

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42CG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/27/2020
NAME OF PROVIDER OR SUPPLIER CRYSTAL REHABILITATION AND HEALTHCARE CEN1		STREET ADDRESS, CITY, STATE, ZIP CODE 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a survey for Complaint Investigation (CI) MS #16771, #16755, and #16763 from 07/17/2020 through 07/27/2020. The SA did not substantiate CI MS #16771 related to Quality of Care, and CI MS #16755 related to Staffing, with no deficiencies cited. The SA substantiated CI MS #16763 related to Abuse and Neglect and Quality of Care due to Pressure Ulcers. During the investigation, the facility was found not to be in compliance with the Minimum Standards for the Institutions for the Aged or Infirm. The SA cited state statutes at M500 and M615. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 04/21/2020, as a result of worsening and infection of Resident #1 's initial pressure ulcer. The facility 's failure assess and put preventative measures in place, resulted in nine (9) new pressure ulcers, and the failure to implement an order to increase Resident #1 's gastric tube feeding for eleven (11) weeks, to meet his nutritional needs and help heal his significant wounds, resulted in the deterioration of his wounds. The facility 's failure to provide preventative measures to residents who were at risk for skin breakdown and to prevent further skin breakdown also affected Residents #2, #3, #4 and #5, which led to further skin breakdown, infections, and hospitalizations. The facility 's failure to provide preventative measures to residents at risk for skin breakdown, placed Residents #1, #2, #3, #4, #5 and other residents at risk, in a situation that caused and/or likely to cause serious injury, harm, impairment, or death.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/07/20

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M 000	Continued From page 1 On 07/20/2020 at 4:30 PM, the SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The IJ and SQC existed at: Rule 45.17.2 - Resident Rights (M500) Rule 45.21.3 - Pressure Sores (M615) The facility submitted a Credible Removal Plan on 07/25/2020 at 1:08 PM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 07/25/2020. The SA validated the Removal Plan on 07/26/2020, and determined the IJ was removed, prior to exit. Therefore the scope and severity for Rule 45.17.2 - Resident Rights (M500) and Rule 45.21.3 - Pressure Sores (M615) was lowered from a Level IV scope and severity to a Level III, while the facility develop a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility had a census of 68, and 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	M 500		8/25/20

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 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 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	M 500		

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M 500	Continued From page 5 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. This Statute is not met as evidenced by: Level IV Based on observation, staff interview, family interview, record review, and facility policy review, the facility failed to provide goods and services to residents necessary to avoid physical harm, for five (5) of five residents reviewed, Residents #1, #2, #3, #4, and #5. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 04/21/2020, as a result of worsening and infection of Resident #1's initial pressure ulcer. The facility's failure assess and put preventative measures in place, resulted in nine (9) new pressure ulcers, and the failure to implement an order to increase Resident #1's gastric tube feeding for eleven (11) weeks, to meet his nutritional needs and help heal his significant wounds, resulted in the deterioration of his wounds. The facility's failure to provide preventative measures to residents who were at risk for skin breakdown and to prevent further skin breakdown also affected Residents #2, #3, #4 and #5, which led to further skin breakdown, infections, and hospitalizations.	M 500	1 The following measures for impacted residents were implemented: Resident # One (1) was evaluated by Registered Dietician (RD) on 07/20/2020, and nine (9) new dietary recommendations were given, implemented, and care plan updated. Pain evaluation performed on 07/20/2020 by DON with no changes to pain medication regimen. Nurse Practitioner assessed Resident # One (1) on 07/22/2020 with no new orders given. MD assessed Resident # One (1) on 07/23/2020, and new orders were given for bilateral venous and arterial Doppler studies. Vendor performed doppler on 07/24/2020 and results pending. Sister facility RN reviewed current treatment orders for effectiveness on 07/23/2020 and deemed orders as appropriate due to current treatments are ordered once a day. Resident # One (1) treatment orders have been implemented. Therapy reviewed current positioning devices for Resident # One (1), and ordered full body wedge, palm guards, and knee separator for Resident # One (1) from supply vendor	

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M 500	Continued From page 6 The facility's failure to provide preventative measures to residents at risk for skin breakdown, placed Residents #1, #2, #3, #4, #5 and other residents at risk, in a situation that caused and/or likely to cause serious injury, harm, impairment, or death. On 07/20/2020 at 4:30 PM, the SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The IJ and SQC existed at Rule 45.17.2 - Resident Rights (M500). The facility submitted a Credible Removal Plan on 07/25/2020 at 1:08 PM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 07/25/2020. The SA validated the Removal Plan on 07/26/2020, and determined the IJ was removed, prior to exit. Therefore the scope and severity for Rule 45.17.2 - Resident Rights (M500) was lowered from a "Level 4" scope and severity to a "Level 3", while the facility develop a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Abuse Prohibition Policy", revised on 12/12/2019, revealed, "Intent: This protocol was intended to assist in the prevention of abuse, neglect and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect ... Policy: 1. The facility will prohibit neglect ... Definitions: ...Neglect is defined as the failure to	M 500	on 07/23/2020. New orders will be implemented upon delivery of these special-order devices. Resident # Two (2) was evaluated by RD on 07/21/2020 with three (3) new recommendations which were implemented and care planned by Corporate Regional Nurse; responsible party notified during care conference held on 07/25/2020. NP assessed Resident # Two (2) on 07/22/2020 with no new orders given. MD assessed Resident # Two (2) on 07/23/2020 with no new orders given. Treatment review for effectiveness completed on 07/24/2020 by sister facility RN and a new order was given by NP to change frequency of treatment order to once a day. Therapy reviewed current positioning devices and deemed current devices as appropriate for care. Resident # Three (3) was evaluated by RD on 07/20/2020 with two (2) new recommendations that were implemented and added to the care plan by Corporate Regional Nurse. Sister facility RN reviewed current treatment orders on 07/24/2020 to determine effectiveness of treatments and deemed current treatments as effective. Therapy reviewed positioning devices for Resident # Three (3) and ordered a full body wedge and abductor contracture cushion from a supply vendor on 07/23/2020. Resident # Three (3) orders are being followed for devices currently in place. New orders will be implemented upon delivery of special-order devices. Resident # Three's (3) care plan was reviewed and revised by MDS RN on 07/24/2020 to reflect current status and new orders.	

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M 500	Continued From page 7 provide goods and services necessary to avoid physical harm, mental anguish, or mental illness ..." Resident #1 Review of Resident #1's "Admission Record", revealed he was admitted on 01/21/2019 with a primary diagnosis of Dementia with Lewy Bodies, Unspecified Dementia with Behavioral Disturbance, Benign Prostatic Hyperplasia, Other Seizures, and Dysphagia (Oropharyngeal Phase). Review of Resident #1's Minimum Data Set (MDS) dated 12/30/2019, revealed, he was "totally dependent on two (2) + person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed)". Resident #1 was not able to reposition himself or turn in the bed unassisted. Review of Resident #1's "Braden Scale For Predicting Pressure Sore Risk", dated 02/19/2020, revealed his score to be eleven (11) which placed him at "High Risk" for developing pressure ulcers. Resident #1 was admitted to the facility without any noted pressure ulcers. Since 02/03/2020, he received eleven new, in-house acquired pressure ulcers, (two Unstageable ulcers, two stage IV pressure ulcers, one (1) stage III pressure ulcer, four stage II pressure ulcers, and one stage one pressure ulcer). A lack of turning and repositioning, with proper application of pressure reducing devices was observed, as well as interviews with staff confirming the formation of multiple pressure ulcers due to preventative pressure reducing devices not being consistently	M 500	Responsible party for Resident # Three (3) was notified of assessment findings, care plan revision and new orders on 07/25/2020 by MDS RN during care conference. Resident # Four (4) was evaluated by RD on 07/20/2020 with one (1) new recommendation given, implemented, and added to care plan by (who). NP assessed Resident # Four (4) on 07/22/2020 with no new orders given. MD assessed Resident # Four (4) on 07/23/2020 with no new orders given. Corporate Wound Consultant reviewed treatments of Resident # Four (4) wounds and made recommendations which were reviewed and ordered by NP on 07/21/2020. Devices reviewed by therapy for Resident # Four (4) and elbow splint, boots, and full body wedge were ordered on 07/23/2020 from supply vendor. Resident # Four (4) orders are being followed for devices currently in place. New special-order device orders will be implemented upon delivery of devices. Resident # Five (5) was hospitalized on 04/07/2020 and subsequently expired due to cardiac arrest. 2. On 07/22/2020 Eighteen (18) Residents with a BIMS of 12 or higher were interviewed Social Services Director to identify issues with care; no concerns identified. Nursing Home Administrator reviewed and analyzed existing resident concerns, grievances, and incident reports completed for unplanned clinical outcomes such as new pressure ulcers for the past thirty (30) days to ensure any allegations of neglect of care have been identified, reported and investigated.	

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M 500	Continued From page 8 used, weekly skin assessments and wound measurements being missed, and orders for enteral tube feedings and supplements, to promote wound healing not being addressed timely. On 07/15/2020 at 10:35 AM, during initial rounds, Resident #1 was observed in bed, lying on his back. On 07/15/2020 at 11:35 AM, Resident #1 was observed in the bed, pillow behind his head, lying on his back, legs drawn up in a fetal position, no positioning devices observed. On 07/15/2020 at 2:10 PM, Resident #1 was observed in the bed, pillow behind his head, lying on his back, legs drawn up in a fetal position, no other positioning devices observed. On 07/15/2020 at 3:45 PM, Resident #1 was observed in the bed, pillow behind his head, lying on his back, legs drawn up in a fetal position, no other positioning devices observed. On 07/16/2020 at 9:00 AM, Resident #1 was observed in the bed, lying on his back, pillow behind his head, a wedge cushion resting in his right axilla, legs pulled into fetal position, with no other positioning devices observed. On 07/16/2020 at 11:40 AM, Resident #1 was observed lying on his right side, with a pillow under his head, and no other positioning devices observed. On 07/16/2020 at 4:15 PM, Resident # 1 was observed in the bed on his back, with a pillow behind his head, legs pulled up in the fetal position with no positioning devices observed.	M 500	Sixty-seven (67) residents residing in the facility on 7/22/2020 were at risk regarding this citation. 3. Beginning 07/23/2020 (Assistant Director of Nursing, Social Services Director, Activities Director, Minimum Data Set Nurses were in-serviced by Nursing Home Administrator on revisions of daily rounds to be completed by leadership team Assistant Director of Nursing, Social Services Director, Activities Director, Minimum Data Set Nurses , shift supervisors, and licensed nurses on various shifts to ensure compliance with turning, repositioning, and positioning devices. Beginning on 07/29/2020 concerns/grievances/incidents are reviewed by Social Services Director with Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurses, Activities Director and nursing supervisors during morning meeting to identify any allegations of abuse or neglect. Allegations of abuse, neglect, and misappropriation will be immediately investigated, addressed, and reported. Beginning on 07/20/2020-07/25/2020 facility staff including Social Services, Activities, Dietary, Housekeeping, Maintenance Nursing, Respiratory have been in-serviced on Abuse and Neglect prevention program, Resident Rights, and Vulnerable Adults Act by Assistant Director of Nursing (ADON). Additional in-services were conducted by ADON on 08/03/2020, 08/13/2020, 08/27/2020, and 08/31/2020 with facility staff including Social Services, Activities, Dietary, Housekeeping, Maintenance Nursing, Respiratory have	

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M 500	Continued From page 9 On 07/17/2020 at 9:10 AM, Resident # 1 was observed in his bed, lying on his back, with a pillow behind his head, legs pulled into the fetal position, and no other positioning devices observed. On 07/17/2020 at 2:00 PM, Resident #1 was observed in the bed, lying on his back, with a pillow behind his head, a wedge cushion in right axilla area, legs pulled into a fetal position, no other positioning devices observed. On 07/16/2020 at 11:40 AM, during an interview with Licensed Practical Nurse (LPN) #1, when asked by the State Agency (SA) about positioning devices/heel cushions for Resident #1, she stated, "they usually be in here somewhere, but I don't see them right now ...whoever see em' off usually put them back on, but they ain't assigned to nobody ...they ain't on the medication or treatment sheets ..." On 07/17/2020 at 3:30 PM, during an interview with the Director of Nursing (DON), when asked by the SA about a turning and repositioning (TAP) schedule and positioning devices for residents, she stated, " ...the nurses are supposed to make sure the aides do it, and check for pillows and stuff, but they was moving residents for COVID and didn't know what to put on them ..." On 07/20/2020 at 10:45 AM, during an interview with Certified Nurse Aide (C.N.A.) #1, concerning positioning devices/heel cushions and a TAP schedule, she stated, "We do our charting on iPads (Interactive Personal Application Devices), and it don't talk about heel boots in it. We answer yes or no if we turn them on our shift ...the nurse is suppose to check the pillows and stuff ...he	M 500	been in-serviced on Abuse and Neglect prevention program, Resident Rights, and Vulnerable Adults Act Additionally beginning 08/02/2020, the Corporate Clinical Specialist began review of grievances, skin and wound program including rounds, weekly assessment of wounds, and weekly reconciliation of Registered Dietician recommendations. 4. Beginning 08/02/2020, weekly audit of daily rounds by Nursing Home Administrator, Director of Nursing, and/or Assistant Director of Nursing for issues related to turning, repositioning, and positioning devices for three (3) months. Beginning 08/02/2020, weekly audits of grievances, concerns, and incident reports to ensure compliance with identification and reporting abuse or neglect by Nursing Home Administrator or Social Services Director for three (3) months. A report will be presented to the Quality Assurance Performance Improvement committee (Nursing Home Administrator, Medical Director, Social Services Director, Dietary Manager, Infection/Prevention Officer, Director of Nursing) monthly for three (3) months, and quarterly thereafter, by the Social Services Director for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	

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M 500	Continued From page 10 (Resident #1), supposed to have them boots on right now, and a pillow by his knees, but they was soaked with urine this morning and had to be sent to laundry ain't no extras to put on him right now ... there ain't no set schedule for turnin' residents, I just know when, 'cause I been doin' this job for a long time ...It ain't written down nowhere to see." On 07/20/2020 at 11:40 AM, during an interview with Registered Nurse (RN) #1, a Minimum Data Set (MDS)/Care Plan Nurse, regarding a TAP program and positioning devices, she stated, "...we should put turning and positioning and heel padding on the care plans. No one is assigned the task of checking if the heel padding is in place. The C.N.A.'s just answer a yes/no question on whether they did it (TAP) or not, because in order for it to be put on their (the C.N.A.'s) Kardex to chart on, we would have to assign exact times to it ...we don't want to lock them into a time." On 07/20/2020 at 11:45 AM, during an interview with RN #2, an MDS/Care Plan nurse, regarding heel cushions/floats, and a TAP schedule, and she stated, "We should be putting those items on the care plan, if we know they are doing them, but we haven't been doing that recently with COVID in the building ..." On 07/20/2020 at 11:45 AM, during an interview with C.N.A. #2, regarding positioning devices/heel cushions and a TAP schedule, she stated, "We have a Kardex on the iPad for some resident info, and we are supposed to get report from the shift leaving ...we tried (to use positioning devices) but couldn't always do it ...there aren't always enough wedges to go around ...we just know when to turn them, it's not written down."	M 500		

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M 500	Continued From page 11 Review of Resident #1's "Visual/Bedside Kardex Report" revealed "Bed Mobility: The resident requires assistance by (x)2 staff to turn and reposition in bed, low air loss mattress to bed ..." there was no mention of a TAP schedule or preventative positioning devices for him. Review of Resident #1's "Skin & Wound Evaluation V5.0" dated 02/03/2020, revealed a new, in-house acquired, stage II (partial thickness loss of skin) pressure ulcer to his Left Trochanter (hip) that measured 1.9 centimeters (cm) Length x 2.2cm Width x 0.2cm Depth with a moderate amount of serosanguineous (serous/bloody) drainage. Additional measures to be put into place were incontinence management, a mattress, moisture barrier, nutrition/dietary supplementation, positioning wedge, repositioning device(s), and a turning/repositioning program. Review of Resident #1's "Skin & Wound Evaluation V5.0" dated 03/04/2020 revealed the Left Trochanter wound had worsened and was now a stage III (full thickness loss of skin), and larger in size at 2.3cm Length x 3.4cm Width, and no Depth recorded. Further review of Resident #1's "Skin & Wound Evaluation V5.0" for April 2020, revealed no assessment or measurements of the left trochanter wound due on 04/21/2020. Review of Resident #1's "Progress Note" dated 04/22/2020 revealed, " ...RP notified of new area noted to resident's right hip ..." On 07/17/2020 at 3:30 PM, during an interview with the DON, regarding Resident #1's missing skin assessment and measurements of his Left Trochanter wound due on 04/21/2020, and the	M 500		

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M 500	Continued From page 12 missing skin assessment and measurements of the "new area" on his right hip on 04/22/2020, she stated, "They weren't done 'cause he was moved to the COVID unit and I don't think they knew about him real good." Further review of Resident #1's wound assessments dated 04/27/2020, revealed, a deterioration in, and the presence of infection to his Left Trochanter (hip) wound, an unstageable (Obscured full thickness loss of skin and tissue loss) wound to his Right Trochanter (hip) identified on 04-22-20, and eight (8) new pressure ulcers with the documented presence of pain. Review of Resident #1's "Skin & Wound Evaluation V5.0" dated 04/27/2020 revealed, his stage III (full thickness skin loss) Left Trochanter (hip) wound was larger at 4.7cm Length x 3.9cm Width, no Depth recorded, and Undermining of 4.5cm, with evidence of redness, warmth, increased pain, heavy purulent (pus) drainage, and a moderate odor; a new, in-house acquired, unstageable pressure ulcer to his Right Trochanter (hip), 2.6cm Length x 3.2cm Width, with noted redness and inflammation; a new, in-house acquired, unstageable (obscured full thickness skin and tissue loss) pressure ulcer to his Sacrum measuring 3.8cm Length x 4.2cm Width, no Depth recorded, with redness, inflammation, warmth and bleeding present; a new, in-house acquired, Deep Tissue Injury (DTI) (persistent non-blanchable deep red, maroon or purple discoloration) to his Left Lateral Malleolus (outside ankle) measuring 2.6cm Length x 2.9cm Width; a new, in-house acquired, stage II blister on his nose measuring 0.5cm Length x 0.6cm Width; a new, in-house acquired, stage II blister on his spine measuring 3.6cm Length x 1.4cm	M 500		

