STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255266	A. BUILDING _____ B. WING _____	C 07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	**100 BURNHAM ROAD BRANDON, MS 39042**

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #18828, MS #18802, MS #18741, MS #18671, and MS #19421 at the facility from 7/25/22 through 7/29/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA did not substantiate MS #18828 for resident's rights, resident not treating with respect/dignity, medications not given per Physician Orders, and abuse. The SA did not substantiate MS #19421 for abuse or MS #18802 for pressure sores, mouth care, hydration, misappropriation, environment, dietary services and physician services. The SA did not substantiate MS #18741 for abuse, but cited F580, F641, F657, F686, and F842 for a pressure wound related to the investigation. The SA substantiated MS #18671 related to Activities of Daily Living (ADL) care and cited F677. The facility held a license for 100 beds, with a census of 76.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		9/16/22

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

Electronically Signed | 08/25/2022

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility	F 580	a. Resident #1 was discharged from the	

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F 580	Continued From page 2 policy review, the facility failed to notify a physician to obtain an order to provide a treatment to a resident admitted with a pressure ulcer for one (1) of two (2) residents reviewed for pressure ulcers. Resident #1 Findings Include: Record review of the facility's "Admission policy", revised 10/17 revealed, " ...Follow-Through 2. The licensed nurse will notify the physician (or medical provider) of pertinent assessment findings and if needed, clarify orders/medications..." Record review of Resident #1's "Face Sheet" revealed the facility admitted him on 2/18/22 with a diagnosis of Encounter for Other Orthopedic Aftercare, and he was discharged from the facility on 3/26/22. Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending treatment orders" and the "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. Record review of Resident #1's "Physician Orders" for the month of February 2022, revealed a Physician Order dated 3/04/22 to "Cleanse stage 2 pressure injury to sacrum with NS (Normal Saline), pat dry, apply hydrogel impregnated gauze and cover with bordered dressing". The interval code was "MTH" to	F 580	facility to his home with Home Health Services on 03/26/2022. b. All residents with wounds have the potential to be affected by this deficient practice. c. On 07/27/2022, an audit was conducted by the facility Treatment Nurse to ensure that all current residents with wounds have Physician orders to treat each wound. The facility Treatment Nurse was in-serviced on 07/28/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses regarding notification of Physician concerning wounds in order to obtain an order to treat. The Treatment Nurse and/or the Director of Nurses will ensure all residents admitted with wounds have accurate orders obtained from the Physician for their wound(s). d. Beginning on 08/18/2022 the Director of Nurses, Registered Nurse Case Manager, and/or Treatment Nurse will assess all new admits. The Director of Nurses will review at least 5 Physician orders per week for 2 weeks, then 3 Physician orders per week for 2 weeks, then 3 Physician orders one time a week for 2 months to ensure all wounds identified on admission have treatment orders. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional	

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F 580	Continued From page 3 indicate treatments on Monday and Thursday. This was the first Physician's Order obtained for a treatment to Resident #1's pressure ulcer to the sacrum, which had been identified upon admission on 2/18/22. Resident #1 was at the facility for 14 days before a Physician's Order was obtained for a treatment to the sacrum. Record review of the electronic Treatment Administration Record (eTAR) for the month of February 2022 revealed there was no documentation that Resident #1 received treatment for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22. Record review of the eTAR for March 2022 revealed there was no documentation that Resident #1 received treatment for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22 until 3/7/22. A record review of Resident #1's Nurses Notes revealed there was no documentation related to notifying the physician or obtaining a Physician's Order for a treatment to the Stage 2 pressure ulcer to the sacrum. On 7/29/22 at 11:00 AM, the State Agency (SA) conducted an interview with the Director of Nursing (DON). She confirmed that the wound care nurse should have gotten a Physician Order for a treatment to the pressure ulcer to the sacrum when the resident was admitted to the facility. She stated that the treatment nurse should not do wound care without a physician's order. On 7/29/22 at 12:06 PM, the SA conducted an	F 580	training and/or disciplinary action will be considered as warranted.	

