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{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 3/16/21 through 3/18/21, was conducted 5/18/21 through 5/20/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 86 certified bed facility was 44 at the time of the survey. The survey sample consisted of 11 Resident/record reviews.	{F 000}		
{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 by: Based on clinical record review, staff interviews, and review of facility documents, the facility staff failed to complete weekly wound assessments for 1 resident (Resident # 110) and to obtain a weekly weight for 1 resident (Resident #106), in the survey sample. The findings included:	{F 684}		

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

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1. Resident #110 was originally admitted to the facility 11/11/20 and readmitted 4/7/21 after an acute care hospital stay. The current diagnoses included; diabetes and end stage renal disease requiring dialysis.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #110 cognitive abilities for daily decision making were intact. In section "E" (Behaviors), the resident was coded for rejecting care 1-3 days per week. In section "G" (Physical functioning) the resident was coded as requiring limited assistance of one person with bed mobility, transfers, walking, locomotion, dressing, eating, toileting, personal hygiene and bathing, and for supervision after set-up with eating.

Review of the resident's clinical record revealed on 4/20/21, a trauma wound was observed on the resident's sacrum secondary to scratching. A nurse's note dated 4/20/21 at 14:43 read; a cluster of two areas, wound bed red. A treatment is in place. Resident states that he feels like something is biting him and he has been scratching areas of his body.

Review of the physician's order summary revealed the following order dated 4/20/21; clean with Normal saline and pat dry. Apply calcium alginate and border gauze to sacral wound, every night shift.

A care plan problem read; The resident has actual impairment to skin integrity related to suspected deep tissue injury to right great toe,

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right third toe and right fifth toe 3/26/21, abrasion to left wrist 4/20/21 and open areas times two to the sacrum 4/21/21. The goal read; the resident will have no complications. The interventions included; treatment as indicated, resident to be followed weekly on wound rounds. Avoid scratching and keep finger nails short.

The 4/20/21, weekly wound report stated the trauma wound to the sacrum measured 1.0 centimeter by 1.0 centimeter by 0.1 centimeters, was without drainage, the wound bed was pink and the wound had no odor.

The 4/27/21 weekly wound report stated the trauma wound to the sacrum measured 0.6 centimeter by 0.8 centimeter by 0.1 centimeters, was with a scant amount of serous drainage, the wound bed was red and the wound had no odor.

No weekly wound report was observed on the clinical record for Resident #110's trauma wound for 5/4/21 or 5/11/21.

On 5/20/21 at approximately 10:45 a.m., an interview was conducted with the Unit Manager and the Director of Nursing. Both stated all wound regardless of the etiology or classification are assessed at least weekly. The assessment would include location, appearance, stage if applicable, size, drainage description if present, wound bed description, surrounding tissue description, and if pain was present.

The Unit Manager and the Director of Nursing also stated the Resident #110 was followed by the wound care physician and for some reason the notes were not on the clinical record but they would be obtained from the wound care

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physician. The Unit Manager stated she believed the wound care physician assessed Resident #110 on 5/5/21 and 5/12/21.

On 5/20/21 at approximately 4:40 p.m., the Administrator presented documents dated 5/6/21 and 5/13/21 titled Resident Review. The document dated 5/6/21, recorded the resident's intake, a fall report, with interventions and read; Resident's wound continues with weekly monitoring and healing well. Area noted as 1.0 centimeter by 1.0 centimeter by 0.1 centimeters. The document dated 5/13/21, read; Good intake, double portions. Reached out to dialysis for dry weight goals. Resident's trauma area to the sacrum noted, healing, weekly wound measurements continue. Area noted as 0.6 centimeter by 0.4 centimeter by 0 centimeters. Continue plan of care.

The Resident Review documents provided by the Administrator on 5/20/21 at approximately 4:40 p.m., only provided measurements of the trauma wound, not a full assessment of the wound.

On 5/20/21 at approximately 6:00 p.m., the above findings were shared with the Administrator, the Administrator-in-training, Director of Nursing, Unit Manager and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided including the wound care physician's progress notes or any other weekly wound care assessments dated for the weeks of 5/4/21 and 5/11/21 were provided to the survey team.