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M 500	Continued From page 13 Width; a new, in-house acquired, stage II blister to his Right Ischial Tuberosity (buttocks) measuring 1.7cm Length x 1.6cm Width; a new, in-house acquired, stage II blister to his Left Medial Malleolus (inside ankle) measuring 0.6cm Length x 1.6cm Width; a new, in-house acquired, stage II blister to his Right Lateral Calf/Shin measuring 0.6cm Length x 0.9cm Width; and a new, in-house acquired, stage one (non-blanchable redness of intact skin) to his right heel measuring 1.9cm Length x 1.8cm Width. All 10 pressure ulcers rated his pain level at three (3), with noted discomfort during treatment and moving. Review of Resident #1's "Progress Note" dated 04/28/2020, revealed, a noted deterioration of the wounds to his left hip and right hip. A culture was performed on 04/27/2020. Review of Resident #1's "Progress Note" dated 05/01/2020, revealed an order for him to have a "Midline" IV (Intravenous) placed and to start the antibiotic Rocephin 1 gram for 14 days, for his left hip infection. Review of Resident #1's "Progress Note" titled "Nutrition/Dietary Note" dated 05/04/2020, revealed Resident #1's current gastric tube (G-tube) feeding and oral intake did not "meet ENNs (Estimated Nutritional Needs)" required to maintain his weight and help heal his extensive wounds. The Registered Dietician (RD), recommended to increase his feeding (Jevity 1.5) to 60 cc/hr (cubic centimeters/hour) for twenty-two (22) hours a day, from the current order of 50cc/hr for twenty-two hours a day. Review of Resident #1's "Order Summary Report ...Active Orders as of 07/16/2020" revealed,	M 500		

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M 500	Continued From page 14 "Enteral Feed Order ...Tube Feeding Continuous: Formula Jevity 1.5 at 50cc/hr x22 hours ..." On 07/20/2020 at 11:40 AM, standing at Resident #1's bedside, LPN #1 confirmed his g-tube feeding, Jevity 1.5, was currently running at 50cc/hr. On 07/21/2020 at 11:15 AM, during interview with the Dietary Manager (DM), regarding Resident #1's g-tube feeding rate not being changed to the RD recommendation from 05-04-2020, she stated, "When the recommendations come through, I am on the email list ... but I only do mighty shakes and magic cups, basically things that would go on their meal tray, double portions etc" On 07/21/2020 at 12:00 PM, during an interview with the RD regarding Resident #1's missed feeding increase from 05/04/2020, and the worsening of his wounds, she stated, " ...I worked remotely and was not in the building ...there was no follow-up with the facility for follow through ...I was covering six (6) other facilities and don't remember checking follow through of recommendations ..." Review of Resident #1's "Progress Note - Skin/Wound Note" dated 07/01/2020 revealed a deterioration with an advancement in staging, and significant size increase of the pressure ulcers to his Left Trochanter (hip), Right Trochanter (hip), Right Calf/shin, and Right Lateral Malleolus (ankle), and two more newly identified in-house acquired wounds. Review of Resident #1's "Progress Note - Skin/Wound Note" dated 07/01/2020 revealed, a now Stage IV (Full thickness skin and tissue loss)	M 500			

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M 500	Continued From page 15 pressure ulcer to his Left Trochanter (hip) measuring 12.2cm Length x 17.0cm Width x 1.5cm Depth with 1.8cm Undermining; an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Right Trochanter (hip) measuring 9.0cm Length x 9.0cm Width with 1.5cm Undermining; an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Left Lateral Malleolus (outer ankle) measuring 2.4cm Length x 1.5cm Width; an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Right Lateral Calf/Shin measuring 4.3cm Length x 2.8cm Width, with a notation of "wound edges are red and irritated from pressure of left leg pressing on right shin ..."; a new, in-house acquired, Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Right Lateral Malleolus (inner ankle) measuring 2.2cm Length x 1.5cm Width; a new, in-house acquired, Stage III (Full thickness skin loss) pressure ulcer to his Right Great Toe Hallux measuring 1.0cm Length x 1.0cm Width with hyper-granulation due to "irritation from toe rubbing mattress ..." Review of Resident #1's care plan created on 07-08-2020 revealed, "Focus: ...The resident has unstageable pressure ulcer lt. hip r/t Immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection ..." Review of the interventions listed, shows no mention of a specialty mattress, moisture barrier use, a positioning wedge, repositioning devices, or a TAP program. Review of Resident #1's care plan created on 07/08/2020 revealed, "Focus: ...The resident has unstageable pressure ulcer rt. hip r/t Immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection ..." Review of the interventions listed, shows no	M 500		

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M 500	Continued From page 16 mention of a specialty mattress, moisture barrier use, a positioning wedge, repositioning devices, or a TAP program. Review of Resident #1's care plan created on 07/08/2020 revealed, "Focus: ...The resident has unstageable pressure ulcer to sacral r/t Immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection ..." Review of the interventions listed, shows no mention of a specialty mattress, moisture barrier use, a positioning wedge, repositioning devices, or a TAP program. Review of Resident #1's care plan created on 07/08/2020 revealed, "Focus: ...The resident has left lateral ankle-unstageable pressure ulcer development - DTI (Deep Tissue Injury) r/t Immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection ..." Review of the interventions listed, shows no mention of a specialty mattress, a positioning wedge, repositioning devices, or a TAP program. Review of Resident #1's care plan created on 07/08/2020 revealed, "Focus: ...The resident has unstageable pressure ulcer-rt lateral ankle r/t Immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection ..." Review of the interventions listed, shows no mention of a specialty mattress, a positioning wedge, repositioning devices, or a TAP program. Review of Resident #1's care plan created on 07/08/2020 revealed, "Focus: ...The resident has Stage III pressure ulcer-rt. great toe r/t Immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection ..."	M 500			

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M 500	Continued From page 17 Review of the interventions listed, shows no mention of a specialty mattress, a positioning wedge, repositioning devices, or a TAP program. On 07/21/2020 at 2:05 PM, during an interview with the DON concerning the systemic failure of the wound care program, she confirmed there were multiple issues such as, incomplete documentation, dressings not getting changed timely, orders not being addressed timely, improper staging of wounds, no one monitoring the turning schedule, and checking for positioning devices since the treatment nurse left. She stated, "The treatment nurse left on May 1, 2020. Body audits were not done ...nothing was done immediately ...Another facility's treatment nurse came on 12/09/2019, 12/10/2019, and 12/23/2019 to train her and help her ...She was written up on 01/22/2020 for not changing dressings on wounds, and again on 04/29/2020 ..." The DON confirmed the facility did not have a plan in place to provide oversight after the write ups, to ensure the treatment nurse was providing wound care, and that orders were started timely. When the State Agency (SA) asked the DON "Why did you continue to let her work if you knew she wasn't doing her job?" and the DON shrugged her shoulders and stated, "I don't know". On 07/25/2020 at 2:15 PM, during an interview with Resident #1's wife, she stated, "The facility has not been upfront with me concerning my husband's wounds. When I left him the last time in early March, during COVID, he had one small wound on his left hip. It was a little blister. I heard from a staff member I know outside the facility, that his wounds were really bad. I called to get an update on all his wounds and asked for him to get an appointment at a wound clinic. When I went	M 500		

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M 500	Continued From page 18 with him to his appointment, I insisted on going into the room with him and saw his wounds myself. I broke down and cried at how large and deep they are. Before COVID, I was there every day because I had noticed some changes in the care. I made sure they changed him and moved him around in the bed. It is heartbreaking to not be allowed in to see my husband, when I know he is in there not being taken care of, and there is nothing I can do about it but pray. He's there because I can't care for him myself. I trusted them to help us and they failed." Resident #2 Review of Resident #2's "Admission Record" revealed, she was admitted to the facility on 11/30/2018 with the primary diagnosis of Nontraumatic Intracerebral Hemorrhage Interventricular, Hypertension, Tracheostomy Status, and Gastrostomy Status. Review of Resident #2's Minimum Data Set (MDS) dated 03/12/2020, revealed, she was "totally dependent on two + person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed)". She had limited range of motion (ROM) to both of her arms and legs. She was bedridden. Review of Resident #2's "Braden Scale For Predicting Pressure Sore Risk" dated 03/07/2020 revealed, she scored a 9, which placed her at "Very High Risk" for pressure sore development. Resident #2 was admitted with a small, Stage IV pressure ulcer to her sacrum. Since 01/21/2020, she has acquired thirteen (13) new pressure ulcers; two Unstageable pressure ulcers, one stage IV pressure ulcer, eight stage III pressure	M 500		

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M 500	Continued From page 19 ulcers, and two Stage II pressure ulcers. A lack of turning and repositioning, and proper application of pressure reducing devices was observed, as well as interviews with staff confirming dressings were not being changed timely, preventative pressure reducing devices were not consistently used, and an order for Resident #2's enteral tube feeding to be increased, to promote wound healing, was not addressed timely. On 07/15/2020 at 10:40 AM, during initial rounds, Resident #2 was observed in bed lying on her back, legs drawn into the fetal position, resting. On 07/15/2020 at 11:40 AM, Resident #2 was observed in bed, lying on her back, a pillow behind her head, legs drawn up in the fetal position, and no other positioning devices observed. On 07/15/2020 at 2:15 PM Resident #2 was observed in the bed, on her back, legs drawn into a fetal position, and no other positioning devices observed in the bed. On 07/15/2020 at 3:50 PM, Resident #2 was observed in the bed, on her back, a pillow behind her head, no other positioning devices observed in the bed, resident remains in the fetal position. On 07/16/2020 at 9:05 AM, Resident #2 was observed lying on her back in the bed, pillow behind her head, legs pulled into fetal position, no heel cushions present, no pillows between legs. On 07/16/2020 at 11:45 AM, Resident #2 was observed lying on her back with a pillow under her head, face turned toward the door, no heel cushions or pillow between her legs observed.	M 500		

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M 500	Continued From page 20 On 07/16/2020 at 4:20 PM, Resident #2 was observed in the bed, on her back, with a pillow behind her head, face turned toward the door, still in the fetal position with no position devices observed. On 07/17/2020 at 9:15 AM, Resident #2 was observed in her bed, lying on her back, with a pillow behind her head, no positioning devices observed in the bed, and she remains in the fetal position. On 07/17/2020 at 2:05 PM, Resident #2 was observed lying on her back in the bed, pillow behind her head, heel cushions present on both feet, legs drawn into fetal position, and no other positioning devices observed. On 07/20/2020 at 11:45 AM, during an interview with LPN #3 concerning positioning devices/heel cushions, she stated, "It is the nurse's responsibility to check if the pads, pillows, and heel boots is on the resident. The aides put them on 'em, but the nurse checks behind 'em. We gotta do med passes in the morning time and have to do treatments too now, it is hard to do it all." On 07/20/2020 at 3:40 PM, during an interview with RN#3 concerning repositioning devices/heel cushions, and the timeliness of wound care, she stated, "The nurses are responsible for making sure the residents are padded up. I try to make sure if I do her treatments, that I put her heel cushions and pillows on where they go, but they usually aren't on when I get in here ...She has so many wounds it is hard to keep up with. Most of the time the dressings aren't dated or initialed, and her wounds drain so much, it is hard to tell how old they are. The nurses have to pass	M 500		

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M 500	Continued From page 21 medications and do all the treatments too since the treatment nurse left a couple months ago. It has been a challenge for them to keep things done." On 07/20/2020 at 4:15 PM, during an interview with Occupational Therapist (OT) #1, regarding her documentation on 05/28/2020, in Resident #2's medical record, she stated, "She was on the COVID unit and was part of my rotation. Due to the lack of staff and no treatment nurse, the therapists were trying to help reposition residents when we could, especially the trach residents ...I overheard her (Resident #2's) C.N.A. telling the nurse her dressings had not been changed on her wounds. I saw the dressings and they were sopping wet with drainage and falling off the wounds. They had not been changed in three (3) days ...The C.N.A. took off the old dressings and told the nurse they needed cleaned and redressed When I went back the next day to see her, her wounds still had no dressing on them and had drained all over the bedding ..." When asked by the SA if she saw dressings not changed often, she stated, "I would find this fairly often ..." Review of Resident #2's "Skin & Wound Evaluation V5.0" dated 01/21/2020 revealed, a Stage IV pressure ulcer she was admitted to the facility with, and six (6) new in-house acquired pressure ulcers (five new stage III pressure ulcers, and one new stage II pressure ulcer). Review of Resident #2's "Skin & Wound Evaluation V5.0" dated 01/21/2020 revealed a Stage IV (Full thickness skin and tissue loss) pressure ulcer to her Sacrum measuring 2.4cm Length x 2.4cm Width; a new, in-house acquired, unstageable (obscured full thickness skin and	M 500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42CG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/27/2020
NAME OF PROVIDER OR SUPPLIER CRYSTAL REHABILITATION AND HEALTHCARE CEN1		STREET ADDRESS, CITY, STATE, ZIP CODE 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930		
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M 500	Continued From page 22 tissue loss) pressure ulcer to her Right Trochanter (hip) measuring 2.3cm Length x 3.0cm Width, with moderate serosanguinous (serous/bloody) drainage; a new, in-house acquired, stage III (full thickness skin loss) pressure ulcer to her Left Shoulder measuring 2.9cm Length x 4.1cm Width; a new, in-house acquired, stage III (full thickness skin loss) pressure ulcer to her Left Chest measuring 1.5cm Length x 2.4cm Width x 0.1cm depth; a new, in-house acquired, Stage III (Full thickness skin loss) pressure ulcer to her Right Lateral Malleolus (outer ankle), measuring 1.0cm Length x 0.8cm Width; a new, in-house acquired, Stage III (full thickness skin loss) pressure ulcer to her right ear, measuring 2.0cm Length x 1.5cm Width, with moderate serosanguinous drainage; and a new, in-house acquired, stage II (partial thickness skin loss) pressure ulcer to Left Trochanter (hip) measuring 2.4cm Length x 2.4cm Width. Review of Resident #2's "Skin and Wound Evaluation V5.0" dated 04/14/2020, revealed the wounds on her Right Trochanter (hip) and Left Trochanter (hip) had doubled in size from the 01-09-2020 measurements. Review of Resident #2's "Skin & Wound Evaluation V5.0" dated 04/14/2020 revealed an Unstageable (Obscured full thickness skin and tissue loss) pressure ulcer to her Right Trochanter (hip) that now measured 6.5cm Length x 3.4cm Width x 1.0cm Depth, with increased drainage; and a Stage II (partial thickness skin loss) pressure ulcer to her Left Trochanter (hip) that now measured 3.6cm Length x 3.9cm Width. Review of Resident #2's "Progress Note" dated 05/28/2020 revealed, "Pt with old bandages on	M 500		

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M 500	Continued From page 23 wounds. Aid removed bandages so that nursing could dress wounds. On 05-28-2020 wounds are exposed and uncovered still. Nursing was notified on 05-27-2020 of soiled bandages." Review of Resident #2's "Progress Note" dated 06/05/2020 revealed, "RN Sup attempted to call RP x1 to inform of new areas noted to resident ..." Review of Resident #2's "Skin & Wound Evaluation V5.0" dated 06/05/2020 revealed, two new, in-house acquired, pressure areas; a Stage IV (full thickness loss of skin and tissue loss) pressure ulcer to her Right Ear measuring 2.3cm Length x 1.3cm Width; and a new, in-housed acquired, Unstageable (obscured full thickness skin and tissue loss) pressure ulcer to her right heel measuring 4.8cm Length x 4.4cm Width. Review of Resident #2's "Progress Note" dated 06/07/2020 revealed, "C.N.A. notified this nurse of new pressure areas to both heels and left ear during AM care ...wedges applied for positioning ..." There were no assessments present for either heel wound. The DON confirmed, the assessments had been missed. Review of Resident #2's "Order Summary Report" dated 07-16-2020, revealed an order dated 06/11/2020, to be started on 06/12/2020 to "Cleanse right heel Unstageable pressure ulcer on Mon, Wed, Fri ...avoid pressure to area, float heel boots, use padded dressing to off load pressure." This order was put in place five (5) days after the wound was found on 06/07/2020." Review of Resident #2's "Skin & Wound Evaluation V5.0" dated 07/08/2020 revealed, a significant increase in size to her stage IV sacral	M 500		

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M 500	Continued From page 24 wound now measuring 5.7cm Length x 3.9cm Width, and four (4) new in-house acquired, pressure ulcers; a new, in-house acquired, Unstageable (Obscured full thickness skin and tissue loss) pressure ulcer on her Right Lateral Foot measuring 1.3cm Length x 2.4cm Width; a new, in-house acquired, Stage III (Full thickness loss of skin) pressure ulcer to her Right Ischial Tuberosity (buttock) measuring 1.4cm Length x 0.9cm Width; a new, in-house acquired, Stage III (full thickness skin loss) pressure ulcer to her Right fourth toe, measuring 1.0cm Length x 0.9cm Width; and a new, in-house acquired, Stage II (Partial thickness skin loss) pressure ulcer to her Left Trochanter (hip) measuring 4.8cm Length x 5.2cm Width. There was no assessment of the Stage IV pressure ulcer to Resident #2's Right Ear. The DON confirmed the assessment had been missed. Review of Resident #2's Treatment Administration Record for July 2020 revealed, and order dated 07/13/2020 to "Cleanse R lateral Prox foot stage 2 pressure ulcer on M, W, F with NS or WC ..." The DON confirmed it was another new, in-house acquired, pressure ulcer they had found, and there was no assessment done for it. The SA attempted to reach Resident #2's family/representative multiple times with no answer or return call. Resident #3 Review of Resident #3's "Admission Record", revealed she was admitted originally on 01/09/2012 with a primary diagnosis of Nontraumatic Intracerebral Hemorrhage, unspecified, Persistent Vegetative State, Epilepsy, Gastrostomy, Contracture of Unspecified Joint.	M 500		

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M 500	Continued From page 25 Review of Resident #3's Minimum Data Set (MDS) dated 12/24/2019, revealed, she was "totally dependent on two + person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed)". Resident #3 was not able to reposition herself or turn in the bed unassisted and was bedbound. Review of Resident #3's "Braden Scale For Predicting Pressure Sore Risk", dated 12/24/2019, revealed her score to be a nine (9), which placed her at "Very High Risk" for developing pressure ulcers. Resident #3 was admitted with no pressure ulcers. Since 01-07-2020, she has acquired eight (8) new pressure ulcers; four Unstageable pressure ulcers, Stage III pressure ulcers, and two stage II pressure ulcers. A lack of turning and repositioning, and proper application of pressure reducing devices was observed, as well as interviews with staff confirming preventative pressure reducing devices were not consistently used, and an order for Resident #3's enteral tube feeding to be increased, to promote wound healing, was not addressed timely. On 07/15/2020 at 10:35 AM, during initial facility tour, Resident #3 was observed in the bed, on her back, looking at the window. On 07/15/2020 at 11:35 AM, Resident #3 was observed in the bed, on her back, looking out the window, legs in fetal position, no positioning devices noted on or around her legs and feet. On 07/15/2020 at 2:15 PM, Resident #3 was observed in the bed, on her back looking out the window, no pillows or positioning devices	M 500		