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F 580	Continued From page 4 interview with RN #1, who is the Wound Care /Treatment Nurse. She confirmed that she should have gotten a Physician's Order on 2/18/22 for Resident #1 because he was admitted to the facility with a pressure ulcer to the sacrum. She confirmed that the eTAR did not have treatments documented for the sacrum wound until 3/7/22. She stated that although it is not documented on the eTAR, she treated the wound from 2/18/22 through 3/4/22 without a Physician Order until one was obtained on 3/4/22. On 7/29/22 at 12:33 PM, the SA conducted an interview with the Administrator. She confirmed that there was not a Physician Order to treat Resident #1's pressure ulcer to the sacrum when he was admitted on 2/18/22. She stated that the nurse should not have treated a wound without a Physician Order and from what she gathered the nurse knew the wound was there but realized a little later that there was no Physician Order.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to accurately code an Admission Minimum Data Sheet (MDS) assessment for one (1) of seven (7) residents sampled. Resident #1 Findings Include: Record review of the facility's policy, "MDS	F 641	a. Resident #1 was discharged to him home with Home Health Services on 03/26/2022. Section M of Resident #1's Admission Minimum Data Set with Assessment Reference Date of 02/24/2022 was corrected on 08/18/2022 by the Director of Nurses and resubmitted to the Centers for	9/16/22

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F 641	Continued From page 5 Process", with a revision date of 12/20, revealed, " ...The RAI (Resident Assessment Instrument) manual is the source document to be used for further MDS coding guidelines, time schedules and requirements ..." Record review of Resident #1's Admission MDS Assessment with an Assessment Reference Date (ARD) of 2/24/22 revealed, "A1900: Admission Date 02/18/2022 ...M0210: Resident has 1+ unhealed PU (Pressure Ulcer/injuries 0. No ..." The MDS assessment indicated that Resident #1 did not have pressure ulcers/injuries when he was admitted to the facility. Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. The Wound Assessment Report indicated that Resident #1 had a pressure ulcer when he was admitted to the facility. On 7/27/22 at 02:16 PM, in an interview with Registered Nurse (RN) #1, she stated Resident #1 was admitted to the facility with a pressure ulcer to the sacrum. On 7/27/22 at 04:30 PM, in an interview with RN #2/MDS nurse, she confirmed the Admission MDS assessment with an ARD of 2/24/22 for Resident #1 was coded incorrectly and that Section M should have reflected the stage 2 pressure ulcer to the sacrum.	F 641	Medicare & Medicaid Services on 08/24/2022. b. All Minimum Data Set Assessments that are not coded accurately have the potential to be affected by this deficient practice. c. All Assessment Nurses completing Minimum Data Sets were in-serviced by the Director of Nurses on 08/17/2022 related to ensuring the Minimum Data Sets are documented accurately, and to use the Resident Assessment Instructions 3.0 User's Manual as a reference guide when completing Minimum Data Sets. Prior to Minimum Data Set submissions to the Centers for Medicare & Medicaid Services, the Minimum Data Sets will be reviewed by the Director of Nurses and by the Registered Nurse Case Manager for accuracy and any errors identified will be corrected. d. Beginning on 08/24/2022 the Director of Nurses will review 5 Minimum Data Set Assessments per week for 2 weeks, then 3 Minimum Data Set Assessments per week for 2 weeks, then 2 Minimum Data Set Assessments per week for 2 months to ensure compliance with accuracy of assessments. Areas of concern will be brought to the Quality Assessment & Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/8/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as	

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F 641	Continued From page 6 On 7/29/22 at 11:00 AM, in an interview with the Director of Nursing (DON). She stated the MDS dated 2/24/22 was coded incorrectly and according to the 2/18/22 Wound Assessment, the pressure ulcer should have been documented on the Admission MDS. She stated that the accuracy of the MDS is very important because it determines payment for the facility. Record review of Resident #1's "Face Sheet" revealed the facility admitted him on 2/18/22 with a diagnosis of Encounter for Other Orthopedic Aftercare, and he was discharged from the facility on 3/26/22.	F 641	warranted.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		9/16/22

