STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255312	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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F 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 requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F842 for CI MS #21990 for failure to maintain accurate medical records. There were no deficiencies cited for CI MS #22155 and CI MS #22051 related to facility staffing and resident safety. The census at the time of the survey was 51 with a bed capacity of 60 beds.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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	F 842		9/7/23

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

Electronically Signed | 08/23/2023

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F 842	Continued From page 1	F 842		

§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 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

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F 842	Continued From page 2 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 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. 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.	F 842	F842 @ 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 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	

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F 842	Continued From page 3 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 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	F 842	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 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	

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F 842	Continued From page 4 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 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	F 842	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 morning prior to 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 training will be reviewed and examnined by the QA Committee every Thursday afternoon at the focused QA meeting thru 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. 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.	

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F 842	Continued From page 5 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.	F 842		