for Resident #1. Resident #1 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1), malnutrition (2) and chronic diabetes mellitus (3) with foot ulcer (4). Resident #1 no longer resided at the facility and could not be interviewed or observed during the survey. Resident #1's most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 05/21/20, coded Resident #1 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Resident #1 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #1 as having diabetic foot ulcer(s) and skin tear(s). The comprehensive care plan for Resident #1 dated "05/11/2020, document in part under "Interventions/Tasks, ...Administer treatment per physician orders, Date Initiated: 10/14/2019."	F 684	1. During Complaint Survey 3 Residents were identified, #1, #5, and #12, were identified to not have documentation regarding wound care treatments as ordered by physician. 2. All Residents have the risk to be affected. All Residents identified been discharged from facility no additional corrective actions were indicated. 3. Education by the Director of Nursing to licensed nursing personnel on documentation and completed treatment records and getting discontinuation orders for skin alterations that have healed initiated on 10/12/2020. All TARs reviewed by DON and no other deficits were identified 10/12/2020. Wound Care Nurse Responsible for the listed deficits is no longer working in facility. Facility has initiated a talent search including a sign on bonus to attract qualified candidates to the Wound Care Nurse Position. Facility has entered into a contract with a 3rd party vendor for enhanced wound care services. 4. Director of Nursing will complete audits of treatment administration records and physician treatment orders weekly x 4 weeks and monthly x 2 months and clinical morning meeting will review orders for completion beginning 10/12/2020. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary	

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F 684	Continued From page 8 The care plan further documented, "Pain left foot related to wound. Date Initiated: 10/14/2019." A physician order dated 1/30/2020 documented, "Clean foot wound with Normal saline (sterile liquid solution), pat dry and reapply new black foam and wound vac (wound vacuum- uses negative pressure to promote healing of wound), every Monday, Wednesday and Friday for wound care." The eTAR (electronic treatment administration record) dated "2/1/2020-2/29/2020" for Resident #1 failed to evidence documentation that following treatments were completed on the dates and times listed below. - On 2/3/20, 2/5/20, 2/7/20, 2/10/20, 2/12/20, 2/19/20 and 2/24/20 scheduled for "0900" (9:00 a.m.). "Clean foot wound with normal saline, pat dry and reapply new black foam and wound vac, every Monday, Wednesday and Friday. One time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care. Start Date, 01/30/2020 0900 (9:00 a.m.), Hold Date from 02/14/2020 17:13 (5:13 p.m.) to 02/17/2020 2112 (9:12 p.m.). D/C Date- 04/13/2020 1721 (5:21 p.m.)." A physician order dated 1/29/2020 documented, "Clean the left hand middle finger wound gently with soap and water. Cover with a bandaid. Apply finger splint to the bottom side of the finger and secure in place by wrapping bandaids around the top of the finger and the base of the finger every day shift for wound care." - On 2/2/20, 2/6/20, 2/8/20, 2/9/20, 2/11/20, 2/14/20, 2/15/20, 2/16/20, 2/18/20, 2/25/20 and 2/27/20 scheduled for "7a-3p" (7:00 a.m.-3:00 p.m.). "Clean the left hand middle finger wound	F 684	additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved.	

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gently with soap and water. Cover with a bandaid. Apply finger splint to the bottom side of the finger and secure in place by wrapping bandaids around the top of the finger and the base of the finger. Every day shift for wound care- Left middle finger. Start date 01/30/2020 0700 (7:00 a.m.), D/C Date 03/03/2020 1647 (4:47 p.m.)."

A physician order dated 10/12/2019 documented, "Mepilex (absorbent wound dressing) border dressings for skin tears on arms and legs change weekly and as needed every day shift every 7 day(s) for skin tears."

- On 2/2/20, 2/9/20 and 2/16/20 scheduled for "7a-3p." "Mepilex border dressing for skin tears on arms and legs, change weekly and as needed. Every day shift every 7 (seven) day(s) for skin tears. Start Date 10/13/2019 0700 (7:00 a.m.), D/C date 03/03/2020 1139 (11:39 a.m.)."