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M 500	Continued From page 26 observed around her legs and feet, legs drawn up into the fetal position. On 07/15/2020 at 3:50 PM, Resident #3 was observed in the bed, on her back, looking out the window, legs drawn up into fetal position, with no pillows or positioning devices observed on or around her legs and feet. On 07/16/2020 at 8:45 AM, Resident #3 observed in bed, lying on her back, looking out the window, legs in fetal position with no observed pillows or positioning devices in place. On 07/16/2020 at 11:30 AM, Resident #3 was observed in the bed, on her back, looking out the window, legs drawn up into fetal position, with no pillows or positioning devices observed on or around her legs and feet. On 07/16/2020 at 4:17 PM, Resident #3 was observed in the bed, on her back, looking out the window, legs drawn up into fetal position, with no positioning devices or pillows in place. On 07/17/2020 at 9:15 AM, Resident #3 was observed in the bed, on her back, looking out the doorway, legs drawn up into fetal position, with a pillow underneath her heels, however, none between her legs, or between her feet and buttocks. On 07/17/2020 at 2:05 PM, Resident #3 was observed in the bed, on her back, looking out the doorway, legs drawn up into the fetal position, with a pillow beneath her heels, however, no pillow between her legs, or between her feet and buttocks. On 07/16/2020 at 4:50 PM, during a joint	M 500		

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M 500	Continued From page 27 interview with the Administrator, and Director of Nursing regarding concerns with Resident #3's multiple new wounds, lack of dietary intervention, and the foam boots she has ordered not being on her, the Administrator stated, " ...there was a change over of Dieticians in the middle of the COVID crisis, some residents were moved to another room and nurse. They may not have known all the specifics for each resident like they should. The DON had no comment. On 07/17/2020 at 12:00 PM, during an interview with C.N.A. #5, concerning pillows and positioning devices for Resident #3, she stated, " ...she is hard to move sometimes 'cause of her contractures, and we don't always have enough pillows or heel boots when she soils them, to put everyplace she needs them ..." On 07/20/2020 at 11:45 AM, during an interview with LPN #3 concerning positioning devices/heel cushions, she stated, "It is the nurse's responsibility to check if the pads, pillows, and heel boots is on the resident. The aides put them on 'em, but the nurse checks behind 'em. We gotta do med passes in the morning time and have to do treatments too now, it is hard to do it all." Review of Resident #3's "Skin & Wound Evaluation V5.0" dated 01/07/2020, revealed an in-house acquired stage III (full thickness skin loss) pressure ulcer to her sacrum that measured 2.2cm Length x 1.2cm Width, with Moderate Serosanguinous (serous/bloody) drainage. Review of Resident #3's "Nutrition/Dietary Note" dated 02-18-2020 revealed, " ...weight changes: 30day ... (-11.5%), 90 day ... (-23.2%), 180 day ... (-23.9%)" weight loss. " ...Current feeding: Jevity	M 500		

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M 500	Continued From page 28 1.5 @ 55cc/hr x 22 hours ...Rec.(recommend) increase feeding to 60cc/hr x 22 hours ..." Review of Resident #3's "Nutrition/Dietary Note" dated 03/16/2020 revealed, "Current feeding: Jevity 1.5 @ 55cc/hr x 22 hours ...Weight loss noted. Rec - Increase feeding to 60cc/hr x 22 hours ..." On 07/21/2020 at 12:00 PM, during an interview with the RD regarding Resident #3's missed feeding increase from 02/18/2020, the worsening of her sacral wound, and acquiring eight new wounds, she stated, " ...I worked remotely and was not in the building ...she had continuous weight loss, and there was no follow-up with the facility for follow through ...I was covering six (6) other facilities and don't remember checking follow through of recommendations ..." Review of Resident #3's "Skin & Wound Evaluation V5.0" dated 03/18/2020, revealed her in-house acquired sacral wound was larger at 2.5cm Length x 1.2cm Width, and 0.3cm Depth, and a new, in-house acquired stage one to her right heel. Review of Resident #3's "Skin & Wound Evaluation V5.0" dated 04/13/2020, revealed a worsening of her sacral wound now measured at 3.5cm Length x 1.2cm Width x 2.0cm Depth, with the notation of the dressing being missing to the wound. Review of Resident #3's "Skin & Wound Evaluation V5.0" dated 07/08/2020, revealed her sacral wound had progressed to a Stage IV, and more than doubled in size at 8.1cm Length x 8.2cm Width, no recorded Depth, and the addition of eight new, in-house acquired wounds (four Unstageable pressure ulcers, two Stage III	M 500		

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M 500	Continued From page 29 pressure ulcers, and two stage II pressure ulcers); a new, in-house acquired stage III pressure ulcer to her Left Lateral Malleolus (outer ankle) 4.0cm Length x 2.5cm Width, a new, in-house acquired Stage III pressure ulcer to her Right Lateral Malleolus (outer ankle) 1.6cm Length x 2.0cm Width, a new, in-house acquired Stage II pressure ulcer to her Right fourth toe 1.1cm Length x 0.8cm Width, and a new, in-house acquired Stage II pressure ulcer to her Right Ischial Tuberosity (buttock) 1.1cm Length x 1.1cm Width, a new, in-house acquired unstageable pressure ulcer to her right heel 4.3cm Length x 2.9cm Width, a new, in-house acquired pressure ulcer to her left heel 3.6cm Length x 3.9cm Width, a new, in-house acquired pressure ulcer to her Left Shin 2.6cm Length x 0.9cm Width, and a new, in-house acquired pressure ulcer to her lower Left Shin 6.4cm Length x 1.4cm Width. Resident #4 Review of Resident #4's "Admission Record" revealed she was admitted to the facility on 09/09/2018 with the primary diagnosis of Unspecified Dementia without Behavioral Disturbance, Alzheimer's, Glaucoma, and Unspecified Protein/Calorie Malnutrition. Review of Resident #4's Minimum Data Set (MDS) dated 06/23/2020, revealed, she required "Total assistance" (full staff performance every time during entire 7-day period) of one person physical assist" for bed mobility. Review of Resident #3's "Braden Scale For Predicting Pressure Sore Risk", dated 06/16/2020, revealed her score to be a six which placed her at "Very High Risk" for developing pressure ulcers.	M 500		

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M 500	Continued From page 30 Resident #4 was admitted to the facility without any pressure ulcers. She began to experience weight loss in May 2020, with several dietary recommendations that were not implemented. Failure to properly apply her pressure reducing wedge devices was observed, as well as interviews with staff confirming it was not consistently used, and multiple orders for Resident #4 to receive dietary supplements were not addressed timely. On 07/17/2020 at 9:20 AM, Resident #4 was observed laying on her right side, in the bed, heel foam boots on, and a pillow between her knees, no wedge cushion observed. On 07/17/2020 at 2:15 PM, Resident #4 was observed in bed, on her left side, heel foam boots on, pillow between her knees, no wedge cushion observed. On 07/20/2020 at 10:05 PM, Resident #4 was observed in bed, on her right side, heel foam boots on left visible foot, unable to see right foot, no wedge cushion observed. On 07/20/2020 at 1:15 PM, Resident #4 observed in bed, on her back, heel boots on, no other positioning devices observed. On 07/20/2020 at 2:50 PM, during an interview with LPN #4, concerning Resident #4's ability to TAP in the bed, and the use of positioning devices, he stated, "She does favor laying on her sides, however, there should be a positioning wedge with her in the bed that helps keep her more on her back, since both her hips have ulcers ...it ain't on there all the time, but I try to position her right before I leave from doing her	M 500		

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M 500	Continued From page 31 treatments ..." Review of Resident #4's Nutrition/Dietary Note dated 05/04/2020, revealed recommendations to start a vitamin with minerals. Review of her June 2020 and July 2020 "Medication Administration Records", revealed no order for a Vitamin with Minerals. Review of Resident #4's Nutrition/Dietary Note dated 05/11/2020, revealed a weight loss of 6%, and a recommendation from the RD to add an HS (hour of sleep) snack. Review of her June 2020 and July 2020 "Medication Administration Records" revealed no order for HS snacks. Review of Resident #4's Nutrition/Dietary Note dated 06/03/2020, revealed a significant weight loss of 7.1% in thirty (30) days, and a significant weight loss of 13.4% in ninety (90) days, with a recommendation to add fortified food to her meal trays daily. Review of Resident #4's Active orders, revealed no order for fortified foods. Review of Resident #4's Nutrition/Dietary Note dated 06/23/2020, revealed an RD dietary recommendation for an appetite stimulant. Review of her June 2020 and July 2020 "Medication Administration Records" revealed no orders for an appetite stimulant. On 07/21/2020 at 12:00 PM, during an interview with the RD regarding Resident #4's multiple missed dietary recommendations, she stated, "...I worked remotely and was not in the building ...she had continuous weight loss, and there was no follow-up with the facility for follow through ...my last day covering that facility was 05/24/2020, so any recommendations after that, were from the new RD ...I was covering six other	M 500		

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M 500	Continued From page 32 facilities and don't remember checking follow through of recommendations ..." Review of Resident #4's "Skin/Wound Note " dated 06/25/2020 revealed two new, in-house acquired pressure ulcers; an unstageable pressure ulcer to her Left Trochanter (hip) 2.1cm Length x 4.5cm Width, with a darkened peri-wound measuring 14.5cm Length x 9.0cm Width, and a Stage II pressure ulcer to her Right Trochanter (hip) 3.5cm Length x 2.0cm Width x <0.2cm Depth, with surrounding tissue red measuring 13.5cm Length x 10.5cm Width. Review of Resident #4's "Skin & Wound Evaluation V5.0" for the month of July 2020, revealed no assessments or measurements for the Left Trochanter or Right Trochanter wounds due on 07/02/2020, 07/09/2020 and 07/16/2020. Review of Resident #4's "Skin and Wound Evaluation V5.0" dated 07/18/2020, revealed her Unstageable Left Trochanter wound was significantly larger at 7.3cm Length x 6.2cm Width. On 07/21/2020 at 2:05 PM, during an interview with the DON concerning Resident #4's multiple missed dietary recommendations, multiple missed skin assessments with wound measurements, and the worsening of her wounds, she stated, "the flow of dietary recommendations was broken for a while. The recommendations were to be given to the care plan nurses to review, obtain orders, and place on the care plans. There were several months of recommendations missed because of it. She was moved to the COVID unit too, I guess the wound assessments just didn't get done, and when we did assess them, they was bigger."	M 500		

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NAME OF PROVIDER OR SUPPLIER CRYSTAL REHABILITATION AND HEALTHCARE CEN1		STREET ADDRESS, CITY, STATE, ZIP CODE 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930		
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M 500	Continued From page 33 Resident #5 Review of Resident #5's "Admission Record" revealed, she was admitted to the facility on 04/10/2017, with a primary diagnosis of Urinary Tract Infection (UTI), Hypertension, Type diabetes, and Depression. She was later diagnoses with Bilateral above the Knee Amputations (AKA), Peripheral Vascular Disease, Unspecified Protein-Calorie Malnutrition, Congestive Heart Failure (CHF), and Glaucoma. Review of Resident #5's Closed Medical Record revealed an "Admission History and Physical" dated 04/07/2020 at 4:16 PM, which indicated, "Chief Complaint sent from nursing home due to decreased responsiveness since yesterday per Emergency Physician Note ...Physical Exam: ...MSK/Extremities: Bilateral lower extremity amputation. Upper extremity edema noted. Hip edema noted as well. Skin/Heme: Some skin weeping noted ...Backside not examined ..." Review of Resident #5's "General Medical Note ...Inpatient SOAP Note" dated 04/07/2020 at 10:15 PM, revealed, " Called by nursing staff for patient having low blood pressure ...diffuse anasarca ...CXR (Chest X-ray) appears to favor right sided pneumonia ...discussed with family poor prognosis of patient with severe pneumonia and urinary tract infection and possible underlying heart failure ..." Review of Resident #5's "Wound (Consult) - Consultation Note" dated 04/08/2020 at 9:53 AM, revealed, "Reason for Referral - Sacral Ulcer ...Chief Complaint/HPI: ...94 year old female with Stage II sacral ulcer. There is significant	M 500		

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M 500	Continued From page 34 maceration. Moderate Pain ...Impression and Plan: 94 year old female with Stage II sacral ulcer. There is significant maceration. Apply Xeroform and ABD. Patient is a DNR (Do Not Resuscitate). No surgical intervention is needed at this time ..." Review of Resident #5's "Inpatient Discharge Summary - Discharge Summary" dated 05/06/2020 at 4:11 PM, revealed, "Hospital Course: ...was admitted on 4/7. It seemed she was sent from her nursing home due to decreased responsiveness ...The patient's condition worsened during the day on 4/8, and the patient subsequently passed away on 4/8 ..." Review of Resident #5's "Death Assessment" dated 04/08/2020 at 3:16 PM, revealed " ...Cause of Death Other: Cardiac Arrest ..." Review of Resident #5's "MDS/Kardex Report" revealed, " ...Dx: ...Acquired Absence of Left Leg Above Knee, Acquired Absence of Right Leg Above Knee, Age-Related Cognitive Decline ...Daily Decision Making - Severely Impaired ...Bed Mobility: Extensive assistance of One person physical assist ...Functional Limitation in Room: Lower Extremity ...Bowel: Always Incontinent, Urinary: Always Incontinent ...Skin and Ulcer Treatment: ...Pressure reducing device for bed ...Nonsurgical dressings ..." A pressure reducing device for chair, Turning/Repositioning program, Nutrition or hydration intervention, and Ulcer care were options present on this form, and were not marked for resident)." Review of Resident #5's Progress Note dated 04/02/2020 revealed, " ... resident requires total asst. x 1 in bed mobility, toileting and eating at this time ..."	M 500		

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M 500	Continued From page 35 Review of Resident #5's Progress Note dated 04/06/2020, revealed "RP (proper name) notified of large area to buttock sacral area (unstageable) ..." Review of Resident #5's "Skin & Wound Evaluation V5.0" dated 04/06/2020, revealed, the wound description section, the location section, and the acquired section to all be blank/unanswered. The only item filled out on this assessment was the "Wound Measurements: ...8.3cm Length x 8.9cm Width ..." No other item on the assessment was filled out. Review of Resident #5's "Treatment Administration Record" for April 2020, revealed an order for "Cleanse sacral area with wound cleanser, pat dry with 4x4, apply puracol sheet fit to wound bed, cover with 4x4's and optifoam dressing, 3xwkly and prn soiled/dislodged dressing ..." On 07/20/2020 at 4:15 PM, during an interview with the DON, concerning a TAP program, incomplete wound assessment, the lack of preventative measures in place, and the Kardex/Care plan not being updated with preventative measures, for Resident #5, she stated, "...she had a wound back last year, and should have had a TAP schedule in place, because she didn't have no legs ...the assessment from 04/06/2020 was for the wound we found the day before she went out to the hospital, I don't know why it wasn't done right ...the Kardex issue goes back to the care plan nurses not putting things on there like they supposed to again ..." When asked by the SA, if she saw Resident #5's wound prior to her discharge to the hospital and subsequent death,	M 500		

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M 500	Continued From page 36 she stated, "Yes, I saw it, and would have described it probably as a big stage II, with a lot of dark tissue around the open center ...it was probably a four (4) or five cm circle ..." The facility submitted an acceptable Removal Plan on 07/25/2020 for the Immediate Jeopardy (IJ) and Substandard Quality of Care. Review of the facility's Removal Plan, revealed, the facility took the following corrective actions to remove the IJ prior to exit: On 07/20/2020 at 4:30PM, the State Agency informed Nursing Home Administrator (NHA) of the immediate jeopardy with substandard quality of care due to pressure ulcers, care plans, abuse/neglect and pain. NHA was informed that Resident # One (1), Resident # Two (2), Resident # Three (3), Resident # Four (4), Resident # Five (5) affected. Extensive failure was identified in multiple areas of pressure ulcer care: As a result of the facility's extensive noncompliance in multiple areas of pressure ulcer care, Resident # One (1), Resident # Two (2), Resident # Three (3), Resident # Four (4) developed recurrent and/or multiple, avoidable Stage III or Stage IV pressure ulcers for residents reviewed for facility acquired pressure ulcers. The facility did not have adequate procedures in place to provide preventative measures to residents who are at risk for skin breakdown, in order to prevent further skin breakdown. The facility failed to provide appropriate care to residents with pressure ulcers resulted in further skin breakdown, infections, and hospitalizations (1) Quality Assurance Performance Improvement	M 500		

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M 500	Continued From page 37 (QAPI) meeting was conducted on 07/20/2020, at 7:00PM, Medical Director, NHA, Director of Nursing (DON), Social Services Director (SSD), Dietary Manager (DM), Minimum Data Set (MDS) nurses and Corporate Nurse Consultant (acting Infection Prevention Officer) present to determine what systems to evaluate that led to deficient practices. Next actions created from QAPI meeting was to complete body audits on total in-house census of all sixty-seven (67) residents to determine the condition of each resident's skin, comprehensive care plan audit to ensure care plan accurately reflects the care of the resident, new evaluation of each resident by registered dietitian, identify system break in wound care program, and evaluate education needs of staff. On 07/22/2020 at 9:00AM. QAPI meeting was held with Medical Director, NHA, Director of Nursing, Social Services, Dietary Manager, Minimum Data Set nurses and Corporate Nurse Consultant (acting Infection Prevention Officer) present. Meeting agenda items included a review of removal plan, request for recommendations regarding wound care program, and new skin concerns identified. Medical Director recommended locating a provider that employs wound care certified nurse practitioners that could visit center weekly. One new policy change was made related to follow up on dietary recommendations within seventy-two (72) hours instead of seven (7) days. This policy was signed off on by the Medical Director. The facility will now follow up on all dietary recommendations within seventy-two (72) hours as well as update the care plan. The Assistant Director of Nursing (ADON) has assumed responsibility for ensuring that orders are written for dietary recommendations and that the recommendations are updated on the care plan. Assistant Director of Nursing signed in-service regarding new policy	M 500		

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M 500	Continued From page 38 of following up on dietary recommendations within seventy-two (72) hours on 07/24/2020. New measure was implemented and signed off on by Medical Director on 07/22/2020 for physician or Nurse practitioner (NP) providing targeted skin assessments for residents with wounds once a month. **The State Agency (SA) validated through document review, observation, and interview, topics covered in the Quality Assurance (QA) mtg held on 07/20/2020, covering the topics of system deficiencies in the wound care program that led to the Immediate Jeopardy (IJ), complete body audits, care plan review, and dietary recommendation review for all residents, and a secondary QA mtg held on 07/22/2020 to address drafting a removal plan, the results of the body audits, change of the consultant recommendation policy, monthly targeting skin assessments by the Medical Director (MD) or Nurse Practitioner (NP), recruitment of a wound verified NP, abuse and neglect inservices, and competency based post test for inservices. The new policy for consultant recommendations was signed by the MD, and put into effect. The Assistance Director of Nursing (ADON) was inserviced on responsibility of ensuring dietary recommendations are written, orders received, and care plans are updated within 72 hours of receiving them. The MD of NP providing the targeted skin assessments will sign off on them once a month. (2) Body Audits, to include all residents with wounds, was initiated on 07/20/2020 and completed on 07/23/2020 a total in-house census of sixty-seven (67) residents by Minimum Data Set Coordinator -Registered Nurse (RN), Corporate Nurse Specialist, RN, Corporate Certified Wound Care Specialist, RN, sister	M 500		

