| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345412 | A. BUILDING _____ B. WING _____ | 02/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRANTWOOD NH & RETIREMENT CENT | 1038 COLLEGE STREET OXFORD, NC 27565 |

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|---|---|---|---|---|
| F 242 SS=E | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, resident and family interviews, the facility failed to provide requested showers to one of one resident (Resident #2) reviewed for choices.<br>Findings included:<br>Resident #2 was admitted to the facility 12/29/16.<br>A review of the admission Minimum Data Set (MDS) dated 1/5/17 revealed Resident #2 was moderately cognitively impaired, and was totally dependent on staff for bathing. Resident #2 was coded as "not very important" for a choice between a bed bath, shower or bath. No behaviors, hallucinations, or rejection of care was present.<br>A review of Resident #2's care plan dated 1/5/17 for "ADL self-care deficit r/t (related to) confusion, dementia" listed an intervention for bathing/showering. The intervention included encouraging the resident to participate to the fullest extent possible with each interaction. | F 242 | For resident #2 and all current residents, the shower room HVAC unit was repaired on 2/21/2017 and heat is operational. If shower room unavailable for use, will use shower in room on 100 hall if room can be made available during period shower room is unavailable. If unable to offer a shower, residents will receive a bed bath. CNAs will have a shower schedule form to sign for showers according to the shower schedule to ensure residents are given the opportunity to have a shower if they choose. The form is to be returned to the DON, and/or her designee, daily for review. Compliance will be reviewed at QAPI meetings for a minimum of six months. Non-compliance will require a new plan of action.<br><br>Staff meeting held on 2/16/17 to review | 2/21/17 |

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

Electronically Signed | 02/23/2017

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|---|---|---|---|---|
| F 242 | Continued From page 1<br>An interview with a family member (FM) of Resident #2 was conducted on 2/7/17 at 8:09 AM. The FM stated Resident #2 had been in the facility since 12/29/16 and was on a shower schedule but had not received a shower since admission. The FM also stated Resident #2 was bathed in bed by the FM, but wanted Resident #2 showered by the staff. She stated Resident #2 had not appeared unclean, but Resident #2 preferred a shower to a bed bath.<br>An interview was conducted with Resident #2 on 2/9/17 at 10:00 AM with Resident #2. She stated, "I get a bed bath every day, but I'd like them to shower me. My (FMs) bathe me when they come to visit, but it would be nice if the staff would bring me to the shower. I have told the aid, but I don't know her name."<br>An interview was conducted on 2/9/17 at 10:10 AM with a nursing assistant (NA #4) typically assigned to the hall where Resident #2 resided. She stated residents were scheduled twice weekly for showers, and were showered according to the schedule, or more if requested. She could not recall if Resident #2 had been showered since admission.<br>An interview was conducted with NA #2 on 2/9/17 at 10:20 AM. She stated showers were scheduled twice weekly, or more if requested. She also stated the residents received bed baths in between shower days, but could not recall Resident #2 being showered since admission.<br>An interview was conducted on 2/9/17 at 10:25 AM with Nurse #2. She stated, "The shower room has not been used since at least December. The heater isn't working in the shower room. It is supposed to be repaired, but I don't know when. So I can tell you no one here, except the residents on the 100 Hall has had a shower because the heat isn't working in the shower | F 242 | survey results including providing showers to residents. Staff reminded of importance of reporting any equipment failures, including heating and air, to the Director of Nursing and/or Administrator immediately. | |

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|---|---|---|---|---|
| F 242 | Continued From page 2 | F 242 | | |

