MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22GH	A. BUILDING: _____ B. WING _____	C 10/18/2021

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) from 10/12/21 through 10/18/21 for complaint # MS18163. During the survey, the facility was determined not to be in substantial compliance with the requirements of participation with the Mississippi regulations for Minimum Standards for institutions for the Aged or Infirm. An extended survey was completed, and deficiencies were cited M500. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/14/21 when the facility neglected to contact the Primary Physician of one (1) of nine (9) residents sampled to update him on the progress of an acute surgical incision so that treatment orders could be changed. The facility failed to get Medical Doctor (MD) orders to remove the 9 staples present on the incision on his admission to the facility on 9/14/21. When the facility neglected to provide the services required, this resulted in the acute surgical incision worsening, dehiscing, becoming necrotic with eschar covering the acute surgical incision and Resident #1 was admitted to the hospital on 10/8/21 with sepsis. The facility's failure to contact the primary MD and get acute surgical wound treatment changes placed this resident and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment, or death. On 10/15/21, at 4:03 PM, the SA notified the Administrator of the IJ and SQC. The SQC and IJ existed at: Rule 45.17.2 Resident Rights (M500) Level IV	M 000		

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M 000	Continued From page 1 The facility submitted an acceptable Removal Plan on 10/16/21, in which they alleged all corrective actions to remove the IJ were completed on 10/15/21 and IJ removed on 10/16/21. The SA validated the Removal Plan on 10/18/21, and determined the IJ was removed on 10/16/21, prior to exit. Therefore, the scope and severity for Rule 45.17.2 Resident Rights were lowered to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 72, and the facility held a license for 110 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		11/12/21

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M 500	Continued From page 2 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 3	M 500		

and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic

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M 500	Continued From page 4 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 5 This Statute is not met as evidenced by: Level IV Based on record review, facility policy review and interviews, the facility failed to ensure a resident was free from neglect and provided the necessary care and services to avoid physical harm as evidenced by the failure to notify the Physician to obtain orders for an acute surgical incision which resulted in the incision dehiscing and developing eschar for one (1) of nine (9) residents reviewed with wounds. Resident #1. Resident #1 admitted to the facility on 9/14/21with an acute surgical incision and the facility did not contact Resident #1's Primary Physician to obtain treatment change for his acute surgical incision resulting in the incision dehiscing and developing eschar. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/14/21 when the facility neglected to contact the Primary Physician of one (1) of nine (9) residents sampled to update him on the progress of an acute surgical incision so that treatment orders could be changed. The facility failed to get Medical Doctor (MD) orders to remove the 9 staples present on the incision on his admission to the facility on 9/14/21. When the facility neglected to provide the services required, this resulted in the acute surgical incision worsening, dehiscing, becoming necrotic with eschar covering the acute surgical incision and Resident #1 was admitted to the hospital on 10/8/21 with sepsis. The facility's failure to contact the primary MD and get acute surgical wound treatment changes	M 500	* Resident # 1 was transferred to the hospital for vomiting up coffee-ground emesis on 10/08/21, and has not returned to the facility since this date. All acute surgical incisions/wounds that are identified as having deterioration will be reported to the attending physician or surgical physician upon being identified. Any resident with surgical wounds/skin issues will be monitored weekly by the High Risk Committee to ensure that deterioration of wound/skin is addressed and physician is notified. * 2 of 74 residents were identified with acute surgical wounds by the Director of Nursing on 10/15/21 to have the potential to be affected by this deficient practice. The 2 residents identified with acute surgical wounds had orders obtained from the surgeons on 10/08/21 for care of one admission and 10/14/21 for the second resident on the readmission . * A directed in-service was held on 11/4/21, with nurses by the Northern Mississippi QI Registered Nurse on the policy on " Seven Components to Reduce, Detect, and Prevent Abuse and Neglect" revised 6/19/21. The in-service included compliance with providing necessary care and services to avoid physical harm including notification of physician and Resident Representative when changes occur. The Quality Assurance Committee which included the Medical Director, Administrator, Director of Nursing , Medical Records Nurses, Admission	

