STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345431	A. BUILDING _____ B. WING _____	C 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN HEALTH AND REHAB	**921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874**

(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
E 000	Initial Comments An unannounced Recertification/ compliant survey was conducted on 7/14/19 through 7/17/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # SZ2511.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 06/18/19 to conduct a complaint survey and exited on 06/19/19 for event ID CO0411. The survey team returned to the facility on 07/14/19 to obtain additional information and to conduct a recertification and complaint survey the team exited on 07/17/19. The recertification event ID was SZ2511. Five of the eighteen allegations investigated during the survey were substantiated with a deficiency at F686.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		8/16/19

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

Electronically Signed | 08/07/2019

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F 636	Continued From page 1	F 636		

(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,

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F 636	Continued From page 2 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and submit comprehensive Minimum Data Set (MDS) assessments within the required timeframe for 3 of 18 (Residents #199, #200, and #201) residents assessments reviewed. The findings included: 1. Resident #199 was admitted to the facility on 4/6/2017 and the most recent MDS assessment for review was a quarterly dated 1/8/2019. Current MDS assessments were unavailable for review. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS nurse stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated Resident #199 had a comprehensive assessment due on 4/10/2019 but the assessment had not yet been completed or submitted. On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new MDS nurse started, to schedule all resident	F 636	Identified residents (#199, 200, and 201) had the necessary late MDS completed by MDS coordinator by 7/25/19. A whole house audit was completed by the Admin and MDS coordinator to insure no other residents were missed outside of the current working list/calendar created that were identified in April with the hiring of the new MDS coordinator. No new residents were found to be deficient other than those previously identified. MDS and interdisciplinary team were educated on importance of timely assessments and need for use of the system built calendar in Matrixcare for full optimization and to keep assessments on track. MDS is to update any changes to the current schedule via paper calendar to the IDT team at time of change. Ongoing audits by Admin for observation and documentation of the Matrixcare calendar as well as paper calendars for any changes. Audit trail report review will be observed from Matrixcare as well. These audits will be five days per week for two weeks, weekly for two weeks, and monthly for two months. All data will be summarized and presented to the facility QAPI meeting monthly by the	

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F 636	Continued From page 3 assessments to be caught up by 8/1/2019. The Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going forward she expected the MDS assessments to be completed and transmitted on time. 2. Resident #200 was admitted to the facility on 4/16/2015, and the most recent MDS assessment available for review was a quarterly dated 1/14/2019. Current MDS assessments were unavailable for review. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS nurse stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated Resident #200 had a comprehensive assessment due on 4/16/2019 but the assessment had not yet been completed or submitted. On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new MDS nurse started, to schedule all resident assessments to be caught up by 8/1/2019. The Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going forward she expected the MDS assessments to be completed and transmitted on time.	F 636	DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 636	Continued From page 4 3. Resident #201 was admitted to the facility on 4/10/2018, and the most recent MDS assessment was a quarterly dated 1/14/2019. Current MDS assessments were not available for review. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS nurse stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated Resident #201 had a comprehensive assessment due on 4/16/2019 but the assessment had not yet been completed or submitted. On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new MDS nurse started, to schedule all resident assessments to be caught up by 8/1/2019. The Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going forward she expected the MDS assessments to be completed and transmitted on time.	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State	F 638		8/16/19

