STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035282	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTE OF SURPRISE	**14775 WEST YORKSHIRE DRIVE SURPRISE, AZ 85374**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and review of policy and procedures, the facility failed to ensure that the care plan for resident #2 was revised after developing pressure ulcers. The deficient practice could result in unsafe and ineffective care for residents with pressure injuries. Findings include: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A clinical record review revealed an admission skin check dated April 6, 2020 indicated the resident had moisture associated skin damage (MASD) to coccyx, sacrum, and bilateral buttocks, moist redness to peri area, and redness to bilateral heels with no open areas. A care plan was initiated on April 6, 2020 with a focus on skin integrity. The goals for this care plan included having improved skin integrity using preventive skin treatments. Interventions for this goal included administer treatment to wound/skin impairment per physician's orders [REDACTED]. The clinical record had physician orders [REDACTED]. This care included washing with soap and water, pat dry, and application of a thin layer of Z guard paste to the effected area. No pressure ulcers were identified in the clinical record. The care plan did not address interventions for repositioning, monitoring for increased moisture to the skin, or elevating of heels. Another order written by a provider on April 10, 2020 was to cleanse buttocks with wound cleanser, pat dry, apply Z guard and cover with [MEDICATION NAME] on the night shift every 3 days for stage 2 pressure sores. An admission minimum data set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 07 which indicated severe cognitive impact. The resident's functional status indicated she needed extensive assistance one to two person assistance for bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene. The resident had an indwelling urinary catheter. Toileting hygiene required substantial assistance (meaning the helper does more than half of the effort). The functional limitation in range of motion to the lower extremity was due to impairment on one side. This required the resident to use a walker and wheelchair. The resident required substantial assistance in rolling left to right while in bed and to move from a lying to sitting position. Resident #2 had two Stage 2 pressure ulcers on admission with a skin and ulcer treatments. Also, the resident had other skin problems that included surgical wound(s), skin tear(s), and moisture associated skin damage (MASD). A clinical record review revealed an admission skin check dated April 13, 2020 indicated the resident had two open areas to the coccyx, shearing, and that the left heels skin was slow to blanch (blanching can indicate decreased blood flow to an area exposed to prolonged pressure). There is no documentation that the care plan has been updated with the change in the resident's skin. On May 1, 2020 there were two provider orders written. The first order instructed the staff to wash with soap and water to the MASD, to coccyx, buttocks, pat dry and apply thin layer of Z guard paste every day and night shift for wound care. The second order stated cleanse buttocks with wound cleanser, pat dry, apply Z guard and cover with [MEDICATION NAME] every night shift every 3 days for stage 2 pressure sores. The care plan did not reflect these changes for the care of the skin integrity for the resident. An interview was conducted with a Licensed Practical Nurse (LPN/staff #210) on June 10, 2020 at 10:40 a.m. She stated that the a generic skin care plan is started on admission. This care plan has goals and interventions added based on wound and skin assessments throughout the residents admission. She stated that any of the clinical staff can update the care plan. An interview was conducted with a Certified Nursing Assistant (CNA/staff #214) on June 10, 2020 at 2:15 p.m. She stated that sometimes she does not get information on how to care for the residents. She stated that the CNAs do not get report most of the time and there is no way for her to access the care plan for the resident. An interview was conducted with a Registered Nurse (RN/staff #216) on June 10, 2020 at 4:02 p.m. She stated that prior to COVID-19, the admission nurse/charge nurse on the floors initiate the care plans. She stated that now, the MDS coordinator now enters the starting care plan based on the initial assessment information. An interview was conducted with the Director of Nursing (staff #61) on June 12, 2020 at 8:45 a.m. She stated that care plans are developed by the charge/admission nurse and the MDS coordinator. She stated the care plan for this resident included measures to decrease the risk for developing pressure ulcers. She stated this included the resident being repositioned frequently. A clinical record review of the care plan revealed there was no interventions for resident #2 to decrease the risk for pressure injuries (i.e. repositioning, speciality bed/mattress, off loading). An interview was conducted with the MDS coordinator/LPN (staff #77) on June 12, 2020 at 12:04 p.m. She stated the care plan is generated from the assessment provided by the admission nurse and information from other staff assessments. She stated that wound/skin assessments are verified by the wound nurse. She stated the skin care plan is generic but can be changed to meet the needs of the resident that has a pressure injury or a change in condition. A facility policy titled Care Plans, Comprehensive Person-Centered revealed that a comprehensive person-centered care plan would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and would be developed and implemented for each resident. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and review of policies, the facility failed to ensure professional standards of practice were implemented regarding a treatment order for one resident (#1) from a sample of 3 residents; and, the facility failed to ensure treatment was administered to one of 3 sampled residents (#2). The deficient practice has the potential for the resident not receiving the appropriate treatment and for additional errors in treatment administration. Findings include: -Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to a physician's orders [REDACTED]. Skin Prep is a liquid film-forming dressing that forms a protective film to the skin. In a review of the Treatment Administration Record (TAR) documented was a section for the Skin Prep. Further review of the TAR revealed licensed staff initials to indicate the treatment had been provided per orders on September 6, 2020. Treatment observations were conducted for resident #1 on September 17, 2020. During the course of the observations staff stated the resident had both legs amputated below the knees and this was observed for resident #1. An interview was conducted with a Licensed Practical Nurse (LPN/staff #163) on September 18, 2020 at 11:27 a.m. She stated if there was a physician's orders [REDACTED]. The staff further stated the initials on the TAR for resident #1 could not have actually been done and the staff in question needed to check the order. Staff #163 stated an incident like this needed to be reported to the Director of Nursing so that it could be corrected. An interview was conducted with the Director of Nursing (DON/staff #204) on September 18, 2020 at 12:48 p.m. She stated the nurse that initialed that heel treatment had been done for resident #1 was not accurate and not according to the standards of practice. She further stated she did not have

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) knowledge of this incident and would expect that other nurses would have brought it to her attention so she could correct the problem. According to a policy on charting and documentation, the following was included: Policy Statement: All services provided to the resident shall be documented in the medical record. Documentation will be accurate. According to a policy related to daily work assignments, the following was included: Policy Statement: All staff will perform assigned duties in accordance with professional standards of practice and facility policy.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff and resident interviews, and review of policy and procedures, the facility failed to ensure one resident (#2) consistently received care and treatments consistent with professional standards of practice to prevent the development of pressure ulcers. The deficient practice could result in the development and worsening of pressure ulcers. Findings include: Resident #2 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record revealed an Admission Skin assessment dated [DATE], that the resident had moisture associated skin damage (MASD) to the coccyx, sacrum, and bilateral buttocks, surgical incisions, moist redness to the peri area, skin tear to the left forearm, redness to bilateral heels (no open areas), and scattered bruises to the bilateral upper and lower extremities and inner thigh. The form included Actual wound(s) at Time of Admission; ALL wounds identified below must have an Initial Wound Review completed. The documentation did not include any pressure ulcers. The Initial Wound Review for wound assessment of pressure ulcers, other ulcers, severe or infected or dehisced surgical sites and suspicious rashes dated April 6, 2020 revealed the resident had a surgical incision. Further review of the clinical record did not reveal any other Initial Wound Reviews. Review of the Braden Scale for Predicting Pressure Sore Risk dated April 6, 2020 revealed a score of 17 which indicated the resident was at the lower risk for pressure ulcers. Review of the care plan regarding skin integrity initiated April 6, 2020 revealed a goal the resident would have improved skin integrity using preventive skin treatments. Interventions included administering wound/skin impairment treatment per physician's orders [REDACTED].e. moisturizing cream to buttocks, and reviewing skin weekly or when changes occur. Further