STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	03/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 02/27/23 to 03/02/23. During the recertification survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies at F644, F655, F656, and F686. The census at the time of survey was 85 and the facility was licensed for 106 beds.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to submit a Change in Status form for a resident with a new	F 644	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We	3/24/23

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

Electronically Signed | 03/13/2023

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F 644	Continued From page 1 diagnosis of anxiety disorder and ensure the Resident was evaluated for a Preadmission Screening and Resident Review (PASARR) Level II for one (1) of two (2) resident reviewed for PASARR. Resident #62. Findings include: Review of the facility policy titled, "Resident Assessment - Coordination with PASARR Program," with a date implemented of 2/1/23, revealed " ... Policy Explanation and Compliance Guidelines: ... b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. ... 2. The Admissions Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. ... Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder ... b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR." Record review of the "Admission Record" revealed Resident #62 had an admission date of 1/24/21. A diagnosis of Anxiety disorder was	F 644	reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. On March 13, 2023, a Change of Condition form was submitted by the Admissions Director for Resident #62 based on the new diagnosis of anxiety. 2. Residents with change of condition in behaviors have the potential to be affected by the failure to submit a Change in Status form. 3. On March 2, 2023, in-servicing of licensed nurses and Social Services Director was initiated by the Staff Development Coordinator (SDC) and Director of Nursing (DON) to notify Admissions Director of a resident who returns to the facility with a change of behavior condition so that a Change in Status form can be submitted. 4. The DON or Admissions Director will monitor resident change of conditions orders upon return to the facility beginning on March 3, 2023, weekly x four weeks, monthly x two months. The monitoring results will be submitted by the DON to the Quality Assurance Performance Improvement Committee beginning on March 23, 2023, for review and recommendations monthly x three months.	

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F 644	Continued From page 2	F 644		

listed on the admission record and dated 5/27/22.

Record review of the medical record revealed there was not a Change in Status Form in the medical record for the diagnosis of Anxiety Disorder for Resident #62.

A telephone interview on 3/1/23 at 12:45 PM, with the Admissions Coordinator, revealed she did not submit a Change in Status Form for the diagnosis of Anxiety Disorder dated 5/27/22, for Resident #62, because Resident #62 did not go out to an inpatient psychiatric facility. She noted she was not aware that a Change in Status Form had to be submitted for a resident for any other reason. She confirmed a Change in Status Form should have been submitted when Resident #62 was diagnosed with Anxiety Disorder on 5/27/22.

An interview on 3/1/23 at 01:35 PM, with the Administrator and the Director of Nursing (DON), revealed that Resident #62 may not be receiving all possible psychiatric assistance due to a Change in Status Form not being submitted for the diagnosis of Anxiety Disorder dated 5/27/22. The Administrator revealed he felt the facility had assessed Resident #62 well and was providing all care needed to meet Resident #62's psychiatric needs, based on the care being provided by the nursing facility's psychiatrist. The Administrator and the DON would not confirm that the Change in Status Form should have been done to allow Resident #62 to be assessed for the possible need of a PASSAR II Evaluation. The Administrator and the DON did confirm that the Change in Status Form should have been completed because it was noted in the federal regulations.

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F 644	Continued From page 3 Record review of the initial Pre-Admission Screening (PAS) dated 2/12/2021 for Resident #62 revealed she did not exhibit any form of behaviors for the first submission for PASARR II evaluation and revealed the PASARR II evaluation was done for the diagnoses of Cyclothymic Disorder and Bipolar Disorder, Unspecified. Record review of the "Summary of Findings Report," from the PASARR Program, with a date of final determination date of 2/22/2021, related to the PAS submitted on 2/12/21 for Resident #62, revealed "... Psychiatric History: The most recent History and Physical (H&P) dated 1/20/2021 and psychiatric evaluation dated 1/26/2021, documents the diagnosis of Bipolar Disorder and Descriptor: Cyclothymic Disorder." Record review of the Nurse Practitioner's (NP) Progress Note dated 5/26/22 revealed "Psychiatric: Obsessive, child-like behaviors becoming more common. Impatience spurs her behaviors..." Record review of Section I of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/29/22 revealed a diagnosis of Anxiety Disorder dated 5/27/22.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655		3/24/23