The progress notes dated 1/1/20 through 2/29/20 for Resident #1 failed to evidence documentation for the incomplete treatment areas documented above on the eTAR in February of 2020.

On 9/22/20 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used their policies and procedures as their standard of practice.

On 9/23/20 at 12:35 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 regarding documentation on the eTAR. LPN #2 stated that they normally did the scheduled treatments in the afternoon after finishing the medications for the day. LPN #2 stated that they documented on the eTAR after

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the treatment was completed. LPN #2 stated that they also documented when the resident refused to have the treatment done. LPN #2 stated that there was a coding system to enter on the computer for resident refusal and to document whether the treatment was completed or not. LPN #2 stated that the check mark on the date meant that the treatment was completed. When asked what the blank spaces meant on the eTAR in the scheduled treatment areas, LPN #2 stated, "If it is blank, it was not done." LPN #2 stated that they were not at the computer and were unable to review the blank areas on the eTARs reviewed by the surveyor at that time.

On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, "If not documented, not done." ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #1. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates.

On 9/23/20 at 4:00 p.m., ASM #2 stated that an encrypted email was being sent with follow up progress notes for Resident #1 documenting treatments received.

On 9/23/20 at 4:00 p.m., ASM #1, the

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administrator provided an encrypted email containing progress notes for Resident #1. The document failed to evidence documentation of treatments provided for the additional dates listed above.

The facility's policy "Wound Care" documented in part, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing...The following information should be recorded in the resident's medical record:
1. The type of wound care given.
2. The date and time the wound care was given.
3. The position in which the resident was placed.
4. The name and title of the individual performing the wound care.
5. Any change in the resident's condition.
6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.
7. How the resident tolerated the procedure.
8. Any problems or complaints made by the resident related to the procedure.
9. If the resident refused the treatment and the reason(s) why.
10. The signature and title of the person recording the data ..."

On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings.

On 9/23/20 at 5:18 p.m., ASM #1, the administrator provided an encrypted email containing progress notes for Resident #1 which documented wound care provided on 1/3/2020, 1/9/2020 and 1/10/2020. The document failed to evidence documentation of the treatments provided for the additional dates listed above.

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No further information was provided prior to exit.

Complaint deficiency

References:

1. Chronic obstructive pulmonary disease (COPD). Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Malnutrition- Food provides the energy and nutrients you need to be healthy. If you don't get enough nutrients -- including proteins, carbohydrates, fats, vitamins, and minerals - you may suffer from malnutrition. This information was obtained from the website: https://medlineplus.gov/malnutrition.html

3. Diabetes mellitus a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Foot ulcer if you have diabetes, your blood glucose, or blood sugar, levels are too high. Over time, this can damage your nerves or blood vessels. Nerve damage from diabetes can cause you to lose feeling in your feet. You may not feel a cut, a blister or a sore. Foot injuries such as these can cause ulcers and infections. Serious cases may even lead to amputation. Damage to the blood vessels can also mean that your feet do not get enough blood and oxygen. It is harder for your foot to heal, if you do get a sore or infection.

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This information was obtained from the website: https://medlineplus.gov/diabeticfoot.html

5. Pressure ulcer are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000147.htm.

2. The facility staff failed to administer prescribed treatments as ordered by the physician for Resident # 5.

Resident #5 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (1), pressure ulcer of sacral region stage four (2) and diabetes mellitus (3).

Resident #5's most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 09/07/2020, coded Resident #5 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Resident #5 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #5 as having two "Stage 3- Full thickness tissue loss. Subcutaneous (under the skin) fat may be visible but bone, tendon or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of the tissue loss. May include undermining and

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tunneling." Section M further documented Resident #5 having one "Stage 4-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling." Section M also documented Resident #5 having surgical wound(s).

On 9/22/20 at approximately 9:30 a.m., an interview was conducted with Resident #5. A brief cognition interview revealed Resident #5 oriented to person and place. Resident #5 stated that the staff provide treatment to them "almost every day." Resident #5 stated that they did not know how often they were supposed to get their treatments. Resident #5 stated that there were days that it took them a while to get to the treatments because they were so busy."