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F 657	Continued From page 7 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure the comprehensive care plan was revised for a resident admitted with a Stage 2 pressure ulcer for one (1) of seven (7) sampled residents. Resident #1. Findings include: Record review of the facility's policy, "Care Plan Process", with a revision date of 08/17, revealed, " ... The Comprehensive care plan is an interdisciplinary communication tool ... The care plan is driven not only by identified resident issues and /or conditions but also by a resident's unique characteristics, strengths, and needs ...based on a thorough assessment ..." Record review of Resident #1's "Face Sheet" revealed the facility admitted him on 2/18/22 with a diagnosis of Encounter for Other Orthopedic Aftercare, and he was discharged from the facility on 3/26/22. Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" indicated as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending	F 657	a. Resident #1 was discharged from the facility to his home with Home Health Services on 03/26/2022. b. All residents have the potential to be affected by this deficient practice. c. On 08/24/2022 an audit was conducted by the Treatment Nurse on all Comprehensive Care Plans for current residents admitted with wounds to verify accuracy. The Registered Nurse Case Manager and the Treatment Nurse were in-serviced on 07/29/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses related to revision of Comprehensive Care Plans for residents admitted with wounds. d. Beginning on 08/18/2022 the Director of Nurses and Treatment Nurse will review 5 Resident Care Plans one time per week for 3 weeks, then 3 Resident Care Plans 1 time per week for 2 weeks, then 2 Resident Care Plans 1 time per week for 2 months. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as	

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F 657	Continued From page 8	F 657		

treatment orders" and the "Date electronically signed" was on 2/18/22 by Registered Nurse (RN) #1.

Record review of Resident #1's "Physician Orders" for the month of February 2022, revealed a Physician Order dated 3/4/22 to "Cleanse stage 2 pressure injury to sacrum with NS (Normal Saline), pat dry, apply hydrogel impregnated gauze and cover with bordered dressing". The interval code was "MTH" to indicate treatments on Monday and Thursday. The order was discontinued on 3/26/22 when Resident #1 discharged from the facility.

Record review of Resident #1's "Care Plan" with the "Problem Onset" date of 2/18/22 and the "Problem/Need of "(Proper Name of Resident #1) is at risk for further skin breakdown r/t (related to) age, mobility impairment, incontinence of B/B (Bowel/Bladder); admitted with surgical wound and alterations in skin." The Stage 2 pressure ulcer to the sacrum identified on Resident #1's Admission "Wound Assessment Report" was not included in the "Problem/Need" section of the care plan. The "Goal & Target Date" revealed, "Will promote wound healing through 5/18/22" and "Will promote no further skin breakdown through 5/18/22". The "Approaches" of the care plan did not include the Physician Orders for a treatment related to the Stage 2 pressure ulcer to the sacrum. Review of the clinical record revealed there were no other care plans for Resident #1 related to skin breakdown or wounds.

On 7/27/22 at 4:30 PM, in an interview with Registered Nurse #1 (RN), she confirmed that she and other nurses use the care plan to give

needed. Additional training and/or disciplinary action will be considered as warranted.

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F 657	Continued From page 9 care to the residents. She stated that the care plan specified that Resident #1 is at risk for further skin break down but did not indicate that he had an actual pressure ulcer to the sacrum when he was admitted to the facility. She stated the care plan was incomplete. On 7/27/22 at 4:30 PM, in an interview with RN #2/Care plan nurse, she stated that the care plan is based on the resident's diagnosis. She confirmed that Resident #1's comprehensive care plan should have included the actual problems, goals, and approaches for the pressure wound. Nurses cannot give adequate care if they do not have an accurate care plan because the care plan is a guide for staff to complete the nursing process for the residents. On 7/29/22 at 11:00 AM, in an interview with the Director of Nursing (DON), she confirmed the comprehensive care plan was incomplete for Resident #1. She stated it should include the actual wounds that the resident had upon admission and that it should have been updated. She stated that the care plan is used as a guide to give care to a specific resident. Nurses and CNAs use the care plan, and they technically cannot give adequate care without an accurate care plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		9/16/22