room. The rooms on the 100 Hall have a shower in the bathroom, that's why they are having showers."
A review of the facility census from January 1, 2017 through January 31, 2017 revealed multiple unoccupied rooms, with showers, on the 100 Hall.
An observation of the unoccupied rooms and showers on the 100 hall was conducted on 2/9/17 at 10:30 AM. No rooms appeared to be under repair, and no room was marked out of service.
A review of a work order dated 1/1/17 sent to the Assistant Maintenance Director (AMD) by the Administrator read, in part, "Heat in shower room not working. Spoke with (company representative) last week but have not seen him."
An interview was conducted with the Administrator on 2/9/17 at 10:40 AM. She stated, "I'll have to get an update on the heater in the shower room. I requested a repair several weeks ago, I believe it was January 9th or 11th, but the heating and air guy we usually use didn't show up. The Assistant Maintenance Director (AMD) called and was told the heating and air man would come 1/24/17. I know it was a Tuesday. He didn't show up again. Maintenance told me he reached out to someone else, I think another company, and we're waiting for them to come. I think one of the NAs told me about the shower room being cold right around the time the pipe burst at the beginning of January, so that's when I let maintenance know. All the rooms on the 100 Hall have a functional shower. We have had usable, unoccupied rooms on the 100 Hall since (Resident #2) was admitted, but she was admitted to a room on the 200 Hall. I didn't think about it because no one actually told me the residents weren't getting showers. If someone had come to me I might have thought about using the 100 Hall for showers, but no none told me

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|---|---|---|---|---|
| F 242 | Continued From page 3<br>they weren't getting showers."<br>An interview was conducted on 2/9/17 at 10:50 AM with NA #3. She stated, "I know the shower room has been out of service since at least January. Bed baths are being given to the residents, except on the 100 Hall. Each room on the 100 Hall has a shower in it so those residents can have a shower. But if a resident requests a shower on another hall we have to tell them it's out of order."<br>An interview was conducted on 2/9/17 at 11:00 AM with the Director of Nursing (DON). She stated, "The residents are supposed to get a shower if they request one. Our only shower room has had a problem with the heater since January. With the heat being out not many residents have gotten a shower. The 100 Hall has a shower in every room. I don't know if we are giving any information to new admissions related to the shower room being out of service. (Resident #2) has been on the 200 Hall since her admission on 12/29/16. I don't know why I didn't think about using the showers on the 100 Hall."<br>An interview with Engineer #1 was conducted on 2/9/17 at 11:30AM: He stated, "I'm here to fix things like the heater in the shower room. It's been broken since late December or early January. When (AMD) and I figured out we couldn't fix it we called (the heating and air company). The work order you were given was the 2nd or 3rd attempt to get them here. I knew about the problem at the end of December, but tried to take care of it myself. When I couldn't get (the heating and air company) here I told (AMD). That was around the 11th or 12th of January." | F 242 | | |
| F 257 SS=E | 483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS | F 257 | | 2/23/17 |

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|---|---|---|---|---|
| F 257 | Continued From page 4<br>(i)(6) Comfortable and safe temperature levels.<br>Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, resident and family interviews, the facility failed to provide a comfortable room temperature in one of one shower room for resident use in the facility.<br>Findings included:<br>An interview with a resident's (Resident #2) family member was conducted on 2/7/17 at 8:09 AM. The family member stated Resident #2 had been in the facility since 12/29/16, in the same room on the 200 Hall, and was on a shower schedule but had not received a shower since admission.<br>A review of a work order dated 1/1/17 sent to the Assistant Maintenance Director (AMD) by the Administrator read, in part, "Heat in shower room not working. Spoke with (company representative) last week but have not seen him."<br>An interview was conducted on 2/9/17 at 10:25 AM with Nurse #2. She stated, "The shower room has not been used since at least December. The heater isn't working in the shower room for the 200 Hall. It is supposed to be repaired, but I don't know when. So I can tell you no one here, except the residents on the 100 Hall has had a shower because the heat isn't working in the shower room on 200 Hall. The rooms on the 100 Hall have a shower in the bathroom, that's why they are having showers."<br>An interview was conducted with the Administrator on 2/9/17 at 10:40 AM. She stated, "I requested a repair on the heater in the shower room several weeks ago, I believe it was January 9th or 11th, but the heating and air repairman we usually use didn't show up. The Assistant | F 257 | For resident #2 and all current residents, the deficient practice was corrected in the shower room on 2/21/17 when the HVAC Contractor made the necessary repairs to render the heating system operational.<br><br>To ensure the deficient practice does not reoccur, a thermometer will be installed in the shower room to be monitored daily by maintenance staff and/or staff using shower room for a temperature within the acceptable range of 71 - 81 degrees F. If temperatures are out of range, thermostat to be checked to ensure setting within acceptable range. If thermostat set appropriately and issue is related to the operation of the HVAC unit, the HVAC contractor will be contacted to make a service call. If contractor does not arrive within 24 hours of scheduled service call, the facility will contact another contractor to make the repairs.<br><br>The temperature monitoring sheets will be submitted to the Administrator or Director of Nursing for compliance. Any non-compliance noted will be reported to QAPI Committee for a minimum of six months. Any non-compliance will require an additional action plan. | |