The comprehensive care plan for Resident #5 dated 9/23/20, documented in part, "Has/At risk for further alteration in skin integrity related to impaired mobility, hx (history) pressure ulcer, neuropathy (diabetic nerve damage) ...Because of current hx and dx (diagnosis) resident is at high risk for skin breakdown and for further breakdown of current areas. Hx of scrotal (scrotum) area, hx sacral (lower back between the hipbones) area ... Date Initiated: 03/18/2016, Revision on 04/22/2019." Under "Interventions/Tasks", it documented in part, "treatment as ordered. Date Initiated: 09/29/2016, Revision on 11/28/2017."

The care plan for Resident #5 also documented, "Resistive/noncompliant with treatment/care (wound care orders) related to believe that treatment isn't needed/working; sits up for long periods of time. Inserts fingers into rectum

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causing trauma, sits on the bed pan for long periods of time. Date Initiated: 12/01/2019, Revision on 01/23/2020." Under "Interventions/Tasks" it documented in part, "Allow for Flexibility in ADL (activities of daily living) routine to accommodate mood, preferences and customary routine, Date Initiated: 01/23/2020." It also documented, "If resisting care, leave (if safe to do so) and return later, Date Initiated: 01/23/2020," and "Provide education about risks of not complying with therapeutic regimen, Date Initiated: 01/23/2020." .... Under "Interventions/Tasks", it documented in part, "Administer treatment per physician orders. Date Initiated: 12/10/2019."

Review of the physicians orders revealed the following an order dated 8/31/20 which documented, "Greers Goo (medicated barrier cream), apply to testicles and groin area Q (every) shift for rash." It further documented an order dated 8/31/20 that documented, "NYAMYC Pow [powder] 100000 (antifungal medicated powder) Apply to groin topically every day and evening shift for rash."

The eTAR (electronic treatment administration record) dated "1/1/2020-1/31/2020" and "2/1/2020-2/29/2020" for Resident #5 failed to evidence documentation that following treatments were completed on the dates and times listed below:

- On 2/15/20 scheduled for "7a-3p," and on 1/22/20 and 2/3/20 scheduled for "3p-11." On 1/30/20 and 2/17/20 scheduled for "11p-7" (between 11:00 p.m. and 7:00 a.m.). Greers Goo, apply to testicles and groin area Q (every) shift for rash. Start date: 10/03/2019 1500 (3:00

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p.m.). D/C Date: 06/02/2020 1349 (1:49 p.m.)."

- On 2/15/20 scheduled for "7a-3p," and on 1/22/20 and 2/3/20 scheduled for "3p-11" (between 3:00 p.m. and 11:00 p.m.). "NYAMYC Pow 100000, Apply to groin topically every day and evening shift for rash. Start Date: 09/25/2019 0700 (7:00 a.m.). D/C Date: 03/03/2020 1531 (3:31 p.m.)."

The progress notes dated 1/1/20 through 2/29/20 for Resident #5 failed to evidence documentation for the incomplete treatment areas documented above on the eTAR in January and February of 2020.

On 9/23/20 at 12:35 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 regarding documentation on the eTAR. LPN #2 stated that they normally did the scheduled treatments in the afternoon after finishing the medications for the shift. LPN #2 stated that they documented on the eTAR after the treatment was completed. LPN #2 stated that they also documented when the resident refused to have the treatment done. LPN #2 stated that there was a coding system to enter on the computer for resident refusal and to document whether the treatment was completed or not. LPN #2 stated that the check mark on the date meant that the treatment was completed. When asked what the blank spaces meant on the eTAR in the scheduled treatment areas, LPN #2 stated, "If it is blank, it was not done." LPN #2 stated that they were not at the computer and were unable to review the blank areas on the eTARs reviewed by the surveyor at that time.

On 9/23/20 at 2:20 p.m., a telephone interview

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was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, "If not documented, not done." ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #5. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates.

On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings.

No further information was provided prior to exit.

Complaint deficiency

References:

1. Osteomyelitis
Osteomyelitis is the medical term for inflammation in a bone. It's usually caused by a bacterial infection. It often affects the long bones of the arms and legs, but can happen in any bone. This information was obtained from the website:
https://kidshealth.org/en/parents/osteomyelitis.html

2. Pressure ulcer
A pressure sore is an area of the skin that breaks

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down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website:https://medlineplus.gov/ency/patientinstructions/000740.htm.