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M 500	Continued From page 6 placed this resident and other residents at risk, in a situation that was likely to cause serious harm, injury, impairment, or death. On 10/15/21, at 4:03 PM, the SA notified the Administrator of the IJ and SQC and provided the facility with the IJ templates. The facility submitted an acceptable Removal Plan on 10/16/21, in which they alleged all corrective actions to remove the IJ were completed on 10/15/21 and IJ removed on 10/16/21. The SA validated the Removal Plan on 10/18/21, and determined the IJ was removed on 10/16/21, prior to exit. Therefore, the scope and severity for Rule 45.17.2 Resident Rights M500, was lowered to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility's policy/procedure for "Seven Components to Reduce, Detect, and Prevent Abuse and Neglect", dated 06/19, revealed "Protect-The facility seeks to support and protect individuals receiving services, their families and staff. Additionally, the facility makes an effort to protect individuals from abuse and neglect during investigation of allegations of abuse or neglect." Record review of the facility's policy/procedure for "Prevention and Treatment of Skin Issues", last revised 02/17, revealed "It is the policy to properly identify and assess residents whose clinical	M 500	Nurse, Administrative Assistant, Infection Preventionist, Dietary Manger and Activity Coordinator met on 10/15/21 and reviewed the policy " Seven Components to Reduce, Detect, and prevent abuse and Neglect", with revision date 6/19/21 and did not recommend any changes to the policies. * Beginning 10/18/21, the Director of Nursing will observe acute surgical wounds weekly for four weeks and then monthly for three months with findings documented on surgical incision/wounds observation form to include notification to the physician and Resident Representative if there are changes noted to the acute surgical wounds, with forms maintained by the Administrator. The Director of Nursing will evaluate the completed observations monthly for three months and make recommendation or changes as needed. All Skin/Wounds will be monitored weekly in the High Risk meeting and report any negative findings to the residents physician by the Director of Nursing or the Treatment Nurse. The Quality Assurance Committee which included Register Nurse, Administrator, Director of Nursing and Medical Director met on 10/15/21 to review the monitoring and will continue to meet quarterly to address any concerns identified from the observations by the Director of Nursing and evaluate the completed observation monthly for three month and mark recommendation or changes as needed. The Quality Assurance Committee will meet monthly for four months to monitor all policies to ensure compliance. An	

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M 500	Continued From page 7 conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." Record review of the Face Sheet revealed that Resident #1 was admitted to the facility on 9/14/2021 with the diagnosis of Osteomyelitis of Vertebra, thoracic region; Pressure ulcer of sacral region, unstageable; Intraspinal abscess and granuloma; Other depressive episodes; Unspecified viral hepatitis C without hepatic coma, Cerebral infarction due to unspecified occlusion or stenosis of right mid cerebral artery; Hemiplegia following cerebral infarction affecting left nondominant side; Dysphagia following cerebral infarction, Cerebral atherosclerosis, Type 2 diabetes mellitus without complications; Chronic obstructive pulmonary disease unspecified; Hyperlipidemia unspecified; Pressure ulcer of sacral region stage 2, Essential hypertension; Constipation, unspecified; Pain, unspecified; Insomnia, unspecified; Other muscle spasm; Other psychoactive substance use, unspecified, uncomplicated; Restlessness and agitation; Post laminectomy syndrome, not elsewhere classified. Record review of Resident #1's September 2021 Physician Orders included: Vancomycin 1,000 milligrams (MG) intravenous (IV) injection into the vein every 12 hours times (X) 12 weeks; pressure ulcer to sacrum, cleanse with normal saline (NS), pat dry, apply zinc to the wound bed, cover with Mepilex daily until healed; and Surgical incision to upper Mid Back, paint with betadine and cover with Mepilex daily until healed, follow up with Neurosurgeon in two months. Record review of Resident #1's October 2021	M 500	additional Quality Assurance meeting was held on 10/29/21 to ensure no new recommendations are needed.	

