STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 12/16/2021

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BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated Complaint survey was conducted 12/14/2021 through 12/16/2021. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00053827 substantiated with deficiency) was investigated during the survey. The census in this 101 certified bed facility was 87 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3).	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		1/11/22

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

Electronically Signed | 01/06/2022

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F 657	Continued From page 1 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, clinical record review, facility document review, and in the course of a complaint investigation the facility staff failed to revise the care plan to reflect interventions for 3 pressure sores, for one Resident (Resident #1) in a sample of three residents. The findings included; Resident #1 was re-admitted to the facility on 10-25-21 after a hospitalization. Emergency room records from the hospitalizations on 10-21-21, and 11-18-21 were reviewed. The MDS document submission, dated 11-14-21, revealed the Resident had pressure sores. One which was unstageable due to slough or eschar (dead necrotic tissue) within the wound bed, which obscured from vision the depth of the wound, and two unstageable pressure injuries due to deep tissue injury (DTI). The care plan was reviewed and revealed the following interventions and the dates those interventions were added to the care plan. 12-2-21 wound care treatment per MD (doctor) order 12-15-21 Turn and reposition every two hours for pressure relief	F 657	F657 Care Plan Timing and Revision 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: During this complaint survey, resident #1 was identified to not have a comprehensive care plan developed and implemented. Resident #1's care plan was revised on 12/15/2021 during the survey. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the risk to be affected by timely revision of care plans 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by Director of Clinical Services to DON and DON/ADON and IDT regarding developing, implementing, and updating care plans; Clinical Morning Meetings will include a review of all resident changes in condition, with the care plans being revised by the team at the meeting to reflect new interventions. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing will complete audits on care plans for new admissions and residents	

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F 657	Continued From page 2 12-15-21 Discontinue skin prep to bilateral heels It is notable to mention that the survey team entered the facility for survey on 12-14-21. The Administration was notified of findings during end of day conference on 12-15-21, and 12-16-21. Further documents were supplied by the facility on 12-16-21, however, the care plan was complete as stated by the DON, and Administrator when they were asked for a copy which was complete and included all discontinuances, changes, and additions from the Resident's initial/first admission to the time of survey. No further information was provided.	F 657	undergoing changes in conditions, treatments, interventions, medications, etc. weekly X 4 weeks and monthly X 2. 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 reviewed by the facility's QAPI Committee for review and will automatically trigger continuation of audits until full compliance is achieved. 5. Date of Compliance January 11, 2022	
F 686 SS=G	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 observations, staff interviews, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to prevent pressure wounds	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer 1. Address how corrective action will be accomplished for those residents found to	1/11/22

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F 686	Continued From page 3 resulting in harm for one Resident (Resident #1) in a sample size of 3 Residents. For Resident #1, the facility staff failed to provide interventions to prevent the worsening of pressure wounds resulting in an avoidable stage 4 sacral wound and unstageable pressure wounds of bilateral heels. The Resident was hospitalized for infected pressure wounds. This is harm. The findings included: On 12/14/2021 at approximately 11:00 A.M., Registered Nurse B (RN B) and this surveyor observed Resident #1 in her room with the head of the bed elevated approximately 60 degrees. Resident #1 had a functional air mattress in place and soft boots on bilateral feet. Resident #1 had a wound "vacuum" Negative Pressure Wound Therapy (NPWT) for a sacral wound. At approximately 11:30 A.M., this surveyor observed the wound physician perform wound assessment and care. Also present in the room were Resident #1's nurse (RN B), the unit manager (Employee E), and Registered Nurse C (RN C), the nurse supervisor. The sacral wound bed was observed to have a small amount of exposed bone, muscle, devitalized (dead) tissue, and granulation (healing) tissue. The wound physician measured the wound to be 12.4 centimeters (length), 8.7 centimeters (width) and 2 centimeters (depth). The undermining was measured at 2.4 centimeters at 6 o'clock (meaning the undermining was located at the bottom portion of the sacral wound). The wound physician applied a topical anesthetic	F 686	have been affected by the deficient practice: Assessment of Resident #1's pressure areas has been documented at least weekly in medical record since survey with appropriate interventions initiated to address all areas of skin breakdown. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who are at risk for development of pressure areas are potentially affected and are addressed in the plan of correction. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Director of Nursing to licensed nursing personnel on prevention of pressure areas, descriptive clinical assessment documentation of pressure areas, and care planning measures related to prevention of and/or worsening of pressure ulcers. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing will complete audits of documentation for pressure ulcer prevention measures weekly x 4 weeks and monthly x 2 months. During clinical morning meeting, the ID team will review orders to ensure timely completion.The result of these 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 reviewed by the facility's QAPI Committee	