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F 638	Continued From page 5 and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and submit quarterly Minimum Data Set (MDS) assessments within the required timeframe for 4 of 18 (Residents #1, #26, #28, and #198) residents assessments reviewed. The findings included: 1.Resident #1 was admitted to the facility on 10/17/2018 with diagnoses to include stroke and hemiplegia. Resident #1 most recent Minimum Data Set (MDS) assessment was dated 1/16/2019. The quarterly MDS assessment due 4/2019 was not available for review. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS nurse stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated she had completed Resident #1's quarterly assessment due on 4/17/2019 but it had not yet been submitted. On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new	F 638	Identified residents (#1, 26, 28, and 198) had the necessary late MDS completed by MDS coordinator by 7/25/19. A whole house audit was completed by the Admin and MDS coordinator to insure no other residents were missed outside of the current working list/calendar created that were identified in April with the hiring of the new MDS coordinator. No new residents were found to be deficient other than those previously identified. MDS and interdisciplinary team were educated on importance of timely assessments and need for use of the system built calendar in Matrixcare for full optimization and to keep assessments on track. MDS is to update any changes to the current schedule via paper calendar to the IDT team at time of change. Ongoing audits by Admin for observation and documentation of the Matrixcare calendar as well as paper calendars for any changes. Audit trail report review will be observed from Matrixcare as well. These audits will be five days per week for two weeks, weekly for two weeks, and monthly for two months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI	

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F 638	Continued From page 6 MDS nurse started, to schedule all resident assessments to be caught up by 8/1/2019. The Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going forward she expected the MDS assessments to be completed and transmitted on time. 2.Resident #26 was admitted to the facility on 11/20/2012 with diagnoses to include stroke, hypertension and dysphagia. Resident #26's annual MDS assessment dated 12/3/2018 and her quarterly assessment dated 6/3/2019 had been completed and submitted for review. The assessment due for 3/2019 was not available for review. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated she had completed Resident #26's quarterly assessment due 6/2019 but had not completed or submitted her quarterly assessment due 3/5/2019. On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new MDS nurse started, to schedule all resident assessments to be caught up by 8/1/2019. The	F 638	committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 638	Continued From page 7	F 638		

Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going forward she expected the MDS assessments to be completed and transmitted on time.

3.Resident #28 was admitted to the facility on 5/23/2014 with diagnoses to include end stage renal disease and diabetes.

Resident #28's annual MDS assessment was dated 6/4/2019, but his quarterly due 3/2019 was unavailable for review.

On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated she had completed Resident #28's annual assessment due 6/2019 but had not completed or submitted his quarterly assessment due 3/6/2019.

On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new MDS nurse started, to schedule all resident assessments to be caught up by 8/1/2019. The Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going

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F 638	Continued From page 8 forward she expected the MDS assessments to be completed and transmitted on time. 4. Resident #198 was admitted to the facility on 1/8/2019, and her last MDS assessment for review was a quarterly on 1/8/2019. The resident had no recent MDS assessments available for review. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated Resident #198's quarterly assessment was due 4/10/2019 and her annual was due 7/10/2019 but she had not yet completed the assessments. On 7/17/2019 at 10:00 AM, an interview was conducted with the Administrator who stated she had created a PIP on 4/1/2019 when the new MDS nurse started, to schedule all resident assessments to be caught up by 8/1/2019. The Administrator stated the plan was to do all the MDS assessments that were due currently and then go back and pick up the old ones until all were caught up. The Administrator stated going forward she expected the MDS assessments to be completed and transmitted on time.	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		8/16/19

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F 640	Continued From page 9 §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		

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F 640	Continued From page 10 (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to transmit a Discharge Tracking MDS (Minimum Data Set) assessment within the required timeframe for 1 of 14 residents (Resident #2) reviewed for assessments. The findings included: Resident #2 was admitted to the facility on 2/28/2019 with diagnoses to include intellectual disability and hypertension. A review of Resident #2's medical record revealed the last assessment completed and submitted to the Center for Medicare/Medicaid System (CMS) data base was a 14-day MDS assessment, dated 2/21/2019. On 7/15/2019 at 3:04 PM, an interview was conducted with the MDS nurse who stated she began her employment at the facility on 4/1/2019 and found resident assessments were overdue to be completed and submitted. The MDS stated the Administrator had started a Performance Improvement Plan (PIP), and she had submitted a calendar to keep track of all the residents while she worked to get all assessments up to date. The MDS nurse stated she had missed Resident	F 640	Identified resident (#2) had the necessary late MDS transmitted by MDS coordinator by 7/25/19. A whole house audit was completed by the Admin and MDS coordinator to insure no other residents were not transmitted outside of the current working list/calendar created that were identified in April with the hiring of the new MDS coordinator. No new residents were found to be deficient other than those previously identified. MDS and interdisciplinary team were educated on importance of timely transmission of assessments. Ongoing audits by Admin for observation and documentation of transmission reports. These audits will be five days per week for two weeks, weekly for two weeks, and monthly for two months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will	