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M 500	Continued From page 8 Physician Orders revealed an order dated 9/28/2021, for the Stage 2 sacrum pressure ulcer. Theorders were changed to Unstageable pressure ulcer to sacrum, cleanse with NS and gauze, pat dry, apply Santyl to wound bed, cover with foam dressing daily until healed. The treatment to the surgical incision to the upper mid back wound care did not change. The Physician Orders have nothing about removal of the 9 staples. The order for treatment of the acute surgical incision are to paint with betadine and cover with dry dressing. This order was in effect from 9/14/21 until transfer to the hospital on 10/8/21. Record review of Resident #1's care plan dated 9/30/21 revealed, "Problem: Resident has a diagnosis of osteomelitis(osteomyelitis) of vertebra thoracic region has intraspinal abcsess and granuloma" approaches revealed "observe for worsening of condition" and "notify MD of any complications". Record review of Resident #1's HIGH RISK MANAGEMENT WORKSHEET written by Registered Nurse (RN) #2 dated 9/14/2021 revealed a Mid upper back surgical incision with Nine (9) staples, "well defined, 95% epithelial tissue, surrounding skin pink with slight edema". Record review of Resident #1's HIGH RISK MANAGEMENT WORKSHEET written by RN #2, dated 10/5/2021, revealed mid upper back surgical incision "treatment successful, no deterioration noted, 95% epithelial tissue, normal-well defined wound edges, surrounding skin pink with slight edema, scant serosanguinous drainage, continue current treatment".	M 500		

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M 500	Continued From page 9	M 500		

Record review of the Nurse Practitioner (NP) #1's Progress Note on 9/21/21 revealed that the surgical incision to the Mid upper back has serous drainage, no odor, edges attached, peri wound pink with slight edema. NP #1 documented she visualized the surgical wound to the mid upper back. NP#1's last Progress Note written 10/5/21 describes the surgical incision to the Mid upper back with drainage Serosanguineous, edges attached, peri-wound pink with slight edema and the progress is improving. She documented she visualized this surgical incision.

At 3:04 PM, Resident #1 was transferred to the hospital. Record review of the 10/8/21 at 4:14 PM hospital Hospitalist History and Physical revealed the admission diagnosis of Sepsis and review of the Inpatient Admission Skin Assessment revealed that Resident #1 has "9 staples noted to top of T-spine with yellow slough noted to edges with redness, swelling and tenderness."

Record review of the signed Treatment Nurse Job Description, signed 8/27/19, by RN#2, revealed the treatment nurse will "complete the weekly skin records accurately describing onset date, size, location, color, healing, odors, cultures, etc. (pressure sore and non-decub skin condition records)" and "assists the nursing department to assure the care plans are followed".

Interview with the Treatment Nurse (RN#2) on 10/12/21 at 12:15 PM, revealed Resident #1 was admitted with 9 staples. There were no orders to remove the staples. He was supposed to have a follow up visit with the neurosurgeon in 2 months. "Sometimes we remove the staples, sometimes the doctor's remove the staples at the follow-up

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M 500	Continued From page 10	M 500		

visit. The order for the surgical incision was to paint with betadine and cover with dry dressing daily. Sometimes the initial Medical Doctor (MD) orders will have when to remove the staples. There are times I will call to see when the doctor wants the staples removed. I did not contact the neurosurgeon or the primary MD here on when to remove the staples.There was no order to remove the staples. No, I didn't call the neurosurgeon about the incision. No, we do not have a wound doctor coming in to assess wounds I never contacted the primary physician to get the orders changed on the surgical incision from paint with betadine daily and cover with a dry dressing."

On 10/14/21 at 11:30 AM, an interview with RN #2, the Treatment Nurse revealed she has been the treatment nurse at the facility for two (2) years. RN #2 revealed she did not admit Resident #1 but performed his treatment the next day. When RN #2 was asked to compare the condition of the resident's incision site on admission, 9/14/21, and when discharged to the hospital on 10/8/2021 RN #2 revealed his treatment was betadine and dressing to the incision site daily. RN#2's first observation and treatment, on 9/15/21 revealed the incision site to be bruised, pink with slight edema, nine (9) staples intact, and a scant drainage with no open areas. Measurements were 8.0 cm (centimeters) X 0.3 cm X 0.1cm on 9/14/21. RN #2 described the incision site the day he was sent to the Emergency Room on 10/8/21 and revealed the site was bruised, staples intact, more open areas along the incision site, the tissue was hard and eschar over the incision site, the right side was redder, and the measurements were 7.4 cm X .6 cm X .1.0 cm. RN #2 revealed she did not call the MD or get a change in treatment order and

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M 500	Continued From page 11	M 500		

does not know why. RN#2 revealed she did not realize a decline in Resident #1's wound.

Interview with NP #1 on 10/12/21 at 1:05 PM revealed "I did change the orders on that incision." "On my second visit, I told (RN#2) to hold off on removing the staples. I remember it dehiscing."

