STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	73UH	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION CO HEALTH AND REHAB CENTER, INC	1111 BRATTON ROAD NEW ALBANY, MS 38652

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI MS #22155, CI MS #22051, and CI MS #21990) at the facility from 08/08/23 through 08/09/23. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements for CI MS #21990 and deficiencies were cited at M735. The SA determined that the facility was in compliance related to CI MS #22155 and CI MS #22051 related to facility staffing and resident safety. The census at the time of the survey was 51 and the facility was licensed for 60 beds.	M 000		
M 735 SS=D	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all	M 735		9/7/23

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M 735	Continued From page 1 disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to maintain accurately documented medical records on pressure ulcers for one (1) of five (5) residents reviewed. Resident #1.	M 735	M735 @ On August 10, 2023, the charge nurse (Registered Nurse, RN) assessed Resident #1s' left and right heel to compare the current documentation of the wound stage, fliud filled blisters, to actual	

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M 735	Continued From page 2 Findings Include: Record review of facility policy titled "Charting and Documentation" with revision date of July 2017 under "Policy Interpretation and Implementation" was documented, " ... .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." Record review of Resident #1's "Wound Assessment Report" for her left heel and right heel with "Date of Assessment" and "Date wound identified" documented as 05/22/23. Record review of "Wound Assessment Report" dated for 05/22/23 and for 06/13/22 also revealed under "Wound Type" as a Fluid filled blister with bruising. Record review of Resident #1's "Wound Assessment Report" for left heel and right heel with "Date of Assessment" and "Date wound identified" documented as 06/20/23. Record review also revealed under "Wound Type" as Pressure Ulcer, Unstageable due to suspected deep tissue injury. Record review of Resident #1's "Matrix for Providers", provided to this State Agency (SA) on 08/08/23 revealed under "Pressure Ulcer(s) that Resident #1 had a Pressure Ulcer that was Present on Admission (POA) from the hospital on 06/20/23. On 08/09/23 at 9:00 AM, an interview with Registered Nurse (RN) #1, who was also the charge nurse, confirmed that the fluid filled blisters were on Resident #1's bilateral heels when she left for the hospital. She also revealed that they had been providing wound care to these	M 735	current wound condition and found that the wounds should be staged to deep tissue injury and correct documentation to reflect that the wounds were facility acquired. On August 10, 2023, the Charge Nurse,RN, then notified residents' Physician of the change in wound status. On August 10, 2023, the Resident's representative was notified by the Charge Nurse, RN, via phone, of the change in Resident's wound status. Resident's medical record, Minimum Date Set (MDS) was changed by MDS,RN, to reflect current wound assessment/status and that wounds were facility acquired. (Attachment #1) @ Any resident of this facility having a wound could be affected by this deficient practice. @ Director of Nurses (DON) and Staff Development Nurse conducted on 8/10/2023 an in-service to the Wound Care Nurse,RN, Charge Nurse, RN, and the Treatment Nurse on the facility pressure injury assessment and documentation policies and procedures. (Attachment #2) On 8/10/2023, all residents with wounds were reviewed by the Wound Care Specialist (WSC), contracted by the facility, and the DON to ensure accurate descriptions, wound staging, and documentation of where the wounds were acquired, and is reflected in the medical records. The WSC will audit/examine the residents wounds and documentation, weekly on Monday or Tuesday for four weeks with the Treatment Nurse and the DON for	