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F 655	Continued From page 4 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and	F 655	By submitting the enclosed materials, we	

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F 655	Continued From page 5 policy review, the facility failed to develop a Baseline Care Plan within 48 hours of admission for one (1) of 20 residents reviewed. Resident #136 Findings include: Resident #136 Review of facility policy titled, "Baseline Care Plan", dated 3/2022, revealed "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." An interview with Registered Nurse (RN) #1 on 3/1/23 at 1:55 PM, revealed the resident was admitted to the facility on 2/24/23 and she initiated the baseline care plan on 2/27/23 and she confirmed that a baseline care plan was not developed within the required time frame. An interview with the Director of Nursing (DON) on 3/1/23 at 3:28 PM, revealed Resident #136 was admitted to the facility on 2/24/23 and his baseline care plan was not initiated until 2/27/23. She confirmed the baseline care plan was not submitted timely within 48 hours of admission. She stated the baseline care plan should be initiated upon arrival and the staff should add the needed information so that care needs can be known and met by staff. She stated the purpose of the care plan is to inform the staff of the care needed for each resident and the facility failed to provide a baseline care plan within 48 hours of admission which could affect the care that was needed during that time.	F 655	are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. On February 27, 2023, the summary baseline care plan was completed by the Registered Nurse Supervisor for Resident #136. 2. Residents admitted to the facility have the potential to be affected by failing to ensure staff fully complete baseline care plans within 48 hours of admission. 3. On March 2, 2023, in-servicing of licensed nurses was initiated by the Staff Development Coordinator (SDC) and Director of Nursing (DON) to include: Baseline Care Plan Policy and Comprehensive Care Plan Policy and that a Baseline Care Plan shall be updated within 48 hours of admission. 4. The DON or Minimum Data Set (MDS) nurses will monitor baseline care plans to ensure they are completed within 48 hours of admission along with comprehensive care plans of residents have the correct diagnosis listed on March 3, 2023, weekly x four weeks, monthly x two months. The monitoring results will be submitted by the DON to the Quality Assurance Performance Improvement Committee beginning on March 23, 2023, for review and recommendations monthly x three months.	

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F 655	Continued From page 6	F 655		

An interview with the DON on 3/2/23 at 8:30 AM, revealed the process for the baseline care plan is that on admission, the floor nurses open or initiate the care plan and they continue to add to it as needed. She stated the Minimum Data Set (MDS) Coordinator is responsible for the comprehensive care plans, but the floor nurses are responsible for initiating the baseline care plan for staff to follow for the care of each resident and that the floor nurse did not initiate this on admission on 2/24/23 and it was not initiated until 2/27/23.

An interview with the MDS Coordinator on 3/2/23 at 10:30 AM, revealed the floor nurses initiate the baseline care plan on admission for each resident. She stated that a 72-hour team meeting is scheduled with therapy, social services, MDS, dietary, nursing, and the resident and/or the resident's representative and the baseline care plan and the goals are discussed. She confirmed that the care plan is needed to inform the staff of the care needs for each resident.

During an interview on 3/2/23 at 12:15 PM, the Administrator confirmed the facility failed to initiate a baseline care plan timely.

Record review of Baseline Care Plan revealed the resident was admitted on 2/24/23 and the baseline care plan was initiated on 2/27/23.

Record review of in-service on the admission process and required assessments according to admission protocol dated 2/13/23 revealed Licensed Practical Nurse (LPN) #1 attended the in-service.