3. Diabetes mellitus
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

3. The facility staff failed to administer prescribed treatments as ordered by the physician for Resident #12.

Resident #12 was admitted to the facility with diagnoses that included but were not limited to diabetes mellitus (1), end stage renal disease (2) and anemia (3). Resident #12 no longer resided at the facility and could not be interviewed or observed during the survey.

Resident #12's most recent MDS (minimum data

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set), a discharge assessment with an ARD (assessment reference date) of 01/02/20, coded Resident #12 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident #12 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #1 as having diabetic foot ulcer(s).

The comprehensive care plan for Resident #12 dated "02/12/2020" documented in part, "Actual skin breakdown related to right heel, Date Initiated: 12/27/2019, Revision on: 02/12/2020." Under "Interventions/Tasks" it documented in part, "Administer treatment per physician orders, Date Initiated: 12/27/2019, Revision on: 02/12/2020."

A physician's note dated 1/1/2020 at 16:21 (4:21p.m.) documented in part, " ... Left diabetic foot ulcer S/P debridement 12/19."

Review of the physician's orders documented the following orders:
- "1/9/2020, Clean left foot/heel wounds with soap and water. Primary dressing: apply santyl (used to remove dead tissue) and alginate calcium. Secondary dressing: Foam silicone. Apply HeelMedix (cushioned boot to reduce pressure on heel) when in bed. Patient may ambulate with gripper socks."
- "1/20/2020, "Apply zinc paste (barrier cream) to buttocks for preventative. Every evening shift for preventative."

The eTAR (electronic treatment administration record) dated "1/1/2020-1/31/2020" and

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"2/1/2020-2/29/2020" for Resident #12 failed to evidence documentation that following treatments were completed on the dates and times listed below:

- On 1/13/20, 1/22/20, 1/25/20, 2/2/20, and 2/6/20 scheduled for "7a-3p." "Clean left foot/heel wounds with soap and water. Primary dressing: apply santyl (used to remove dead tissue) and alginate calcium. Secondary dressing: Foam silicone. Apply HeelMedix (cushioned boot to reduce pressure on heel) when in bed. Patient may ambulate with gripper socks. Do not apply shoe to the left foot. Every day shift for wound care. Start Date: 01/10/2020 0700 (7:00 a.m.), D/C Date: 08/26/2020 1452 (2:52 p.m.)."

- On 1/11/20, 1/23/20, 1/27/20, 2/1/20, 2/3/20 and 2/6/20 scheduled for "3p-11" (between 3:00 p.m. and 11:00 p.m.). "Apply zinc paste (barrier cream) to buttocks for preventative. Every evening shift for preventative. Start Date: 01/10/2020 1500 (3:00 p.m.), D/C (discontinue) Date- 08/26/2020 1452 (2:52 p.m.)."

The progress notes dated 1/1/20 through 2/29/20 for Resident #12 failed to evidence documentation for the incomplete treatment areas documented above on the eTAR in January and February of 2020.

On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed.

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When asked what blank boxes on the eTAR mean ASM #2 stated, "If not documented, not done." ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #12. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates.

On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings.

No further information was provided prior to exit.

Complaint Deficiency

References:

1. Diabetes mellitus
A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

2. End-stage kidney disease
The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

3. Anemia
Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, staff interview, facility document review and in the course of a complaint investigation it was determined facility staff failed to provide treatments as ordered by the physician for the care of a pressure ulcer for one of 14 residents in the survey sample, Resident #5. The findings include: Resident #5 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (1), pressure ulcer of sacral region stage four (2) and diabetes mellitus (3). Resident #5's most recent MDS (minimum data set), a five day assessment with an ARD (assessment reference date) of 09/07/2020,	F 686	1. During Complaint Survey 1 Resident was identified, #5, was identified to not have documentation regarding wound care treatments as ordered by physician. 2. All Residents have the risk to be affected. Resident #5 has been discharged from facility no additional corrective actions were indicated. 3. Education by the Director of Nursing to licensed nursing personnel on documentation and completed treatment records and getting discontinuation orders for skin alterations that have healed initiated on 10/12/2020. All TARs reviewed by DON and no other deficits were identified 10/12/2020. Wound Care Nurse	10/19/20