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M 500	Continued From page 39 facility RN, and Medical Records RN. Resident # Six (6), Resident # Seven (7), and Resident # Eight (8) were noted to have new skin issues identified through audit, new orders for treatment were obtained and implemented. Resident # Six (6) has excoriation to sacrum. The facility reported excoriation on Resident # Six (6) to physician on 7/22/20, new treatment order obtained, care plan revised to reflect change in condition and treatment and responsible party notified. On 07/22/2020 Physician gave order to evaluate appropriateness of cushion on Resident # Six (6) specialized motorized wheelchair that has cushion to relieve pressure. Wheelchair company visited on 07/23/2020 to assess wheelchair and facility approved order for a new cushion on 07/24/2020. Resident has suprapubic catheter and colostomy so cause of excoriation is not pressure but moisture caused by sweating. Resident # Seven (7) was assessed and noted Moisture Associated Skin Dermatitis (MASD) on buttocks. MD was notified and gave order to apply barrier cream after each incontinent episode. Moisture barrier cream order was implemented on 07/22/2020 at 12:08PM by Certified Nursing Assistant (C.N.A). Resident # Seven (7)'s care plan was revised on 07/22/2020 by RN to include every two (2) hour checks by nursing staff to monitor for incontinent care need. **The State Agency (SA) validated through document review, observation, and interview, the facility completed body audits on all 67 residents present in the building between 07/20/2020 and 07/23/2020. Audit sheets were verified, alert residents interviewed on receiving a body audit, the three residents with new areas identified were reviewed by the physician, orders given were verified in the medical records and care plans were verified to have been updated.	M 500		

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M 500	Continued From page 40 Responsible Party was notified of change of status of MASD to sacrum, new order and revision to plan of care on 7/22/2020 by Administrator. Resident # Eight (8) was assessed and noted to have two (2) new areas presenting as stage II on left lateral foot and a stage III on left lateral 5th toe on 07/22/2020. The Nurse Practitioner was notified and new order obtained for treatment of stage II on left lateral foot and left lateral 5th toe with xeroform Monday, Wednesday, Friday. New treatment orders with Xeroform implemented by Licensed Practical Nurse (LPN) under the supervision of an RN on 07/22/2020. Bilateral lower extremity venous and doppler studies were performed on 07/23/2020 per NP orders which resulted in diagnosis of peripheral arterial disease (PAD) and resulting in treatment order change to left lateral 5th toe to paint with betadine which was implemented on 07/24/2020 by LPN under direction of RN; care plan was revised with diagnosis of PAD and change of treatment orders by MDS RN . **The State Agency (SA) validated through document review, and interview, the facility notified Resident #8's Responsible Party concerning his skin areas, treatments were obtained, doppler study was scheduled and completed with a new diagnosis of PAD added to the resident's care plan. The orders were verified as changed to Betadine on 07/24/2020. (3) The following measures for impacted residents were implemented: Resident # One (1) was evaluated by Registered Dietician (RD) on 07/20/2020, and nine (9) new dietary recommendations were given, implemented, and care plan updated. Pain evaluation performed on 07/20/2020 by DON with no changes to pain	M 500		

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M 500	Continued From page 41 medication regimen. Nurse Practitioner assessed Resident # One (1) on 07/22/2020 with no new orders given. MD assessed Resident # One (1) on 07/23/2020, and new orders were given for bilateral venous and arterial Doppler studies. Vendor performed doppler on 07/24/2020 and results pending. Sister facility RN reviewed current treatment orders for effectiveness on 07/23/2020 and deemed orders as appropriate due to current treatments are ordered once a day. Resident # One (1) treatment orders have been implemented. Therapy reviewed current positioning devices for Resident # One (1), and ordered full body wedge, palm guards, and knee separator for Resident # One (1) from supply vendor on 07/23/2020. New orders will be implemented upon delivery of these special-order devices. Resident # Two (2) was evaluated by RD on 07/21/2020 with three (3) new recommendations which were implemented and care planned by Corporate Regional Nurse; responsible party notified during care conference held on 07/25/2020. NP assessed Resident # Two (2) on 07/22/2020 with no new orders given. MD assessed Resident # Two (2) on 07/23/2020 with no new orders given. Treatment review for effectiveness completed on 07/24/2020 by sister facility RN and a new order was given by NP to change frequency of treatment order to once a day. Therapy reviewed current positioning devices and deemed current devices as appropriate for care. Resident # Three (3) was evaluated by RD on 07/20/2020 with two (2) new recommendations that were implemented and added to the care plan by Corporate Regional Nurse. Sister facility RN reviewed current treatment orders on 07/24/2020 to determine effectiveness of treatments and deemed current treatments as effective. Therapy reviewed positioning devices for Resident # Three (3) and	M 500		

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M 500	Continued From page 42 ordered a full body wedge and abductor contracture cushion from a supply vendor on 07/23/2020. Resident # Three (3) orders are being followed for devices currently in place. New orders will be implemented upon delivery of special-order devices. Resident # Three's (3) care plan was reviewed and revised by MDS RN on 07/24/2020 to reflect current status and new orders. Responsible party for Resident # Three (3) was notified of assessment findings, care plan revision and new orders on 07/25/2020 by MDS RN during care conference. Resident # Four (4) was evaluated by RD on 07/20/2020 with one (1) new recommendation given, implemented, and added to care plan by (who). NP assessed Resident # Four (4) on 07/22/2020 with no new orders given. MD assessed Resident # Four (4) on 07/23/2020 with no new orders given. Corporate Wound Consultant reviewed treatments of Resident # Four (4) wounds and made recommendations which were reviewed and ordered by NP on 07/21/2020. Devices reviewed by therapy for Resident # Four (4) and elbow splint, boots, and full body wedge were ordered on 07/23/2020 from supply vendor. Resident # Four's (4) orders are being followed for devices currently in place. New special-order device orders will be implemented upon delivery of devices. Resident # Five (5) was hospitalized on 04/07/2020 and subsequently expired due to cardiac arrest. **The State Agency (SA) validated through document review, observation, and interview, the facility ensured Residents #1 - #4 were all evaluated by the RD, seen by the NP, MD, and had therapy evaluate them all for positioning devices. All orders and recommendations were updated on the care plans, and RP's notified of the changes. Billing statement reviewed for all	M 500		

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M 500	Continued From page 43 ordered specialty positioning devices. (4) Audit of comprehensive care plans was completed for a total census of 67 residents in the facility on 07/20/2020 - 07/23/2020 by Corporate Nurse Consultants RNs. There were sixty-seven (67) dietary recommendations added to care plans for forty (52) residents on 07/20/2020 -07/21/2020 by Corporate Nurse Consultants. Dietary recommendations were implemented on care plans by Corporate Nurse Consultants for a total census of 67 residents. Thirteen (13) care plans were updated related to pain interventions/orders that were previously implemented by not addressed on the comprehensive care plan previously. There were eight (8) resident care plans updated related to positioning devices, and eleven (11) care plans updated related to pressure relieving devices. There were thirteen (12) resident care plans updated related to skin. There were fifteen (15) resident care plans updated related to wound treatments. Sixty-six (66) of sixty-seven (67) resident care plans were updated related to preventative care. There were five (5) resident care plans updated related to at risk for skin impairment. **The State Agency (SA) validated through document review, and interview, that a complete audit was done for all comprehensive care plans, and care plans were updated with dietary recommendations, pain interventions, positioning devices, pressure relieving devices, skin and wound treatments, preventative skin care, and residents noted to be at risk for skin impairment. (5) Census on 07/20/2020 was sixty-eight (68) with one (1) resident in hospital. A total census of 67 residents in facility were evaluated for pain by	M 500		

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M 500	Continued From page 44 Director of Nursing on 07/20/2020-07/22/2020. Two (2) residents were assessed as needing additional pain treatment orders. NP ordered Tylenol as needed on 07/20/2020 for Resident # Eight (8) and Resident # Nine (9) to receive prior to wound care and therapy. Resident # Eight's (8) care plan was updated by MDS RN to reflect new pain treatment on 07/23/2020. Resident # Nine's (9) care plan was updated by MDS-RN to reflect new pain treatment on 07/23/2020. The sixty-five (65) remaining residents evaluated by DON did not complain of pain nor display pain grimaces. Pain evaluations completed on all sixty-five (65) residents reflected that current pain medication regimens were sufficient to meet current needs. **The State Agency (SA) validated through document review, and interview, the facility performed pain evaluations on all 67 residents in house. Two residents pain management was revised with new orders that were care planned. (6) An audit of positioning and pressure redistributing devices (examples: wedges, cushions, heel protectors) for sixty-seven (67) residents in the facility on 07/21/2020 was completed by facility therapy team members (physical and occupational therapy). Residents with positioning and pressure redistributing devices were identified and deemed in working order. The facility has fifty-seven (57) positioning and pressure redistributing devices available in the center on 07/22/2020. The facility has ordered seventy-one (71) positioning and pressure redistributing devices from a vendor to ensure that there is an adequate supply for when devices require laundry services. Sixty-seven resident's charts were reviewed on 7/22/2020 by MDS RNs for device orders, care planning and flow to Kardex. Twenty-one (21) positioning	M 500		

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M 500	Continued From page 45 devices and ten (10) pressure relieving devices were added to Kardex. Rehab staff (Rehab director, Physical Therapist, and Occupational Therapist) initiated in-services on 7/22/2020 with direct care staff on device use. This in-service equipped direct care staff with education and skills for proficiency with device use to implement immediately following education. Direct care staff educated by lead restorative aide on how to access and utilize Kardex on 7/22/2020. Twenty-two (22) of twenty-six (26) CNAs were educated and able to provide return demonstration on accessing Kardex. No staff will be allowed to work in the facility until they have been in-serviced on the use of positioning devices. **The State Agency (SA) validated through document review, observation, and interview, the facility therapy team did a positioning and pressure redistributing device audit on all 67 residents in house. Necessary positioning devices were put in place or ordered. Billing receipt for products orders reviewed. Inservice verified on device use with the direct care staff. (7) The following in-services were done for all nursing staff: Turning, repositioning devices, recognizing stages of skin breakdown, who to report changes in skin to, wound prevention and skin care program, comprehensive care plan, care plan revisions, implementation of care plan and Kardex, new policy ensuring consultant/Registered Dietician recommendations are followed up on within 72 hours and change in condition. Abuse and neglect reporting initiated by NHA. All in-serviced were initiated 7/20/2020 and completed by 07/23/2020 by DON/RN Supervisor/LPN. Sister facility RNs and sister facility Licensed Practical Nurse (LPN) initiated	M 500		

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M 500	Continued From page 46 in-services and performed competency check offs with nursing staff on skin care and wound prevention on 07/23/2020. Sister facility RNs initiated in-services with licensed nurses on wound care and check offs for dressing changes on 07/23/2020. No nursing staff will be allowed to work without completion of required in-services. Forty-two (42) of forty-six (46) nursing staff members received in-service. The total breakdown of the forty-two (42) nursing staff educated are: five (5) of five (5) RNs, eleven (11) LPNs, twenty-six (26) CNAs were provided with education. ADON in-serviced on being responsible for ensuring dietary recommendations are followed up on within seventy-two (72) hours on 07/23/2020. **The State Agency (SA) validated through document review, and interview, the In-services were completed, and sign in sheet reviewed. (8) Inservice with MDS/Care Plan Coordinators on care plan process by Corporate MDS Consultant (RN) on 07/21/2020 at 8:04PM. The following information was reviewed: The comprehensive care plan is an interdisciplinary communication tool composed by MDS/Care Plans RNs. MDS/Care Plans RNs are responsible for updating care plans. Interim DON is monitoring care plan program. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed by member of the interdisciplinary team (Social Services Director, Dietary Manager, C.N.A., Nurse, Activities Director, and MD) and revised periodically as needed, and the services provided	M 500		

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M 500	Continued From page 47 or arranged must be consistent with each resident's written plan of care. Use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. The overall care plan should be oriented towards: 1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation). 2. Managing risk factors to the extent possible or indicating the limits of such interventions. 3. Addressing ways to try to preserve and build upon resident strengths. 4. Applying current standards of practice in the care planning process. 5. Evaluating treatment of measurable objectives, timetables and outcomes of care. 6. Respecting the resident's right to decline treatment. 7. Offering alternative treatments, as applicable. 8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. 9. Involving resident, resident's family and other resident representatives as appropriate. 10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs. 11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes. 12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting. **The State Agency (SA) validated through document review, and interview, the In-services were completed, and sign in sheet reviewed.	M 500		

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M 500	Continued From page 48 (9) In-service conducted by NHA with interdisciplinary team (Director of Nursing, Social Services Director, MDS/Care Plan Coordinators, Dietary Manager, and Director of Therapy) on care plans, pain, and consultation follow up on 07/21/2020 at 9:30AM. The facility has designated an RN certified in Wound Treatment Strategies to provide wound care with oversight from the interim DON. Inservice with Interim DON on Skin Care and Wound Care Program by Corporate Wound Specialist on 07/21/2020 at 1:00PM-3:00PM. The following was reviewed: 1. How to print a wound report in PCC and how to determine when new assessments due 2. Frequency of assessments: Braden, skin and wound 3. How to locate and navigate items the skin and wound binder (I-drive) 4. Facility wound and skin treatment protocols with description of products 5. Pressure Injury Staging, MASD, arterial and diabetic wounds 6. Separate treatment orders for each wound, and an order for every intervention 7. Care Plans matching current wounds on report 8. How to monitor PCC for assessments due, overdue or incomplete and the frequency to perform each 9. How to locate, edit and close in-progress wound assessments in PCC 10. Nexion therapeutic support surface (air mattress) algorithm The center has a skin and wound care program. The center had a break in the program. The parts that were not followed were weekly evaluations of wounds to obtain measurements	M 500			

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M 500	Continued From page 49 and monitor if wounds were improving, stalling, or worsening. This led to center not changing treatment orders biweekly for stalling or worsening of wounds. (10) Audit of wound care program has been started as of 07/24/2020 and to be continued weekly by DON and Corporate Clinical Specialist-RN for three (3) months for documentation compliance. (11) Resident Care monitoring audits have begun as of 07/24/2020. Audits are conducted by Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), RNs, LPNs, NHA, Social Services Director, and Activities Director. These individuals will alternate monitoring for all three (3) shifts. The following items are audited: 1. Rounds every two (2) hours to ensure turning and repositioning 2. Rounds every two (2) hours to ensure appropriate use and availability of positioning and pressure relieving devices 3. Rounds every two (2) hours to check dressings present with dates and initialing of three (3) different residents each round. Due to system break with skin and wound care program, the facility also reported an allegation of abuse/ neglect on 07/21/2020 at 11:24AM to the MSDH Complaint Unit. NHA left message on complaint voicemail box. All residents with a BIMS of 12 or higher were interviewed by Social Services Director on 07/22/2020. There were no allegations of abuse or neglect from the interviews. Facility wide in-services on Abuse/Neglect began on 07/20/2020. On 07/23/2020, facility wide in-services were initiated by Human Resources Director to include testing	M 500		

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M 500	Continued From page 50 for knowledge-based competency on abuse. Forty-two (42) of sixty-six (66) staff members have completed knowledge-based competency. The center did not report specific staff members to MS Board of Nursing or MS Attorney General's office due to this being a systemic issue with the program and not an individual person issue. No staff will be allowed to work without completing required in-service. **The State Agency (SA) validated through document review, and interview, the In-services were completed, and sign in sheet reviewed. A copy of the report sent to MSDH (Mississippi State Department of Health) was reviewed as complete. (12) The facility alleges that all actions to remove the Immediate Jeopardy, identified on 07/20/2020, were completed as of 07/25/2020.	M 500		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level IV Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent the development of pressure ulcers and the worsening of existing pressure ulcers for five (5) of 5 residents, Residents #1, #2, #3, #4	M 615	1. The following measures for impacted residents were implemented: Resident # One (1) was evaluated by Registered Dietician (RD) on 07/20/2020, and nine (9) new dietary recommendations were given, implemented, and care plan updated. Pain evaluation performed on 07/20/2020	8/25/20

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M 615	Continued From page 51 and #5. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 04/21/2020, as a result of worsening and infection of Resident #1's initial pressure ulcer. The facility's failure to assess and put preventative measures in place, resulted in Resident #1 developing nine (9) new pressure ulcers. The failure to implement an order to increase Resident #1's gastric tube feeding for eleven (11) weeks to meet his nutritional needs and help heal his significant wounds, resulted in the deterioration of his wounds. The facility's failure to provide preventative measures to residents who were at risk for skin breakdown and to prevent further skin breakdown also affected Residents #2, #3, #4 and #5. The facility's failure to provide goods and services necessary to treat and prevent pressure ulcers caused significant harm to Residents #1, #2, #3, #4, #5 and placed other residents at risk for skin breakdown, in a situation that caused and/or likely to cause serious injury, harm, impairment, or death. On 07/20/2020 at 4:30 PM, the SA informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The IJ and SQC existed at: Rule 45.21.3 - Pressure Sores (M615) The facility submitted a Credible Removal Plan on 07/25/2020 at 1:08 PM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of	M 615	by DON with no changes to pain medication regimen. Nurse Practitioner assessed Resident # One (1) on 07/22/2020 with no new orders given. MD assessed Resident # One (1) on 07/23/2020, and new orders were given for bilateral venous and arterial Doppler studies. Vendor performed doppler on 07/24/2020 and results pending. Sister facility RN reviewed current treatment orders for effectiveness on 07/23/2020 and deemed orders as appropriate due to current treatments are ordered once a day. Resident # One (1) treatment orders have been implemented. Therapy reviewed current positioning devices for Resident # One (1), and ordered full body wedge, palm guards, and knee separator for Resident # One (1) from supply vendor on 07/23/2020. New orders will be implemented upon delivery of these special-order devices. Resident # Two (2) was evaluated by RD on 07/21/2020 with three (3) new recommendations which were implemented and care planned by Corporate Regional Nurse; responsible party notified during care conference held on 07/25/2020. NP assessed Resident # Two (2) on 07/22/2020 with no new orders given. MD assessed Resident # Two (2) on 07/23/2020 with no new orders given. Treatment review for effectiveness completed on 07/24/2020 by sister facility RN and a new order was given by NP to change frequency of treatment order to once a day. Therapy reviewed current positioning devices and deemed current devices as appropriate for care. Resident # Three (3) was evaluated by RD on	