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F 655	Continued From page 7 Record review of Staff Education Record dated 2/22/23 revealed in-service on Skin Observations was done and LPN #1 attended. Record review of Admission Record revealed Resident #136 was admitted to the facility on 2/24/23. Diagnoses included Atherosclerotic Heart Disease, Type 2 Diabetes Mellitus, Congestive Heart Failure, and Chronic Kidney Disease. Record review of the Minimum Data Set (MDS) dated 3/1/23, Section C revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		3/24/23

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F 656	Continued From page 8 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to develop a Comprehensive Person-Centered Care Plan for a resident with a new diagnosis of Anxiety disorder, for 1 (one) of 20 residents reviewed for care plans. Resident #62 Findings include: Review of the facility policy titled, "Comprehensive Care Plans," with a date implemented of 12/22, revealed "Policy: It is the	F 656	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. On March 1, 2023, comprehensive care plan was updated by Minimum Data Set (MDS) Nurse for Resident #62 to include the diagnosis of anxiety disorder.	

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F 656	Continued From page 9 policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Record review of the Care Plans for Resident #62 revealed she did not have a Comprehensive Person-centered Care Plan in the medical record for the diagnosis of Anxiety Disorder dated 5/27/22. During an interview and record review of the care plans on 3/1/23 at 9:56 AM, with the Assistant Minimum Data Set (MDS) Coordinator revealed there was not a Comprehensive Person-centered care plan developed for Resident #62's diagnosis of Anxiety disorder dated 5/27/22. She was not able to locate a care plan to address the new diagnosis of Anxiety disorder in the electronic health system, and noted her psychiatric care plan was last updated on 7/26/22 and did not include the diagnosis of Anxiety disorder. A record review of the care plans for Resident #62 and interview on 3/1/23 at 10:00 AM, with the MDS Coordinator, revealed there was not a Comprehensive Person-centered care plan for the diagnosis of Anxiety disorder in the electronic health record and that the care plan had not been developed for Resident #62's diagnosis of anxiety disorder dated 5/27/22. She noted that a Comprehensive Person-centered care plan should have been developed for the new psychiatric diagnosis for Resident #62. An interview on 3/1/23 at 01:35 PM, with the	F 656	2. Residents with comprehensive care plans have the potential to be affected by failure to develop comprehensive person-centered care plans. 3. On March 2, 2023, in-servicing of licensed nurses was initiated by the Staff Development Coordinator (SDC) and Director of Nursing (DON) to include: Baseline Care Plan Policy and Comprehensive Care Plan Policy and that a Baseline Care Plan shall be updated within 48 hours of admission. 4. The DON or Minimum Data Set (MDS) nurses will monitor baseline care plans to ensure they are completed within 48 hours of admission along with comprehensive care plans of residents have the correct diagnosis listed on March 3, 2023, weekly x four weeks, monthly x two months. The monitoring results will be submitted by the DON to the Quality Assurance Performance Improvement Committee beginning on March 23, 2023, for review and recommendations monthly x three months.	

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F 656	Continued From page 10 Administrator and the Director of Nursing (DON), confirmed there was a likelihood that Resident #62 was not receiving all possible psychiatric assistance due to the Comprehensive Person-centered care plan not being developed for the diagnosis of Anxiety Disorder. Confirmed that the care plan should have been completed for the diagnosis of Anxiety Disorder. The DON confirmed that the Comprehensive Person-centered care plan should have been developed for Resident #62's diagnosis of Anxiety disorder to ensure all staff would be aware of all diagnoses and care Resident #62 should receive. She did not confirm there may be a likelihood that care for the Anxiety Disorder could not be provided by the staff, due to the care plan not being developed. The DON confirmed each resident care plans should include all care provided to each individual resident. Record review of the Admission Record revealed Resident #62 was admitted on 1/24/21. The current diagnoses list included a diagnosis of Anxiety disorder dated 5/27/22. Record review of Section I of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 6/29/22 revealed a diagnosis of Anxiety disorder.	F 656		
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	F 686		3/24/23