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{F 684}	Continued From page 4	{F 684}		

2. The facility staff failed to obtain a physician ordered daily weights for one day on May 13th 2021, for Resident #106.

Resident #106 was originally admitted to the facility 06/02/20 and readmitted 12/22/20 after an acute care hospital stay. The current diagnoses included; Congestive Heart Failure and Peripheral Disease.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/18/2021 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making.

In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bed mobility, locomotion, dressing, eating, toileting, personal hygiene and bathing. Requires total dependence of two persons with transfers.

The Care Plan dated 3/24/21 indicated: "Focus: Resident #106 has a diagnoses of CHF (Congestive Heart Failure). Goal: Resident will experience decreased episodes of shortness of breath, and chest pain. Interventions: Monitor weight daily, notify MD (Medical Doctor) if patient has weight gain greater than 3 lbs. (pounds) in 24 hours or greater than 5 lbs. in a week. Monitor weight per protocol.

According to the Physician Order Summary for May 2021, Resident #106 should have received the following orders: Weigh resident daily notify MD (Medical Doctor) of 3 lb. weight gain in one

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day/5 lb. in one week. One time a day for CHF (Congestive Heart Failure) monitoring.

A review of the MAR (Medication Administration Record) revealed on May 13th, 2021 that a weight was not obtained but listed a code of 19.

A review of nursing notes reads as follows:

5/13/2021 15:31(3:31 PM) Medication Administration Note Text: Weigh Resident Daily. Notify MD of 3 lb. weight gain in one day/5 lb. in one week one time a day for CHF (Congestive Heart Failure) MONITORING. Did not obtain weight.

5/13/2021 10:17 IDT (Interdisciplinary Team) Progress Note Reason: IDT team meeting held to discuss resident's weight and skin.

On 5/20/21 at approximately 2:40 PM., an interview was conducted with LPN (Licensed Practical Nurse) #1 concerning Resident #106's daily weight not listed on the MAR (Medication Administration Record) for May 13, 2021. After reviewing the MAR she stated, "The code 19 listed on the MAR means see nurses note." "It says didn't obtain weight."

On 5/20/21 at approximately 4:20 PM an interview was conducted with LPN (Licensed Practical Nurse) #6. Concerning Resident #106 receiving daily weights. She stated, "I just didn't obtain the weight. He was a mechanical lift requiring two people."

On 05/20/2021 at approximately 4:55 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was

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{F 684}	Continued From page 6 offered to the facility's staff to present additional information but no additional information was provided.	{F 684}		
{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 observations, clinical record review, staff interviews, and review of the Plan of Correction (POC), the facility staff failed to ensure existing pressure ulcers measure and treatments are implemented to promote continued healing and prevent opportunities to develop further pressure related injuries for 1 of 11 residents (R#105) in the survey sample. The findings included: Resident #105 was admitted to the nursing facility on 4/21/17 with diagnoses that included stroke with muscle weakness, vascular dementia, left hip hemiarthroplasty, osteoarthritis and pain.	{F 686}		

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The Minimum Data Set (MDS) Significant Change in Status assessment dated 4/8/21 coded the resident with short and long term memory and severely impaired in the cognitive skills for daily decision making. Resident #111 was assessed totally dependent on one staff for bed mobility, transfers, toilet use, personal hygiene, dressing, bathing and eating. The wheelchair is her main mobility device. The resident is coded always incontinent of bowel and bladder. She was assessed with no weight loss. The resident was coded to have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. She was assessed at risk for the development of pressure ulcers/injuries and coded for one facility acquired Stage II unhealed pressure ulcer/injuries. The resident was coded to have treatments to include pressure reducing device for chair, bed, turning and repositioning, pressure ulcer /injury care, applications of ointments/medications and application of dressings to feet.

The Braden Scale Pressure Ulcer Risk Assessment dated 4/8/21 that coincided with the above MDS indicated that the resident was at high risk (scored 10.0) for the development of pressure ulcers/injuries related to sensory perception, moisture, activity, mobility, friction and shear.