review of the care plan initiated April 6, 2020 revealed the resident had a self-care deficit as evidenced by the need for assistance with activities of daily living related to fatigue, muscle weakness, and musculoskeletal impairment. Interventions included the resident required the assistance of 1 - 2 staff for bathing, dressing, personal hygiene/oral care, toilet use, and transfers. The care plan initiated April 6, 2020 also included the resident had an indwelling urinary catheter and was incontinent of bowel. The physician orders [REDACTED]. Review of the Treatment Administration Record (TAR) for April 2020 revealed the treatment was not provided as ordered on April 16 on the night shift. A physician order [REDACTED]. A physician order [REDACTED]. Review of the Treatment Administration Record (TAR) for April 2020 revealed the treatment was not provided as ordered on April 16, 2020. The admission minimum data set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 7 which indicated the resident had severe cognitive impairment. The MDS assessment included the resident had two stage 2 pressures ulcers upon admission, MASD, surgical wounds, skin tears, and an indwelling urinary catheter. The assessment also included the resident required the assistance of 2+ persons for bed mobility. A Weekly Skin Check dated April 13, 2020 revealed the resident had two open areas on the coccyx, shearing, and that a dressing was applied as ordered. The documentation did not include an assessment of the two open areas. The Weekly Skin Check dated April 20, 2020 revealed the coccyx dressing was in place and did not include any other documentation regarding the coccyx. The Weekly Skin Check dated April 27, 2020 included coccyx zguard and [MEDICATION NAME]. The documentation did not include an assessment of the coccyx. Review of the Follow Up Question Report for April 6 to May 1, 2020, revealed turning and repositioning was not consistently done. Further review of the clinical record revealed no evidence the stage 2 pressure ulcers were assessed to include measurements, description of the wound bed and surrounding skin, if drainage was present, etc. Resident #2 was discharged on [DATE]. An interview was conducted with the facility wound nurse (LPN/staff #210) on June 10, 2020 at 10:40 a.m. She stated that she follows up with the admission assessment of the skin with the weekly wound assessment. She stated there may be six or seven days in-between the admission nurse assessment and the wound nurse first assessment. She stated she has trained the admission nurses how to assess and document wounds. She stated that all wounds should have a complete assessment, including description of the wound and measurements. An interview was conducted via phone with a Certified Nursing Assistant (CNA/staff #214) on June 10, 2020 at 2:15 p.m. She stated there were times when the dressing on the resident were days old. She stated the dressing would be saturated. She stated resident #2 would express pain when she would change the dressing and complained about it often. She stated she was not sure if the night staff every changed the dressing. She stated resident #2 had a very large wound on her coccyx. She stated that there was a delay in getting the air mattress. She stated it was often difficult to find help to reposition the resident. An interview was conducted with resident #2 via phone on June 10, 2020 at 3:20 p.m. She stated she was left on her back for hours at a time. She stated that she had irritated skin from her urine but she did not have any open sores when she arrived at the facility. She stated the dressing on her bottom was often damp for long periods of time. An interview was conducted via phone with a Registered Nurse (RN/staff #216) on June 10, 2020 at 4:02 p.m. She stated that she does wound assessments for the resident; however she has not received any training specifically for assessing wounds. She stated the electronic medical record software has a guide to help identify the wounds. She stated that when staging the wound, granulated tissue is a stage 2 wound. The size of the wound is measured in inches when the wound is large and in centimeters when the wound is small. She stated that if there is no depth she would leave it blank. An interview was conducted with the Director of Nursing (staff #61) on June 12, 2020 at 8:45 a.m. She stated that there are no measurements documented in the clinical record for the resident's open wounds. She stated that there is a doctor order to treat pressure sores. She stated that per the facility's policy, a complete assessment of these open areas was not conducted while the resident was in the facility. An interview was conducted via phone with the MDS coordinator/LPN (staff #77) on June 12, 2020 at 12:04 p.m. She stated the care plan is generated from the assessment provided by the admission nurse and other staff. She stated that wound/skin assessments are verified by the wound nurse. She stated the skin care plan is generic but can be changed to meet the needs of the resident that has a pressure