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F 686	Continued From page 11 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 observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide the necessary assessment and treatment to promote the healing of a pressure ulcer for one (1) of three (3) residents reviewed for pressure ulcers. Resident # 136. Findings include: Review of facility policy titled, "Pressure Injury Prevention and Management" dated 3/2022, revealed, "This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries." Policy also revealed, "...3. Assessment of Pressure Injury Risk will be completed by a licensed nurse. 4. Interventions for Prevention and to Promote Healing: a. After completing an assessment/evaluation, a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions shall be introduced. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. c. Interventions for	F 686	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. On February 27, 2023, a skin assessment was completed for Resident #136 by the Wound Care Nurse. 2. Residents with skin issues have the potential to be affected by the failure to obtain a skin assessment upon admission 3. On March 2, 2023, in-servicing of licensed nurses was initiated by the Staff Development Coordinator (SDC) and Director of Nursing (DON) to complete a resident skin assessment upon admission to the facility and direct any skin issues noted to the Wound Care Nurse or Nurse Practitioner. 4. The DON or Wound Care Nurse will monitor newly admitted residents skin assessments for any noted skin issues on March 3, 2023, weekly x four weeks,	

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F 686	Continued From page 12 prevention will be implemented for residents who are assessed at risk or who have a pressure injury present. d. Treatments in accordance with current standards of practice will be provided for all resident who have a pressure injury present." An interview on 2/27/23 at 12:10 PM, with Resident #136 revealed he had sores on his bottom that have healed then recurred multiple times over the past several years. He stated he had no pain from these areas and no dressings to his bottom were needed at this time. An interview with the Director of Nursing (DON) on 2/28/23 at 12:30 PM, revealed the resident had pressure ulcers on his buttocks that were present on admission on 2/24/23, and he received care to these areas. She stated the resident had been a resident in the facility in the past and he also had these wounds during that previous admission. An interview and observation with the Treatment Nurse of the wound care on 2/28/23 at 3:00 PM, revealed Resident #136 was receiving wound care for two stage two pressure ulcers, one on his left buttock and one on his right buttock. The Treatment Nurse stated the resident had an order for dressing changes daily and the wounds have improved. An interview on 3/1/23 at 1:40 PM, with the Treatment Nurse revealed she works Monday - Thursday on the day shift and if a resident is admitted during the time that a Treatment Nurse is not in the facility, the admitting Licensed Practical Nurse (LPN) will do an "informal skin assessment and look over the resident" and will notify the treatment nurse of any findings. She	F 686	monthly x two months. The monitoring results will be submitted by the DON to the Quality Assurance Performance Improvement Committee beginning on March 23, 2023, for review and recommendations monthly x three months.	

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stated the LPNs do not diagnose or stage any area of concern, but they note what they saw and notify her of the findings, and she will contact the nurse practitioner and get orders. The Treatment Nurse stated she was notified of Resident #136's admission skin concerns and notified the Nurse Practitioner (NP). She stated when she came in on Monday, 2/27/23, she did the full skin assessment and documented the findings on the wound assessment form.

An interview with Registered Nurse (RN) #1 Supervisor on 3/1/23 at 1:55 PM, revealed the facility has guidelines with timeframe's to follow for new admissions and the skin assessment should be done within 24 hours of admission. She stated the LPNs do a basic head to toe to check for bruising, edema, redness, or other concerns on admissions and notify the Treatment Nurse of the findings. She stated the LPN could communicate to the Treatment Nurse by the secure conversation site where messages can be sent from one staff member to another. She stated there is also a wound care communication book where concerns are documented to be used by the Treatment Nurse so she can follow up on concerns. There were no notations for this resident in the communication book (through record review as well as through interview as RN Supervisor was looking for an entry). She stated that since information on Resident #136 was not in the communication book, the communication must have been through the secure message system, but she did not have access to the messages sent between other staff members.

A phone interview with LPN #1 on 3/1/23 at 2:10 PM, revealed she completed the admission when Resident #136 came in on Friday evening. She

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stated that typically when a new resident is admitted, she does a head-to-toe check and documents the findings, and she will notify the DON and the wound nurse and get orders if concerns are noted. She cannot remember the situation with this resident's skin assessment, but stated she was on her way into work at 3:00 PM, so she will look at her notes and we will continue the interview then.