Resident #111 started hospice services on 4/5/21 due to stroke involving decreased cognitive functions. An area identified by hospice services was that the resident was at risk for skin breakdown and the caregiver would care for the resident's skin, monitor areas for breakdown and demonstrate methods to prevent breakdown through hospice care. Skin would be assessed at

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each visit, instruct on methods for skin care (moisture control, repost signs and symptoms of rash, redness and breakdown). Instruct risk for skin breakdown and manage/prevent skin breakdown.

The care plan developed by the nursing facility dated 1/27/21 and revised on 4/28/21 indicated the Resident #105 was at risk to impaired skin integrity due to impaired mobility, incontinence and very high Braden score. The care plan identified recent blister to great toe on 4/1/21 that opened with black Eschar and resolved on and Moisture Associated Skin Damage (MASD) identified on 5/19/21 that resolved. The goal set for the resident by the staff was that the resident would be free from signs and symptoms of breakdown through next review. Some of the approaches the staff would take to accomplish this goal included pressure reduction devices if ordered.

The care plan developed by the nursing facility dated 11/30/20 identified that the resident had acquired pressure ulcers that had resolved (right buttocks, Stage 2-3 resolved on 3/31/21; left buttocks, Stage 2-3 resolved on 12/30/20; sacrum Stage 4, resolved on 1/20/21, blister to left great toe, resolved on 5/11/21). The resident also had history of MASD on the right and left buttocks on 11/28/20 and MASD to mid sacral area identified during the survey on 5/19/20).

The goal set by the staff for the resident was that she would show signs of healing and remain free of pressure ulcers and infection. Some of the approaches the staff would implement to accomplish this goal included administer treatments as orders, avoid positioning resident

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on her back and position frequently, low air loss mattress and pressure relief cushion to wheelchair.

Resident #105 had hospice orders dated 4/2/21 to have gauze placed between the left great and second toe and pillow placed between legs to prevent further areas from developing. This treatment regimen was reviewed during the IDT meeting dated 4/2/21. The treatment continued per physician orders dated "4/1/21, left big toe: apply Skin Prep to fluid filled blister and leave open to air, place pillow between legs and gauze between big toe and second toe to prevent friction, apply heel protectors on both feet every night shift for wound." On 4/21/21, "skin prep wipes apply to left big toe dorsal topically one time a day for eschar." On 5/1/21 to current, "left big toe: Apply skin prep to toe and leave open to air, place pillow between legs and gauze between big toe and second toe to prevent friction, apply heel protectors on both feet every day and night shift for wound." There was a physician's order dated 12/8/20 for pressure reducing cushion to chair.

The following observations were made of Resident #111:

On 5/18/21 at 11:15 a.m. to 2:30 p.m., the resident was in her wheelchair without a chair cushion. On 5/18/21 at 4:30 p.m., Personal Care Aid (PCA) #2 and Certified Nursing Assistant (CNA) #8 placed the resident in bed. A skin assessment revealed large areas of hyper pigmentation where previous pressure ulcers had been, but presently healed. A small open area was observed in the middle of the resident's sacrum that the CNA stated maybe built up

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barrier cream. There was no gauze pad applied between the left great toe and second toe. PCA #2 and CNA #8 placed a pillow between the resident's legs after placing the resident on her left side.

On 5/19/21 from 9:00 a.m. to 11:00 a.m., the resident was observed in bed without a pillow between her legs. The resident was placed in her high back wheelchair at approximately 11:00 a.m. with a regular pillow in the seat of her wheelchair. At approximately 2:00 p.m., PCA #3 placed the resident back to bed. The pillow was clearly visible in the wheelchair. The PCA did not place a pillow between the resident's legs. There was no gauze pad between the left great toe and second toe. At 2:30 p.m., PCA#3 stated she washed the resident's legs and feet and applied lotion, but she did not notice a gauze pad between the toes or that one was inside the socks she removed. At 3:10 p.m., the assigned Licensed Practical Nurse (LPN) #2 and the LPN#1/Unit 2 Manager were present during inspection of the resident's buttocks and sacrum which was after the resident had a bowel movement. The areas were cleansed and free of the barrier cream. LPN#2 and LPN #1/Unit Manager observed the small open area on the resident's sacrum. LPN#1 stated she would get the Director of Nursing (DON) to make an assessment of the open area. The DON determined the area was Moisture Associated Skin Damage (MASD) and the barrier cream was the appropriate treatment. None of the above LPN's or the DON was informed of the small open area.