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M 615	Continued From page 52 07/25/2020. The SA validated the Removal Plan on 07/26/2020, and determined the IJ was removed, prior to exit. Therefore the scope and severity for Rule 45.21.2 - Pressure Sores (M615) was lowered from a "Level 4" scope and severity to a "Level 3", while the facility develop a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Pressure Ulcer Prevention Program" policy, revised 07/2018, revealed: "Standard: All resident will be assessed for the risk of pressure ulcer development. Based on the results of this assessment, specific interventions will be implemented to prevent the development of avoidable pressure ulcers, or, to treat existing ulcers. Procedure: 1. All residents will be screened for risk of pressure ulcer development utilizing the Braden Scale/Norton Scale ...2. Residents identified as being at risk will have interventions identified in their plan of care to prevent the occurrence of pressure ulcers. 3. The following is a list of commonly used interventions to prevent the development of pressure ulcers - Frequent turning and positioning ...monitor resident's nutritional intake, pad between bony prominences ...utilize pressure relieving devices as needed ... 4. All resident will have a head to toe assessment completed on a weekly basis by a licensed nurse to identify any skin breakdown. The results of this assessment will be documented in the resident's medical record. 5. If a pressure ulcer/skin breakdown is identified, the following will be done - The licensed nurse will complete a thorough assessment of the affected	M 615	07/20/2020 with two (2) new recommendations that were implemented and added to the care plan by Corporate Regional Nurse. Sister facility RN reviewed current treatment orders on 07/24/2020 to determine effectiveness of treatments and deemed current treatments as effective. Therapy reviewed positioning devices for Resident # Three (3) and ordered a full body wedge and abductor contracture cushion from a supply vendor on 07/23/2020. Resident # Three (3) orders are being followed for devices currently in place. New orders will be implemented upon delivery of special-order devices. Resident # Three's (3) care plan was reviewed and revised by MDS RN on 07/24/2020 to reflect current status and new orders. Responsible party for Resident # Three (3) was notified of assessment findings, care plan revision and new orders on 07/25/2020 by MDS RN during care conference. Resident # Four (4) was evaluated by RD on 07/20/2020 with one (1) new recommendation given, implemented, and added to care plan by (who). NP assessed Resident # Four (4) on 07/22/2020 with no new orders given. MD assessed Resident # Four (4) on 07/23/2020 with no new orders given. Corporate Wound Consultant reviewed treatments of Resident # Four (4) wounds and made recommendations which were reviewed and ordered by NP on 07/21/2020. Devices reviewed by therapy for Resident # Four (4) and elbow splint, boots, and full body wedge were ordered on 07/23/2020 from supply vendor. Resident # Four's (4) orders are being	

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M 615	Continued From page 53 area ... include size, stage, location, drainage and odor. The licensed nurse will notify the physician and the family. Treatment will be initiated per physicians' orders. The resident's plan of care will be updated to reflect interventions. The interdisciplinary team will be notified so that appropriate referrals may be made to the dietitian, therapy etc ...The Director of Nursing (DON) or designee will track and monitor pressure ulcers weekly. In the event the primary assessing nurse is not by state practice act allowed to stage a PrU (Pressure Ulcer), then the DON/Designee must view and stage the PrU weekly. The DON/designee will report results to the Quality Assurance/Improvement Committee on a quarterly basis." Review of the facility's document titled, "Pressure Ulcer Prevention and Treatment Toolkit", dated 07/2018, revealed: "This toolkit is intended to assist the resident's care team in assessing, developing the plan of care, monitoring the plan implementation and effectiveness, and revising the plan of care as indicated, to meet the individual resident's needs ...the team is more likely to reduce the development of new pressure ulcers and promote healing of existing ulcers ...A comprehensive assessment should address risk factors that had been identified as having an impact on the development, treatment and healing of pressure ulcers, such as pressure points, and under nutrition ... Skin Assessment: Regularly conduct thorough skin assessments on each resident who is at risk of developing pressure ulcers. Such skin assessments allow early detection of developing or existing skin breakdown or to verify the integrity of the skin. When conducting skin assessments: evaluate all areas at risk of constant pressure, positioning in bed, positioning in chair, presence of contractures	M 615	followed for devices currently in place. New special-order device orders will be implemented upon delivery of devices. Resident # Five (5) was hospitalized on 04/07/2020 and subsequently expired due to cardiac arrest. 2. 07/21/2020 -07/25/2020 care plans and kardexes were reviewed and revised by Minimum Data Set nurses to include turning and repositioning, positioning and pressure relieving devices, skin integrity issues , and nutritional recommendations. Residents residing in the facility have the potential to be impacted related to care plans/kardexes not being updated. 3. On 07/21/2020 Minimum Data Set nurses were educated by Corporate Case Mix Specialist Registered Nurse on updating care plans and kardexes with devices, skin integrity issues, and nutrition recommendations as necessary. Beginning on 07/20/2020-07/25/2020 Licensed nurses were in serviced by sister facility nurses, nurse supervisors, and charge nurses on review of orders and documentation of devices and skin care. Certified Nursin/g Assistants were in serviced to ensure appropriate person-centered care is provided /per the kardex. On 07/30/2020 Clinical standards meeting were re-initiated by the Corporate Clinical Specialist and interdisciplinary team to review orders and change in status to be held minimally on a weekly basis during which care plans and kardexes will be reviewed and revised to reflect current care needs. 4. Beginning 08/02/2020 the Director of Nursing or Corporate Clinical Specialist	

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M 615	Continued From page 54 or deformities... Examine all pressure points. The most common include: sacrum, heel, greater trochanter, ischial tuberosity, fibular head, scapula, ankle, and elbow. Repositioning: Repositioning should occur at least every two hours, but more frequent repositioning may be warranted for individuals who are at higher risk for pressure ulcer development... If feasible, use pillows to raise heels off the bed ...Nutrition: ...An Interdisciplinary Team should develop nutritional goals. Unless contraindicated, goal for a resident with nutritional compromise who has a PU (pressure ulcer) or is at risk of developing one should include protein intake of approximately 1.2-1.5gm/kg body weight daily (higher end of the range if larger, more extensive or multiple wounds) ..." Review of facility's document titled, "Nutrition Support for Pressure Ulcers - Nutritional Information From The Role of Nutrition in Pressure Ulcer Prevention And Treatment - National Pressure Ulcer Advisory Panel White Paper" revised 07/2018, revealed, "Important Nutritional Support For Pressure Ulcers: 1. Calories - the most important Factor in healing pressure ulcers is adequate calories ... glucose is the major fuel source for collagen synthesis. Collagen is the matrix, or base for repairing tissue. So without adequate glucose, there is not adequate healing ...Every day the resident has calorie intake below the desired amount, there is no wound healing ...and may be actual decline ...it is our policy that all new wounds be reviewed by the dietitian within 72 hours ...there must be a combined effort to make sure that the dietitian is contacted, and her recommendations are presented to the physician and carried out... Delay in this process can mean a delayed healing process ...2. Protein - protein is also required for	M 615	will audit three (3) comprehensive care plans and kardexes weekly for four (4) weeks to validate care plans and kardexes reflect Resident's current status and care needs, then audit once a week for four (4) weeks then monthly thereafter for three (3) months. Director of Nursing will report trends to Quality Assurance Performance Improvement committee (Nursing Home Administrator, Medical Director, Social Services Director, Dietary Manager, Infection/Prevention Officer, Director of Nursing) monthly for three (3) months. The Administrator is responsible for on-going monitoring and compliance. 2. Body audits completed on 67 of 67 Residents on 07/21/2020 by Registered Nurses. Three (3) residents identified with previously unidentified skin integrity issues. New orders were received from medical provider. Care plans and Kardex were updated to reflect current resident status and care needs. 3. Beginning 07/29/2020, skin checks are performed weekly to identify new areas. If new areas identified an evaluation with measurements will be completed by the licensed nurses. The Director of Nursing, wound care nurse and/or Corporate Clinical Specialist will further assess wound, review treatment orders, care plan and kardex for appropriate interventions. Beginning 07/29/2020, Registered Nurses or licensed practical nurses completed Braden scales and body audits on new admissions and readmissions to ensure identification of skin integrity concerns. Skin integrity concerns noted upon admission and readmission are added to	

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M 615	Continued From page 55 healing ...all stages of wound healing require adequate protein ...Team work is essential for healing wounds. A break in the system will mean poor outcome." Review of the facility's "Consultant Recommendations and Follow Up" policy, undated, revealed, "Consultants will visit the facility at a time scheduled with the pertinent department head and Administrator/DON. 2. A list of recommendations will be left with the Administrator and Director of Nurses with copies distributed to other disciplines as necessary ...4. The recommendations will be followed up on within seven (7) days ...5. Documentation will include physicians' orders, nurses' notes, and care plan revision where necessary & appropriate ...8. The consultant will review the consultant report book during his/her visit to the facility to assure follow up has occurred." Resident #1 Review of Resident #1's "Admission Record", revealed, he was admitted on 01/21/2019 with a primary diagnosis of Dementia with Lewy Bodies, Unspecified Dementia with Behavioral Disturbance, Benign Prostatic Hyperplasia, Other Seizures, and Dysphagia, Oropharyngeal Phase. Review of Resident #1's Minimum Data Set (MDS) dated 12-30-2019, revealed, he was "totally dependent on two + person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed)". Resident #1 was not able to reposition himself or turn in the bed unassisted. Review of Resident #1's "Braden Scale For Predicting Pressure Sore Risk", dated 02-19-2020, revealed his score to be eleven (11),	M 615	care plan and kardexes to provide necessary care interventions. New wound care nurse started on 08/10/2020 and completed orientation with Corporate Wound Specialist on 08/12/2020. New contract with wound care physician was implemented on 08/06/2020 to include weekly rounds and reassess effectiveness of current interventions with facility staff. Beginning 08/11/2020, Nurse leadership team including Director of Nursing, Assistant Director of Nursing, MDS Nurses, Medical Records Nurse ensures preventative measures and a plan of care are in place to promote positive skin integrity and nutrition. Beginning on 08/03/2020 the Director of Nursing/Assistant Director of Nursing or Corporate Clinical Specialist will communicate any Residents with skin integrity concern to the Registered Dietician for further recommendation. The Director of Nursing will reconcile Registered Dietician recommendations to validate the medical provider has been notified of recommendations and validate orders have been provided by the medical provider during the Clinical Standards meeting. The facility's skin care program has been reviewed to ensure that it was inclusive of the following: Prevention (turning and repositioning) along with completion of Braden scales as scheduled, implementation of preventative positioning devices Weekly skin checks reconciled to validate completion as well as identification of new	

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M 615	Continued From page 56 which placed him at "High Risk" for developing pressure ulcers. Resident #1 was admitted to the facility without any noted pressure ulcers. Since 02/03/2020, Resident #1 has eleven new in-house acquired pressure ulcers, (two Unstageable ulcers, two Stage IV pressure ulcers, one Stage III pressure ulcer, four Stage II pressure ulcers, and one Stage I pressure ulcer). A lack of turning and repositioning, with proper application of pressure reducing devices was observed, as well as interviews with staff confirming the formation of multiple pressure ulcers, an increase in Resident #1's pain level, preventative pressure reducing devices were not consistently used, weekly skin assessments and wound measurements were missed, and an order for Resident #1's enteral tube feeding to be increased to promote wound healing was not addressed timely. On 07/15/2020 at 10:35 AM, during initial rounds, Resident #1 was observed in bed, lying on his back. On 07/15/2020 at 11:35 AM, Resident #1 was observed in the bed, pillow behind his head, lying on his back, wedge triangle behind resident's head on left side, legs drawn up in a fetal position, no other positioning devices observed. On 07/15/2020 at 2:10 PM, Resident #1 was observed in the bed, on his back, legs pulled up in the fetal position, no heel pillows present, triangle wedge was on the floor near his window, no other positioning devices observed. On 07/15/2020 at 3:45 PM, Resident #1 was observed in the bed, pillow behind his head, lying on his back, legs drawn up in a fetal position, no	M 615	skin integrity concerns. Support services (positioning devices, pressure relieving devices, and nutrition) needs identified, implemented and care plan/kardexes updated to reflect resident specific needs. On 09/07/2020 additional in-services conducted with facility staff on the following: Nurses ☐ skin care program, how to write orders, wound staging and measurements, proper treatment and prevention strategies, how to respond to stop and watch Nurses and Certified Nursing Assistants (C.N.A.) ☐ individualized person centered turning and repositioning program, weekly skin checks, positioning and pressure relieving devices Therapy ☐ positioning devices CNAs ☐ Complete stop and watch for skin issues and reduced meal or fluid intake Beginning 07/24/2020, routine rounds to validate that care interventions are occurring and skin integrity is maintained when possible. 4. Beginning 08/02/2020, weekly audits will be conducted by the Director of Nursing/Corporate Clinical Specialist for three (3) months to include weekly skin checks completion per schedule, completion of Braden scales per schedule, pressure injury treatment observations completed on three (3) residents weekly with the wound care nurse, Registered Dietician recommendations executed within seventy-two (72) hours, skin wound and treatment documentation completed per orders, audits completed as scheduled related to observations of positioning and	

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M 615	Continued From page 57 other positioning devices observed. On 07/15/2020 at 3:45 PM, Resident #1 was observed in the bed, on his back, in the same position as prior rounds, legs in fetal position, wedge triangle remains on the floor near window, no other positioning devices observed. On 07/16/2020 at 9:00 AM, Resident #1 was observed in the bed, lying on his back, pillow behind his head, a wedge cushion resting in his right axilla, legs pulled into fetal position, with no other positioning devices observed. On 07/16/2020 at 11:40 AM, Resident #1 was observed lying on his right side, with a pillow under his head, and no other positioning devices observed, just prior to him receiving wound care. Wound care was observed by State Agency (SA), as completed by Licensed Practical Nurse (LPN) #1, without concerns or breach in infection control. Wounds were observed to be a Stage IV, full thickness wound to Resident #1's Left Trochanter (hip), with exposed muscle in the wound bed; an unstageable pressure ulcer to Resident #1's Right Trochanter (hip), with wound bed covered in a large, hard, dark black eschar; an unstageable pressure ulcer to Resident #1's Left Lateral Malleolus (outer ankle), the wound bed was bleeding, covered in a large amount of loose slough, with bone exposed in the center of the wound bed; an unstageable pressure ulcer to Resident #1's Right Calf/Shin, covered in a large, hard, dark eschar, with a small area of slough present; an unstageable pressure ulcer to Resident #1's Right Lateral Malleolus (outer ankle), with half of the wound bed covered in slough; and a Stage III pressure ulcer, with full thickness loss of skin, on Resident #1's Right Great Toe (Hallux), with muscle exposed in the	M 615	preventative care items implemented per orders and/or care plan, and weekly rounds completed by contracted wound care physician. The Director of Nursing will review components of skin and wound program weekly during the Clinical Standards meeting and report findings to the Corporate Clinical Specialist and Quality Assurance Performance Improvement committee (Nursing Home Administrator, Medical Director, Social Services Director, Dietary Manager, Infection/Prevention Officer, Director of Nursing) monthly for three (3) months and quarterly thereafter. The Administrator and Corporate Clinical Specialist is responsible for on-going monitoring and compliance.	

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M 615	Continued From page 58 center of the wound bed. On 07/16/2020 at 4:15 PM, Resident # 1 was observed in the bed on his back, with a pillow behind his head, legs pulled up in the fetal position with no positioning devices observed. On 07/17/2020 at 9:10 AM, Resident # 1 was observed in his bed, lying on his back, with a pillow behind his head, legs pulled into the fetal position, and no other positioning devices observed. On 07/17/2020 at 2:00 PM, Resident #1 was observed in the bed, lying on his back, with a pillow behind his head, a wedge cushion in right axilla area, legs pulled into a fetal position, no other positioning devices observed. On 07/16/2020 at 11:40 AM, during an interview with Licensed Practical Nurse (LPN) #1, when asked by the State Agency (SA) about positioning devices/heel cushions for Resident #1, she stated, "they usually be in here somewhere, but I don't see them right now ...whoever see em' off usually put them back on, but they ain't assigned to nobody ...they ain't on the medication or treatment sheets ..." On 07/17/2020 at 3:30 PM, during an interview with the DON, when asked by the SA about a turning and repositioning (TAP) schedule and positioning devices for residents, she stated, "...the nurses are supposed to make sure the aides do it, and check for pillows and stuff, but they was moving residents for COVID and didn't know what to put on them, that's why wounds is a mess right now." On 07/20/2020 at 10:45 AM, during an interview	M 615		

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M 615	Continued From page 59 with Certified Nurse Aide (C.N.A.) #1, concerning positioning devices/heel cushions and a TAP schedule, she stated, "We do our charting on iPads (Interactive Personal Application Devices), and it don't talk about heel boots in it. We answer yes or no if we turn them on our shift ...the nurse is supposed to check the pillows and stuff ...he (Resident #1), supposed to have them boots on right now, and a pillow by his knees, but they was soaked with urine this morning and had to be sent to laundry ain't no extras to put on him right now ... there ain't no set schedule for turnin' residents, I just know when, 'cause I been doin' this job for a long time ...It ain't written down nowhere to see." On 07/20/2020 at 11:45 AM, during an interview with C.N.A. #2, regarding positioning devices/heel cushions and a TAP schedule, she stated, "We have a Kardex on the iPad for some resident info, and we are supposed to get report from the shift leaving ...we tried (to use positioning devices) but couldn't always do it ...there aren't always enough wedges to go around ...we just know when to turn them, it's not written down." On 07/20/2020 at 11:40 AM, during an interview with Registered Nurse (RN) #1, a Minimum Data Set (MDS)/Care Plan Nurse, regarding a TAP program and positioning devices, she stated, "...we should put turning and positioning and heel padding on the care plans. No one is assigned the task of checking if the heel padding is in place. The C.N.A.'s just answer a yes/no question on whether they did it (TAP) or not, because in order for it to be put on their (the C.N.A.'s) Kardex to chart on, we would have to assign exact times to it ...we don't want to lock them into a time." On 07/20/2020 at 11:45 AM, during an interview	M 615		

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M 615	Continued From page 60 with RN #2, an MDS/Care Plan nurse, regarding heel cushions/floats, and a TAP schedule, and she stated, "We should be putting those items on the care plan, if we know they are doing them, but we haven't been doing that recently with COVID in the building ..." On 07/20/2020 at 11:40 AM, during an interview with the DON, she confirmed she oversaw the wound program, and the treatment nurse had "Left abruptly" on 05/01/2020. She found issues with incomplete documentation, staging of wounds, and Certified Nurse Aides (C.N.A.'s) were coming to tell her about their "concerns with the wounds and lack of care". Review of Resident #1's "Visual/Bedside Kardex Report" revealed "Bed Mobility: The resident requires assistance by (x)2 staff to turn and reposition in bed, low air loss mattress to bed ..." there was no mention of a TAP schedule or preventative positioning devices for him. Review of Resident #1's "Skin & Wound Evaluation V5.0", dated 02/03/2020, revealed a new, in-house acquired, Stage II (partial thickness loss of skin) pressure ulcer to his Left Trochanter (hip) that measured 1.9 centimeters (cm) Length x 2.2cm Width x 0.2cm Depth with a moderate amount on serosanguineous (serous/bloody) drainage. Additional measures to be put into place were incontinence management, a mattress, moisture barrier, nutrition/dietary supplementation, positioning wedge, repositioning device(s), and a turning/repositioning program. Review of Resident #1's "Skin & Wound Evaluation V5.0", dated 03/04/2020 revealed the Left Trochanter wound had worsened and was now a Stage III (full thickness loss of skin), and	M 615		

