STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Re-certification Survey at the facility from 8/21/23 through 8/24/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F623 for Notice Requirements Before Transfer/Discharge, F656 for Develop/Implement Comprehensive Care Plan, and F686 for Treatment/Services to Prevent/Heal Pressure Ulcer. The census at the time of the survey was 84 with a bed capacity of beds 98.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		9/21/23

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

Electronically Signed | 09/14/2023

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F 623	Continued From page 1	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to send a copy of a transfer/discharge notice for a resident to the State Long-Term Care Ombudsman for three (3)	F 623	F623 1. Copies of resident transfer/discharge notices were emailed to the State	

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F 623	Continued From page 3 of four (4) residents sampled for transfer notification. Resident #1, Resident #14, and Resident #88. Findings include: The facility provided documentation on letter head dated 8/23/23 that read, "We do not have a policy that specifically addresses notification of transfers to the Ombudsman." Resident #1 Record review of the Departmental Notes for Resident # 1 revealed the resident was transferred to the hospital on 6/30/23 for fever and wheezing. An interview with the Medical Records Nurse on 8/22/23 at 2:35 PM, revealed she was responsible for sending out the written notification of transfer/discharge to the Responsible Party and the Ombudsman. She confirmed that she did not send a copy of the transfer notification to the State Long-Term Care Ombudsman. She revealed that she had not sent any resident transfer/discharge notifications to the Ombudsman since April or May 2022. She stated, "Things have been hectic, and it just slipped my mind." She stated, "Honestly, I just thought about it when you asked for it." She acknowledged that she should have been sending out the notifications. An interview with the Ombudsman on 8/22/23 at 2:51 PM, confirmed that she had not received a monthly list of resident transfer/discharges from the facility in a while. She revealed that she was unsure of the last time she had received any	F 623	Ombudsman for Resident #1, Resident #14, and Resident #88 on 08/30/2023 by the Medical Records Licensed Practical Nurse (LPN). 2. The facility has determined that all residents have the potential to be affected by failure to notify the State Long-Term Care Ombudsman of facility-initiated resident transfer/discharges. 3. The facility will notify the State Ombudsman office of all facility-initiated transfers/discharges monthly. The facility "Notice of Bed hold" policy was revised on 08/25/23 to state "the State Ombudsman office will be notified of facility-initiated transfers no later than the 10th day of each month". The Medical Records staff was in-serviced on proper notification of the State Long-Term Ombudsman per the newly revised Policy and Procedure on 08/25/23 by the Director of Nurses (DON). Notification of facility-initiated transfer/discharges for the months of January, February, March, April, May, June and July of 2023 were emailed to the State Long-Term Care Ombudsman on 08/30/23 by the Medical Records LPN. Notification of facility-initiated transfer/discharges for the months of March, April, May, June, July, August, September, October, November and December of 2022 were emailed to the State Long-Term Care Ombudsman on 09/08/23 by the Medical Records LPN. 4. Notification of facility-initiated transfers/discharges for August 2023 were emailed to the State Long-Term Care Ombudsman on 09/05/23 by the Medical	