During the above observation, LPN #2 was asked if she placed the gauze pad between the resident's left great toe and second toe, as well

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as the pillow between the legs since she signed off on the treatments (5/19/21), she offered no response. LPN#1/Unit Manager was asked if she assured the gauze pad was in place between the resident's toes, as well as a pillow between her legs since she signed off on the treatments for 5/18/21, to which she was unable to affirm that she or the aide rendered those treatments. Both LPN #2 and #1 signed off on the Treatment Administration Record (TAR) that the treatments were rendered at least for their shifts from 7:00 a.m. to 7:00 p.m.

5/20/21 at 12:15 p.m., the Regional Director of Clinical Services was present when PCA#3 stated she placed a regular pillow in the resident's chair as a cushion and was never told there was a special cushion. The PCA also said she was never told to place a pillow between the resident's legs. At 12:30 p.m., the Regional Director of Clinical Services stated she instructed the PCA about the placement of the pressure reduction cushion in the resident's high back wheelchair which was found in the resident's room, as well as placement of a pillow between the legs.

The facility's plan of correction with allegation of compliance dated 4/15/21 indicated that as a result of their most recent quarterly quality assurance meeting dated 4/29/21, all pressure injury audits were reviewed to reveal no issues that needed to be addressed for any of the facility residents and that care plan interventions were consistently implemented. On 5/20/21 at 4:45 p.m., and interview was conducted with the Administrator, the Licensed Practical Nurse (LPN)/Unit 2 Manager, the DON and the Regional Director of Clinical Services. They stated although April audits would be reviewed in May,

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{F 686}	Continued From page 12 when they review resident audits as a part of their QA process, if they see a negative outcome or potential problem, they follow-up immediately, talk to the staff involved, educate all staff and depending on if there was a trend, they will come up with another QAPI plan. They stated they talk about the audits daily and deal with any identified issues related to pressure injury prevention or assessment, correction is make right away. The DON stated she or her designee will audit 24 resident per week for pressure ulcer prevention and intervention at different times and if find anything to address them immediately. It had been determined that the resident's pressure areas were recently healed and she was at high risk for recurrent ones, thus all preventative treatments were essential components to maintaining intact skin. The nursing staff providing care during the observations had been educated and signed off on pressure ulcer prevention to include turning and positioning, use of pressure reducing/relieving devices and skin observation per their QAPI plan. The facility's policy and procedure titled Skin and Wound Care Best Practices dated 7/1/2012 and revised on 3/12/21 indicated that skin care and pressure injury prevention included pressure reduction/redistribution for those at risk by providing pressure redistribution/relief devices (cushions, support surface) according to IDT assessment and recommendations.	{F 686}		
{F 698} SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis.	{F 698}		

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{F 698}	Continued From page 13	{F 698}		

The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, clinical record review, staff interviews, and review of facility documents, the facility's staff failed to establish transportation to and from the dialysis facility for 1 of 11 residents (Resident # 110), in the survey sample.

The findings included:

Resident #110 was originally admitted to the facility 11/11/20 and readmitted 4/7/21 after an acute care hospital stay. The current diagnoses included; endstage renal disease requiring dialysis.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #110 cognitive abilities for daily decision making were intact. In section "E" (Behaviors), the resident was coded for rejecting care 1-3 days per week. In section "G" (Physical functioning) the resident was coded as requiring limited assistance of one person with bed mobility, transfers, walking, locomotion, dressing, eating, toileting, personal hygiene and bathing, and for supervision after set-up with eating.