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F 686	Continued From page 23 coded Resident #5 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Resident #5 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M coded Resident #5 as having two "Stage 3- Full thickness tissue loss. Subcutaneous (under the skin) fat may be visible but bone, tendon or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling." Section M further documented Resident #5 having one "Stage 4-Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling." On 9/22/20 at approximately 9:30 a.m., an interview was conducted with Resident #5. A brief cognition interview revealed Resident #5 oriented to person and place. Resident #5 stated that the staff provide treatment to them "almost every day." Resident #5 stated that they did not know how often they were supposed to get their treatments. Resident #5 stated that there were days that it took them a while to get to the treatments because they were so busy. The comprehensive care plan for Resident #5 documented in part, "Actual skin breakdown including stage 4 (four) wound to right heel and sacrum, DTI (deep tissue injury) to left heel, right great toe diabetic ulcer and moisture associated ulceration noted under and around bilateral sides of scrotum. Date Initiated 12/10/2019. Revision on: 08/17/2020." Under "Interventions/Tasks", it documented in part, "Administer treatment per	F 686	Responsible for the listed deficits is no longer working in facility. Facility has initiated a talent search including a sign on bonus to attract qualified candidates to the Wound Care Nurse Position. Facility has entered into a contract with a 3rd party vendor for enhanced wound care services. 4. Director of Nursing will complete audits of treatment administration records and physician treatment orders weekly x 4 weeks and monthly x 2 months and clinical morning meeting will review orders for completion beginning 10/12/2020. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved.	

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physician orders. Date Initiated: 12/10/2019."

The physician's orders for Resident #5 dated 9/4/2020 documented, "Wound care: Sacrum- Cleanse with NS (normal saline), pack with calcium alginate rope (absorbent dressing), cover with bordered gauze every day shift for healing PU (pressure ulcer).

The physician's orders failed to evidence documentation of an order for the treatment to the right heel, however the orders documented an order dated 9/17/2020 "Right AKA (above the knee amputation) site: leave steri-strips in place, will fall off with continued healing."

The progress notes for Resident #5 documented in part, "9/1/2020 14:04 (2:04 p.m.) ...Skin Note ...Right heel- wound resolved: right above the knee amputation ..."

The eTAR (electronic treatment administration record) dated "1/1/2020-1/31/2020" and "2/1/2020-2/29/2020" for Resident #5 failed to evidence documentation that following treatments were completed for the pressure ulcer (sacrum) on the dates and times listed below.
" On 1/14/20, 1/22/20, 1/23/20, 1/29/20, 2/15/20 and 2/25/20 scheduled for "7a-3p" (between 7:00 a.m. and 3:00 p.m.). "Clean the sacral wound with soap and water daily. Pack collagen (protein) into the wound and cover with calcium alginate (absorbent dressing) and foam. Change dressing daily and when soiled. Every day shift for wound care. Start Date: 01/14/2020 0700 (7:00 a.m.), D/C (discontinue) 03/26/2020 1338 (1:38 p.m.)."
" On 1/22/20, 1/23/20, 1/29/20 and 2/15/20 scheduled for "7a-3p." "Clean the right heel

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wound with soap and water daily. Apply calcium alginate to the wound bed then a gauze dressing. Change dressing daily. Apply HeelMedix boots (padded footwear to relieve pressure to heels) to bil (bilateral) feet as preventative. Every day shift for wound care, Start Date 01/14/2020 0700 (7:00 a.m.). D/C Date- 03/26/2020 1336 (1:36 p.m.)."

The progress notes dated 1/1/20 through 2/29/20 for Resident #5 failed to evidence documentation for the incomplete pressure ulcer treatment dates documented above on the eTAR in January and February of 2020.

On 9/22/20 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used their policies and procedures as their standard of practice.