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F 623	Continued From page 4 notifications. An interview with the Administrator on 8/22/23 at 2:56 PM, confirmed that the facility had not been sending out transfer/discharge notifications to the Ombudsman, and she acknowledged that she was not aware they were not being sent. Record review of the Face Sheet revealed Resident # 1 was admitted to the facility on 7/10/23 with medical diagnoses of Scoliosis, Quadriplegia, Gastrostomy Status and Epilepsy. Resident #14 Record review of the Departmental Notes revealed that Resident #14 was transferred to the emergency room for Nausea and Vomiting on 6/21/23. On 8/22/23 at 2:40 PM, an interview with the Medical Records Nurse confirmed that she did not send a copy of Resident #14's transfer notification to the State Long-Term Care Ombudsman. She confirmed that she had not sent any resident transfer/discharge notifications to the Ombudsman since April or May 2022. Record review of the Face Sheet revealed that Resident #14 was admitted to the facility on 3/15/15 with medical diagnoses that included Cerebrovascular Disease, Hemiplegia, Type 2 Diabetes Mellitus, Essential (primary) Hypertension and Chronic Kidney Disease. Resident #88 Record review of the Departmental Notes revealed that Resident #88 was transferred to the	F 623	Records LPN. Beginning 09/05/23 the Administrator, (DON), or the Staff Development Nurse (SDN) will perform audits of the State Ombudsman notification monthly x3 months to ensure all facility-initiated transfers/discharges have been reported to the Ombudsman by the 10th of each month. Statement of deficiencies and the plan of correction were reviewed by the Quality Assurance (QA) Committee on 09/14/23. All findings from audits by the DON, SDN, MDS nurses, and/or the Medical Records staff will be reported to the QA Committee for evaluation of effectiveness; the QA committee will review these findings monthly for at least three months and make recommendations and/or changes as needed. If concerns are identified after the initial three-month period the QA Committee will continue monthly review of findings; if compliance has been found, the QA Committee will review audit findings quarterly.	

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F 623	Continued From page 5 emergency room for vomiting and bleeding from the surgical site to the left groin. The resident was transferred to the Emergency Department at the Hospital from the facility on 6/16/23. An interview with the Director of Nursing on 8/23/23 at 3:05 PM, confirmed that the transfer/discharge notification to the State Long -Term Care Ombudsman was not sent; therefore, the Ombudsman was not made aware of the transfer or the later discharge from the facility. Record review of the Face Sheet for Resident #88 revealed Resident #88 was re-admitted to the facility on 8/22/23 with medical diagnoses that included Peripheral Vascular Disease, Atherosclerosis of Unspecified Type Bypass Graft of the Left Leg and Cerebral Infarction.	F 623		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		9/21/23

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F 656	Continued From page 6 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to develop a comprehensive care plan to prevent the reoccurrence of a pressure ulcer for a resident with a contracture to a hand on one (1) of three (3) residents care plans reviewed for pressure ulcers. Resident #27. Findings include:	F 656	F 656 1. Resident #27's careplan was updated on 08/23/23 to indicate her risk for impaired skin integrity due to contractures of her hands. New orders for wound care were received and initiated on 08/23/23 by the Treatment nurse. New orders were received for Occupational Therapy (OT) evaluation for contracture management	

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F 656	Continued From page 7 Review of the facility policy titled,"Nursing Care Plans", with an effective date of 9/2016 revealed, "Policy: Care, treatment, and services are planned to ensure that they are individualized to the patients needs. The (name of the facility) shall provide an individualized, interdisciplinary plan of care for all patients that is appropriate to the patient's need, strengths, and results of diagnostic testing, limitations and goals. The activities defined in the plan of care shall be planned to occur in the time frame that meets the healthcare needs of the patient... Procedure: The planning of care, treatment and services will include the following: Care planning is based on data collected from patient assessment. Developing a plan of care, treatment and services that includes patient care goals that are reasonable and measurable... Determining how the planned care, treatment and services will be provided. Documenting the plan of care, treatment and services..." Review of Resident #27's care plan revealed a care plan description for Skin/Pressure Ulcers/Incontinence: I have potential for skin breakdown related to (R/T) Impaired Mobility with an intervention start date of 7/20/2023 to evaluate right hand due to wound created by right hand contracture. An observation, on 08/21/23 at 11:30 AM and 3:37 PM revealed Resident #27 with contractures noted to her right hand. The resident's index finger on her right hand was sticking straight up, and the next four fingers were closed tightly against her hand. The resident's thumb was pressing into her palm. There was no pressure relieving devices in Resident #27's right hand.	F 656	on 08/23/23 by the Treatment nurse. The careplan for Resident #27 was updated to reflect these new orders. 2. The facility has determined that all residents with contractures have a potential to be affected by failure to develop a comprehensive careplan to prevent complications from contractures. 3. An Inservice on creating and updating comprehensive careplans was conducted on 08/24/23 with the Minimum Data Set (MDS) nurses by the Director of Nurses (DON). All residents with contractures will be screened by Physical and/or Occupational therapy for contracture management when the contracture is identified. Measures will be put in place to prevent injury or decline associated with the contracture; these measures will be reflected on the careplan. All residents with contractures were screened by Physical Therapy (PT) and/or Occupational Therapy (OT) for contracture management beginning 08/25/23. 4. On 08/24/23 the MDS LPN and MDS RN began auditing the careplans of residents with known contractures to ensure that the residents' contractures, their risk for complications related to the contractures and any ordered interventions are accurately reflected on the careplans. Beginning 08/28/23 the DON, Staff Development Nurse (SDN), MDS nurses, or the Medical Record (MR) staff will conduct an audit of the Twenty-four (24) hour report and all new orders to ensure the careplan accurately	