Review of Resident #110's physician orders revealed an order dated 5/18/21, which read; May

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attend dialysis at (name of the facility) on Monday, Wednesday and Friday with chair time at 12:15 p.m., and pick up at 11:15 a.m.

On 5/19/21 at approximately 11:30 a.m., and again at approximately 12:40 p.m., Resident #110 was observed in bed dressed in a gray hooded shirt and gray pants. The resident stated transportation didn't arrive to transport him to dialysis and he didn't want to go anyway because; it takes too long. "I get tired staying there all that time".

The Nurse Practitioner's progress note date 5/19/21 at 11:46 read Resident is not going to dialysis today because he is tired. Resident was educated related to the consequences of dialysis refusal at which he didn't respond. No physical evidence of pain and physical distress noted to the resident during visit. Director of Nursing informed related resident's dialysis refusal.

On 5/19/21 at 12:10 p.m., an interview was conducted with Licensed Practical Nurse #3 was the charge nurse assigned to resident #110 for the 7:00 a.m., - 7:00 p.m., shift. LPN #3 stated she was unaware why the resident had not gone to dialysis but she would look into it. LPN #3 never offered a response related to Resident #110 not attending dialysis on 5/19/21.

On 5/19/21 at 3:00 p.m., an interview was conducted with the Certified Nursing Assistant (CNA) #1 for she was assigned to care for the resident for the day. CNA #1 stated the resident was dressed by the prior shift for dialysis. CNA #1 also stated after breakfast she went in to check on Resident #110 and remind him of his dialysis appointment the resident told her he

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wasn't going to dialysis and the information was reported. CNA #1 stated she was unaware what time the transport company arrived to transport the resident for she didn't see them come in but stated they normally arrive at approximately 11:00 a.m. CNA #1 also stated previously the resident was transported by wheel chair to dialysis but recently he the transport company was using a stretcher.

An interview was conducted on 5/19/21 at approximately 3:10 p.m., with the transportation company's representative. The representative stated the standing order for Resident #110's transport to dialysis had been canceled due to a hospitalization and at the time of our conversation it had not been re-established therefore; transportation didn't come to the facility on 5/19/21 to transport the resident.

On 5/19/21, at approximately 4:00 p.m., the Administrator and Director of Nursing stated the Nurse Practitioner saw the resident earlier that day to discuss the resident's refusal of dialysis. Neither the Administrator or the Director of Nursing could state what time the transportation company arrived to transport the resident. The Administrator stated if the resident had stated he wanted to attend dialysis the would have put him on the facility's van for transport.

On 5/19/21, at approximately 4:00 p.m., an interview was conducted with Maintenance Director. The Maintenance Director stated the facility has one van and he would be the driver if they used it to transport but the resident would be accompanied by a nursing staff member. The Maintenance Director further stated the van can't accommodate a resident requiring use of a

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stretcher.

On 5/20/21, at approximately 4:15 p.m., an interview was conducted with a Registered Nurse (RN) of the dialysis center Resident #110 attended. The RN stated they thought the resident was still in the hospital for no one contacted them that he had returned to the nursing facility. The RN stated Resident #110 attended the dialysis center prior to his admission to the nursing facility and he had always been non-compliant, he never wanted to complete the dialysis session or missed many dialysis sessions. The RN further stated the Social Worker had worked expeditiously with the resident, offering encouragement and strategies to aid him to tolerate the dialysis sessions and they had seen an improvement over time. The RN also stated transportation for dialysis is arranged by the center for persons living in the community, their home and other but not for individuals living in nursing facilities. The RN stressed it is the responsibility of the nursing facility to arrange transportation for residents to and from dialysis sessions.