injury or a change in condition. A facility policy titled Wound Care indicated the purpose of the policy is to provide guidelines for the care of wounds to promote healing. It included that the staff should review the resident's care plan to assess for any special needs of the resident. The documentation of wound care must include the type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name and title of the individual performing the wound care, any change in the resident's condition, all assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints, if the resident refused the treatment and reasons why, and the signature and title of the person recording the data. An additional facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol included the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. The nurse shall describe and document/report a full assessment (including location, stage, length, width, depth, presence of exudates or necrotic tissue), pain assessment, mobility status, current treatments including support surfaces, and all active diagnoses. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interviews, and review of policies and procedures, the facility failed to ensure clinical record documentation was completely documented for three residents (#'s 1, 2, and 3) regarding pressure ulcers. The sample size was 3. The deficient practice has the potential for clinical records to inaccurately and incompletely reflect the status of all residents. Findings include: -Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per the admission/initial wound assessment dated [DATE] documentation revealed the resident had an unstageable pressure ulcer on the right front knee stump. There was no evidence of measurements of the pressure ulcer. In a review of a nursing progress note dated September 7, 2020 and noted as a LATE ENTRY documentation now revealed measurements for the pressure ulcer. The measurements were as follows: 12 centimeters (cm) x 12 cm x unable to determine

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) depth (UTD). Per a nursing progress note dated September 8, 2020 documentation revealed the resident was seen and examined by the wound physician. The measurements of the right knee area were now documented to be 6.5 cm x 8.1 cm x 0.1 cm. In a review of a nursing progress note dated September 16, 2020 and noted as a LATE ENTRY documentation now revealed this note was a late entry related to the admitted , which was September 5, 2020. Measurements were noted to be the same that were documented on September 7, 2020 which was two days after the resident's admitted . An interview was conducted with a Licensed Practical Nurse (LPN/staff #163) on September 18, 2020 at 11:27 a.m. She stated if she wanted or needed to make a late entry note in the resident's clinical record she must first inform her manager. She stated it is expected that all charting and documentation be completed during the work shift and then the staff would not have to make any late entries. An interview was conducted with a Registered Nurse (RN/staff #153) on September 18, 2020 at 11:42 a.m. She stated she is a new employee and unsure of the protocol for documenting late entries in the clinical record, however stated she would say anything beyond 1-2 days would be too long for the staff to remember. Staff #153 also stated she would have to inform her supervisor as to why a late entry is being done. An interview was conducted with the Director of Nursing on September 18, 2020 at ___. She stated her expectation is a timeframe of 24 hours to make a late entry note in the resident's clinical record. An interview was conducted with the Corporate Resource Nurse (staff #208) on September 18, 2020 at 1:36 p.m. The staff stated there is no regulation regarding late entries in the clinical record and further stated she thought it would be okay as long as the staff could remember. According to a facility policy on Charting Errors and/or Omissions the following was included: Statement: Accurate medical records shall be maintained by this facility. Late entries in the medical record shall be dated at the time of the entry and noted as a late entry. According to a policy on charting and documentation, the following was included: Policy Statement: All services provided to the resident shall be documented in the medical record. Documentation will be accurate and complete. Entries may only be recorded in accordance with state law and facility policy. According to a policy related to daily work assignments, the following was included: Policy Statement: All staff will perform assigned duties in accordance with professional standards of practice and facility policy. According to a policy regarding the role of the Quality Assurance and Performance Improvement (QAPI) the following was included: Duties and responsibilities: The QAPI team will examine randomly selected medical records to assure that they accurately describe the resident's condition and are always complete enough to enable others to get a picture of the resident's problems and plan of