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F 656	Continued From page 8 An interview, on 08/22/23 at 03:20 PM with Registered Nurse (RN) #1 revealed that Resident #27 previously had a pressure ulcer to the palm of her right hand but that it had healed on 7/18/23. RN #1 observed Resident #27's hand and confirmed that there was an open area due to pressure from the contracture. An interview on 08/23/23 at 3:35 PM with Licensed Practical Nurse (LPN) #2 confirmed she develops the care plans. She stated the purpose of the care plan is to establish a baseline to show the care the resident needs. She stated that she adds daily to the existing care plan from physician orders written the previous day and if something is discontinued, she resolves the problem. She stated that she was not notified of Resident #27's wound being healed. She stated that if she had known the wound was healed she would have added to the care plan to assess the area for recurrent breakdown. She stated that a care plan for splints or hand rolls would be generated from a physician order. An interview, on 8/23/23 at 3:40 PM with Registered Nurse (RN) #1 revealed changes with the residents are written on the 24 hour report and are discussed in their stand up meetings. An interview, on 8/23/23 at 3:55 PM with RN #2 revealed the Minimum Data Set (MDS) nurses do not get a copy of the 24 hour report. She stated that she did not know how that (the information that the pressure ulcer healed) got missed. She stated it was a lack of communication. An interview, on 8/24/23 at 9:46 AM with the Administrator (ADM) revealed that the information concerning the pressure ulcer on Resident #27's	F 656	reflects the changes. Audits will be conducted daily times 5 days then three times weekly for 3 weeks then twice weekly times 4 weeks then once weekly times 4 weeks. Statement of deficiencies and the plan of correction were reviewed by the Quality Assurance (QA) Committee on 09/14/23. All findings from audits by the DON, SDN, MDS nurses, and/or the Medical Records staff will be reported to the QA Committee for evaluation of effectiveness; the QA committee will review these findings monthly for at least three months and make recommendations and/or changes as needed. If concerns are identified after the initial three-month period the QA Committee will continue monthly review of findings; if compliance has been found, the QA Committee will review audit findings quarterly.	

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F 656	Continued From page 9 hand healing should have been picked up by the MDS nurses in stand-up and a care plan for prevention should have been done. She stated, "We missed it." A review of the facility Face Sheet for Resident #27 revealed she admitted to the facility on 06/29/2017 with diagnoses of Unspecified Dementia, Heart Failure, Unspecified Psychosis, Hypothyroidism, Major Depressive Disorder and personal history of Malignant Neoplasm of Breast.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review, the facility failed to prevent the recurrence of a pressure ulcer related to a contracture of a resident's hand for one (1) of three (3) residents reviewed on sample for pressure ulcers. Resident #27.	F 686	F 686 1. On 08/22/23 new orders were received and initiated for wound care to the right hand wound of Resident #27. Occupational Therapy (OT) screen for contracture management was completed	9/21/23