On 5/20/21, at approximately 5:15 p.m., the Administrator presented a schedule of rides for Resident #110 transports to the dialysis center. The Administrator stated the Administrator-in-training contacted the transportation company at approximately 1:00 p.m., and learned that on 5/19/21 the resident's standing order had been canceled based on the resident no longer attending the facility for dialysis services. The Administrator-in-training provided a document showing services were reactivated 5/20/21 for services to resume 5/21/21 with a pickup time of 11:15 a.m., and a return to the

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{F 698}	Continued From page 17 facility time of 4:15 p.m. On 5/20/21, at approximately 5:45 p.m., an interview was conducted with Unit Manager, who stated the Interdisciplinary Team (IDT) at the dialysis center contacted the nursing facility to inform them that Resident #110 was no longer to attend dialysis in a wheel chair because of his behaviors, attendance concerns and intolerance to the dialysis process/length of time dialysis required therefore; use of the stretcher was instituted to encourage resident tolerance. On 5/20/21 at approximately 6:00 p.m., the above findings were shared with the Administrator, the Administrator-in-training, Director of Nursing, Unit Manager and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but none was provided.	{F 698}		
{F 868} SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality	{F 868}		

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assessment and assurance activities are necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, staff interviews, and review of facility policies, it was determined the facility's Quality Assessment and Assurance (QA&A) committee failed to identify quality deficiencies in the areas of Quality of Care, F-684, Pressure Injuries F-686, and Dialysis F-698.

The findings included:

On 5/19/21 at approximately 9:49 AM., an email was forwarded to the administrator requesting documents for QA&A meetings held from April 2021 to May 2021 to include the audits.

A Patient at Risk (PAR) & QAPI document was received on 5/19/21 at approximately 10:50 AM from the administrator. Data Reviewed for: March Meeting Date: 4/29/2021. QAPI Meeting Attendance Sheet. The document showed that all of the necessary QA/QAPI team members were present at the meeting. No audits were emailed per surveyors' request.

On May 19, 2021 at approximately 11:06 AM an email was received from the administrator reading: "Our QAPI review for the audits you are looking for will be discussed in our April QAPI meeting which will be reviewed May 27th."

The QA&A committee failed to address the F-684 Quality of Care for two residents. One resident for not assuring weekly non-pressure ulcer assessments were completed and the other for not obtaining an ordered daily weight on a

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{F 868}	Continued From page 19 resident with CHF (Congestive Heart Failure). During the survey look back period Resident #110 had been identified with a trauma wound to the sacrum on 4/20/21. Review of the clinical record revealed two weekly wound assessments (4/20/21 and 4/27/21) but no further wound assessments could be located. On 5/20/21 at approximately 10:45 a.m., an interview was conducted with the Unit Manager and the Director of Nursing. Both stated all wounds regardless of the etiology or classification are assessed at least weekly. The assessment would include location, appearance, stage if applicable, size, drainage description if present, wound bed description, surrounding tissue description, and if pain was present. The Unit Manager and the Director of Nursing also stated that Resident #110 was followed by the wound care physician and for some reason the notes were not on the clinical record but they would be obtained from the wound care physician. The Unit Manager stated she believed the wound care physician assessed Resident #110 on 5/5/21 and 5/12/21. At the time the survey concluded the missing weekly trauma wound assessments had not been provided. Also during the survey the QA&A committee failed to address Quality of Care for Resident #106. A review of Resident #106's MAR (Medication Administration Record) revealed that a daily weight had not been obtained per physicians order. On 5/20/21 at approximately 2:40 PM., an interview was conducted with LPN (Licensed Practical Nurse) #1 concerning Resident #106's weight not being listed on the MAR (Medication Administration Record) for May 13, 2021. After reviewing the MAR she stated, "The code 19 listed on the MAR means see	{F 868}		

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nurses note." "It (the nurses note) says didn't obtain weight."

On 5/20/21 at approximately 4:20 PM an interview was conducted with LPN (Licensed Practical Nurse) #6. Concerning Resident #106 receiving daily weights. She stated, "I just didn't obtain the weight. He was a mechanical lift requiring two people."

During the survey one resident Resident #110 was recognized with dialysis concerns. Review of his physician order summary revealed an order dated 5/18/21, which read; May attend dialysis at (name of the facility) on Monday, Wednesday and Friday with chair time at 12:15 p.m., and pick up at 11:15 a.m. On Wednesday 5/19/21 transportation didn't arrive to the facility to transport the resident.