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F 640	Continued From page 11 #2, and he had discharged on 2/25/2019, so she would get the Discharge Tracking MDS submitted. On 7/16/2019 at 3:41 PM, an interview was conducted with the Administrator who stated she expected the MDS to be transmitted on time.	F 640	be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	
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, facilituy staff, wound clinic staff, Power of Attorney (POA) and Physician interviews, and record reviews the facility failed to assess a pressure ulcer and failed to carry out a wound clinic referral which resulted in a decline and infection of the wound for 1 of 5 residents (Resident #47) reviewed for pressure ulcers. Findings included:	F 686	Identified resident # 47 is no longer a resident of this facility. A whole house skin sweep was performed by a licensed nurse and a Med Aide on 7/11/19 with a follow up whole house skin sweep by Licensed nurses (ADON, DON, MDS) to insure no further skin issues were found and undocumented or not addressed. This second skin sweep was	8/16/19

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F 686	Continued From page 12 Resident #47 was admitted to the facility on 2/19/2019 with diagnoses which included fractured hip, osteoporosis, Methicillin-resistant Staphylococcus aureus (MRSA-a bacterium causing infections), hypokalemia, osteoarthritis, degenerative joint disease in the spine (DJS), acute cystitis, dysphagia and hypertension. Resident #47 was discharged to the hospital on 4/15/2019. Resident #47's care plan dated 2/19/2019 revealed a plan which focused on risk for pressure ulcer related to immobility and incontinence with a goal that her skin would remain intact. The interventions were to conduct a systematic skin inspection, keep clean and dry as possible, turn and reposition every 2 hours, reduce friction by using a pull sheet and report any redness or skin breakdown to nurse. The care plan was not updated after this date. Resident #47's Braden Skin Assessment dated 2/19/2019 revealed she was at a mild risk for pressure sores. An admission progress note by the Director of Nursing (DON) dated 2/19/2019, revealed the Resident #47 was admitted on 2/19/2019 from the hospital with redness on her buttocks from incontinence. Resident #47's admission Minimum Data Set (MDS) assessment dated 2/26/2019 revealed her cognition was moderately impaired. She required total staff assistance for activities of daily living (ADLs), except for eating, in which she was independent. She had no pressure ulcer on admission, and she was not coded as palliative or	F 686	completed on 8/7/19. Review of consults and referrals for physicians were/are reviewed in morning meeting each day of the work week and follow up initiated as appropriate. Any identified canceled appointments (either by family or facility) must be reported to the DON or Administrator immediately for discussion to reschedule with the family/resident and physician. A 30 day look back was completed for missed or canceled appointments for the facility to insure no further appointments were missed. Licensed nurses, Medication aides, and CNAs were educated on the importance of a good skin check daily with bath or showers. Weekly skin checks to be completed and documented on provided forms by licensed staff. The forms for documentation will have staging, size of wounds, changes as noted as well as needed order changes. Weekly skin reports completed and submitted no later than Wednesday of each week. Skin reports are to be reviewed during weekly At Risk meeting. Skin reports will list all wound measures and staging for each resident. CNAs or Med Aides have been educated to report skin issues to a licensed nurse immediately to apply appropriate interventions timely. Licensed nurses have been educated to notify physician immediately and family or resident's RP once an intervention has been applied per the physician recommendation. Education is to be complete by 8/9/19. The DON will be responsible for measurements, form	

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hospice care.