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F 686	Continued From page 4 and removed wet, yellow (slough), dead tissue from the wound bed as well as dead connective tissue and bone. The unit manager then applied the new NPWT sponge/film dressing and achieved a vacuum seal with the wound vacuum device. At 11:50 A.M., the wound physician examined the right heel. The wound physician and this surveyor observed depigmented, epithelial tissue on the right heel. The wound physician stated the right heel wound was healed. The wound physician then examined the left heel wound. The wound was covered with black, dead tissue. The wound physician measured the wound to be 13.3 centimeters (length) and 11.6 centimeters (width). The wound physician applied a topical anesthetic and removed a small amount of the dead tissue on the lateral portion of the left heel wound. A new dressing was applied to the left heel and both feet were placed in soft boots to protect them from further damage from pressure. On 12/14/2021 at 12:20 P.M., an interview with the Director of Nursing (DON) was conducted. When asked about Resident #1's wounds, the DON indicated that [Resident #1] arrived from the hospital with a MASD [moisture-associated skin damage] rash and verified the wounds were acquired at the facility. A copy of the physician wound notes and nursing skin assessments were requested. On 12/14/2021 at approximately 5:15 P.M., the facility staff provided 8 pages of documents each entitled, "Skin Monitoring CNA [certified nursing assistant] Shower Review." Each document had 2 anatomical figures (font and back) pictured and a list of options to select. The document dated	F 686	and will automatically trigger continuation of audits until full compliance is achieved. 5. Date of Compliance January 11, 2022	

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10/25/2021 [the day of readmission from the hospital] had handwritten by staff that the mid-posterior (back) section of the anatomical man labeled as "rashes" and handwritten in "MASD." The posterior feet were labeled as "soft heels" and handwritten in "redden [sic] non-blanchable [sic]." The document was signed by a CNA and Licensed Practical Nurse C (LPN C). There were no further descriptions or measurements included.

The same type of document dated 10/28/2021 had the posterior feet labeled as "swelling" and "soft heels." The posterior region of of the man diagram, had staff circling with a pen the right upper arm, right elbow, right forearm, right hand, and back region from the arm pits to the back of knees and labeled as "rashes." The posterior feet (heels) were labeled as "swelling" and "soft heels." The document was signed by a CNA and a nurse. There were no further descriptions or measurements included.

The same type of document dated 11/04/2021 had the posterior mid-region labeled as "pressure" and the posterior feet labeled as "abnormal color." The document was signed by a CNA and a nurse. There were no further descriptions or measurements.

The same type of document dated 11/11/2021 labeled the posterior mid-region as "decubitus" and the posterior feet were labeled as "blisters" and "abnormal color." The document was signed by a CNA and a nurse. There were no further descriptions or measurements included.

On 12/14/2021 and 12/15/2021, Resident #1's electronic clinical record was reviewed. Upon

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review, it was revealed that Resident #1 had two recent hospitalizations on (10/21/2021-10/25/2021) and (11/18/2021-12/02/2021).

During that review of the clinical record under the "Observation" tab, a document completed by (LPN C) dated 10/25/2021 at 3:54 P.M. entitled, "Admission Skin Assessment" included the following headers and documented the following answers from the nurse, for each header selection:

"Scars: no
Bruises: no
Skin Tears: no
Reddened areas: no
Pressure sores: no
Rashes: no."

The MASD and soft, reddened, non-blanchable heels that were documented on the "CNA shower reviews" were not documented, nor addressed in the admission skin assessment.

A nursing readmission note written by (LPN C) dated 10/25/2021 at 2:00 P.M. was reviewed. The MASD and soft, reddened, non-blanchable heels were not documented nor addressed in the admission narrative note. There was no evidence the physician was notified of the findings.

The care plan was reviewed. There was no evidence the care plan was revised to address the moisture-associated skin damage, nor the soft, reddened, non-blanchable bilateral heels on readmission (10/25/2021).