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F 686	Continued From page 10 Findings include: A review of the facility policy titled, "Decubitus Injuries, Prevention," with an effective date of 9/2016 and a review date of 10/22 revealed, "Policy: Prevention of pressure sores is primarily a nursing responsibility. The most effective means of preventing skin breakdown are relief of pressure on the skin, maintenance of adequate circulation, hydration, and an adequate diet... Try to prevent any moisture, diarrhea, urinary incontinence, sweating and the like, because excretions may cause skin maceration..." Observations on 08/21/23 at 11:30 AM and 3:37 PM, revealed Resident #27 lying in bed on her back with contractures noted to her right hand. The resident's index finger on her right hand was sticking straight up, and the next four fingers were closed tightly against her hand. The resident's thumb was pressing into her palm. There was no pressure relieving devices in Resident # 27's hand. There was a foul odor noted coming from the right hand. An observation and interview, on 08/22/23 at 03:00 PM, revealed Resident #27 lying in bed with a rolled-up bath cloth in her right hand under her four fingers but not under her thumb. Licensed Practical Nurse (LPN) #1 was present in resident's room and removed the bath cloth from Resident #27's right hand and a small amount of a brown substance was noted on the bath cloth when it was removed. LPN #1 opened the resident's hand and revealed an open area to the palm of the right hand and noted a foul odor. Resident #27 confirmed that her hand hurt when it was opened. LPN #1 confirmed that Resident #27 had previously had an open area to that hand	F 686	on 08/25/23. 2. The facility has determined that all residents with a history of healed pressure ulcers have a potential to be affected by failure to implement measures to prevent recurrence. 3. Measures to prevent recurrence of pressure ulcers will be put in place by the nursing department upon identification of a pressure ulcer and/or when the pressure ulcer heals. All healed pressure ulcers will continue to be monitored by a nurse for a period of at least two weeks to ensure preventative measures are effective. On 08/22/23, the Certified Nurses Assistant (CNA) and Licensed Practical Nurse (LPN) assigned to Resident #27 were inserviced on contracture management/prevention by the Staff Development Nurse (SDN). On 08/23/24, the treatment nurse was inserviced by the Director of Nurses (DON) on implementing preventative measures when ulcers are healed, how to properly input therapy orders, and properly updating the 24-hour report and proper careplaning of these changes. All residents underwent a complete body audit by an LPN or Registered Nurse (RN) beginning 08/23/23 and with no new pressure ulcers identified. On 08/25/23 the Charge nurses began evaluating all residents for contractures. Physical Therapy (PT) and/or Occupational Therapy (OT) began completing screens for contracture management on those residents with contractures beginning 08/25/23. Nurses and Certified Nurses Assistants (CNA)	

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	25A190	A. BUILDING _____ B. WING _____	08/24/2023

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F 686	Continued From page 11	F 686		

but that it had healed. LPN #1 confirmed that it would be her responsibility as a nurse taking care of Resident #27 to observe the area of any contracture for any skin issues. LPN #1 confirmed there was an open area in the palm of Resident #27's right hand.

An interview, on 08/22/23 at 03:20 PM, with Registered Nurse (RN) #1 revealed that Resident #27 previously had a pressure ulcer to the palm of her right hand but that it healed. RN #1 stated that she contacted therapy to assess Resident #27 for something to prevent further breakdown. RN #1 stated that she made therapy aware that Resident #27 had a roll for her hand in the drawer in her room and that it was not being used but RN #1 did not follow up with therapy after that point. RN #1 stated that it was the responsibility of the nurses and nurse aides to complete weekly body audits. RN #1 stated that she checked on Resident #27's hand every other day for about a week after it healed to make sure it did not open back up, but she did not know who was looking at it after that. RN #1 observed Resident # 27's hand and confirmed that there is an open area due to pressure from the contracture. RN #1 measured the pressure injury to the right-hand. The pressure ulcer measurements revealed: Length 1.30 centimeters(cm), Width 1.00 cm, and Depth 0.30 cm.