The Treatment Aministration Records (TAR) for February 2019 through April 2019 revealed daily documentation that dressing treatments had been conducted as ordered and were signed off by nursing staff. No description of the wound was included on the TAR.

Nursing progress notes addressing care and description of Resident #47's sacrum area are as follows:

On 2/26/2019 DON's note revealed the excoriated areas to the buttocks had increased in size.

On 3/4/2019 Nurse #1's note revealed the excoriated areas on buttocks and sacral fold continued and a new treatment was initiated.

On 3/23/2019 Nurse #2's note revealed resident #47 sat in the wheelchair for long hours of the day and night and was turned every two hours for pressure relief. It also revealed the dressing was dry and intact. The care plan had not been updated to address Resident #47's pressure relieving device for the wheelchair.

On 3/25/2019 Nurse #3's note revealed Resident #47 was on bedrest and had an air mattress on the bed.

On 3/25/2019 Nurse #3's note revealed the wound was 16 centimeters (CM) x 10 CM and was measured per pharmacy request. There was no documentation included that addressed the appearance or deterioration of the wound

completion and report completion in the absence of a designated wound nurse. Upon hiring of a wound nurse, the DON will monitor all forms, reports, and measures for accuracy and completeness of assessment.

Ongoing audits by Admin or DON of skin/wound notes and wound reports. These audits will be weekly for four weeks, and monthly for two months. Ongoing audits as well for consults or referrals by the Admin or DON. Daily audits for 5 of 7 days per week for 2 weeks, then weekly for two weeks, and then monthly for 2 months.

All data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

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On 3/27/2019 Nurse #1's note revealed a new wound care treatment had been initiated and an indwelling catheter was inserted.

On 4/9/2019 Nurse #4's note revealed the wound bed was covered with dark gray tissue with a moderate amount of foul-smelling purulent drainage. The wound also had some yellow slough.

On 4/10/2019 Nurse #4's note revealed the depth of the wound was worsening and the entire area around the wound was tunneling. The wound was packed using six or seven 4 x 4 gauzes.

On 4/12/2019 Nurse # 5's nurses noted revealed the wound had a foul odor with moderate yellowish and bloody drainage and had yellow slough hanging from the wound.

On 4/13/2019 the Nurse #4's note revealed the outer area of the wound continued to decline by an increase in depth and tunneling all around the wound. There was some scattered necrotic tissue with yellow stringy adhered tissue to the outer edge of the wound. Daughter at bedside questioning the decline in the wound.

On 4/14/2019 Nurse #4's note revealed the dressing was changed with no change to the wound observed. Resident #47's temperature was 101 and Tylenol was given with a decrease in temperature to 97.0.

On 4/15/2019 Nurse note revealed Resident #47 was transported to the Emergency room with the chief complaint of wound infection and was admitted with the diagnosis of urinary tract

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infection and dehydration.

The Emergency department provider notes dated 4/15/2019 revealed Resident #47 had a stage four sacral decubitus with the bone visible in the wound. The wound edges were somewhat indurated. The wound culture dated 4/22/2019 revealed pseudomonas in the wound and the physician planned to discharge Resident #47 on 4/22/2019 with an antibiotic.

A review of the medical record revealed no other nurse notes pertaining to care of the wound care from 3/5/2019 through 3/22/2019, and from 3/28/2019 through 4/8/2019.

Physician orders related to the care of the sacral wound were as follows:

Physician orders dated 3/4/2019 revealed to cleanse buttocks and sacral folds with normal saline, apply wound collagen gel to excoriated areas, and cover with border gauze every day until healed.

The Physician orders dated 3/23/2019 read to cleanse sacral wound with normal saline, apply Santyl (a debriding ointment) and cover with dry dressing daily x 14 days, and refer to wound clinic.

A review of physician orders dated 3/27/2019 revealed to insert indwelling urinary catheter due to stage 3 sacral decubitus, clean sacral area with one-fourth strength Dakin's solution (an antiseptic), pack with Santyl and cover with gauze, apply collagen wound gel to outer area, apply gauze, and cover with border gauze.