care. -Resident #2 was admitted on [DATE] with [DIAGNOSES REDACTED]. The admission evaluation summary dated September 3, 2020 revealed concerns identified that may impact nutritional health included current pressure ulcer or recently healed pressure ulcer. The Braden/Clinical Risk progress note dated September 3, 2020 included a score of 14 indicating the resident was considered at risk for skin integrity occurrence. The admission skin check evaluation dated September 3, 2020 and completed by the licensed practical nurse/wound nurse (LPN/staff #195) included the following wounds: 1) Unstageable DTI (deep tissue injury) to the left heel measuring 5 cm (centimeters) x 4.5 cm; 2) Right heel open ulcer measuring 4 cm x 5.5 cm; and, 3) Unstageable DTI to the right lateral to the big toe measuring 1 cm x 3 cm. The documentation did not include description of the wound bed, wound edges, surrounding tissue, presence of exudate, odor, drainage, tunneling or undermining. The initial wound reviews dated September 3, 2020 revealed the following: 1) Diabetic wound to the left heel. The documentation now included depth unable to be determined, necrotic tissue or eschar, stage was N/A (not applicable), no exudate, no wound edges, the skin color surrounding the wound was maroon/deep purple, with [MEDICAL CONDITION], and the wound skin temperature was cool; 2) Diabetic wound to the right heel. The documentation now included depth unable to be determined, with necrotic tissue or eschar, stage was N/A (not applicable), no exudate, attached wound edges, reddened skin surrounding the wound, with [MEDICAL CONDITION], and the wound skin temperature was warm; 3) The type of wound to the right lateral great toe was not identified but the wound now was described with necrotic tissue or eschar, attached wound edges, [MEDICAL CONDITION], no exudate, warm and reddened surrounding skin. Another initial wound review documented as LATE ENTRY and dated September 3, 2020 revealed an unstageable pressure injury to the sacro-coccyx area, present on admission, measuring 2 cm x 2 cm, depth unable to be determined, with necrotic tissue or eschar, scant serous exudate, attached wound edges, fragile surrounding skin, with non-[MEDICAL CONDITION], and the wound skin temperature was warm. However, this note was only created on September 8, 2020 (5 days after the wound was identified). The wound doctor progress note dated September 10, 2020 revealed assessments that include the following wounds identified: 1) Unstageable deep tissue pressure injury to the left heel; 2) Unstageable pressure injury to the right heel; and, 3) Unstageable pressure injury to the sacral area. There was no wound to the right lateral great toe identified and documented. The weekly wound reviews documented as LATE ENTRY note and dated September 10, 2020 revealed the following wounds: 1) Suspected deep tissue pressure injury to the left heel, that measured 3.2 cm x 4.8 cm x 0.1 cm, with granulation tissue, scant serous exudate, attached wound edges, had health and intact skin surrounding the wound and had [MEDICAL CONDITION]; and, 2) Unstageable pressure wound to the right heel, that measured 3 cm x 4 cm x 0.2 cm, with necrotic tissue (eschar), scant exudate, attached wound edges, fragile skin surrounding the wound and had [MEDICAL CONDITION]. However, these reviews were not created or completed until September 16, 2020 (6 days after the assessment). Another weekly wound review dated September 10, 2020 included an unstageable pressure injury to the sacrum, measuring 1.4 cm x 1.2 cm x 0.1 cm, with slough, small serous exudate, attached wound edges, non-[MEDICAL CONDITION] and warm and reddened surrounding skin. This review was not documented as late entry. However, review of the documentation revealed that this was also not created or completed until September 16, 2020 (6 days after the assessment). -Resident #3 was admitted at the facility on August 18, 2020 with [DIAGNOSES REDACTED]. The daily skilled note summary dated September 10, 2020 revealed skin concerns were noted, wound nurse was notified and an assessment was done by the wound nurse. The eINTERACT SBAR (Situation, Background, Assessment, Recommendation) summary dated September 10, 2020 revealed a change in condition related to skin wound or ulcer and the resident had developed a device-related pressure injury. The documentation did not include stage, measurement, drainage, description of the wound bed, edges, and surrounding skin. The initial wound review note documented as a LATE ENTRY note and dated September 10, 2020 included stage II pressure injury to the right rear shoulder, onset date of September 10, measuring 1.8 cm (centimeter) x 2.4 cm x 0.1 cm, with scant serous exudate, [MEDICATION NAME] tissue, attached wound edges and reddened surrounding skin. However, this note was only created on September 16, 2020 (6 days after the wound was identified). An interview with a Licensed Practical Nurse (LPN/staff #132) was conducted on September 18, 2020 at 11:35 a.m. She stated any findings including evaluations, skin issues or