On 9/23/20 at 12:35 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #2 regarding documentation on the eTAR. LPN #2 stated that they normally did the scheduled treatments in the afternoon after finishing the medications for the day. LPN #2 stated that they documented on the eTAR after the treatment was completed. LPN #2 stated that they also documented when the resident refused to have the treatment done. LPN #2 stated that there was a coding system to enter on the computer for resident refusal and to document whether the treatment was completed or not. LPN #2 stated that the check mark on the date meant that the treatment was completed. When asked what the blank spaces meant on the eTAR in the scheduled treatment areas, LPN #2 stated, "If it is blank, it was not done." LPN #2 stated that they were not at the computer and were unable to review the blank areas on the eTARs reviewed by

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the surveyor at that time.

On 9/23/20 at 2:20 p.m., a telephone interview was conducted with ASM (administrative staff member) #2, the director of nursing regarding documentation on the eTAR. ASM #2 stated that staff were expected to document for treatments after they were completed on the eTAR and not to document them unless they were completed. When asked what blank boxes on the eTAR mean ASM #2 stated, "If not documented, not done." ASM #2 was provided a list of the blank treatment dates listed above from the eTARs dated 1/1/20-1/31/20 and 2/1/20-2/29/20 for Resident #5. ASM #2 stated that they would look through the progress notes again to ensure that there was no additional documentation to support that the treatments were completed on those dates.

The facility's policy "Wound Care" documented in part, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing...The following information should be recorded in the resident's medical record:
1. The type of wound care given.
2. The date and time the wound care was given.
3. The position in which the resident was placed.
4. The name and title of the individual performing the wound care.
5. Any change in the resident's condition.
6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.
7. How the resident tolerated the procedure.
8. Any problems or complaints made by the resident related to the procedure.
9. If the resident refused the treatment and the

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reason(s) why.
10. The signature and title of the person recording the data ..."

On 09/23/20 at approximately 5:05 p.m., ASM (administrative staff member) # 1, the administrator was made aware of the findings.

No further information was provided prior to exit.

Complaint deficiency

References:

1. Osteomyelitis
Osteomyelitis is the medical term for inflammation in a bone. It's usually caused by a bacterial infection. It often affects the long bones of the arms and legs, but can happen in any bone. This information was obtained from the website:
https://kidshealth.org/en/parents/osteomyelitis.html

2. Pressure ulcer
A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The

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F 686	Continued From page 28 pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. 3. Diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to ensure a proper transfer per the plan of care to prevent an avoidable accidents for one of 14 residents in the survey sample Resident #2. On 12/2/19, Resident #2 was transferred from her bed to the weight chair by a CNA (certified nursing assistant) and was subsequently lowered to the floor. The CNA failed to ensure Resident #2 was transferred with the assistance two staff members as assessed.	F 689	1. During Complaint Survey 1 Resident was identified, #2, was identified to not have been transferred per the plan of care. 2. All Residents have the risk to be affected. Resident #2 has been discharged from facility no additional corrective actions were indicated. 3. Education by the Director of Nursing to licensed/Certified Nursing Staff on safe	10/19/20

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F 689	Continued From page 29 The findings include: Resident #2 was admitted to the facility on 11/13/2019 with diagnoses that included but were not limited to: paraplegia (1), osteomyelitis (2), pressure ulcer (injury) (3), stage IV (four) (3), diabetes, high blood pressure, malnutrition (4), and atrial fibrillation (5). The most recent complete MDS (minimum data set) assessment, a Medicare five day/admission assessment, with an assessment reference date of 11/20/2019, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or two staff members for all of her activities of daily living except eating in which was only required supervision. For transfers the resident was coded as requiring extensive assistance of two staff members. In Section V - Care Area Assessment, the resident was coded as triggering the care area for falls. An "X" was placed under that column. The column for Care Planning Decision, documented an "X" next to falls. Indicating the resident should be care planned for falls. The SBAR (situation, background, assessment and review) dated 12/2/2019 at 11:44 a.m. documented in part, "Change in condition noted related to lowered to the floor." The "Fall Investigation" dated 12/2/2019, documented in part, Equipment - Weight chair and bed were checked. Activity - transferring to weight chair. Resident diagnosis - a check mark	F 689	transferring Resident per plan of care initiated on 10/12/2020. 4. Director of Nursing will complete staff transferring Residents weekly x 4 weeks and monthly x 2 months beginning 10/12/2020. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved.	