The physician's orders for October 2021 were

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reviewed. There was a physician's order with a start date of 04/16/2021 that documented, "Apply zinc oxide after each incontinence episode and PRN [as needed] every shift." There were no admission physician orders regarding the bilateral heels.

A review of the Treatment Administration Record (TAR) for October 2021 revealed that the zinc oxide was not signed off as administered on 10/20/2021 day shift, nor on 10/21/2021 when Resident #1 was sent out to the hospital. The resident returned 10-25-21 from the hospital, and on 10/29/2021 the zinc oxide was not signed off as administered on night shift.

The nursing progress notes from 10/25/2021 through 11/04/2021 were reviewed. The MASD and soft, reddened, non-blanchable heels were not addressed within that date range.

A nurse's note dated 11/04/2021 [10 days after admission] at 6:26 P.M. documented, "CNA was changing resident and informed nurse of a sacral pressure ulcer. On assessment, a 2.5 cm x 5 cm open area with red, shiny tissue to wound bed noted. Scant amount of serosanguinous drainage with no odor present. Resident is non-verbal, but shows no signs of pain or discomfort. Surrounding tissue is non-blanchable. RP & MD [responsible party and medical doctor] notified. [MD name] was on call for [MD name]. He stated to have the NP [nurse practitioner] look at the area in the morning, otherwise, NNO [no new orders] given. Wound was cleaned with NS and dressing applied. Resident tolerated procedure well." The bilateral heels were not addressed in this narrative note.

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A weekly skin assessment dated 11/04/2021 at 6:37 P.M. under the header "Pressure Sores" documented "Sacral stage 2." The bilateral heels were not addressed in this assessment. There were no further weekly skin assessments documented until a readmission skin assessment dated 12/02/2021.

A nursing progress note dated 11/04/2021 at 10:28 P.M. documented, "Resident's Braden Score assessment of 9.0 indicates high risk for developing pressure ulcers. Will continue to monitor closely for signs of further skin breakdown."

A nursing progress note written by (LPN C) dated 11/05/2021 at 2:27 P.M. documented, "resident have [sic] new order for zinc sulfate 220 mg Po QD [220 milligrams by mouth daily], vit c 500 mg Po bid [vitamin C 500 milligrams by mouth twice a day], consult wound physician, clean open area on sacrum with normal saline, pat dry, apply xeroform, cover with 4x4 dressing." There were no further nursing notes until 11/09/2021.

A review of the physician's orders for November 2021 revealed there were orders for wound physician consult dated 11/05/2021; zinc sulfate 220 mg QD with a start date of 11/06/2021 and vitamin C 500 mg twice a day with a start date of 11/06/2021.

A review of the Medication Administration Record for November 2021 revealed that the zinc sulfate was signed off as administered twice a day from 11/06/2021 through 11/18/2021 [discharge to hospital date] with the exception of 11/15/2021 at 5:00 P.M when it was not documented as administered.

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A physician's order with a start date of 11/06/2021 and end date of 11/10/2021 documented, "cleans [sic] open area on sacrum with normal saline, pat dry, apply xeroform cover with dressing 4x4."

A review of the Treatment Administration Record for November 2021 revealed that wound treatment entitled, "cleans [sic] open area on sacrum with normal saline, pat dry, apply xeroform cover with dressing 4x4" was signed off as administered on 11/06/2021, 11/07/2021, and 11/09/2021. However, the wound treatment for 11/08/2021 was not documented as administered and left blank.

An excerpt of a nurse practitioner's progress note dated 11/05/2021 documented, "Notified by nursing of the sacral wound. Examined patient with nurse present. Wound measuring 2.5 cm x 5 cm, partial-thickness with red/pink wound base with mild serosanguineous drainage, no odor. Orders provided. Patient nonverbal at baseline. Discussed with nursing to ensure repositioning every 2 hours to offload sacral pressure." However, this order was never entered into the nursing care plan up until the time of survey.

A nurse's note written by (RN C) dated 11/09/2021 at 6:01 P.M. documented, "Resident seen by wound MD with no reported pain or discomfort during visit or treatment. Orders updated to continue treatments as ordered. V.O.R.B. [verbal order read back] per [wound physician name]: Cleanse Unstageable sacral wound with NS - Pat Dry - Apply a thin layer of Santyl Ointment - Cover with a Gauze Island Boarder Dressing Daily. MD/RP aware. Refer to wound notes. Will continue to monitor."