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|---|---|---|---|---|
| F 257 | Continued From page 5 | F 257 | | |

Maintenance Director (AMD) called and was told the heating and air repairman would come 1/24/17. He didn't show up again. Maintenance told me he reached out to someone else, I think another company, and we're waiting for them to come. I think one of the NAs told me about the shower room being cold right around the time the pipe burst at the beginning of January, so that's when I let maintenance know. All the rooms on the 100 Hall have a functional shower. We have had usable, unoccupied rooms on the 100 Hall since (Resident #2) was admitted, but she was admitted to a room on the 200 Hall. "

An observation of the shower room was conducted on 2/9/17 at 10:45 AM. Unused medical equipment and resident care items, which included lifts and shower chairs, were observed stored in the shower room.

An interview was conducted on 2/9/17 at 10:50 AM with NA #3. She stated, "I know the shower room has been out of service since at least January. Bed baths are being given to all the residents, except on the 100 Hall. Each room on the 100 Hall has a shower in it so those residents can have a shower. But if a resident requests a shower on another hall (other than the 100 Hall) we have to tell them it's out of order and give them a bed bath."

An interview was conducted on 2/9/17 at 11:00 AM with the Director of Nursing (DON). She stated, "The residents are supposed to get a shower if they request one. Our shower room heater on the 200 Hall has had a problem since January. With the heat being out not many residents have gotten a shower. The 100 Hall has a shower in every room. I don't know if we are giving any information to new admissions related to the shower room being out of service.

(Resident #2) has been on the 200 Hall since her

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|---|---|---|---|---|
| F 257 | Continued From page 6 | F 257 | | |

admission on 12/29/16. I don't know why I didn't think about using the showers in the rooms on the 100 Hall."

An interview with Engineer #1 was conducted on 2/9/17 at 11:30AM: He stated, "I'm here to fix things like the heater in the shower room. It's been broken since late December or early January. When (AMD) and I figured out we couldn't fix it we called (the heating and air company). The work order you were given was the 2nd or 3rd attempt to get them here. I knew about the problem at the end of December, but tried to take care of it myself. When I couldn't get (the heating and air company) here I told (AMD). That was around the 11th or 12th of January. The 1st time I called (the heating and air company) he said he'd be out that evening. He never showed. I called a couple of days later and left a message. He didn't respond. I ran into him at the store a few days later and he said he'd be out the first part of the following week. He never showed. That's when I got (AMD) to call. He didn't respond to (AMD) either, so he then let the Administrator know."

An interview with the AMD was conducted on 2/9/17 at 11:52 AM: He stated, "The heating unit has a problem we have not been able to identify. The original work order for me was 1/19/17, but (Engineer) had been working on it on his own before that. I have no record in my log book. (The heating and air company) who originally installed the unit, is who I have been trying to contact. I've been hoping they would cover the repairs under a warranty. I had another company (company name) come out so I have a back-up plan. They were on site 2/3/17 and telephoned me with some very expensive options to get it operational. I'm still hopeful the company that installed the unit will cover the repair, and they are supposed to be