An interview with the DON on 3/1/23 at 3:00 PM, revealed the RN's and LPNs are trained on assessments of residents, including skin, and on a resident's admission, the LPN is to perform a head-to-toe assessment and contact the Treatment Nurse for any concerns. She stated the LPNs do not stage or diagnosis, but they are responsible to do a thorough assessment and report their findings and the RNs are responsible to perform the full skin and wound assessment including measurements. The facility schedules RNs on Monday through Friday from 7:00 AM until 3:00 PM, and on Saturday and Sunday from 7:00 AM until 7:00 PM. The DON revealed the admitting LPN (LPN #1) on the evening shift on Friday 2/24/23, should have completed a thorough head to toe assessment and contacted the Treatment Nurse and reported her findings, but according to the documentation, the wound assessment was not done on this resident until Monday, 2/27/23. She stated LPN #1 should have assessed and reported findings to the Treatment Nurse and orders should have been given and implemented. Then, when the RN came in on Saturday, the full wound and skin evaluation with pictures and measurements should have been done. She stated the resident had these wounds during a past admission at the facility. She revealed that without admission

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documentation, it is difficult to know for certain if wounds improved or deteriorated or remained unchanged from Friday until Monday. She confirmed that on admission, the resident was not assessed properly, and the Treatment Nurse and the Nurse Practitioner were not notified of skin concerns, therefore, treatments to promote healing were not ordered and implemented timely.

An interview with LPN #1 on 3/1/23 at 3:25 PM, revealed she worked Friday (2/24/23) evening shift when Resident #136 was admitted. She stated when the resident came in, she did a brief skin assessment, but did not check his back side. She stated, "I was busy taking care of residents and passing medications and I just didn't look." She confirmed she had been in-serviced and she knew she should have completed a thorough assessment and contacted the Treatment Nurse with her findings. She stated she only observed the areas to his left forearm and to his toes, and she did not observe his bottom area. She revealed she did not contact the Treatment Nurse to notify her of the findings.

During an interview on 3/1/23 at 3:28 PM, the DON confirmed the facility failed to provide a timely assessment and treatment to a resident with a pressure wound, so therefore, wound healing was not promoted. She confirmed she felt that the residents received good care at the facility, but that the lack of an assessment and treatment for this resident "does not meet the standards of care that we want for our residents." She stated that working in a nursing home is a busy job, but the staffing at the facility is more than sufficient, and the staff know they can call for assistance if needed.

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An observation of wound care and wound measurements and interview with the Treatment Nurse on 3/2/23 at 9:00 AM, revealed the automated camera system for wound measurements system was not working, so the measurements were done manually. The wound to the left buttock measured 0.5 centimeters (cm) by (x) 0.2 cm x 0.5 cm. The wound to the right buttock measured 1.0 cm x 1.5 cm x 0.5 cm. There was no drainage noted.

An interview with LPN #3 on 3/2/23 at 10:00 AM, revealed she worked Friday 2/24/23 and saw Resident #136 briefly when he arrived. She stated LPN #1 was to do the admission and the assessment for the resident and she is not sure why it was not completed, but when she worked on Monday 2/27/23, she realized the admission assessment task was not completed. She stated since she did see the resident briefly on arrival to facility, she was able to complete part of the information on the form, but since she had not done a skin assessment, she was unable to document a direct observation. She stated that since she did not do the skin assessment on admission, and LPN #1 was to do this, she was unaware of any skin concerns, therefore she did not notify the Treatment Nurse. She stated the standard procedure is for the admission LPN to perform the assessment on admission and to notify the Treatment Nurse for skin concerns and to document findings on the admission assessment form and the LPN that admitted Resident #136 failed to do this.