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The physician order dated 4/15/2019 revealed to send the resident to the hospital emergency department for evaluation.

Resident #47's 30-day MDS assessment dated 3/20/2019 revealed her cognition was moderately impaired and she required total staff assistance for ADLs, except for eating and locomotion which were independent. The assessment noted there was no pressure ulcer and she was not coded as palliative or hospice care.

Resident #47's Braden Skin Assessment dated 3/29/2019 revealed she was at a high risk for pressure sores.

On 6/18/2019 at 10:30 AM, an interview was conducted with Nursing Assistant (NA) #1, who stated Resident #2 did not like to be turned in bed but would turn over to her side when encouraged.

On 7/16/2019 at 11:45 AM an interview was conducted with the Medication Technician (MT). The MT stated Resident #47 stopped eating shortly after she was admitted to the facility, and she would whine and shake her head no when care was provided for her.

On 6/19/2019 at 3:10 PM, an interview was conducted with Nurse #1, who was familiar with Resident #47's care and stated she was admitted for rehabilitation and it took a lot of encouragement for the resident to participate in activities of daily living. Nurse #1 also stated Resident #47 had an indwelling catheter and a debriding agent was used on the wound, but the wound was not improving. Preventative measures were used which included wedges to prop up, pressure relieving mattress on the bed and

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cushion in the wheelchair.

On 7/16/2019 at 10:19 AM, a second interview was conducted with Nurse #1. The nurse stated when Resident #47 was first admitted her sacral area was red but not opened and they were using a cream on it. The nurse stated the wound opened and orders were changed to a hydrogel with gauze covering it. The nurse stated she had informed the Physician of the treatment and the condition of the wound, but he elected to keep the same treatment regimen at that time. The nurse stated Resident #47 was very noncompliant in her nutrition and she had to be prompted and encourage to eat, and she would refuse food. The nurse stated she would refuse to turn and that contributed to her wound decline. The nurse stated Resident #47 would drink her med pass and she was getting the dressing changed daily. The nurse stated she was not told to measure the wound and thought the DON/ADON (Assistant Director of Nursing) were covering that.

On 7/15/2019 at 3:46 PM, an interview was conducted with Nurse #3 who stated Resident #47's dressing was changed daily when she cared for her. The Nurse stated the previous MDS nurse measured pressures wounds weekly and documented the results in the medical record. Nurse #3 stated when the previous MDS nurse left the facility it was not conveyed to the floor staff to measure and document on wounds. Nurse #3 stated floor staff had always conducted the dressing changes and that remained in place. The Nurse stated the Resident #47 would get out of bed daily when she first came to the facility, but shortly after, and she was unsure of the time frame, the resident did not want to get up, did not eat well and the wound change happened very

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fast. The Nurse stated she was working when the resident's family member was at the facility, observed the wound and wanted the resident to be sent to the hospital. The Nurse stated she called the Physician and he ordered the wound clinic visit and a change of treatment, and she informed the family who was okay with the orders.

On 7/16/2019 at 10:40 AM an interview was conducted with Nurse #4. The Nurse stated she cared for Resident #47 after she was moved to her hall, but she already had the declining pressure ulcer. The Nurse stated she did not measure the wound and did not think anyone was measuring it, as floor nurses were never informed to measure the wounds even after the previous MDS/wound nurse had resigned. The nurse stated she changed the dressing daily. The nurse stated she did not call the Physician about the wound but had added the resident to the Physician's list to be seen on 4/17/19, but the resident was discharged to the hospital on 4/15/19. The nurse stated she thought the wound deteriorated because of a series of things which included her lack of motivation to move, and her poor appetite. The nurse stated Resident #47 was totally dependent on staff because of lack of will and not lack of function.