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| F 257 | Continued From page 7<br>here this afternoon. If they don't show up I'll have to use the other company." | F 257 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to perform a Significant Change in Status Assessment (SCSA) following hospice enrollment for 1 of 1 residents reviewed for hospice care (Resident #92).<br><br>Findings included:<br><br>Resident #92 was admitted to the facility on 9/8/16. Diagnoses included hypertension, acute renal failure, and pulmonary nodule.<br><br>Review of Resident #92's most recent comprehensive Minimum Data Set (MDS) assessment, dated 9/15/16, revealed the resident was assessed as not receiving hospice care.<br><br>Review of Resident #92's informed consent and | F 274 | For Resident #92, a Significant Change in Status Assessment (SCSA)to reflect the election of hospice care was completed for Assessment Reference Date(ARD)date of 10/24/2016 on 2/16/17.<br><br>To ensure the deficient practice is corrected for all current resident's with an election of hospice services, MDS records were reviewed on 2/16/2017 to ensure an SCSA was completed for all current residents with an election for hospice.<br><br>To ensure the deficient practice does not reoccur, Patient Accounts staff will inform MDS Coordinator of hospice election of any resident. MDS records for resident's who have elected hospice will be reviewed | 2/16/17 |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 274 | Continued From page 8<br>election of benefits for hospice revealed the resident's effective date of hospice election was 10/20/16.<br><br>Review of Resident #92's MDS assessments revealed the resident had no SCSA after the effective date of election for hospice care.<br><br>During an interview on 2/8/17 at 4:10 PM, the Director of Nursing (DON) stated that Resident #92's effective date for hospice was 10/20/16.<br><br>During an interview on 2/9/17 at 8:30 AM, MDS Nurse #1 stated when a resident elected hospice therapy when in the facility, a SCSA would be done. She further stated that it was an oversight that Resident #92 had not had a SCSA and that a SCSA should have been done after the resident elected hospice care.<br><br>During an interview on 2/9/17 at 9:10 AM, the DON stated that it was her expectation that Resident #92's election of hospice was captured in a SCSA after the effective date of hospice election. | F 274 | in QAPI for a minimum of six months. Any non-compliance will require a follow-up action plan. | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that | F 278 | | 3/2/17 |

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|---|---|---|---|---|
| F 278 | Continued From page 9<br>the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews, and record review, the facility failed to accurately code the Minimum Date Set for 1 of 2 residents reviewed for range of motion (Resident #77).<br><br>Findings included:<br><br>Resident #77 was admitted on 3/01/2016. Admission diagnoses included epilepsy, dementia and depression.<br><br>A physician progress note dated 11/04/2016 indicated Resident #77 had a hand contracture. | F 278 | For Resident #77, the MDS completed for ARD 12/09/2016 was corrected to reflect bilateral upper extremities had functional limitations.<br><br>To ensure the deficient practice is corrected for all current residents, current residents will be assessed for contractures which limit range of motion. The MDS will be corrected and resubmitted as needed for those residents identified to have contractures limiting the resident's range of motion. | |

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| F 278 | Continued From page 10<br><br>A physician progress noted dated 12/05/2016 indicated she had seen an orthopedic physician for pain and decreased motion in both hands related to swan-neck deformities of her fingers.<br><br>Her most recent Quarterly Minimum Data Set (MDS) assessment dated 12/09/2016 indicated she had moderate cognitive impairment, required extensive to total assistance with activities of daily living (ADLs) and had no upper extremity range of motion impairment.<br><br>An observation and interview with Resident #77 was conducted on 2/08/2017 at 9:06 AM. Resident #77's hands were observed with several fingers contracted downward onto her palms. She stated her hands had contractures since admission into the facility. She also stated she was unable to comb her hair or feed herself.<br><br>An interview with nurse aid (NA) #1 was conducted on 2/08/2017 at 9:52 AM. The NA stated Resident #77 required extensive to total care because she had contractures of her hands and was unable to use them to assist with her care.<br><br>An interview with the occupational therapist (OT) was conducted on 2/08/2017 at 11:05 AM. The OT stated Resident #77 had contractures of both hands and ataxic movement (impaired coordination) which made self-care difficult.<br><br>An interview with Nurse #1 was conducted on 2/08/2017 at 3:51 PM the nurse stated Resident #77's hands had been contracted since admission and she had required extensive assistance with ADLs since admission. | F 278 | To ensure the deficient practice does not reoccur, a random sampling of 10 residents will be assessed monthly by the Director of Nursing, clinical nurse manager or their designee for contractures limiting range of motion and the MDS will be reviewed in QAQI meeting to ensure accuracy of coding. The results of the assessment and MDS review will be presented to QAQI for a minimum of six months. Any non-compliance will require a follow-up action plan.<br><br>Met with MDS Coordinator on 2/13/17 to discuss areas of concern brought to our attention during survey regarding the MDS process. Met with MDS Coordinator again on 2/16/17 to discuss plan of correction related to survey results as related to MDS coding and importance of coding accuracy. On 2/22/17 reviewed the plan for monitoring the MDS for accuracy.<br><br>Meeting scheduled on 3/2/17 to educate nurses on importance of reporting contractures and or decreased range of motion to the MDS Coordinator promptly. | |