A phone interview with the Nurse Practitioner (NP) on 3/2/23 at 10:45 AM, revealed she was not notified of Resident #136's skin concerns

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when he was admitted on Friday or through the weekend. She stated when she saw him on Monday, she did a physical exam and at that time she found the areas to his buttocks. She stated two areas were noted, and since she had taken care of him last year in August, she was aware he had these at that time also. She stated the areas were like dry skin patches, but since slightly open, she staged them as stage 2. She stated that prior to a resident being admitted to the facility, the hospital sends her the resident's record and the medication list and when she received these from the hospital there was no indication of a skin concern to his bottom and there was also no wound care ordered. She stated since she was not notified by staff of a skin concern and it was not in the preadmission record from the hospital, she had no way of knowing there was an issue. She stated on Monday when she did Resident #136's assessment, she noted the areas and ordered the treatment to be done.

An interview with the Treatment Nurse on 3/2/23 at 11:30 AM, to clarify her earlier statement. She stated LPN #1 did not notify her of any skin concerns to Resident #136. She was also not notified throughout the weekend. She stated she did the skin assessment on Monday and the treatments were started. She stated that with her earlier statement, she meant to say that normally she would be notified by the LPN on any skin concerns and the NP would be notified and orders for treatment would be given, but this did not occur.

An interview with the Administrator on 3/2/23 at 12:15 PM, revealed the facility's policies were not followed. The Administrator confirmed the facility failed to promote the healing of a pressure wound

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by not timely assessing and treating a resident with pressure wounds, and this is not the standard of care they want for their residents.

Record review of Physician's Orders revealed an order dated 2/27/23, to cleanse Stage 2 to left buttock with wound cleanser, pat dry with 4x4 gauze and apply small amount of Medi-honey to wound bed and cover with foam dressing every day for treatment.

Record review of Physician's Orders revealed an order dated 2/27/23, to cleanse Stage 2 to right buttock with wound cleanser, pat dry with 4x4 gauze and apply small amount of Medi-honey to wound bed and cover with foam dressing every day for treatment.

Record review of the Electronic Treatment Administration Record for February 2023 revealed wound care to stage 2 pressure ulcers to left and right buttock was done on 2/28/23. There were no other dates of wound care done during February 2022.

Record review of Nursing Admission Screening/History form for Resident #136 revealed he was admitted to the facility on 2/24/23. There is no documentation date and time of completion of this form, but the interview with LPN #3 revealed she completed this on 2/27/23.

Record review of Nurse Practitioner's History and Physical dated 2/27/23 for Resident #136 revealed two pressure wounds, one on right buttock stage 2 and one on left buttock stage 2, both with the date identified of 2/27/23.

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Record review of hospitalization discharge summary record from 2/21/23 until 2/24/23, revealed the resident with a Decubital Ulcer status: Acute.

Record review of Resident #136's Progress Note by LPN #1 dated 2/24/23 at 18:15 (6:15 PM), Type: Admission Summary revealed no documented skin assessment was completed.

Record review of the Wound Evaluation dated 2/27/23 revealed a Stage 2 Pressure Ulcer to left buttock measuring length of 3.23 cm and width of 2.19 cm; and a Stage 2 Pressure Ulcer to right buttock measuring length of 0.86 cm and width of 0.46 cm.

Record review of in-service on the admission process and required assessments according to admission protocol dated 2/13/23 revealed LPN #1 attended the in-service.

Record review of Staff Education Record dated 2/22/23 revealed in-service on Skin Observations was done and LPN #1 attended.

Record review of the Admission Record revealed Resident #136 was admitted to the facility on 2/24/23. Diagnoses included Fluid Overload, Atherosclerotic Heart Disease, Type 2 Diabetes Mellitus, Hypertension, Congestive Heart Failure, and Chronic Kidney Disease.

Record review of the Brief Interview for Mental Status (BIMS) score dated 3/1/23 revealed a BIMS of 13, which indicated the resident was cognitively intact. The Admission Five Day Minimum Data Set has not been completed but is due 3/3/23.

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