On 10/12/21 during an interview at 2:50 PM, the SA asked NP #1 to view the facility's photos of the incision and asked if that was improving. NP #1 stated "No, I re-read my notes and saw that I was writing improving. I was more focused on his sacral pressure ulcer and not the incision. I didn't see where I wrote a new order for the incision either."

Interview on 10/13/21 at 2:09 PM with Physician #1 revealed that he usually has the staples on a back incision removed 10-14 days after surgery. "I was not notified that it got worse. Someone should have contacted me about that incision, and no one did. This is not typical of NP #1."

Interview 10/14/21 at 9:50 AM with Physician #1 revealed "There should have been wound treatment changes and if the wound was getting worse they should have contacted me."

Interview with the facility's Medical Director on 10/15/21 at 7:50 PM, revealed "I supervise the nurse practitioner. She usually sees (name of Physician #1) patients. I do review the charts of the residents she sees for (name of Physician #1). I am really surprised she didn't do more for Resident #1's surgical incision. I've seen the photos of his back incision and it was dehiscing when he left to go to the hospital. It was a healing incision when he was admitted to the

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M 500	Continued From page 12	M 500		

nursing home. Neurosurgeons are usually very specific with their treatments. Betadine does not help healing. I'm really shocked they used betadine on it. My big concern is, if you are admitting somebody and they have an acute surgical wound with staples in it and the admitting orders do not include when the staples are to come out, the admitting nurse should call and ask about the removal of the staples and wound treatment. A nurse should have called him and gotten orders for this surgical wound. Regardless our facility should have called (name of Physician #1) and asked about it."

At 4:03 PM on 10/15/21, the SA with the Director of Nurses, Administrator, facility's Quality Improvement Nurse and the facility's Regional Administrator and informed the group of the IJ at facility for Notification of RP, Neglect, Care plans MD with changes in condition and Quality of Care.

Interview with RN #2 on 10/18/21 revealed she acknowledged that neglect is when a resident is denied goods or services that will help a resident heal.

REMOVAL PLAN

October 15, 2021
RE: Removal Plan
On October 15, 2021, at 4:03 PM the State Agency notified the Administrator that the facility was in Immediate Jeopardy (IJ) related to neglect, notification of Medical Doctor (MD), quality of care and failure to follow care plans and templates were provided to the Administrator.

The facility failed to inform Resident #1's physician and Resident Representative of a

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	22GH	A. BUILDING: _____ B. WING _____	C 10/18/2021

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GRENADA LIVING CENTER	1950 GRANDVIEW DRIVE GRENADA, MS 38901

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M 500	Continued From page 13	M 500		

significant change and a need to alter treatment in Resident #1's surgical wound. The facility neglected to provide wound care services to Resident #1 by failure to obtain wound care orders for a deteriorating surgical wound. The facility failed to follow and implement Resident #1's comprehensive care plan approach of notifying the physician of any significant change. The facility failed to ensure Resident #1 received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan as evidenced by failure to notify the physician of a deteriorating surgical wound and obtain treatment orders to address the decline in the wound.

Corrective Action:
1. The facility Quality Assurance Committee (QA) Meeting was held on Thursday October 14, 2021 at 9:30 AM with the committee consisting of the facility Director of Nurse (DON), Administrator (ADM), Medical Director by phone, Infection Preventionist, Registered Nurse (RN) #3, Licensed Practical Nurse #1 (LPN), LPN #2, (RN) #4, LPN #3, Occupational Therapist (OT), Physical Therapist Assistant (PTA) , LPN #4, and RN #2. Topics discussed included treatments, reporting and follow up with changes in condition to physician and Resident Representative, abuse and neglect, adherence to orders as prescribed, ensuring that residents representative information is accurately entered into the computer system and infection control.