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was placed next to paralysis (lower extremity). Description of incident - Resident was being transferred from her bed to the weight chair and was lowered to the floor by the CNA (certified nursing assistant). Additional comments - education was provided to the CNA.

The "Employee Education Attendance Record" dated 12/2/2019, documented in part, "At the completion of this training session the participant will: appropriate transfer techniques, CNA Kardex, Appropriate body mechanics and requesting assistance as needed."

The comprehensive care plan dated 11/13/2020 failed to evidence documentation tor the assessed risk of falls for Resident #2. The care plan dated 11/14/2020, documented in part, "Focus: ADL (activities of daily living) - Self-care deficit related to functional quadriplegia, impaired mobility, paraplegia." The "Goal" documented in part, "Will not develop complications related to decreased mobility." The "Interventions" documented occupational therapy and physical therapy evaluation and treatment per physician's orders.

The resident "Care Card" with no date documented, documented, "Mobility: Ambulation - assist of two persons. Bed Mobility - assist of two persons. Transfer with Mechanical Lift. Transfer - Assist of two persons."

The "Resident Evaluation" dated, 11/13/2019, documented in part, "Fall Risk Predictive Factors Assessment - A. Mental status - alert, oriented, reliable safety awareness. B. Ambulatory Elimination Status - Impaired mobility. Vision Status - adequate. Orthostatic Blood Pressure -

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unable to determine. Falls History - no falls in past 3 months. Medications: Respond below based on the following types of medications - anesthetics, antihistamines, antihypertensive, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemics, psychotropics, sedatives/hypnotics - Takes 1 - 2 of these medications currently and/or in the last 7 days. Predisposing Diseases/Conditions - Respond below back on the following predisposing conditions: Hypertension, Vertigo, CCVA (stroke) Parkinson's, Loss of Limb, seizures, arthritis, osteoporosis, fractures, dementia, delirium, wandering, anger. None present. (Of note, the resident had the diagnoses of hypertension and anemia.)

The "Fall Risk Evaluation" dated 12/2/2020, documented the resident had a score of "5." There was no documentation of what the score of "5" indicated on the form.

The CNA above was no longer employed by the facility and was unavailable for interview. The nurse that documented the SBAR was no long employed by the facility and was unavailable for interview.

An interview was conducted with CNA #5, on 9/23/2020 at 12:20 p.m. When asked how she knows what kind of transfer assistance a resident requires, CNA #5 stated that it's on the kardex in POC (point of care electronic record). When asked if it documents a mechanical lift, can you transfer the person without the lift, CNA #5 stated, "No, you have to use the lift and the lift requires you have two persons at all times."

An interview was conducted with LPN (licensed

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practical nurse) #2 on 9/23/2020 at 12:35 p.m. When asked how a staff know what kind of assistance a resident requires for transfers, LPN #2 stated it's in the care plan and on the kardex. When asked if the staff could transfer a resident without a lift, if the Kardex documents to use a mechanical lift, LPN #2 stated if it says mechanical lift, then that's the only safe way to transfer the resident.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/23/2020 at 2:54. When asked if the CNA attempted to transfer Resident #2 on 12/2/2019 by himself, ASM #2 stated, "Yes, he did." The "Resident Evaluation" dated 11/13/2019 and the "Fall Risk Evaluation dated 12/2/2019 were reviewed with ASM #2. When asked what the "Resident Evaluation" meant in relation to falls, ASM #2 stated the resident would be at risk based on the assessment. When asked what a "5" on the Fall Risk Evaluation indicated, ASM #2 stated that the resident was at risk for falls.

The facility policy, "Safe Lifting and Movement of Residents" documented in part, "In order to protect the safety and well-boing of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort and medical condition will be incorporated into goals ad decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan."

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ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 9/23/2020 at 4:15 p.m.

No further information was provided prior to exit.

(1) Paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435

(2) Osteomyelitis, an infection of bone and bone marrow usually caused by bacteria Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423.