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The wound physician note dated 11/09/2021 under the header "Review of Systems" and sub-header "Support Surface" an excerpt documented, "Bed: Group 2 [meaning a specialty air mattress was on the bed]. Under the header "Focused Wound Exam (Site 1) Unstageable (due to necrosis) sacrum full thickness" the following sub-headers and entries included but were not limited to: "Wound size (L x W x D) [length x width x depth] ...6.2 x 8.4 x 0.1 centimeters. Exudate [drainage]: light sero-sanguinous [serum and blood]. Thick adherent devitalized necrotic tissue: 75%. Granulation tissue: 25%." Under the sub-header "Procedure note" an excerpt documented, " ....curette was used to surgically excise 39.06 square centimeters of devitalized tissue and necrotic subcutaneous fat and surrounding connective tissues were removed at a depth of 0.3 centimeters and healthy bleeding was observed." Under the header "Exam" an excerpt documented, "Left lower extremity ....dry skin dermatitis" and "Right lower extremity ....dry skin dermatitis." However, the condition of the heels was not assessed.

A nurse's note dated 11/13/2021 at 3:19 P.M. [19 days after the heels were noted to be reddened and non-blanchable on admission on 10/25/2021] documented, "writer was helping cna to change resident when turning her we saw her left lateral heel 9 cm X 5 cm X 0 depth, left heel 8 cm X 5 cm X 0 depth and right heel 5 cm X 3 1/2 cm X 0 depth have dark color like bruise like looking. reported to the supervisor."

There were no physician's orders dated 11/13/2021 addressing the bilateral heels.

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A nurse's note dated 11/14/2021 at 9:42 P.M. [10 days after sacral wound was discovered] documented, "N.O. [nurse order] Turn and Reposition every 2 hours. Alternating from Left side to Right side then middle (supine). Repeat cycle to relieve pressure to area on sacrum. Writer spoke with [name] from dietary in reference to obtaining Prostat to be given via PEG for area to sacrum. [name] stated she will consult with nurse practitioner tomorrow to start Prostat via PEG. N.O. skin prep to skin prior to applying dressings to any area requiring dressing. RP aware."

The Treatment Administration Record for November 2021 was reviewed. An order with a start date of 11/14/2021 and an end date of 11/18/2021 [the date Resident #1 went to the hospital] entitled, "Turn and reposition every 2 hours. Alternating from left side to right side then middle (supine). Repeat cycle to relive pressure to area on sacrum" was not signed off as administered on 11/14/2021 at 4:00 P.M. and 6:00 P.M. (blank) and on 11/15/2021 at 4:00 P.M. and 6:00 P.M. (indicating Resident #1 was left in the same position for 6 hours on 11/15/2021). This order was never documented in the nursing care plan up to the time of survey.

A physician's order dated 11/15/2021 documented, "Apply bilateral heel off loading boots to be worn anytime in bed." This physician's order for a pressure-reducing intervention was 21 days after the heels were noted to be reddened and non-blanchable on admission on 10/25/2021. This order was never documented in the nursing care plan up to the time of survey.

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BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

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A physician's order dated 11/15/2021 documented, "Sureprep [skin protectant] bilateral heels twice a day." This physician's treatment order to protect the skin was 21 days after the heels were noted to be reddened and non-blanchable on admission on 10/25/2021. This order was never documented in the nursing care plan up to the time of survey.

The care plan was reviewed. Under a problem which included "Skin breakdown R/T [related to] immobility/incontinence" with an approach start date of 12/15/2021 [51 days after the bilateral heels were noted to be soft, reddened, and non-blanchable] documented, "Skin prep to bilateral heels." Applying off-loading boots to both feet was not on the care plan.

A wound physician's note dated 11/16/2021 under the header "Focused Wound Exam (Site 1) Unstageable (due to necrosis) sacrum full thickness" and sub-header "Wound Progress" documented, "Deteriorated." Under the header "Additional Wound Detail" it was documented, "Now a stage 4, larger; d/c [discontinue] santyl, start Dakins [antiseptic solution] & crushed Flagyl [antibiotic]." Under the sub-header "Procedure note" an excerpt documented, " ....curette was used to surgically excise 75.33 square centimeters of devitalized tissue and necrotic muscle and surrounding fascial fibers at a depth of 2.4 centimeters and healthy bleeding tissue was observed." Under the header "Focused Wound Exam (Site 2) Unstageable DTI [deep tissue injury] of the left heel partial thickness", the following sub-headers and entries included but were not limited to: "Etiology: Pressure; Stage: Unstageable DTI with intact skin; Wound size (L x W x D)[length x width x depth] ...12.4 x 11.6 x

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(not measurable) centimeters." Under the header "Focused Wound Exam (Site 3) Unstageable DTI [deep tissue injury] of the right heel partial thickness", the following sub-headers and entries included but were not limited to: "Etiology: Pressure; Stage: Unstageable DTI with intact skin; Wound size (L x W x D)[length x width x depth] ...4.5 x 5.2 x (not measurable) centimeters."