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M 615	Continued From page 61 larger in size at 2.3cm Length x 3.4cm Width, and no Depth recorded. Further review of Resident #1's "Skin & Wound Evaluation V5.0", for April 2020, revealed no assessment or measurements of the left trochanter wound due on 04/21/2020. Review of Resident #1's "Progress Note", dated 04/22/2020 revealed, " ...RP notified of new area noted to resident's right hip ..." On 07/17/2020 at 3:30 PM, during an interview with the DON, regarding Resident #1's missing skin assessment and measurements of his Left Trochanter wound due on 04-21-2020, and the missing skin assessment and measurements of the "new area" on his right hip on 04/22/2020, she stated, "They weren't done 'cause he was moved to the COVID unit and I don't think they knew about him real good." Further review of Resident #1's "Skin & Wound Evaluation V5.0", dated 04/27/2020, revealed, a deterioration in, and the presence of infection to his Left Trochanter (hip) wound, an unstageable (Obscured full thickness loss of skin and tissue loss) wound to his Right Trochanter (hip) identified on 04/22/2020, and eight (8) new pressure ulcers with the documented presence of pain. Review of Resident #1's "Skin & Wound Evaluation V5.0" dated 04/27/2020 revealed, his Stage III (full thickness skin loss) Left Trochanter (hip) wound was larger at 4.7cm Length x 3.9cm Width, no Depth recorded, and Undermining of 4.5cm, with evidence of redness, warmth, increased pain, heavy purulent (pus) drainage, and a moderate odor; a new, in-house acquired,	M 615		

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M 615	Continued From page 62 unstageable pressure ulcer to his Right Trochanter (hip), 2.6cm Length x 3.2cm Width, with noted redness and inflammation; a new, in-house acquired, unstageable (obscured full thickness skin and tissue loss) pressure ulcer to his Sacrum measuring 3.8cm Length x 4.2cm Width, no Depth recorded, with redness, inflammation, warmth and bleeding present; a new, in-house acquired, Deep Tissue Injury (DTI) (persistent non-blanchable deep red, maroon or purple discoloration) to his Left Lateral Malleolus (outside ankle) measuring 2.6cm Length x 2.9cm Width; a new, in-house acquired, Stage II blister on his nose measuring 0.5cm Length x 0.6cm Width; a new, in-house acquired, Stage II blister on his spine measuring 3.6cm Length x 1.4cm Width; a new, in-house acquired, Stage II blister to his Right Ischial Tuberosity (buttocks) measuring 1.7cm Length x 1.6cm Width; a new, in-house acquired, Stage II blister to his Left Medial Malleolus (inside ankle) measuring 0.6cm Length x 1.6cm Width; a new, in-house acquired, Stage II blister to his Right Lateral Calf/Shin measuring 0.6cm Length x 0.9cm Width; and a new, in-house acquired, stage one (non-blanchable redness of intact skin) to his right heel measuring 1.9cm Length x 1.8cm Width. All 10 pressure ulcers rated his pain level at three (3), with noted discomfort during treatment and moving. Review of Resident #1's "Progress Note" dated 04/28/2020, revealed, "Contacted RP (Formal Name) regarding blisters on nose, back, Lt Med ankle, Rt lateral calf and Rt lower buttock, also informed of wounds to Rt heel, Lt lateral ankle (not open yet), sacrum, Rt hip and Lt hip (deteriorating and culture performed yesterday) ..."	M 615		

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M 615	Continued From page 63 Review of Resident #1's "Progress Note" dated 04/29/2020, revealed, " ...Resident's wound on lt. hip malodorous ..." Review of Resident #1's "Progress Note" dated 05/01/2020, revealed, "New order noted per NP (Nurse Practitioner) to begin resident on Rocephin 1gram IV (Intravenously) via midline (to be inserted per nursePro) x 14 days r/t infection noted to left hip ..." On 07/21/2020 at 3:45 PM, during an interview with RN #2, regarding the decline in Resident #1's wounds, his infected wound, and the large increase in his number of wounds, she stated, " ...I don't know what's going on, we changed everybody's wound treatment orders to Monday, Wednesday, and Friday because of COVID, which should have give them more time to be checking on folks ..." When asked by the SA if assessments were done on residents with wounds, to see if it was appropriate to change the frequency of their dressing changes, which would make them go three days, over the weekend, without a dressing change, she stated, "No, we didn't do any assessments, we don't have anybody in the facility it should affect too bad ..." Review of Resident #1's "Progress Note", titled "Nutrition/Dietary Note", dated 05/04/2020, revealed Resident #1's current gastric tube (G-tube) feeding and oral intake did not "meet ENNs (Estimated Nutritional Needs)" required to maintain his weight and help heal his extensive wounds. The Registered Dietician (RD), recommended to increase his feeding (Jevity 1.5) to 60 cc/hr (cubic centimeters/hour) for twenty-two (22) hours a day, from the current order of 50cc/hr for twenty-two hours a day.	M 615			

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M 615	Continued From page 64 Review of Resident #1's "Order Summary Report ...Active Orders As of 07/16/2020" revealed, "Enteral Feed Order ...Tube Feeding Continuous: Formula Jevity 1.5 at 50cc/hr x 22 hours ..." On 07/20/2020 at 11:40 AM, standing at Resident #1's bedside, LPN #1 confirmed his g-tube feeding, Jevity 1.5, was currently running at 50cc/hr. On 07/21/2020 at 11:15 AM, during an interview, with the Dietary Manager (DM), regarding Resident #1's G-tube feeding rate not being changed to the RD's recommendation from 05/04/2020, she stated, "When the recommendations come through, I am on the email list ... but I only do Mighty Shakes and Magic Cups, basically things that would go on their meal tray, double portions etc" On 07/21/2020 at 12:00 PM, during an interview with the RD regarding Resident #1's missed feeding increase from 05-04-2020, and the worsening of his wounds, she stated, " ...I worked remotely and was not in the building ...there was no follow-up with the facility for follow through ...I was covering six (6) other facilities and don't remember checking follow through of recommendations ..." Review of Resident #1's "Progress Note - Skin/Wound Note", dated 07/01/2020, revealed, a deterioration with an advancement in staging, and significant size increase of the pressure ulcers to his Left Trochanter (hip), Right Trochanter (hip), Right Calf/shin, and Right Lateral Malleolus (ankle), and two more newly identified in-house acquired wounds. Review of Resident #1's "Progress Note -	M 615		

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M 615	Continued From page 65 Skin/Wound Note" dated 07/01/2020 revealed, a now Stage IV (Full thickness skin and tissue loss) pressure ulcer to his Left Trochanter (hip) measuring 12.2cm Length x 17.0cm Width x 1.5cm Depth with 1.8cm Undermining; an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Right Trochanter (hip) measuring 9.0cm Length x 9.0cm Width with 1.5cm Undermining; an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Left Lateral Malleolus (outer ankle) measuring 2.4cm Length x 1.5cm Width; an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Right Lateral Calf/Shin measuring 4.3cm Length x 2.8cm Width, with a notation of "wound edges are red and irritated from pressure of left leg pressing on right shin ..."; a new, in-house acquired, Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer to his Right Lateral Malleolus (inner ankle) measuring 2.2cm Length x 1.5cm Width; a new, in-house acquired, Stage III (Full thickness skin loss) pressure ulcer to his Right Great Toe Hallux measuring 1.0cm Length x 1.0cm Width with hyper-granulation due to "irritation from toe rubbing mattress ..." On 07/21/2020 at 2:05 PM, during an interview, with the DON, concerning the systemic failure of the wound care program, she confirmed there were multiple issues with the wound program, such as, incomplete documentation, dressings not getting changed timely, orders not being addressed timely, improper staging of wounds, no one monitoring the turning schedule, and checking for positioning devices since the treatment nurse left. She stated, "The Treatment Nurse left on May 1st, 2020. Body audits were not done ... nothing was done immediately ...She was written up on 01/22/2020 for not changing	M 615		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 42CG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/27/2020
NAME OF PROVIDER OR SUPPLIER CRYSTAL REHABILITATION AND HEALTHCARE CEN1		STREET ADDRESS, CITY, STATE, ZIP CODE 902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 615	Continued From page 66 dressings on wounds, and again on 04/29/2020 ..." The DON confirmed the facility did not have a plan in place to provide over sight after the write ups, to ensure the Treatment Nurse was providing wound care, and that orders were started timely. When the State Agency (SA) asked the DON "Why did you continue to let her work if you knew she wasn't doing her job?" and the DON shrugged her shoulders and stated, "I don't know". On 07/25/2020 at 2:15 PM, during an interview with Resident #1's wife, she stated, "The facility has not been upfront with me concerning my husband's wounds. When I left him the last time in early March, during COVID, he had one small wound on his left hip. It was a little blister. I heard from a staff member I know outside the facility, that his wounds were really bad. I called to get an update on all his wounds and asked for him to get an appointment at a wound clinic. When I went with him to his appointment, I insisted on going into the room with him and saw his wounds myself. I broke down and cried at how large and deep they are. Before COVID, I was there every day because I had noticed some changes in the care. I made sure they changed him and moved him around in the bed. It is heartbreaking to not be allowed in to see my husband, when I know he is in there not being taken care of, and there is nothing I can do about it but pray. He's there because I can't care for him myself. I trusted them to help us and they failed." Resident #2 Review of Resident #2's "Admission Record" revealed, she was admitted to the facility on 11/30/2018 with the primary diagnosis of Nontraumatic Intracerebral Hemorrhage Interventricular, Hypertension, Tracheostomy	M 615		

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M 615	Continued From page 67 Status, and Gastrostomy Status. Review of Resident #2's Minimum Data Set (MDS) dated 03/12/2020, revealed, she was "totally dependent on two + person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed)". She had limited range of motion (ROM) to both of her arms and legs. She was bedridden. Review of Resident #2's "Braden Scale For Predicting Pressure Sore Risk", dated 03/07/2020 revealed, she scored a nine (9), which placed her at "Very High Risk" for pressure sore development. Resident #2 was admitted with a small, Stage IV pressure ulcer to her Sacrum. Since 01/21/2020, Resident #2 has acquired thirteen (13) new pressure ulcers; two Unstageable pressure ulcers, one Stage IV pressure ulcer, eight Stage III pressure ulcers, and two Stage II pressure ulcers. A lack of turning and repositioning, and proper application of pressure reducing devices was observed, as well as interviews with staff confirming dressings were not being changed timely, preventative pressure reducing devices were not consistently used, and an order for Resident #2's enteral tube feeding to be increased, to promote wound healing, was not addressed timely. On 07/15/2020 at 10:40 AM, during initial rounds, Resident #2 was observed in bed lying on her back, legs drawn into the fetal position, resting. On 07/15/2020 at 11:40 AM, Resident #2 was observed in bed, lying on her back, a pillow behind her head, legs drawn up in the fetal	M 615		

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M 615	Continued From page 68 position, and no other positioning devices observed. On 07/15/2020 at 2:15 PM Resident #2 was observed in the bed, on her back, legs drawn into a fetal position, and no other positioning devices observed in the bed. On 07/15/2020 at 3:50 PM, Resident #2 was observed in the bed, on her back, a pillow behind her head, no other positioning devices observed in the bed, resident remains in the fetal position. On 07/16/2020 at 9:05 AM, Resident #2 was observed lying on her back in the bed, pillow behind her head, legs pulled into fetal position, no heel cushions present, no pillows between legs. On 07/16/2020 at 11:45 AM, Resident #2 was observed lying on her back with a pillow under her head, face turned toward the door, no heel cushions or pillow between her legs observed. On 07/16/2020 at 4:20 PM, Resident #2 was observed in the bed, on her back, with a pillow behind her head, face turned toward the door, still in the fetal position with no position devices observed. On 07/17/2020 at 9:15 AM, Resident #2 was observed in her bed, lying on her back, with a pillow behind her head, no positioning devices observed in the bed, and she remains in the fetal position. On 07/17/2020 at 2:05 PM, Resident #2 was observed lying on her back in the bed, pillow behind her head, heel cushions present on both feet, legs drawn into fetal position, and no other positioning devices observed.	M 615		

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M 615	Continued From page 69 On 07/20/2020 at 3:30 PM, the State Agency (SA) surveyor observed wound care for Resident #2, performed by RN #3 without any concerns regarding infection control or technique. Resident #2's wounds were observed to be as follows: Right Trochanter (hip), Stage IV pressure ulcer with muscle exposed in center of wound bed, bleeding; a Stage III pressure ulcer to Resident #2's right Ischium, with full skin loss to wound bed; a Stage III pressure ulcer with full loss of skin on Resident #2's coccyx; an unstageable pressure ulcer to Resident #2's right lateral foot with a small area of slough to the wound bed; a Stage III pressure ulcer with full thickness loss of skin on Resident #2's right fourth toe, between the 4th toe and small toe, with a clean wound bed; an unstageable pressure ulcer to Resident #2's right heel covered in slough; a Stage IV pressure ulcer to Resident #2's Left Shoulder, with a large amount of slough to wound bed and bone exposed in the center; a large Stage II pressure ulcer to Resident #2's Left Trochanter with a clean wound bed. On 07/20/2020 at 11:45 AM, during an interview, with LPN #3, concerning positioning devices/heel cushions, she stated, "It is the nurse's responsibility to check if the pads, pillows, and heel boots is on the resident. The aides put them on 'em, but the nurse checks behind 'em. We gotta do med passes in the morning time and have to do treatments too now, it is hard to do it all." On 07/20/2020 at 3:40 PM, during an interview with RN #3 concerning repositioning devices/heel cushions, and the timeliness of wound care, she stated, "The nurses are responsible for making sure the residents are padded up. I try to make	M 615		

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M 615	Continued From page 70 sure if I do her treatments, that I put her heel cushions and pillows on where they go, but they usually aren't on when I get in here ...She has so many wounds it is hard to keep up with. Most of the time the dressings aren't dated or initialed, and her wounds drain so much, it is hard to tell how old they are. The nurses have to pass medications and do all the treatments too since the treatment nurse left a couple months ago. It has been a challenge for them to keep things done." Review of Resident #2's "Skin & Wound Evaluation V5.0", dated 01/21/2020 revealed, a Stage IV pressure ulcer she was admitted to the facility with, and six (6) new in-house acquired pressure ulcers (five new Stage III pressure ulcers, and one new Stage II pressure ulcer). Review of Resident #2's "Skin & Wound Evaluation V5.0", dated 01/21/2020, revealed a Stage IV (Full thickness skin and tissue loss) pressure ulcer to her Sacrum measuring 2.4cm Length x 2.4cm Width; a new, in-house acquired, unstageable (obscured full thickness skin and tissue loss) pressure ulcer to her Right Trochanter (hip) measuring 2.3cm Length x 3.0cm Width, with moderate serosanguinous (serous/bloody) drainage; a new, in-house acquired, Stage III (full thickness skin loss) pressure ulcer to her Left Shoulder measuring 2.9cm Length x 4.1cm Width; a new, in-house acquired, Stage III (full thickness skin loss) pressure ulcer to her Left Chest measuring 1.5cm Length x 2.4cm Width x 0.1cm depth; a new, in-house acquired, stage III (Full thickness skin loss) pressure ulcer to her Right Lateral Malleolus (outer ankle), measuring 1.0cm Length x 0.8cm Width; a new, in-house acquired, Stage III (full thickness skin loss) pressure ulcer to her right	M 615		

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M 615	Continued From page 71 ear, measuring 2.0cm Length x 1.5cm Width, with moderate serosanguinous drainage; and a new, in-house acquired, Stage II (partial thickness skin loss) pressure ulcer to Left Trochanter (hip) measuring 2.4cm Length x 2.4cm Width. Review of Resident #2's "Skin and Wound Evaluation V5.0", dated 04/14/2020, revealed, the wounds on her Right Trochanter (hip) and Left Trochanter (hip) had doubled in size from the 01/09/2020 measurements. Review of Resident #2's "Skin & Wound Evaluation V5.0", dated 04/14/2020 revealed an Unstageable (Obscured full thickness skin and tissue loss) pressure ulcer to her Right Trochanter (hip) that now measured 6.5cm Length x 3.4cm Width x 1.0cm Depth, with increased drainage; and a Stage II (partial thickness skin loss) pressure ulcer to her Left Trochanter (hip) that now measured 3.6cm Length x 3.9cm Width. Review of Resident #2's "Progress Note" dated 05/28/2020 revealed, "Pt with old bandages on wounds. Aid removed bandages so that nursing could dress wounds. On 05/28/2020 wounds are exposed and uncovered still. Nursing was notified on 05/27/2020 of soiled bandages." On 07/20/2020 at 4:15 PM, during an interview with Occupational Therapist (OT) #1, regarding her documentation on 05/28/2020, in Resident #2's medical record, she stated, "She was on the COVID unit and was part of my rotation. Due to the lack of staff and no treatment nurse, the therapists were trying to help reposition residents when we could, especially the trach residents ...I overheard her (Resident #2's) Certified Nurse Aide (C.N.A.) telling the nurse her dressings had	M 615		

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M 615	Continued From page 72 not been changed on her wounds. I saw the dressings and they were sopping wet with drainage and falling off the wounds. They had not been changed in three (3) days ...The C.N.A. took off the old dressings, and told the nurse they needed cleaned and redressed When I went back the next day to see her, her wounds still had no dressing on them and had drained all over the bedding ..." When asked by the SA if she saw dressings not changed often, she stated, "I would find this fairly often ..." Review of Resident #2's "Progress Note" dated 06-05-2020 revealed, "RN Sup (Supervisor) attempted to call RP x1 to inform of new areas noted to resident ..." Review of Resident #2's "Skin & Wound Evaluation V5.0", dated 06/05/2020 revealed, two new, in-house acquired, pressure areas; a Stage IV (full thickness loss of skin and tissue loss) pressure ulcer to her Right Ear measuring 2.3cm Length x 1.3cm Width; and a new, in-housed acquired, Unstageable (obscured full thickness skin and tissue loss) pressure ulcer to her right heel measuring 4.8cm Length x 4.4cm Width. Review of Resident #2's "Progress Note" dated 06/07/2020 revealed, "C.N.A. notified this nurse of new pressure areas to both heels and left ear during AM care ...wedges applied for positioning ..." There were no assessments present for either heel wound. The DON confirmed, the assessments had been missed. Review of Resident #2's "Order Summary Report" dated 07/16/2020, revealed an order dated 06/11/2020, to be started on 06/12/2020 to "Cleanse right heel Unstageable pressure ulcer on Mon, Wed, Fri ...avoid pressure to area, float	M 615		