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." Stage 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.) This information was obtained from the

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F 689	Continued From page 34 following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf (4) Malnutrition is state of poor nutrition, resulting from an insufficient, excessive or unbalanced diet.) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 349. (5) Atrial fibrillation a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		10/19/20

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F 842	Continued From page 35 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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	495391	A. BUILDING _____ B. WING _____	C 09/24/2020

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F 842	Continued From page 36 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to document the wound measurements of a pressure injury, in the clinical record, for one of 14 residents in the survey sample, Resident #2. The findings include: Resident #2 was admitted to the facility on 11/13/2019 with diagnoses that included but were not limited to: paraplegia (1), osteomyelitis (2), pressure ulcer (injury) (3), stage IV (four) (3), diabetes, high blood pressure, malnutrition (4), and atrial fibrillation (5). The most recent complete MDS (minimum data set) assessment, a Medicare five day/admission assessment, with an assessment reference date of 11/20/2019, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or two staff members for all of her activities of daily living except eating in which was only required supervision. For transfers the resident was coded as requiring extensive assistance of	F 842	1. During Complain Survey, 1 of 14, # 2, Residents did not have a complete medical record. Resident #2 has been discharged from the facility. 2. All Residents have the risk to be affected. Resident #2 has been discharged from facility no additional corrective actions were indicated. 3. Education by the Director of Nursing and Administrator to licensed/Certified Staff and Medical records on maintaining a complete and accurate medical record initiated on 10/12/2020. 4. The Director of Nursing or designee will complete an audit for a complete and accurate medical record weekly x 4 weeks and monthly x 2 months beginning 10/12/2020. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved.	

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two staff members. In Section M - Skin Conditions, the resident was coded as having a stage IV (4) pressure injury.

The "Resident Evaluation" dated 11/13/2019, documented the resident had a open area on the sacrum that measured 4x4 (centimeters[cm] - length by width), 2.5 (cm) deep, pinkish with yellow slough intermittently, edges defined, some tunneling.

The wound care physician notes dated 11/14/2019, documented the residents pressure injury wound, on the sacrum, as being 8x6x2 cm (length by width by depth).

The wound care physician notes dated 11/21/2019, documented the residents pressure injury wound, on the sacrum, as being 6x5.5x1.9 cm.

Review of the clinical record failed to evidence of any wound measurements after 11/21/2019.

A request was made for any wound tracking documents from 11/21/2019 through 12/12/2019 of ASM (administrative staff member) #1, the administrator, on 9/23/2020 at 1:59 p.m.

On 9/23/2020 at 3:47 p.m. the following documents were presented. "Weekly Wound Management Tracking Tool" dated 11/27/2019, 12/5/2019 and 12/12/2019:

- The Weekly Wound Management Tracking Tool dated 11/27/2019 documented Resident #2's wound measurements as 6 x 5.5 x 3.8 cm.

- The Weekly Wound Management Tracking Tool

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dated 12/5/2019 documented Resident #2's wound measurements as 6 x 5.5 x 3.8 cm.

- The Weekly Wound Management Tracking Tool dated 12/12/2019 documented Resident #2's wound measurements as 6 x 6.3 x 3.8 cm. None of these measurements were in the clinical record.

ASM #1, the administrator, informed this surveyor on 9/23/2020 at 3:47 p.m. that it was correct, the above measurements were not in the clinical record. When asked if they should be, ASM #1 stated, "Yes, Ma'am."

The facility policy, "Charting and Documentation" documented in part, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...Documentation of procedures and treatments will include care-specific details, including: the date and time the procedures/treatment was provided. The name and title of the individual(s) who provided care. The assessment data and/or any unusual findings obtained during the procedure/treatment."

ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 9/23/2020 at 4:15 p.m.

No further information was provided prior to exit.

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(1) Paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435.

(2) Osteomyelitis, an infection of bone and bone marrow usually caused by bacteria Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423.

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue." Stage 4 is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.) This information was obtained from the following website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

(4) Malnutrition is state of poor nutrition, resulting from an insufficient, excessive or unbalanced diet.) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 349.

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F 842	Continued From page 40 (5) Atrial fibrillation a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria)(Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55	F 842		