A nurse's noted dated 11/18/2021 at 10:40 A.M. documented, "resident have fever 100.3 given prn [as needed] Tylenol and altered mental status. np [nurse practitioner] assessed and want to be sent to hospital. Rp [responsible party] aware."

The physician orders were reviewed. There was not a physician's order for an air mattress until 12/03/2021 upon Resident #1's readmission to the facility on 12/02/2021.

A review of the hospital records revealed that the stage 4 sacral wound was infected. Resident #1 received intravenous antibiotics, a surgical debridement of the sacral wound, and a wound vac [NPWT] placement before returning to the facility on 12/02/2021.

On 12/14/2021 at 2:00 P.M., an interview with (LPN C) was conducted. When asked about the process for Residents found to have reddened, non-blanchable area on the heels, (LPN C) stated that would be considered a stage 1 pressure wound. (LPN C) also stated that she would notify the NP or MD and enter in standing orders for skin prep (a skin protectant). When asked where the skin assessments are documented, (LPN C) stated that skin assessments are done weekly and entered into the electronic health record.

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(LPN C) stated there are also papers with an anatomical man (CNA shower sheet) that is filled out and given to the unit manager or the DON. When asked about the admission skin assessment for Resident #1, (LPN C) stated that she performed the skin assessment while giving Resident #1 a bed bath and recorded her findings on the CNA shower sheet. (LPN C) then stated she gave the Director of Nursing the paper once completed. When asked what her findings were, she stated she couldn't remember.

On 12/15/2021, the facility staff provided a copy of their policy entitled, "Pressure Ulcer Prevention and Treatment." In Section 3 under the header "Assessment" and sub-header entitled, "When assessing the ulcer itself, the nurse will:", it was documented, "Differentiate the type of ulcer (pressure-related versus non-pressure-related) or make a referral to the MD/NP for this differentiation. Interventions may vary depending on the specific type of ulcer; determine the ulcer's stage (for pressure ulcers) and describe and monitor the ulcer's characteristics; measure the size of the ulcer; monitor the progress toward healing and for potential complications; determine if the signs of infection are present; assess, treat, and monitor pain, if present; and monitor the application of dressings and treatments." Under the header "Interventions" in Section 1(a), it was documented, "Based upon the assessment and the resident's clinical condition, choices and identified needs, basic or routine care for the resident at risk for pressure ulcer development should include interventions to ...redistribute pressure (such as repositioning, protecting heels, etc.)."

On 12/15/2021 at approximately 4:15 P.M., the

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administrator and DON were notified of findings.

The care plan was reviewed. Under a problem which included "Skin breakdown R/T [related to] immobility/incontinence" with an approach start date of 12/15/2021 [41 days after the discovery of the sacral wound and during survey] documented, "Turn and reposition every 2 hours for pressure relief."

On 12/16/2021, the facility staff submitted several written statements attesting to Resident #1 being on air mattress for many months. The facility staff also submit 2 Quality Assurance reports. On the Quality Assurrance report dated 11/04/2021 under the sub-header "Date and results of most recent skin assessment, it was documented, "11/04/2021 open area to sacrum and red heels." However, there was no evidence in the clinical record that Resident #1's bilateral heel wounds were assessed/measured or a treatment plan put into place until 11/13/2021 and 11/14/2021, 9 days following their Quality Assurance report. Under the header "Pressure Injury Investigation - Actions Taken", it was documented that Resident #1 had a urinary tract infection that was treated with antibiotics and hyponatremia resulting in a hospitalization (10/21/2021-10/25/2021). However, there were no pressure-reducing interventions or wound assessments or treatments included in the action plan. The Quality Assurance report dated 11/13/2021 contained the same action plan as the one dated 11/04/2021. Under the header "Final Review/Summary of Actions" documented the following: "Physician notified; Resident/Resident Representative notified; referral to wound clinic/wound specialist; investigation did not find suggestions of abuse or neglect."