On 7/15/2019 at 4:47 PM, an interview was conducted with Nurse #5 who stated she cared for Resident #47 when she was moved to her hall after the pressure wound was already deteriorated. The Nurse stated she measured the wound for the Pharmacist one time. The nurse stated she did not know the expectation for measuring the wound as the previous MDS nurse had measured all wounds and documented them

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weekly before she left the facility. The nurse stated she changed the dressings daily as per the orders and treatment record, but the resident had very poor intake and refused eating and getting out of bed.

On 7/16/2019 at 4:01 PM, an interview was conducted with the Certified Occupational Therapy Assistant (COTA), and Physical Therapy Assistant (PTA) who stated when they started working with Resident #47, she could stand and pivot for transfer on 2/20/2019. The COTA stated by 3/1/2019 Resident #47 had declined to using a sit to stand lift for transfers, and by 3/6/2019 she could not sit unassisted in the chair and required 100% cueing. The COTA and PTA stated Resident #47 was discharged from therapy on 4/10/2019 because she was making no progress and by that time, she needed total assistance for activities of daily living (ADLs) and required maximum assistance to roll in bed.

On 6/19/2019 at 1:20 pm an interview with the DON revealed that she was called into the resident room on 2/19/2019 to assess Resident #47's buttock and found an area on the buttock right in the middle of the buttock cheek that was beginning to open but had not yet opened. The DON stated a barrier cream for Resident #47's buttocks was started on 2/19/2019, when she was admitted and that was standard treatment used as a preventative measure for all residents in the facility.

On 7/16/2019 at 3:22 PM, an interview was conducted with the DON who stated the wound might have been avoidable if the resident was not already declining when she was admitted to the facility. The DON stated Resident #47 would not

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move or eat and the facility talked to Resident #47's family member to have her help convince Resident #47 to turn. The DON confirmed the resident was not on hospice, palliative or comfort care while she was a resident at the facility. The DON stated the wound was not consistently measured and she had told staff to measure once per week, but that was not done. The DON stated she expected the nurses to measure the wound weekly and report wound status to the Physician.

The interview with the Physician on 6/20/2019 at 12:36 pm revealed that the nurse called and informed him of the cancelled appointment and that was when he gave a new order for treatment. The Physician stated by Resident #47 not going to the wound clinic appointment, it presented a chance for the wound to fester or get worse and it slowed the healing of the wound. He also stated he believed sending Resident # 2 to the clinic would have hastened the healing process.

On 7/16/2019 at 2:32 PM, a second interview was conducted with the Physician who stated Resident #47's pressure wound should have been avoidable, but he did not know why it was not. The Physician stated he thought her not wanting to participate in therapy and laying on the wound too much made the wound worse. The Physician stated staff did informed him the wound was getting worse and he ordered the wound clinic visit, and after another call by staff he ordered a change of treatment.

A review of an appointment calendar dated 3/28/2019 revealed Resident #47 was scheduled for an appointment with the wound clinic on 3/28/2019 at 3:30 pm. The calendar showed the

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appointment was cancelled on 3/27/2019 by Medication Technician #1.

The interview with Medication Technician (MT)#1 on 6/19/2019 at 1:51 pm revealed the appointment was cancelled on 3/27/2019 because the family was unable to go with her and the physician would not see Resident #47 the first time without a family member present. The MT stated that she informed the doctor of the cancellation and wrote it on the appointment schedule.

On 7/16/2019 at 11:45 AM a second interview was conducted with the MT who stated she was at the desk when the ADON stated the family had called and informed staff they could not be at the wound clinic appointment, so he had cancelled her appointment and told the MT to call the transport and cancel them for that date. The MT understood the ADON would reschedule the resident for another appointment.

On 7/16/2019 at 11:58 AM an interview was conducted with the ADON who stated a family member had called and could not go with the resident to the wound clinic appointment. The ADON stated the clinic wanted a family member present and so he cancelled the appointment. The ADON stated he was unfamiliar with the resident and did not ask the wound clinic if they could see the resident without the family member present. The ADON stated he could not remember if he tried to reschedule an appointment with the wound clinic and had no way to verify that.