2 An additional QA meeting was held on Friday October 15, 2021 at 7:45 PM with the committee consisting of the facility DON, ADM, Medical Director, Infection Preventionist, RN #2 and RN #1 on Policy and Procedures of the Care Plan Process, Change in Resident Medical Status,

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M 500	Continued From page 14 Weekly Treatment Evaluation, Prevention and Treatment of Skin Issues, Seven Components to Reduce, Detect, and Prevent Abuse and Neglect. No policy changes were made, however, the facility made procedural changes on October 15, 2021, to include obtaining surgical wound care orders from the surgeon and/or attending physician for all new surgical wounds and deteriorating surgical wounds. The DON will assess acute surgical wounds weekly for any changes and notify the physician and/or surgeon of deteriorating surgical wounds for further orders. 3. The DON and ADM immediately initiated in-services with RNs and LPNs on October 11, 2021, at 1:00 PM on notification of physician, and Resident Representative regarding changes in condition of wounds. In-services were initiated on October 13, 2021, at 6:30 AM by the DON and ADM with RN's, LPN's, Certified Nurse Aides (CNA), Temporary Nurse Aides, Dietary staff, Housekeeping and Laundry staff, Activities, Social Services and Office staff on Change in Medical Status, Prevention of Abuse and Neglect, and Infection Control. In-services were initiated on October 13, 2021, at 6:30 AM with RN's and LPN's on the Weekly Treatment Evaluations, Prevention and Treatment of Skin Issues by the DON and ADM. On October 15, 2021 at 6:30 PM In-services were initiated by the DON and ADM with LPN's and RN's on the Care plan Process, what is a Care Plan, and following the Care plan. In-services will be on-going and no employee will be allowed to work until participation of the in-services are completed. 4. A 100% skin audit of all residents in the facility was performed by the RN's paired with	M 500		

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M 500	Continued From page 15 LPN's beginning October 13, 2021 and concluding October 15, 2021 with no negative findings. 5. On October 15, 2021, the DON did a record review of the two residents with acute surgical incisions to ensure intervention of physician notification of deteriorating surgical wound was present on the care plan. Of the two residents with acute surgical wounds, it was identified as one resident not having a Care Plan for his acute surgical wound. A Care Plan was initiated by the DON on October 15, 2021, for that surgical wound. 6. On October 13-15, 2021, RN #2, DON, LPN #1, LPN #2, LPN #3, RN #4, RN #5, and RN #1 performed body audits on seventy-four residents that included non-pressure areas. Five of seventy-four active residents were identified with new areas that included a rash, abrasion, irritation, dry skin with callus, and bunion with discoloration. The Physicians were notified, and new orders obtained on the five residents with new areas identified. The Physician #1 visited the facility on October 15, 2021, and assessed two of five active residents identified with new skin conditions and Resident Representatives were notified of new orders and condition on October 15, 2021. New treatment orders were initiated on October 14, 2021, for the other three residents by their physician and the Resident Representative was notified. 7. RN #2 received additional employee education by RN #6 on October 15, 2021, at 8:30 PM on notifying the surgeon and/or attending physician when a surgical wound has a change for the worse or is not responding to current treatment for further orders and if clarifications of	M 500		

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M 500	Continued From page 16 orders is needed. 8. Nurse Practitioner received additional employee education by Registered Nurse #6 on October 15, 2021, at 9:00 PM on notifying the surgeon and/or attending physician anytime a surgical wound is not responding to current treatment or deteriorating for further orders and when a resident has a new surgical wound, the surgeon and/or attending physician should be contacted for orders to include staple and/or suture removal. The facility alleges removal of the immediacy as of October 16, 2021, 8:00 AM. VALIDATION OF REMOVAL PLAN 1. Record review and interviews confirmed the facility Quality Assurance Committee (QA) Meeting was held on October 14, 2021 at 9:30 AM with the committee consisting of the facility Director of Nurse (DON), Administrator (ADM), Medical Director by phone, Infection Preventionist, Registered Nurse (RN) #3, Licensed Practical Nurse #1 (LPN), LPN #2, (RN) #4, LPN #3, Occupational Therapist (OT), Physical Therapist Assistant (PTA), LPN #4, and RN #2. Topics discussed included treatments, reporting and follow up with changes in condition to physician and Resident Representative, abuse and neglect, adherence to orders as prescribed, ensuring that resident's representative information is accurately entered into the computer system and infection control. Interviews with the facility Medical Director, Administrator, Director of Nurses/Infection	M 500		

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M 500	Continued From page 17	M 500		

Preventionist, four (4) RN's and one (1) LPN confirmed participation in the QA meeting held on October 14, 2021.