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M 615	Continued From page 73 heel boots, use padded dressing to off load pressure." This order was put in place five days after the wound was found on 06/07/2020." Review of Resident #2's "Skin & Wound Evaluation V5.0" dated 07/08/2020 revealed, a significant increase in size to her Stage IV sacral wound now measuring 5.7cm Length x 3.9cm Width, and four new in-house acquired, pressure ulcers; a new, in-house acquired, Unstageable (Obscured full thickness skin and tissue loss) pressure ulcer on her Right Lateral Foot measuring 1.3cm Length x 2.4cm Width; a new, in-house acquired, Stage III (Full thickness loss of skin) pressure ulcer to her Right Ischial Tuberosity (buttock) measuring 1.4cm Length x 0.9cm Width; a new, in-house acquired, Stage III (full thickness skin loss) pressure ulcer to her Right fourth toe, measuring 1.0cm Length x 0.9cm Width; and a new, in-house acquired, Stage II (Partial thickness skin loss) pressure ulcer to her Left Trochanter (hip) measuring 4.8cm Length x 5.2cm Width. There was no assessment of the Stage IV pressure ulcer to Resident #2's Right Ear. The DON confirmed the assessment had been missed. Review of Resident #2's Treatment Administration Record for July 2020, revealed, an order dated 07/13/2020 to "Cleanse R lateral Prox foot stage 2 pressure ulcer on M, W, F with NS or WC ..." The DON confirmed it was another new, in-house acquired, pressure ulcer they had found, and there was no assessment done for it. The SA attempted to reach Resident #2's family/representative multiple times for interview, with no answer or return call. Resident #3	M 615		

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M 615	Continued From page 74 Review of Resident #3's "Admission Record", revealed she was admitted originally on 01/09/2012 with a primary diagnosis of Nontraumatic Intracerebral Hemorrhage, unspecified, Persistent Vegetative State, Epilepsy, Gastrostomy, Contracture of Unspecified Joint. Review of Resident #3's Minimum Data Set (MDS) dated 03/17/2020, revealed, she was "totally dependent on two + person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed)". Resident #3 was not able to reposition herself or turn in the bed unassisted and was bedbound. Review of Resident #3's "Braden Scale For Predicting Pressure Sore Risk", dated 12/24/2019, revealed her score to be a nine which placed her at "Very High Risk" for developing pressure ulcers. Resident #3 was admitted with no pressure ulcers. Since 01/07/2020, Resident #3 has acquired eight new pressure ulcers; four Unstageable pressure ulcers, Stage III pressure ulcers, and two Stage II pressure ulcers. A lack of turning and repositioning, and proper application of pressure reducing devices was observed, as well as interviews with staff confirming preventative pressure reducing devices were not consistently used, and an order for Resident #3's enteral tube feeding to be increased, to promote wound healing, was not addressed timely. On 07/15/2020 at 10:35 AM, during initial facility tour, Resident #3 was observed in the bed, on her back, looking at the window.	M 615		

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M 615	Continued From page 75 On 07/15/2020 at 11:35 AM, Resident #3 was observed in the bed, on her back, looking out the window, legs in fetal position, no positioning devices noted on or around her legs and feet. On 07/15/2020 at 2:15 PM, Resident #3 was observed in the bed, on her back looking out the window, no pillows or positioning devices observed around her legs and feet, legs drawn up into the fetal position. On 07/15/2020 at 3:50 PM, Resident #3 was observed in the bed, on her back, looking out the window, legs drawn up into fetal position, with no pillows or positioning devices observed on or around her legs and feet. On 07/16/2020 at 8:45 AM, Resident #3 observed in bed, lying on her back, looking out the window, legs in fetal position with no observed pillows or positioning devices in place. On 07/16/2020 at 11:30 AM, Resident #3 was observed in the bed, on her back, looking out the window, legs drawn up into fetal position, with no pillows or positioning devices observed on or around her legs and feet. On 07/16/2020 at 4:17 PM, Resident #3 was observed in the bed, on her back, looking out the window, legs drawn up into fetal position, with no positioning devices or pillows in place. On 07/17/2020 at 9:15 AM, Resident #3 was observed in the bed, on her back, looking out the doorway, legs drawn up into fetal position, with a pillow underneath her heels, however, none between her legs, or between her feet and buttocks.	M 615		

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M 615	Continued From page 76 On 07/17/2020 at 2:05 PM, Resident #3 was observed in the bed, on her back, looking out the doorway, legs drawn up into the fetal position, with a pillow beneath her heels, however, no pillow between her legs, or between her feet and buttocks. On 07/16/2020 at 4:50 PM, during a joint interview with the Administrator, and DON regarding concerns with Resident #3's multiple new wounds, lack of dietary intervention, and the foam boots she has ordered not being on her, the Administrator stated, "...there was a changeover of Dieticians in the middle of the COVID crisis, some residents were moved to another room and nurse. They may not have known all the specifics for each resident like they should. The DON had no comment. On 07/17/2020 at 12:00 PM, during an interview with C.N.A. #5, concerning pillows and positioning devices for Resident #3, she stated, "...she is hard to move sometimes 'cause of her contractures, and we don't always have enough pillows or heel boots when she soils them, to put everywhere she needs them ..." On 07/20/2020 at 11:45 AM, during an interview with LPN #3 concerning positioning devices/heel cushions, she stated, "It is the nurse's responsibility to check if the pads, pillows, and heel boots is on the resident. The aides put them on 'em, but the nurse checks behind 'em. We gotta do med passes in the morning time and have to do treatments too now, it is hard to do it all." Review of Resident #3's "Skin & Wound Evaluation V5.0", dated 01/07/2020, revealed an in-house acquired Stage III (full thickness skin	M 615		

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M 615	Continued From page 77 loss) pressure ulcer to her sacrum that measured 2.2cm Length x 1.2cm Width, with Moderate Serosanguinous (serous/bloody) drainage. Review of Resident #3's "Nutrition/Dietary Note" dated 02-18-2020 revealed, "...weight changes: 30day ... (-11.5%), 90 day ... (-23.2%), 180 day ... (-23.9%)" weight loss. "...Current feeding: Jevity 1.5 @ 55cc/hr x 22 hours ...Rec.(recommend) increase feeding to 60cc/hr x 22 hours ..." Resident #3 takes nothing by mouth, she is tube fed for 100% of her nourishment intake. Review of Resident #3's "Nutrition/Dietary Note" dated 03-16-2020 revealed, "Current feeding: Jevity 1.5 @ 55cc/hr x 22 hours ...Weight loss noted. Rec - Increase feeding to 60cc/hr x 22 hours ..." On 07/21/2020 at 12:00 PM, during an interview, with the RD, regarding Resident #3's missed feeding increase from 02/18/2020, the worsening of her sacral wound, and acquiring eight new wounds, she stated, "...I worked remotely and was not in the building ...she had continuous weight loss, and there was no follow-up with the facility for follow through ...I was covering six other facilities and don't remember checking follow through of recommendations ..." Review of Resident #3's "Skin & Wound Evaluation V5.0", dated 03/18/2020, revealed her in-house acquired sacral wound was larger at 2.5cm Length x 1.2cm Width, and 0.3cm Depth, and a new, in-house acquired Stage I to her right heel. Review of Resident #3's "Skin & Wound Evaluation V5.0", dated 04/13/2020, revealed a worsening of her sacral wound now measured at	M 615		

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M 615	Continued From page 78 3.5cm Length x 1.2cm Width x 2.0cm Depth, with the notation of the dressing being missing to the wound. Review of Resident #3's Progress Note dated 05/25/2020, revealed, "Pt showing increase in size to R heel wound ...Therapist provided a new heel protector to R heel. Therapist positioned wedges under BLE so that heels are not touching gluteal region to prevent further breakdown ..." Review of Resident #3's "Skin & Wound Evaluation V5.0", dated 07/08/2020, revealed her sacral wound had progressed to a Stage IV, and more than doubled in size at 8.1cm Length x 8.2cm Width, no recorded Depth, and the addition of eight new, in-house acquired wounds (four Unstageable pressure ulcers, two Stage III pressure ulcers, and two Stage II pressure ulcers); a new, in-house acquired Stage III pressure ulcer to her Left Lateral Malleolus (outer ankle) 4.0cm Length x 2.5cm Width, a new, in-house acquired Stage III pressure ulcer to her Right Lateral Malleolus (outer ankle) 1.6cm Length x 2.0cm Width, a new, in-house acquired Stage II pressure ulcer to her Right fourth toe 1.1cm Length x 0.8cm Width, and a new, in-house acquired Stage II pressure ulcer to her Right Ischial Tuberosity (buttock) 1.1cm Length x 1.1cm Width, a new, in-house acquired unstageable pressure ulcer to her right heel 4.3cm Length x 2.9cm Width, a new, in-house acquired pressure ulcer to her left heel 3.6cm Length x 3.9cm Width, a new, in-house acquired pressure ulcer to her Left Shin 2.6cm Length x 0.9cm Width, and a new, in-house acquired pressure ulcer to her lower Left Shin 6.4cm Length x 1.4cm Width. SA made several attempts to reach Resident #3's	M 615		

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M 615	Continued From page 79 family for interview, with no answer or return call. Resident #4 Review of Resident #4's "Admission Record", revealed, she was admitted to the facility on 09/09/2018 with the primary diagnosis of Unspecified Dementia without Behavioral Disturbance, Alzheimer's, Glaucoma, and Unspecified Protein/Calorie Malnutrition. Review of Resident #4's MDS, dated 06/23/2020, revealed, she required "Total assistance" (full staff performance every time during entire 7-day period) of one person physical assist" for bed mobility. Review of Resident #3's "Braden Scale For Predicting Pressure Sore Risk", dated 06/16/2020, revealed her score to be a six which placed her at "Very High Risk" for developing pressure ulcers. Resident #4 was admitted to the facility without any pressure ulcers. She began to experience weight loss in May 2020, with several dietary recommendations that were not implemented. Failure to properly apply her pressure reducing wedge devices was observed, as well as interviews with staff confirming preventative, pressure reducing wedge devices were not consistently used, and multiple orders for Resident #4 to receive dietary supplements were not addressed timely. On 07/17/2020 at 9:20 AM, Resident #4 was observed laying on her right side, in the bed, heel foam boots on, and a pillow between her knees, no wedge cushion observed. On 07/17/2020 at 2:15 PM, Resident #4 was	M 615		

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M 615	Continued From page 80 observed in bed, on her left side, heel foam boots on, pillow between her knees, no wedge cushion observed. On 07/20/2020 at 10:05 PM, Resident #4 was observed in bed, on her right side, heel foam boots on left visible foot, unable to see right foot, no wedge cushion observed. On 07/20/2020 at 1:15 PM, Resident #4 observed in bed, on her back, heel boots on, no other positioning devices observed. On 07/20/2020 at 2:50 PM, during an interview, with LPN #4, concerning Resident #4's ability to TAP in the bed, and the use of positioning devices, he stated, "She does favor laying on her sides, however, there should be a positioning wedge with her in the bed that helps keep her more on her back, since both her hips have ulcers ...it ain't on there all the time, but I try to position her right before I leave from doing her treatments ..." Review of Resident #4's Nutrition/Dietary Note, dated 05/04/2020, revealed recommendations to start a vitamin with minerals. Review of Resident #4's June 2020 and July 2020 "Medication Administration Records", revealed no order for a Vitamin with Minerals. Review of Resident #4's Nutrition/Dietary Note, dated 05/11/2020, revealed a weight loss of 6%, and a recommendation from the RD to add an HS (hour of sleep) snack. Review of Resident #4's June 2020 and July 2020 "Medication Administration Records" revealed no order for HS snacks.	M 615		

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M 615	Continued From page 81 Review of Resident #4's Nutrition/Dietary Note dated 06/03/2020, revealed a significant weight loss of 7.1% in thirty (30) days, and a significant weight loss of 13.4% in ninety (90) days, with a recommendation to add fortified food to her meal trays daily. Review of Resident #4's Nutrition/Dietary Note dated 06-23-2020, revealed an RD dietary recommendation for an appetite stimulant. Review of Resident #4's June 2020 and July 2020 "Medication Administration Records" revealed no orders for an appetite stimulant. On 07/21/2020 at 12:00 PM, during an interview with the RD regarding Resident #4's multiple missed dietary recommendations, she stated, " ...I worked remotely and was not in the building ...she had continuous weight loss, and there was no follow-up with the facility for follow through ...my last day covering that facility was 05/24/2020, so any recommendations after that, were from the new RD ...I was covering six other facilities and don't remember checking follow through of recommendations ..." Review of Resident #4's "Skin/Wound Note", dated 06/25/2020 revealed two new, in-house acquired pressure ulcers; an unstageable pressure ulcer to her Left Trochanter (hip) 2.1cm Length x 4.5cm Width, with a darkened peri-wound measuring 14.5cm Length x 9.0cm Width, and a Stage II pressure ulcer to her Right Trochanter (hip) 3.5cm Length x 2.0cm Width x <0.2cm Depth, with surrounding tissue red measuring 13.5cm Length x 10.5cm Width. Review of Resident #4's "Skin & Wound	M 615		

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M 615	Continued From page 82 Evaluation V5.0", for the month of July 2020, revealed no assessments or measurements for the Left Trochanter or Right Trochanter wounds due on 07/02/2020, 07/09/2020 and 07/16/2020. Review of Resident #4's "Skin and Wound Evaluation V5.0", dated 07/18/2020, revealed her Unstageable Left Trochanter wound was significantly larger at 7.3cm Length x 6.2cm Width. On 07/21/2020 at 2:05 PM, during an interview, with the DON concerning Resident #4's multiple missed dietary recommendations, multiple missed skin assessments with wound measurements, and the worsening of her wounds, she stated, "the flow of dietary recommendations was broken for a while. The recommendations were to be given to the care plan nurses to review, obtain orders, and place on the care plans. There were several months of recommendations missed because of it. She was moved to the COVID unit too, I guess the wound assessments just didn't get done, and when we did assess them, they was bigger." The SA attempted to reach family for interview multiple times and did not receive a return call. Resident #5 Review of Resident #5's "Record of Admission" revealed, she was admitted to the facility on 04/10/2017, with a primary diagnosis of Urinary Tract Infection (UTI), Hypertension, Type II Diabetes, and Depression. She was later diagnosed with Bilateral above the Knee Amputations (AKA), Peripheral Vascular Disease, Unspecified Protein-Calorie Malnutrition, Congestive Heart Failure (CHF), and Glaucoma.	M 615		

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M 615	Continued From page 83 Review of Resident #5's Closed Medical Record, revealed, an "Admission History and Physical" dated 04/07/2020 at 4:16 PM, which indicated, "Chief Complaint sent from nursing home due to decreased responsiveness since yesterday per Emergency Physician Note ...Physical Exam: ...MSK/Extremities: Bilateral lower extremity amputation. Upper extremity edema noted. Hip edema noted as well. Skin/Heme: Some skin weeping noted ...Backside not examined ..." Review of Resident #5's "General Medical Note ...Inpatient SOAP Note", dated 04/07/2020 at 10:15 PM, revealed, " Called by nursing staff for patient having low blood pressure ...diffuse anasarca ...CXR (Chest X-ray) appears to favor right sided pneumonia ...discussed with family poor prognosis of patient with severe pneumonia and urinary tract infection and possible underlying heart failure ..." Review of Resident #5's "Wound (Consult) - Consultation Note" dated 04/08/2020 at 9:53 AM, revealed, "Reason for Referral - Sacral Ulcer ...Chief Complaint/HPI ...94 year old female with Stage II sacral ulcer. There is significant maceration. Moderate Pain ...Impression and Plan: 94 year old female with Stage II sacral ulcer. There is significant maceration. Apply Xeroform and ABD. Patient is a DNR (Do Not Resuscitate). No surgical intervention is needed at this time ..." Review of Resident #5's "Inpatient Discharge Summary - Discharge Summary", dated 05/06/2020 at 4:11 PM, revealed, "Hospital Course: ...was admitted on 4/7. It seemed she was sent from her nursing home due to decreased responsiveness ...The patient's	M 615		

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M 615	Continued From page 84 condition worsened during the day of 04/08/2020, and the patient subsequently passed away on 04/08/2020 ..." Review of Resident #5's "Death Assessment", dated 04/08/2020 at 3:16 PM, revealed " ...Cause of Death Other: Cardiac Arrest ..." Review of Resident #5's "MDS/Kardex Report" revealed, " ...Dx: ...Acquired Absence of Left Leg Above Knee, Acquired Absence of Right Leg Above Knee, Age-Related Cognitive Decline ...Daily Decision Making - Severely Impaired ...Bed Mobility: Extensive assistance of One person physical assist ...Functional Limitation in Room: Lower Extremity ...Bowel: Always Incontinent, Urinary: Always Incontinent ...Skin and Ulcer Treatment: ...Pressure reducing device for bed ...Nonsurgical dressings ...(pressure reducing device for chair, Turning/Repositioning program, Nutrition or hydration intervention, nor Ulcer care were marked for resident)." Review of Resident #5's Progress Note, dated 04/02/2020 revealed, " ...resident requires total asst. x 1 in bed mobility, toileting, and eating at this time ..." Review of Resident #5's Progress Note, dated 04/06/2020, revealed "RP (proper name) notified of large area to buttock sacral area (unstageable) ..." Review of Resident #5's "Skin & Wound Evaluation V5.0", dated 04/06/2020, revealed, the wound description section, the location section, and the acquired section to all be blank/unanswered. The only item filled out on this assessment was the "Wound Measurements: ...8.3cm Length x 8.9cm Width ..." No other item	M 615			

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M 615	Continued From page 85 on the assessment was filled out. Review of Resident #5's "Treatment Administration Record" for April 2020, revealed, an order for "Cleanse sacral area with wound cleanser, pat dry with 4x4, apply puracol sheet fit to wound bed, cover with 4x4's and optifoam dressing, 3 x wkly and prn soiled/dislodged dressing ..." On 07/20/2020 at 4:15 PM, during an interview, with the DON, concerning a TAP program, incomplete wound assessment, the lack of preventative measures in place, and the Kardex not being updated with preventative measures, for Resident #5, she stated, "...she had a wound back last year, and should have had a TAP schedule in place, because she didn't have no legs ...the assessment from 04/06/2020 was for the wound we found the day before she went out to the hospital, I don't know why it wasn't done right ...the Kardex issue goes back to the care plan nurses not putting things on there like they supposed to again ..." When asked by the SA, if she saw Resident #5's wound prior to her discharge to the hospital and subsequent death, she stated, "Yes, I saw it, and would have described it probably as a big Stage II, with a lot of dark tissue around the open center ...it was probably a four (4) or five (5) cm circle ..." The SA attempted to reach family for interview multiple times and did not receive a return call. The facility submitted an acceptable Removal Plan on 07/25/2020 for the Immediate Jeopardy (IJ) and Substandard Quality of Care. Review of the facility's Removal Plan, revealed, the facility took the following corrective actions to	M 615		