The interview with a staff member at the wound clinic on 6/19/2019 at 4:00 pm revealed the

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F 686	Continued From page 22 physician liked to have a family member accompany a patient for the initial visit. She further stated the clinic could have sent the facility the consent to treat form and the facility could have faxed it to the POA for a signature, and then the facility could have just sent the consent form with a copy of Resident #2 history and Physical for the physician to review before the appointment. An interview with the Power of Attorney on 6/20/2019 at 11:00 revealed she had the capability to send and receive faxes. She further revealed the facility did not informed her Resident #47 appointment had been cancelled before her visitation on 4/14/2019. A review of Resident #47 physician orders revealed no order to discontinue the wound clinic referral.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		8/16/19

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F 688	Continued From page 23 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply hand rolls (cloth) daily for contracture management for 1 of 2 residents reviewed. (Resident #26). The findings included: Resident #26 was originally admitted to the facility on 11/20/12 with diagnoses including Cerebrovascular Disease, Arteriosclerosis, Dysphagia, Spasm, Muscle pain, chronic, Hypertension, and Arthritis. According to the Quarterly Minimum Data Set (MDS) dated 6/3/19, Resident #26 was cognitively impaired and required total assistance in most areas of activities of daily living. Review of Section G of the MDS in the area of functional status, revealed Resident #26 had impairment in both hands. Review of Resident #26's Care Plan which was updated on 6/3/19, revealed Resident #26 had bilateral contractures in both hands and arms. Resident #26 was at risk for further contracting and new contractures. Start date: 12/13/18. Goal, target date: 3/13/19, noted to prevent further contractures, decrease tone and increase range of motion. Interventions included maintain body functional alignment when at rest in bed and chair. Reposition frequently. Hand roll (cloth) in both hands at all times. Remove for bathing, replace with new hand roll (cloth) and change as needed. During an interview on 7/14/19 at 1:58 PM,	F 688	Upon observation, NA#2 placed hand rolls in the resident #26 hands. Facility rounds by the DON and ADON were completed to insure that no other residents in the center were affected by or with a potential risk by this deficient practice on 7/18/19. Any identified residents, would have interventions identified and implemented by 8/9/19. Care plans and CNA care cards updated for any resident identified. Education to Certified Nursing Assistants, Medication aides and Licensed Nurses was provided by the DON or ADON; this education was complete by 08/09/19. This training will also be provided to nurse assistants upon hire during orientation. Ongoing audits by the Admin, DON, or ADON for observation and review of residents identified to insure interventions are provided to residents. These audits will be conducted five days per week for two weeks, then weekly for two weeks, then monthly for two months. All data will be summarized and presented to the facility QAPI meeting monthly by the DON or Admin. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued	

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	345431	A. BUILDING _____ B. WING _____	C 07/17/2019

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F 688	Continued From page 24 Resident #26's family member revealed someone used to provide range of motion for Resident #26, however, she said no one had done anything recently. An observation revealed both of Resident #26's hands were contracted. There were no hand rolls in her hands. During an observation on 7/16/19 at 11:30 AM, Resident #26 was observed in bed asleep. There were no hand rolls in her hands. During an observation on 7/16/19 at 2:54 PM, Resident #26 was observed asleep in bed. There were no hand rolls in her hands. Both of her hands were clinched tight. Small pillows were placed under each hand. Her hands were against the pillows on her chest. During an observation on 7/16/19 at 4:49 PM, Resident #26 was asleep in bed. There were no hand rolls in her hands. Both of her hands were clinched tight. Small pillows were placed under each hand. Her hands were against the pillows on her chest. During an observation on 7/17/19 at 9:30 AM, Resident #26 was observed asleep in bed. The resident did not have hand rolls in her hands. During an interview on 7/17/19 at 9:33 AM, NA#1 revealed Resident #26 required total care. She stated range of motion exercises were provided during her bath. She stated she usually put hand cloths between both of her hands and she put a pillow between her legs and heel protectors on her feet. NA#1 revealed she repositioned Resident #26 every two hours. She stated she placed pillows on her shoulders and back. She stated she had worked with Resident #26 since	F 688	compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