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M 735	Continued From page 3 areas prior to her leaving the facility. She also stated, "It is my understanding if someone had a fluid filled blister with bruising and you couldn't see anything underneath, it should have been staged as a suspected deep tissue injury to start with." RN #1 confirmed that Resident #1's fluid filled blisters had not opened and they had not been staged prior to leaving for the hospital. On 08/09/23 at 10:30 AM, an interview Registered Nurse (RN) #2, who was the Wound Care Supervisor, confirmed that the wounds were documented as "Present on Admission" from the hospital because they had worsened while resident was there in the hospital and not in the facility. On 08/09/23 at 3:00 PM, an interview with Director of Nursing (DON), revealed that Resident #1 was being treated for fluid filled blisters on her bilateral heels. She revealed that RN #2, Wound Care Supervisor, typically staged the wounds and she (DON) went by what she said because RN #2 had the training. DON revealed that resident had been sent out to the hospital earlier in the day for other issues besides the wound and that there was no documentation noted where the wounds had been assessed on this date prior to departure to the hospital. DON revealed that the blisters opened while in the hospital and when resident came back, the wounds looked a lot worse. DON confirmed that she knew about the blisters but was not aware of the bruising. She confirmed that this resident had these wounds prior to this hospital stay and confirmed that this should not have been documented to look like they were hospital acquired and that they did not accurately document this information on the medical record. On 08/10/23 at 4:00 PM, an interview with	M 735	accurancy and provide focused instruction and demonstration instructions on wound assessments and documentation commencing on August 14, 2023 and ending on September 5, 2023. On 8/10/2023, as a result of the audit of the wounds and documentation, an additional change in wound documentation was effected on another resident. The Physician and Resident's Representative was notified via phone of the change in documentation of the wound status. Audit and corrections presented to the QA Committee.(Attachment #3) The WSC and DON will provide the results of the wound assessments focused audit to the Quality Assurance Nurse (QA) on each Thursday morning commencing on August 17, 2023 and end on September 7, 2023 by the DON. Then the Charge Nurse, RN, will monitor wounds and documentation weekly until November 17, 2023, the DON will review and monitor wound care and documentation every other week beginning September the 11th and ending on November 17, 2023. The facilities' wound care specialist will then review and monitor wound care and documentation at least once a month after the focus monitoring period (September 7th, 2023). Results of all monitoring by Charge Nurse, DON, and Contracted Wound Specialist will be provided to the QA nurse on or before Thursday morining prior to the facility QA meeting. The QA nurse will present the results of audits at the beginning of each QA meeting. (Attachemnt # 4) @ Results of the audits, monitoring and	

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M 735	Continued From page 4 Administrator (ADM), confirmed that they had messed up, that there was a problem with accuracy of the wound documentation. He revealed that they had staff in place who were trained in these areas, and he would make sure they fixed it. Record review of Resident #1's "Face Sheet" revealed that resident was admitted on 12/21/18 and readmitted on 03/29/21 with the following diagnoses to include: Pneumonia, Hypertensive Heart Disease without heart failure, Type 2 Diabetes Mellitus, Alzheimer's Disease, Pain, Age-related physical debility, Pressure-induced Deep Tissue Damage of Right Heel, and Pressure-induced deep tissue Damage of Left Heel. Record review of Resident #1's Electronic Medical Records (EMR) documented that her most recent readmit date was 06/20/23 and documentation reflected that bilateral heels were Pressure-induced Deep Tissue Damage. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date of 06/26/2023 documented under Section C that resident had Brief Interview for Mental Status (BIMS) Score of 99 which indicated that resident was unable to participate in the interview.	M 735	training will be reviewed and examnined by the QA Committee every Thursday afternoon at the focused QA meeting, until the 17th of November 2023 attended by Administrator, DON, QA Nurse, Admission's Nurse, Treatment Nurse, Charge Nurse, Medical Record's Nurse, MDS Nurse, Infection Control Nurse, designated Certified Nursing Assestant, Social Director, and Physician when available. After 17 November 2023 the QA committee will review wound care and wound care documentaion as part of facilities ongoing QA efforts. Recommendations for alteration/changes will be discussed and implemented when justified. The focused QA meetings for the accurate wound assessments and documentation will commence on August 10, 2023 and end on November 17, 2023. (Attachment #5) At the end of this period, the facility will return to our monthly examination of these areas by our QA committee.	