treatment not administered or resident refusal had to be documented right away in the progress notes. She stated the nurse should not leave his/her shift without completing the progress notes. She stated this is very important especially when there is a skin issue or a new wound that was identified and treatment orders were received. If the nurse who receive the orders did not document in the electronic record, the incoming staff have no way of knowing about it and can result to treatment being missed. In an interview with the wound nurse (staff #195) conducted on September 18, 2020 at 12:03 p.m., she stated she sees the wound at least weekly and as needed and document in the Weekly Evaluation or weekly wound review note. She said that when the weekly evaluation form is completed, it will generate the same data in the weekly wound review. She stated in cases when she has to add something to or revise her wound documentation, she will write in the progress note about it. Staff #195 also stated that there is no timeframe to complete her documentation in the clinical record. She said that it is okay to write a late entry note even if it is beyond 24 hours as long as the nurse remembers the details of the assessment including measurements or the nurse has paper notes to go by. She stated all her wound documentation and assessments are electronic and she does not keep paper documentation. She stated she is good in remembering the resident's wounds including their measurements because she sees them on a regular basis if not daily; and, this is all she does. She further stated that for this reason, it is possible to remember measurements of the wounds after several days from the encounter. However, she stated it is not a standard of practice. During an interview with the Director of Nursing (DON/staff #204) conducted on September 18, 2020 at 12:48 p.m., she stated sssessments/evaluations, findings, resident refusals or any event that happened during the shift must be documented in the clinical record.She stated late entry notes must be completed within 24 hours as a standard of practice because it will be hard to remember things/findings/issues that need to be documented if the late entry note is done longer than 24 hours. In an interview conducted with the Corporate Resource Nurse (staff #208) on September 18, 2020 at 1:36 p.m. she stated there is really no within 24 hours rule or regulation related to how late can any documentation be entered in the records. She stated that as long as the nurse remember the details, the nurse can enter a late entry note even beyond 24 hours.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**

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F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) staff identified and then implemented action steps related to a Plan of Correction (POC) that had been developed following a June 2020 complaint survey. Findings include: During the course of the survey multiple concerns were identified regarding pressure ulcers and care plan revisions. -Regarding the care revisions: In a review of the facility plan of correction dated June 29, 2020 documentation included the statement that the facility staff would conduct audits to ensure the deficient practice was being monitored and corrected. Audits would ensure that care plan revisions were being completed and audits would continue for three months. However, the facility POC documentation revealed the last audit had been completed on September 1, 2020 and therefore the facility staff did not identify problems with care plan revisions after that date. In addition to the audits, the POC documented there would be monitoring of corrective actions to ensure the deficient practice would not recur. Specifically, the Director of Nursing (DON) would perform routine audits to identify issues or trends and for three months the results of the audits would be presented to the QAPI committee for review and recommendations. Again, the date of the last audit was September 1, 2020. In a review of the QAPI documentation for June, July, August, and September, 2020 there was no evidence that the committee had recognized any specific concerns with care plan revisions. -Regarding the pressure ulcers: In a review of the facility plan of correction dated June 29, 2020 documentation included the statement that the facility staff would conduct audits to ensure the deficient practice was being monitored and corrected. Audits would ensure that the staff were in compliance with policies and procedures on skin and wound care management. In addition, audits would continue for three months. However, the facility POC documentation revealed the last audit had been completed on September 1, 2020 and therefore the facility staff did not identify problems with pressure ulcers after that date. In addition to the audits, the POC documented there would be measures that would be implemented to monitor the continued effectiveness of the corrective actions to ensure deficient practice had been corrected and would not recur. Specifically, the Director