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F 688	Continued From page 25 she was admitted to the facility. NA#1 stated she did not work on Resident #26's hall today and she did not know if Resident #26 had hand rolls in her hands. During an interview on 7/17/19 at 9:47 AM, Nurse #4, who was assigned to Resident #26 revealed in reference to Resident #26's contractures, hand rolls were placed in her hands and the resident was usually positioned with pillows. She stated range of motion exercises was usually provided with her care. During an interview on 7/17/19 at 10:52 AM, NA#2 who was assigned to work with Resident #26 revealed she had worked with Resident #26 before and she knew about the hand rolls that were to be placed in her hands. She stated she placed the hand rolls in Resident #26's hands at 9:30 AM or 10:00 AM this morning. She stated she had to get Resident #26's hands opened a little. She stated she was aware Resident #26 was to have the hand rolls in her hands. During an interview on 7/17/19 at 1:56 PM, the Administrator stated she expected preventive intervention should have been utilized as appropriate. She revealed the hand rolls should have been placed in Resident #26's hands to prevent further decline.	F 688		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		8/16/19

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F 732	Continued From page 26 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, facility record reviews and staff interviews, the facility failed to post the daily nurse staffing sheet on the correct days for 2 of 4 days and failed to document accurate information on the daily nurse staffing sheets for 3 of 4 days (7/14/19, 7/15/19, and 7/16/19) of the	F 732	Nursing staff was immediately posted by the ADON upon identification. New staffing sheets were created to post on each unit (assisted and skilled) to identify staffing metrics and census on	

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F 732	Continued From page 27 survey. The findings included: On 7/14/19 at 2:16PM, an observation was made of the posted facility daily staffing sheet. The nurse staffing sheet was dated 7/12/19, combined the skilled nursing facility beds and the assisted living beds with the census listed as 46/6. On 7/14/19 at 3:13 PM, an observation was made of the posted facility daily staffing sheet. The nurse staffing sheet was dated 7/12/19, combined the skilled nursing facility beds and the assisted living bed with the census listed as 46/6. On 7/16/19 at 11:23 AM an observation was made of the posted facility daily staffing sheet. The nurse staffing sheet was dated 7/15/19, combined the skilled nursing facility beds and the assisted living bed with the listed census as 47/6. On 7/16/19 at 11:26 AM the Assistant Director of Nursing posted the daily staffing sheet with the date recorded as 7/16/19. The nurse staffing sheet combined the skilled nursing facility beds and the assisted living bed with the census listed as 46/6. During an interview on 7/16/19 at 3:57 PM the Assistant Director of Nursing stated he completed the nurse staff posting on Mondays. He stated the resident census number had been incorrect the day before, so he adjusted the number and posted the daily staffing sheet with the correct census number. On 7/17/19 at 8:57 AM the Director of Nursing stated she would expect the daily staff sheet would be posted every day and reflect all staff	F 732	each unit. Education provided to admin nursing and licensed nurses in the center to prevent further issue. Posting is to occur prior to midnight for the next day. The Admin or DON will observe and document staff hours posting in the facility. These audits will occur five days per weeks for two weeks, then weekly for two weeks, then monthly for two months. All data will be summarized and presented to the facility Quality Assurance Performance Improvement (QAPI) meeting monthly by the Admin or DON. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services.	

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F 732	Continued From page 28 working each shift. On 7/17/19 at 12:36 PM the Administrator stated she expected the staff posting would be posted daily and available for residents and visitors to see prior to the beginning of 1st shift on the date covered.	F 732		