2. Record review and interviews confirmed a QA meeting held on October 15, 2021, at 7:45 PM committee consisting of the facility DON, ADM, Medical Director, Infection Preventionist, RN #2 and RN #1 on Policy and Procedures of the Care Plan Process, Change in Resident Medical Status, Weekly Treatment Evaluation, Prevention and Treatment of Skin Issues, Seven Components to Reduce, Detect, and Prevent Abuse and Neglect. There were no policy changes, however, the facility made procedural changes on October 15, 2021, to include obtaining surgical wound care orders from the surgeon and/or attending physician for all new surgical wounds and deteriorating surgical wounds. Interviews confirmed the DON will assess acute surgical wounds weekly for any changes and notify the physician and/or surgeon of deteriorating surgical wounds for further orders.
Interviews with the facility Medical Director, Administrator, Director of Nurses/Infection Preventionist, four (4) RN's and one (1) LPN confirmed participation in the QA meeting held on October 15, 2021.

3. Record review and interviews confirmed in-services with RNs and LPNs on October 11, 2021, at 1:00 PM on notification of physician, and Resident Representative regarding changes in condition of wounds. Interviews confirmed in-services were also initiated on October 13, 2021, at 6:30 AM by the DON and ADM with RN's, LPN's, Certified Nurse Aides (CNA), Temporary Nurse Aides, Dietary staff, Housekeeping and Laundry staff, Activities,

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M 500	Continued From page 18 Social Services and Office staff on Change in Medical Status, Prevention of Abuse and Neglect, and Infection Control. Interviews confirmed in-services were initiated on October 13, 2021, at 6:30 AM with RN's and LPN's on the Weekly Treatment Evaluations, Prevention and Treatment of Skin Issues by the DON and ADM. On October 15, 2021, at 6:30 PM In-services were initiated by the DON and ADM with LPN's and RN's on the Care plan Process, what is a Care Plan, and following the Care plan. In-services will be on-going, and no employee will be allowed to work until participation of the in-services are completed. Staff interviews included six (6) RN's, 6 LPN's, ten (10) CNA's, 1 administrative assistant, three (3) housekeeping/laundry staff, 1 social worker. 4. Record review and interviews confirmed the facility performed a 100% skin audit of all residents beginning October 13, 2021, and concluding October 15, 2021 with no negative findings. Interviews were with 6 RN's and 6 LPN's. 5. Record review and interview with the DON confirmed that on October 15, 2021, she did a record review of the two residents with acute surgical incisions to ensure intervention of physician notification of deteriorating surgical wound was present on the care plan. Of the two residents with acute surgical wounds, she identified one resident did not a Care Plan for his acute surgical wound. A Care Plan was initiated by the DON on October 15, 2021, for that surgical wound. 6. Record review and interviews confirmed that on October 13-15, 2021, facility nurses performed body audits on seventy-four residents that	M 500		

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M 500	Continued From page 19	M 500		

included non-pressure areas. Five of seventy-four active residents were identified with new areas that included a rash, abrasion, irritation, dry skin with callus, and bunion with discoloration. Record review confirmed the Physicians were notified, and new orders obtained on the five residents with new areas identified. Record review confirmed that Physician #1 visited the facility on October 15, 2021, and assessed two of five active residents identified with new skin conditions and Resident Representatives were notified of new orders and condition on October 15, 2021. Record review confirmed that treatment orders were initiated on October 14, 2021, for the other three residents by their physician and the Resident Representative was notified. Staff interviews with 2 RN's, 1 LPN and the DON confirmed these body audits. Interview with Physician #1 confirmed his visit to the facility on 0ctober 15, 2021 to assess two of his patients with new skin conditions.

7. Record review and interview with RN #2 confirmed she received additional employee education by RN #6 on October 15, 2021, at 8:30 PM on notifying the surgeon and/or attending physician when a surgical wound has a change for the worse or is not responding to current treatment for further orders and if clarifications of orders is needed. Interview with RN #6 confirmed she conducted the employee education with RN #2.

8. Record review confirmed that the Nurse Practitioner received additional employee education by Registered Nurse #6 on October 15, 2021, at 9:00 PM on notifying the surgeon and/or attending physician anytime a surgical wound is not responding to current treatment or

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M 500	Continued From page 20 deteriorating for further orders and when a resident has a new surgical wound, the surgeon and/or attending physician should be contacted for orders to include staple and/or suture removal. Interview with RN #6 confirmed that the Nurse Practitioner received the addition education.	M 500		