of Nursing (DON) would conduct regular and random audits to determine compliance to facility policies and procedures related to treatments and services to prevent and heal pressure ulcers. Further documented was that for three months the audits would be presented to the monthly QAPI committee for review and recommendations. In a review of the QAPI documentation for June, July, August, and September, 2020 there was no evidence that the committee had recognized any specific concerns with pressure ulcers. During an interview with the DON/staff #204, conducted on September 18, 2020 at 12:48 p.m., she stated that the facility is conducting audits as part of the their POC. However, she stated she was not sure where the documentation of the audits are maintained and what the facility does with the data obtained from the audits. She also stated that the clinical team meet every morning to discuss any issues related to pressure ulcers and care plans to ensure the facility is compliant with the POC. She stated as part of the POC, staff were provided inservice training and inservice packets to guide them with wound treatment and management. She further stated nurses who are not trained with wound management would also be provided with an inservice training. An interview with the Administrator (staff # 206) was conducted on September 18, 2020 at 1:22 p.m. She stated as part of the POC, the facility meets daily as a team in the clinical rounds to discuss issues or concerns related to pressure ulcers and care plans. Regarding the pressure ulcer issues, she stated that the facility identified that there were wrong people on the team so the facility gave parameters for staff to follow related to wounds and eventually a new wound nurse was hired. She stated that facility audits are ongoing and the data from the audits is part the QAPI process. She said QAPI meet monthly and the results of the audits are then presented and discussed during the QAPI committee. An exit conference was conducted with the Corporate Resource Nurse (staff #208), staff #204, and staff #206 on September 18, 2020 at 1:36 p.m. The staff reviewed the facility POC documentation and multiple audits. Staff #208 stated the facility is conducting regular audits which are ongoing and the issues on wound are regularly discussed in QAPI. She also stated that the QAPI is reviewing the results of the audit and is monitoring progress to compliance on a regular basis. Review of the QAPI documentation was conducted with staff #208 during the interview. However, the survey team was not provided with copies when requested. Staff #208 showed that an area that the facility was conducting audits was regarding Licensed Practical Nurses (LPNs) assessing and staging pressure ulcers. She stated that this area was being monitored for compliance by the facility and the only time an LPN can assess and stage the wound is when the LPN is wound certified. Staff #208 did not mention the status of the facility's compliance on pressure ulcers related to their POC. In addition, staff #208 did not present specific information from the QAPI documentation to indicate there were ongoing problems with pressure ulcers and care plans. In a review of the facility inservice packets, the following information dated June 26, 2020 was presented to the nursing staff. Title: Documentation of pressure ulcer/injury care. 1) Wound assessments are to be documented that includes the stage of the pressure ulcer and the measurements- length x width x depth. 2) Current treatment plan and response to the treatment/care plan, and document changes to the plan of care based upon assessment findings. According to a policy on the QAPI program the following was included: Statement: The facility shall develop, implement, and maintain an ongoing, facility wide QAPI program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. There are five strategic elements: 1) It is ongoing, comprehensive, involves the full range of services, covers all systems of care and management with priority of quality of care and quality of life, and goals, targets, and benchmarks are established based on best evidence. 2) leadership is ought, resources allocated, leadership staff are accountable, staff are trained in systems and culture, and staff are encouraged to report quality concerns. 3) Systems are in place to monitor care and services, designed to incorporate feedback, care processes and outcomes are monitored using performance indicators, adverse events are tracked, and action plans are implemented to prevent recurrence of adverse events. 4) Performance Improvement Projects (PIP's) are initiated when problems are identified. PIP's systematically gather information to clarify issues and intervene for improvements. 5) Root cause analysis is used to determine whether identified issues are exacerbated by the way care and services are organized or delivered. Root cause analysis serves as a highly structured approach to fully understanding the nature of the identified problem, its cause and the implications of making changes to solve the problem.