An interview, on 08/23/23 at 09:45 AM, with Certified Nurse Aide (CNA) #1 stated that the nurse aides do skin audits daily when they are bathing the residents. CNA #1 confirmed that the area noted to residents' right hand should have been identified before yesterday. She stated that she identified the area yesterday (08/22/23) when she was providing care for the resident, and she

were inserviced on properly observing the resident's skin for breakdown, wound prevention, proper skin hygiene, contracture prevention and management beginning 09/13/23.

4. Beginning 08/28/23 the DON, Staff Development Nurse (SDN), Minimum Data Set (MDS) nurses, or the Medical Record staff will conduct an audit of the Twenty-four (24) hour report and all new orders to ensure newly healed pressure ulcers have measures in place to prevent recurrence. Audits will be conducted daily times 5 days then three times weekly for 3 weeks then twice weekly times 4 weeks then once weekly times 4 weeks.

Statement of deficiencies and the plan of correction were reviewed by the Quality Assurance (QA) Committee on 09/14/23. All findings from audits by the DON, SDN, MDS nurses, and/or the Medical Records staff will be reported to the QA Committee for evaluation of effectiveness; the QA committee will review these findings monthly for at least three months and make recommendations and/or changes as needed. If concerns are identified after the initial three-month period the QA Committee will continue monthly review of findings; if compliance has been found, the QA Committee will review audit findings quarterly.

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F 686	Continued From page 12	F 686		

put the rolled-up bath cloth in her right hand. She stated that she worked last Friday (08/18/23) and the pressure area was not present then. She stated that the process would be to notify the nurse of any new skin concerns. CNA #1 stated that if the resident was supposed to have any measures in place such as a hand roll it would be in their activity documentation and that there is no documentation for that.

An interview, on 08/23/2023 at 10:20 AM, with Occupational Therapist confirmed that she did not receive an order to evaluate the resident for possible interventions related to the right-hand contracture.

An interview, on 08/23/2023 at 10:35 AM, with Director of Nursing (DON) stated that the nurse does a weekly body audit with the nurse aide when bathing and that the nurse aides do body audits when giving baths and report any changes to the nurse. The DON confirmed that the area of skin should have been identified prior to yesterday, 08/22/23. The DON confirmed there was no interventions present to prevent breakdown from the contracture.

An interview, on 8/23/23 at 3:40 PM, with RN #1 revealed changes with the residents are written on the 24 hour report and are discussed in their stand up meetings.

An interview, on 8/23/23 at 3:55 PM with RN #2 revealed the Minimum Data Set (MDS) nurses do not get a copy of the 24 hour report. She stated that she did not know how that got missed, it was a lack of communication.

An interview, on 8/24/23 at 9:46 AM with the

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F 686	Continued From page 13	F 686		

Administrator (ADM) revealed that everybody doing care for the resident was responsible for assessing the skin breakdown and something should have been in place to prevent the recurrence of the pressure ulcer.

A record review of the Wound Assessment Report revealed Resident # 27 had a stage 2 pressure ulcer to her right palm that was identified on 07/01/23 and received treatment until healed on 07/18/23.

A record review of the Wound Assessment Report dated 8/22/23 revealed Resident #27 had a stage 3 pressure ulcer to her right palm identifed on 8/22/23 with treatment ordered.

Record review of the Completed Care Task form revealed that from 7/18/23 through 8/22/23 under body audit there were no new skin concerns.

A record review of the facility Face Sheet for Resident #27 revealed she admitted to the facility on 06/29/2017 with diagnoses of Unspecified Dementia, Heart Failure, Unspecified Psychosis, Hypothyroidism, Major Depressive Disorder and personal history of Malignant Neoplasm of Breast.

A review of the MDS with an Assessment Reference Date (ARD) of 06/13/2023 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated that Resident #27 was not interviewable.