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F 686	Continued From page 16 On 12/16/2021 by the end of survey, the administrator and DON stated they had no further information or documentation to submit.	F 686		
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; (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,	F 842		1/11/22

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F 842	Continued From page 17 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 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 observation, resident interview, clinical record review, facility document review, and in the course of a complaint investigation the facility staff did not maintain a complete and accurate clinical record for one Resident (Resident #1) in a	F 842	F842 Resident Records – Identifiable Information 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 842	Continued From page 18 survey sample of three residents. The findings included; Resident #1's clinical record had nursing skin assessments were incomplete, inaccurate, and in conflict with each other. On 12/14/2021 at 12:20 P.M., an interview with the Director of Nursing (DON) was conducted. When asked about Resident #1's wounds, the DON indicated that [Resident #1] arrived from the hospital with a MASD [moisture-associated skin damage] rash and verified the wounds were acquired at the facility. A copy of the physician wound notes and nursing skin assessments were requested. On 12/14/2021 at approximately 5:15 P.M., the facility staff provided 8 pages of documents each entitled, "Skin Monitoring CNA [certified nursing assistant] Shower Review." Each document had 2 anatomical figures (font and back) pictured and a list of options to select. The "shower review" document dated 10/25/2021 [the day of readmission from the hospital] had handwritten by staff that the mid-posterior (back) section of the anatomical man labeled as "rashes" and handwritten in "MASD." The posterior feet were labeled as "soft heels" and handwritten in "redden [sic] non-blanchable [sic]." The document was signed by a CNA and Licensed Practical Nurse C (LPN C). There were no further descriptions or measurements included. During that review of the clinical record under the "Observation" tab, a document completed by	F 842	practice: During this complaint survey resident #1 did not have an accurate medical record. The skin assessments for resident #1 conducted since the survey have been reviewed by the DON or ADON, clarified where possible when discrepancies are found, and are being uploaded to the electronic medical record. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents' records are potentially affected by missing or inaccurate information. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Director of Nursing and Administrator will be provided to licensed/certified staff and medical records staff on maintaining a complete and accurate medical record including skin assessments from the EHR that are consistent with the manual skin assessments forms. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or designee will complete an audit for a complete and accurate medical record to ensure that skin assessments that are completed in the EHR are consistent with the manual skin assessment forms weekly x 4 weeks and monthly x 2 monthsThe result of these 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 reviewed by the	

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F 842	Continued From page 19 (LPN C) dated 10/25/2021 at 3:54 P.M. entitled, "Admission Skin Assessment" included the following headers and documented the following answers from the nurse, for each header selection: "Scars: no Bruises: no Skin Tears: no Reddened areas: no Pressure sores: no Rashes: no." The MASD and soft, reddened, non-blanchable heels that were documented on the "CNA shower reviews" were not documented, nor addressed in the admission skin assessment, thus contradicting each other. The same type of "shower review" document dated 10/28/2021 had the posterior feet labeled as "swelling" and "soft heels." The posterior region of the man diagram, had staff circling with a pen the right upper arm, right elbow, right forearm, right hand, and back region from the arm pits to the back of knees and labeled as "rashes." The posterior feet (heels) were labeled as "swelling" and "soft heels." The document was signed by a CNA and a nurse. There were no further descriptions or measurements included. The same type of document dated 11/04/2021 had the posterior mid-region labeled as "pressure" and the posterior feet labeled as "abnormal color." The document was signed by a CNA and a nurse. There were no further descriptions or measurements. The same type of document dated 11/11/2021	F 842	facility's QAPI Committee for review and will automatically trigger continuation of audits until full compliance is achieved. 5. Date of Compliance January 11, 2022	

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labeled the posterior mid-region as "decubitus" and the posterior feet were labeled as "blisters" and "abnormal color." The document was signed by a CNA and a nurse. There were no further descriptions or measurements included.

A nursing readmission note written by (LPN C) dated 10/25/2021 at 2:00 P.M. was reviewed. The MASD and soft, reddened, non-blanchable heels were not documented nor addressed in the admission narrative note.

The Administrator and Director of Nursing were made aware of the incomplete and inaccurate clinical record on 12-15-21. No further information was provided for this particular deficiency.