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F 677	Continued From page 10 Based on interviews, record reviews, and facility policy review, the facility failed to provide shower/bath assistance as scheduled to one (1) of three (3) residents reviewed who were dependent on staff for Activities of Daily Living (ADL) Care. Resident #7 A review of the facility's policy titled "Bathing", with a revision date of 10/17, revealed the purpose is to ensure resident comfort and dignity, to cleanse the body and promote skin health, and to observe for skin abnormalities (e.g., breakdown, redness, bruising) ..." On 7/27/22 at 3:35 PM, an observation of Resident #7 (Res #7) revealed the resident lying in bed wearing an off white, blue flowered print, short sleeve shirt. Resident's hair appeared unwashed and oily. On 7/28/22 at 4:04 PM, an observation and interview with Res #7 confirmed the shirt she was wearing (an off white, blue flowered print, short sleeve shirt) was the same shirt she had on the day before. Res #7 stated she had been wearing the shirt for a week because she had not had a bath in a week. The resident further stated her hair had not been washed in a month. Res #7 denied ever refusing to take a bath or receive care. A record review of the facility's "Bath Schedule" revealed Res #7's bath days were Mondays, Wednesdays, and Fridays. A record review of "Completed Care Details" for Res #7 revealed between the dates of 06/29/22 through 7/28/22 the resident received a complete bed bath on 7/18/22. There were no other dates	F 677	a. Resident #7 was assessed on 08/18/2022 by the Director of Nurses for any adverse effects related to how the facility failed to provide shower/bath assistance as scheduled. There were no adverse effects noted. b. All residents have the potential to be affected by this deficient practice. c. On 08/17/2022 an audit was conducted by the Facility Administrator and Director of Nurses to ensure all residents are provided shower/bath assistance according to the facility bath schedule. The certified Nurse's Aide assigned to provide baths/showers was in-serviced on 08/19/2022 regarding the bath schedule by the Facility Administrator and Director of Nurses. The Facility Administrator and Director of Nurses will ensure all residents are provided baths/showers as scheduled. d. Beginning on 08/18/2022 the Facility Administrator and Director of Nurses will observe 5 residents 1 time per week for 3 weeks, then 3 residents 1 time per week for 2 weeks, then 2 residents per week for 1 week to ensure all residents are provided baths/showers as scheduled. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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F 677	Continued From page 11	F 677		

for a complete bed bath or whirlpool bath, in the last 30 days.

On 7/29/22 at 11:00 AM, an interview with the Director of Nursing (DON) confirmed that it is very important for a resident to get their bath. She stated the nurses should be verifying that the Certified Nurse Aides (CNA)s are completing resident baths as scheduled. The DON stated that if a resident refused a bath, it should be reported to the nurse. The DON stated having hair washed should be included in the resident's bath unless the resident or family requests otherwise. The CNAs should let the nurses know if the resident is combative, refuses care, or anything else and that information should be documented.

A record review of the Nurses notes for Res #7 revealed no entries of Res #7 being combative or refusing care.

On 7/29/22 at 12:33 PM, an interview with the Administrator revealed residents have their hair washed when they get their baths. She stated that all activities of daily living are documented in the computer.

A record review of Resident #7 Face sheet revealed that the resident was admitted on 08/26/20 with diagnoses including Overactive Bladder and Major Depressive Disorder.

A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/22, revealed Res #7 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident had no cognitive dysfunction and a review of Section G revealed

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F 677	Continued From page 12 she required the one person to physically assist with bathing.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to obtain a Physician's Order and to document that wound care was provided for one (1) of two (2) residents reviewed for pressure ulcers. Resident #1 Findings Included: Record review of the facility's policy "Admission", revised 10/17, "Follow-Through 1. The licensed nurse will notify the physician (or medical provider) of pertinent assessment findings and if needed clarify orders/medications ..." Record review of the facility's policy, "Dressing Change Policy and Procedure", with a revision date of 08/21, revealed, " ...Steps in the	F 686	a. Resident #1 was discharged from the facility to his home with Home Health Services on 03/26/2022. b. All residents have the potential to be affected by this deficient practice. c. On 07/27/2022 an audit was conducted by the facility Treatment Nurse to ensure that all current residents with wounds have a Physician order to treat, and that treatment of the wound is documented. The facility Treatment Nurse was in-serviced on 07/28/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses regarding notification of Physician regarding	9/16/22