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|---|---|---|---|
| | 345412 | A. BUILDING _____ B. WING _____ | 02/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRANTWOOD NH & RETIREMENT CENT | 1038 COLLEGE STREET OXFORD, NC 27565 |

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| F 278 | Continued From page 11<br><br>An interview with the MDS nurse was conducted on 2/09/2017 at 11:42 AM. The MDS nurse stated Resident #77's functional ROM had not been coded correctly on the most recent Quarterly MDS assessment.<br><br>An interview with the Director of Nursing (DON) was conducted on 2/09/2017 at 12:20 PM. The DON stated it would be her expectation for the MDS to be accurate and reflect the condition of the resident. | F 278 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain | F 279 | | 2/21/17 |

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| F 279 | Continued From page 12<br>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility failed to care plan pressure ulcers that included measurable goals and interventions for | F 279 | Resident #64 is no longer a resident in the facility. | |

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| F 279 | Continued From page 13<br>pressure ulcer healing and prevention for 1 of 2 sampled residents (Resident #64) reviewed for pressure ulcers.<br><br>Findings included:<br><br>Resident #64 was admitted to the facility on 1/4/17 with diagnoses that included pneumonia and congestive heart failure.<br><br>Completion of the Braden Scale for Predicting Pressure Sore Risk, dated 1/4/17, indicated Resident #64 was at risk for developing pressure ulcers.<br><br>Nurse Progress notes, written 1/11/17 at 12:16 PM, indicated Resident #64 had a purple suspected deep tissue injury on her right great toe.<br><br>The 1/11/17 Admission Minimum Data Set (MDS) indicated Resident #64 was cognitively intact, required extensive assistance for bed mobility, ambulated only once or twice and required only supervision for personal hygiene. The MDS coded the resident as being at risk for developing a pressure ulcer and also coded the resident as having a pressure ulcer that was categorized as a deep tissue injury that had not been present on admission.<br><br>Review of the Care Area Assessment (CAA), completed on 1/11/17, indicated pressure ulcers was a problem for Resident #64. A decision was made by the interdisciplinary team to care plan the resident's pressure ulcers with interventions to assist in healing the wound and prevent further skin breakdown. | F 279 | To ensure the deficient practice is corrected for all current residents, Care Area Assessments(CAA)for all current residents were reviewed for indication of interdisciplinary team to care plan interventions related to pressure ulcers. Director of Nursing reviewed Care Plans as indicated to ensure pressure ulcers were care planned.<br><br>To ensure the deficient practice does not reoccur, the interdisciplinary team will review the CAA Outcome Summary Report during care plan meetings to ensure any CAA triggers are care planned as indicated. The QAPI Committee will randomly audit 5 resident CAAs monthly for indication of interdisciplinary team's decision to care plan for pressure ulcers and review the care plan for compliance. Monitoring to continue for a minimum of six months. Any non-compliance will require a follow-up action plan. | |

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| F 279 | Continued From page 14<br>The care plan, with an initiation date of 1/11/17 was reviewed. There was no evidence seen that Resident #64's pressure ulcer had been care planned.<br><br>The MDS nurse reported on 2/9/17 at 10:45 AM that information for completion of the MDS came from the chart and observations and interviews with residents. She added if a decision had been made to care plan pressure ulcers for a resident, as documented on the CAA, there was no reason not to care plan. The MDS nurse reviewed the care plan for Resident #64 and acknowledged she had not care planned pressure ulcers although the CAA had indicated it was to be care planned. The MDS nurse stated the care plan omission was an oversight. | F 279 | | |