An interview was conducted on 5/19/21 at approximately 3:10 p.m., with the transportation company's representative. The representative stated the standing order for Resident #110's transport to dialysis had been canceled due to a hospitalization and at the time of our conversation it had not been re-established therefore; transportation didn't come to the facility on 5/19/21 to transport the resident.

On 5/20/21, at approximately 5:15 p.m., the Administrator presented a schedule of rides for Resident #110 transports to the dialysis center. The Administrator stated the Administrator-in-training contacted the transportation company at approximately 1:00 p.m., and learned that on 5/19/21 the resident's standing order had been canceled based on the resident no longer attending the facility for dialysis

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services. The Administrator-in-training provided a document showing services were reactivated 5/20/21 for services to resume 5/21/21 with a pickup time of 11:15 a.m., and a return to the facility time of 4:15 p.m.

During the survey one resident Resident #105 was recognized for not using the correct positioning device. The facility's plan of correction with allegation of compliance dated 4/15/21 indicated that as a result of their most recent quarterly quality assurance meeting dated 4/29/21, all pressure injury audits were reviewed to reveal no issues that needed to be addressed for any of the facility residents and that care plan interventions were consistently implemented.

On 5/20/21 at 4:45 p.m., and interview was conducted with the Administrator, the Licensed Practical Nurse (LPN)/Unit 2 Manager, the DON and the Regional Director of Clinical Services. They stated although April audits would be reviewed in May, when they review resident audits as a part of their QA process, if they see a negative outcome or potential problem, they follow-up immediately, talk to the staff involved, educate all staff and depending on if there was a trend, they will come up with another QAPI plan. They stated they talk about the audits daily and deal with any identified issues related to pressure injury prevention or assessment, correction is make right away.

The DON stated she or her designee will audit 24 resident per week for pressure ulcer prevention and intervention at different times and if find anything to address them immediately. Resident #105, who was at high risk for pressure injuries and had recent healed pressure injuries, was

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observed during the survey without her pressure relieving chair cushion, pillow between the legs and gauze pad between the left great toe and second toe until brought to the attention of the surveyor. The nursing staff providing care during the observations had been educated and signed off on pressure ulcer prevention to include turning and positioning, use of pressure reducing/relieving devices and skin observation per their QAPI plan.

Policy Titled: Quality Assurance and Performance Improvement (QAPI) Program Policy. Date: 11/28/17. Last Revised: 5/28/20. QAPI efforts are a component of the facility QAA (Quality Assessment and Assurance) Committee's responsibilities. The QAA Committee is responsible for both Quality Assessment and Assurance activities (QA) and ongoing, proactive, Performance Improvement (PI) activities. The purpose of QAPI in the facility is to take proactive approach to continually improving delivery of care and services and to engage residents, caregivers, and other clinical/operational partners in maximizing quality of life and quality of care. The committee will meet at least quarterly. The Centers for Medicare and Medicaid Services (CMS) has identified five strategic elements which can help to form the basis of an effective QAPI program. 3. Feedback, Data Systems and Monitoring. The facility program will establish system(s) for monitoring care and services, drawing data from multiple sources, including the facility assessment. The program should accurately incorporate feedback from residents , staffs, families, and others as appropriate. This includes investigating, tracking, and monitoring adverse events and allegations of abuse of all types as well as implementing actions plans to

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prevent recurrence. The focus will be on high-risk, high-volume, and problem prone areas. The facility will conduct performance improvement projects (PIPS) to examine, evaluate and improve care.

On 5/20/21 at approximately 6:35 PM a debriefing was held with the administrator concerning the above issues and audit concerns. The administrator stated, "We talk about our audits daily. We have not found any issues yet. We're doing them (audits). Pressure Ulcer issues we correct right away. We take it to QA because we want to discuss areas of improvement. We do QAPI every month but we also have quarterly and weekly audits. We meet every last Thursday of the month. We've had one QAPI so far. We received the 2567 (Plan of Correction) on 4/01/21 and had the meeting on 4/29/21. It's (audits) being done throughout the week. We do twenty-four residents in a week. If anything is found out of place we address it then. If we find anything. We discuss issues every morning. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.