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F 686	Continued From page 13 Procedure ...2. Review topical treatment order ..." Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending treatment orders" and the "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. Record review of Resident #1's "Physician Orders" for the month of February 2022, revealed a Physician Order dated 3/04/22 to "Cleanse stage 2 pressure injury to sacrum with NS (Normal Saline), pat dry, apply hydrogel impregnated gauze and cover with bordered dressing". The interval code was "MTH" to indicate treatments on Monday and Thursday. The Physician's Order for wound care treatment was not received until 14 days after Resident #1 was admitted to the facility. Record review of the electronic Treatment Administration Record (eTAR) for the month of February 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22. Record review of the eTAR for March 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22 until 3/7/22. A record review of the Nurse's Notes for Resident	F 686	wounds in order to obtain an order to treat, and ensuring documentation of wound treatment is completed. d. Beginning on 08/18/2022 the Director of Nurses and Treatment Nurse will perform wound care rounds to ensure all residents with wounds have Physician orders to treat, and that treatment of the wound is documented, 3 times per week for 3 weeks, then 2 times per week fir 2 weeks, then 1 time per week for 2 months. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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F 686	Continued From page 14 #1 revealed there was no wound treatment documentation or physician orders for the Stage 2 pressure wound to the sacrum until 3/4/22. In an interview with the Director of Nursing (DON) on 7/29/22 at 11:00 AM, she confirmed there was no wound care orders received from the physician when Resident #1 was admitted to the facility and the treatment nurse should not do wound care without an order. In an interview with Registered Nurse (RN) #1 on 7/29/22 at 12:06 PM, she confirmed that she is the Treatment Nurse for the facility. She stated that she should have gotten a wound care order from the physician when Resident #1 was admitted on 2/18/22 with the sacrum pressure ulcer. She explained that although she was treating the pressure wound to the sacrum from 2/18/22 through 3/4/22, she did not have a Physician's Order and she was not documenting it on the eTAR. During an interview with the Administrator on 7/29/22 at 12:33 PM, she confirmed that there was not a wound care order for Resident #1 for the pressure ulcer to his sacrum. She also confirmed that if the nurse had completed wound care, she should have documented it on the eTAR. Record review of Resident #1's "Face Sheet" revealed the facility admitted him on 2/18/22 with a diagnosis of Encounter for Other Orthopedic Aftercare, and he was discharged from the facility on 3/26/22.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		9/16/22

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F 842	Continued From page 15	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

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F 842	Continued From page 16 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to maintain an accurate medical record regarding wound care treatment for one (1) of two (2) residents reviewed for wounds. Resident #1 Findings Include: Record review of the facility's policy, "Medical Records", with a revision date of 04/17, revealed, "Policies and Procedures This facility maintains a	F 842	a. Resident #1 was discharged from the facility to his home with Home Health Services on 03/26/2022. b. All residents have the potential to be affected by this deficient practice. c. On 07/27/2022, an audit of medical records for all residents with wounds was conducted by the Treatment Nurse to ensure accuracy of medical records	

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F 842	Continued From page 17 separate resident record on each resident ...that are complete, accurate ..." Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending treatment orders" and the "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. Record review of the electronic Treatment Administration Record (eTAR) for the month of February 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22. Record review of the eTAR for March 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22 until 3/7/22. A record review of the Nurse's Notes revealed there was no documentation for Resident #1 that indicated wound care was provided. On 7/29/22 at 12:06 PM, in an interview with RN #1, she confirmed that the resident was admitted to the facility on 2/18/22 with a stage 2 pressure ulcer to his sacrum. She stated she treated the pressure wound without a physician order and without documenting the treatment on the eTAR. On 07/29/22 at 12:33 PM, in an interview with the	F 842	regarding wound care treatment. The facility Treatment Nurse was in-serviced on 07/28/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses regarding ensuring wound care treatment is being documented accurately in the resident's medical record. d. Beginning on 08/18/2022, the Director of Nurses and Treatment Nurse will perform an audit of medical records for residents with wounds to ensure accuracy 3 times per week for 3 weeks, then 2 times per week for 2 weeks, then 1 time per week for 2 months. Areas of concerns will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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F 842	Continued From page 18 Administrator, she confirmed that if the nurse was treating the pressure ulcer, she should have documented on the eTAR.	F 842		