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M 615	Continued From page 86 remove the IJ prior to exit: On 07/20/2020 at 4:30PM, the State Agency informed Nursing Home Administrator (NHA) of the immediate jeopardy with substandard quality of care due to pressure ulcers, care plans, abuse/neglect and pain. NHA was informed that Resident # One (1), Resident # Two (2), Resident # Three (3), Resident # Four (4), Resident # Five (5) affected. Extensive failure was identified in multiple areas of pressure ulcer care: As a result of the facility's extensive noncompliance in multiple areas of pressure ulcer care, Resident # One (1), Resident # Two (2), Resident # Three (3), Resident # Four (4) developed recurrent and/or multiple, avoidable Stage III or Stage IV pressure ulcers for residents reviewed for facility acquired pressure ulcers. The facility did not have adequate procedures in place to provide preventative measures to residents who are at risk for skin breakdown, in order to prevent further skin breakdown. The facility failed to provide appropriate care to residents with pressure ulcers resulted in further skin breakdown, infections, and hospitalizations (1) Quality Assurance Performance Improvement (QAPI) meeting was conducted on 07/20/2020, at 7:00PM, Medical Director, NHA, Director of Nursing (DON), Social Services Director (SSD), Dietary Manager (DM), Minimum Data Set (MDS) nurses and Corporate Nurse Consultant (acting Infection Prevention Officer) present to determine what systems to evaluate that led to deficient practices. Next actions created from QAPI meeting was to complete body audits on total in-house census of all sixty-seven (67) residents to determine the condition of each resident's skin,	M 615		

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M 615	Continued From page 87 comprehensive care plan audit to ensure care plan accurately reflects the care of the resident, new evaluation of each resident by registered dietitian, identify system break in wound care program, and evaluate education needs of staff. On 07/22/2020 at 9:00AM. QAPI meeting was held with Medical Director, NHA, Director of Nursing, Social Services, Dietary Manager, Minimum Data Set nurses and Corporate Nurse Consultant (acting Infection Prevention Officer) present. Meeting agenda items included a review of removal plan, request for recommendations regarding wound care program, and new skin concerns identified. Medical Director recommended locating a provider that employs wound care certified nurse practitioners that could visit center weekly. One new policy change was made related to follow up on dietary recommendations within seventy-two (72) hours instead of seven (7) days. This policy was signed off on by the Medical Director. The facility will now follow up on all dietary recommendations within seventy-two (72) hours as well as update the care plan. The Assistant Director of Nursing (ADON) has assumed responsibility for ensuring that orders are written for dietary recommendations and that the recommendations are updated on the care plan. Assistant Director of Nursing signed in-service regarding new policy of following up on dietary recommendations within seventy-two (72) hours on 07/24/2020. New measure was implemented and signed off on by Medical Director on 07/22/2020 for physician or Nurse practitioner (NP) providing targeted skin assessments for residents with wounds once a month. **The State Agency (SA) validated through document review, observation, and interview, topics covered in the Quality Assurance (QA) mtg	M 615		

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M 615	Continued From page 88 held on 07/20/2020, covering the topics of system deficiencies in the wound care program that led to the Immediate Jeopardy (IJ), complete body audits, care plan review, and dietary recommendation review for all residents, and a secondary QA mtg held on 07/22/2020 to address drafting a removal plan, the results of the body audits, change of the consultant recommendation policy, monthly targeting skin assessments by the Medical Director (MD) or Nurse Practitioner (NP), recruitment of a wound verified NP, abuse and neglect inservices, and competency based post test for inservices. The new policy for consultant recommendations was signed by the MD, and put into effect. The Assistance Director of Nursing (ADON) was inserviced on responsibility of ensuring dietary recommendations are written, orders received, and care plans are updated within 72 hours of receiving them. The MD of NP providing the targeted skin assessments will sign off on them once a month. (2) Body Audits, to include all residents with wounds, was initiated on 07/20/2020 and completed on 07/23/2020 a total in-house census of sixty-seven (67) residents by Minimum Data Set Coordinator -Registered Nurse (RN), Corporate Nurse Specialist, RN, Corporate Certified Wound Care Specialist, RN, sister facility RN, and Medical Records RN. Resident # Six (6), Resident # Seven (7), and Resident # Eight (8) were noted to have new skin issues identified through audit, new orders for treatment were obtained and implemented. Resident # Six (6) has excoriation to sacrum. The facility reported excoriation on Resident # Six (6) to physician on 7/22/20, new treatment order obtained, care plan revised to reflect change in condition and treatment and responsible party notified. On 07/22/2020 Physician gave order to	M 615		

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M 615	Continued From page 89 evaluate appropriateness of cushion on Resident # Six (6) specialized motorized wheelchair that has cushion to relieve pressure. Wheelchair company visited on 07/23/2020 to assess wheelchair and facility approved order for a new cushion on 07/24/2020. Resident has suprapubic catheter and colostomy so cause of excoriation is not pressure but moisture caused by sweating. Resident # Seven (7) was assessed and noted Moisture Associated Skin Dermatitis (MASD) on buttocks. MD was notified and gave order to apply barrier cream after each incontinent episode. Moisture barrier cream order was implemented on 07/22/2020 at 12:08PM by Certified Nursing Assistant (C.N.A). Resident # Seven (7)'s care plan was revised on 07/22/2020 by RN to include every two (2) hour checks by nursing staff to monitor for incontinent care need. **The State Agency (SA) validated through document review, observation, and interview, the facility completed body audits on all 67 residents present in the building between 07/20/2020 and 07/23/2020. Audit sheets were verified, alert residents interviewed on receiving a body audit, the three residents with new areas identified were reviewed by the physician, orders given were verified in the medical records and care plans were verified to have been updated. Responsible Party was notified of change of status of MASD to sacrum, new order and revision to plan of care on 7/22/2020 by Administrator. Resident # Eight (8) was assessed and noted to have two (2) new areas presenting as stage II on left lateral foot and a stage III on left lateral 5th toe on 07/22/2020. The Nurse Practitioner was notified and new order obtained for treatment of stage II on left lateral foot and left lateral 5th toe with xeroform Monday,	M 615		

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M 615	Continued From page 90 Wednesday, Friday. New treatment orders with Xeroform implemented by Licensed Practical Nurse (LPN) under the supervision of an RN on 07/22/2020. Bilateral lower extremity venous and doppler studies were performed on 07/23/2020 per NP orders which resulted in diagnosis of peripheral arterial disease (PAD) and resulting in treatment order change to left lateral 5th toe to paint with betadine which was implemented on 07/24/2020 by LPN under direction of RN; care plan was revised with diagnosis of PAD and change of treatment orders by MDS RN . **The State Agency (SA) validated through document review, and interview, the facility notified Resident #8's Responsible Party concerning his skin areas, treatments were obtained, doppler study was scheduled and completed with a new diagnosis of PAD added to the resident's care plan. The orders were verified as changed to Betadine on 07/24/2020. (3) The following measures for impacted residents were implemented: Resident # One (1) was evaluated by Registered Dietician (RD) on 07/20/2020, and nine (9) new dietary recommendations were given, implemented, and care plan updated. Pain evaluation performed on 07/20/2020 by DON with no changes to pain medication regimen. Nurse Practitioner assessed Resident # One (1) on 07/22/2020 with no new orders given. MD assessed Resident # One (1) on 07/23/2020, and new orders were given for bilateral venous and arterial Doppler studies. Vendor performed doppler on 07/24/2020 and results pending. Sister facility RN reviewed current treatment orders for effectiveness on 07/23/2020 and deemed orders as appropriate due to current treatments are ordered once a day. Resident # One (1) treatment orders have been	M 615		

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M 615	Continued From page 91 implemented. Therapy reviewed current positioning devices for Resident # One (1), and ordered full body wedge, palm guards, and knee separator for Resident # One (1) from supply vendor on 07/23/2020. New orders will be implemented upon delivery of these special-order devices. Resident # Two (2) was evaluated by RD on 07/21/2020 with three (3) new recommendations which were implemented and care planned by Corporate Regional Nurse; responsible party notified during care conference held on 07/25/2020. NP assessed Resident # Two (2) on 07/22/2020 with no new orders given. MD assessed Resident # Two (2) on 07/23/2020 with no new orders given. Treatment review for effectiveness completed on 07/24/2020 by sister facility RN and a new order was given by NP to change frequency of treatment order to once a day. Therapy reviewed current positioning devices and deemed current devices as appropriate for care. Resident # Three (3) was evaluated by RD on 07/20/2020 with two (2) new recommendations that were implemented and added to the care plan by Corporate Regional Nurse. Sister facility RN reviewed current treatment orders on 07/24/2020 to determine effectiveness of treatments and deemed current treatments as effective. Therapy reviewed positioning devices for Resident # Three (3) and ordered a full body wedge and abductor contracture cushion from a supply vendor on 07/23/2020. Resident # Three (3) orders are being followed for devices currently in place. New orders will be implemented upon delivery of special-order devices. Resident # Three's (3) care plan was reviewed and revised by MDS RN on 07/24/2020 to reflect current status and new orders. Responsible party for Resident # Three (3) was notified of assessment findings, care plan revision and new orders on 07/25/2020 by MDS	M 615		

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M 615	Continued From page 92 RN during care conference. Resident # Four (4) was evaluated by RD on 07/20/2020 with one (1) new recommendation given, implemented, and added to care plan by (who). NP assessed Resident # Four (4) on 07/22/2020 with no new orders given. MD assessed Resident # Four (4) on 07/23/2020 with no new orders given. Corporate Wound Consultant reviewed treatments of Resident # Four (4) wounds and made recommendations which were reviewed and ordered by NP on 07/21/2020. Devices reviewed by therapy for Resident # Four (4) and elbow splint, boots, and full body wedge were ordered on 07/23/2020 from supply vendor. Resident # Four's (4) orders are being followed for devices currently in place. New special-order device orders will be implemented upon delivery of devices. Resident # Five (5) was hospitalized on 04/07/2020 and subsequently expired due to cardiac arrest. **The State Agency (SA) validated through document review, observation, and interview, the facility ensured Residents #1 - #4 were all evaluated by the RD, seen by the NP, MD, and had therapy evaluate them all for positioning devices. All orders and recommendations were updated on the care plans, and RP's notified of the changes. Billing statement reviewed for all ordered specialty positioning devices. (4) Audit of comprehensive care plans was completed for a total census of 67 residents in the facility on 07/20/2020 - 07/23/2020 by Corporate Nurse Consultants RNs. There were sixty-seven (67) dietary recommendations added to care plans for forty (52) residents on 07/20/2020 -07/21/2020 by Corporate Nurse Consultants. Dietary recommendations were implemented on care plans by Corporate Nurse	M 615		

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M 615	Continued From page 93 Consultants for a total census of 67 residents. Thirteen (13) care plans were updated related to pain interventions/orders that were previously implemented by not addressed on the comprehensive care plan previously. There were eight (8) resident care plans updated related to positioning devices, and eleven (11) care plans updated related to pressure relieving devices. There were thirteen (12) resident care plans updated related to skin. There were fifteen (15) resident care plans updated related to wound treatments. Sixty-six (66) of sixty-seven (67) resident care plans were updated related to preventative care. There were five (5) resident care plans updated related to at risk for skin impairment. **The State Agency (SA) validated through document review, and interview, that a complete audit was done for all comprehensive care plans, and care plans were updated with dietary recommendations, pain interventions, positioning devices, pressure relieving devices, skin and wound treatments, preventative skin care, and residents noted to be at risk for skin impairment. (5) Census on 07/20/2020 was sixty-eight (68) with one (1) resident in hospital. A total census of 67 residents in facility were evaluated for pain by Director of Nursing on 07/20/2020-07/22/2020. Two (2) residents were assessed as needing additional pain treatment orders. NP ordered Tylenol as needed on 07/20/2020 for Resident # Eight (8) and Resident # Nine (9) to receive prior to wound care and therapy. Resident # Eight's (8) care plan was updated by MDS RN to reflect new pain treatment on 07/23/2020. Resident # Nine's (9) care plan was updated by MDS-RN to reflect new pain treatment on 07/23/2020. The sixty-five (65) remaining residents evaluated by DON did	M 615		

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M 615	Continued From page 94 not complain of pain nor display pain grimaces. Pain evaluations completed on all sixty-five (65) residents reflected that current pain medication regimens were sufficient to meet current needs. **The State Agency (SA) validated through document review, and interview, the facility performed pain evaluations on all 67 residents in house. Two residents pain management was revised with new orders that were care planned. (6) An audit of positioning and pressure redistributing devices (examples: wedges, cushions, heel protectors) for sixty-seven (67) residents in the facility on 07/21/2020 was completed by facility therapy team members (physical and occupational therapy). Residents with positioning and pressure redistributing devices were identified and deemed in working order. The facility has fifty-seven (57) positioning and pressure redistributing devices available in the center on 07/22/2020. The facility has ordered seventy-one (71) positioning and pressure redistributing devices from a vendor to ensure that there is an adequate supply for when devices require laundry services. Sixty-seven resident's charts were reviewed on 7/22/2020 by MDS RNs for device orders, care planning and flow to Kardex. Twenty-one (21) positioning devices and ten (10) pressure relieving devices were added to Kardex. Rehab staff (Rehab director, Physical Therapist, and Occupational Therapist) initiated in-services on 7/22/2020 with direct care staff on device use. This in-service equipped direct care staff with education and skills for proficiency with device use to implement immediately following education. Direct care staff educated by lead restorative aide on how to access and utilize Kardex on 7/22/2020. Twenty-two (22) of twenty-six (26) CNAs were	M 615		

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M 615	Continued From page 95 educated and able to provide return demonstration on accessing Kardex. No staff will be allowed to work in the facility until they have been in-serviced on the use of positioning devices. **The State Agency (SA) validated through document review, observation, and interview, the facility therapy team did a positioning and pressure redistributing device audit on all 67 residents in house. Necessary positioning devices were put in place or ordered. Billing receipt for products orders reviewed. Inservice verified on device use with the direct care staff. (7) The following in-services were done for all nursing staff: Turning, repositioning devices, recognizing stages of skin breakdown, who to report changes in skin to, wound prevention and skin care program, comprehensive care plan, care plan revisions, implementation of care plan and Kardex, new policy ensuring consultant/Registered Dietician recommendations are followed up on within 72 hours and change in condition. Abuse and neglect reporting initiated by NHA. All in-serviced were initiated 7/20/2020 and completed by 07/23/2020 by DON/RN Supervisor/LPN. Sister facility RNs and sister facility Licensed Practical Nurse (LPN) initiated in-services and performed competency check offs with nursing staff on skin care and wound prevention on 07/23/2020. Sister facility RNs initiated in-services with licensed nurses on wound care and check offs for dressing changes on 07/23/2020. No nursing staff will be allowed to work without completion of required in-services. Forty-two (42) of forty-six (46) nursing staff members received in-service. The total breakdown of the forty-two (42) nursing staff educated are: five (5) of five (5) RNs, eleven (11)	M 615		

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M 615	Continued From page 96 LPNs, twenty-six (26) CNAs were provided with education. ADON in-serviced on being responsible for ensuring dietary recommendations are followed up on within seventy-two (72) hours on 07/23/2020. **The State Agency (SA) validated through document review, and interview, the In-services were completed, and sign in sheet reviewed. (8) Inservice with MDS/Care Plan Coordinators on care plan process by Corporate MDS Consultant (RN) on 07/21/2020 at 8:04PM. The following information was reviewed: The comprehensive care plan is an interdisciplinary communication tool composed by MDS/Care Plans RNs. MDS/Care Plans RNs are responsible for updating care plans. Interim DON is monitoring care plan program. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed by member of the interdisciplinary team (Social Services Director, Dietary Manager, C.N.A., Nurse, Activities Director, and MD) and revised periodically as needed, and the services provided or arranged must be consistent with each resident's written plan of care. Use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. The overall care plan should be oriented towards: 1.Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation). 2. Managing risk factors to the extent possible or	M 615		

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M 615	Continued From page 97 indicating the limits of such interventions. 3. Addressing ways to try to preserve and build upon resident strengths. 4. Applying current standards of practice in the care planning process. 5. Evaluating treatment of measurable objectives, timetables and outcomes of care. 6. Respecting the resident's right to decline treatment. 7. Offering alternative treatments, as applicable. 8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. 9. Involving resident, resident's family and other resident representatives as appropriate. 10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs. 11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes. 12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting. **The State Agency (SA) validated through document review, and interview, the In-services were completed, and sign in sheet reviewed. (9) In-service conducted by NHA with interdisciplinary team (Director of Nursing, Social Services Director, MDS/Care Plan Coordinators, Dietary Manager, and Director of Therapy) on care plans, pain, and consultation follow up on 07/21/2020 at 9:30AM. The facility has designated an RN certified in Wound Treatment Strategies to provide wound care with oversight from the interim DON. Inservice with Interim DON on Skin Care and	M 615		

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M 615	Continued From page 98 Wound Care Program by Corporate Wound Specialist on 07/21/2020 at 1:00PM-3:00PM. The following was reviewed: 1. How to print a wound report in PCC and how to determine when new assessments due 2. Frequency of assessments: Braden, skin and wound 3. How to locate and navigate items the skin and wound binder (I-drive) 4. Facility wound and skin treatment protocols with description of products 5. Pressure Injury Staging, MASD, arterial and diabetic wounds 6. Separate treatment orders for each wound, and an order for every intervention 7. Care Plans matching current wounds on report 8. How to monitor PCC for assessments due, overdue or incomplete and the frequency to perform each 9. How to locate, edit and close in-progress wound assessments in PCC 10. Nexion therapeutic support surface (air mattress) algorithm The center has a skin and wound care program. The center had a break in the program. The parts that were not followed were weekly evaluations of wounds to obtain measurements and monitor if wounds were improving, stalling, or worsening. This led to center not changing treatment orders biweekly for stalling or worsening of wounds. (10) Audit of wound care program has been started as of 07/24/2020 and to be continued weekly by DON and Corporate Clinical Specialist-RN for three (3) months for documentation compliance.	M 615		

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M 615	Continued From page 99 (11) Resident Care monitoring audits have begun as of 07/24/2020. Audits are conducted by Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), RNs, LPNs, NHA, Social Services Director, and Activities Director. These individuals will alternate monitoring for all three (3) shifts. The following items are audited: 1. Rounds every two (2) hours to ensure turning and repositioning 2. Rounds every two (2) hours to ensure appropriate use and availability of positioning and pressure relieving devices 3. Rounds every two (2) hours to check dressings present with dates and initialing of three (3) different residents each round. Due to system break with skin and wound care program, the facility also reported an allegation of abuse/ neglect on 07/21/2020 at 11:24AM to the MSDH Complaint Unit. NHA left message on complaint voicemail box. All residents with a BIMS of 12 or higher were interviewed by Social Services Director on 07/22/2020. There were no allegations of abuse or neglect from the interviews. Facility wide in-services on Abuse/Neglect began on 07/20/2020. On 07/23/2020, facility wide in-services were initiated by Human Resources Director to include testing for knowledge-based competency on abuse. Forty-two (42) of sixty-six (66) staff members have completed knowledge-based competency. The center did not report specific staff members to MS Board of Nursing or MS Attorney General's office due to this being a systemic issue with the program and not an individual person issue. No staff will be allowed to work without completing required in-service. **The State Agency (SA) validated through	M 615		

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M 615	Continued From page 100 document review, and interview, the In-services were completed, and sign in sheet reviewed. A copy of the report sent to MSDH (Mississippi State Department of Health) was reviewed as complete. (12) The facility alleges that all actions to remove the Immediate Jeopardy, identified on 07/20/2020, were completed as of 07/25/2020.	M 615		