STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676347	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMARILLO CENTER FOR SKILLED CARE	**6641 W AMARILLO BLVD AMARILLO, TX 79106**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct an accurate comprehensive assessment of each resident's status for 1 (Resident #1) of 7 residents whose records were reviewed for comprehensive assessments. The facility inaccurately indicated that Resident #1 did not have any pressure sores on his MDS dated [DATE] for the seven day look back. This failure placed a resident at risk for not getting an accurate assessment and could result in improper care. Findings include: Record review on Resident #1's MDS Section M0210, dated 9-2-2020, revealed that Resident #1 was coded as not having any unhealed pressure ulcer/injuries. Record review of Resident #1's weekly skin assessment, dated 8-26-2020, revealed that the resident was found to have an unstageable pressure ulcer to his coccyx. During an interview with the DON on 9-18-2020 at 2:02 PM, she was asked if it was the facility's expectation that if a resident has an unhealed pressure sore, that it would be coded as such in the MDS seven day look back period. She confirmed that it was the facility's expectation that pressure sores be coded correctly during the seven day look back. She confirmed that Section M0210, dated 9-2-2020 was not coded correctly, and should have shown that resident #1 had a pressure injury. During an interview with MDS on 9-18-2020, at 2:10 PM, he was asked if a resident had a pressure sore during the seven day look back if it should be coded in section M of the MDS. MDS responded that yes, it should be coded as such. MDS confirmed that Resident #1's MDS was not coded correctly. During an interview with DON on 9-18-2020 at 2:02 PM she stated that the facility follows the RAI manual. Record review of document by Centers of Medicare and Medicaid services titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, dated October 2019, revealed in part: (page M-4) - For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care for 1 of 7 Residents (Resident #1) reviewed for pressure ulcers. - LVN A failed to demonstrate competency in skills by failing to correctly document and trigger further assessment when a pressure sore was found on Resident #1. This failure has the potential to affect residents by placing them at an increased and unnecessary risk of pain, and of exposure to communicable diseases and infections. Findings include: Record review of Resident #1's chart revealed he was admitted on [DATE]. Skin assessment done on admission showed that there were no skin issues at that time. Weekly skin assessment done on 8-26-2020 revealed that Resident had an unstageable pressure sore on his coccyx that was acquired while at the facility. LVN A only stated the size of the wound and did not describe the wound in detail (color, odor, area around wound). Further review showed that LVN A, who found the pressure sore, did not initiate/trigger further assessment and did not document that she had notified the wound care nurse, the physician, or the DON. The LVN also did not document that she alerted the family. During an interview with DON on 9-18-2020 at 2:00 PM, she confirmed that LVN A should have initiated/triggered further assessment when she found the sore on 8-26-2020. She also confirmed that it was her expectation that the wound be documented thoroughly, not just the size, but the shape and color of the skin. DON confirmed it was her expectation that the sore be documented correctly and that the MD and family were contacted. During an interview with LVN A on 9-18-2020 at 2:05 PM, LVN A she was asked why she did not initiate/trigger further assessment when she found the pressure sore on 8-26-2020. LVN A responded that she normally does but must have forgotten to trigger further assessment on Point Click Care. She was asked if it was the facility's expectation that a pressure sore be documented thoroughly and completely. She stated that it was, and that she did not document the sore correctly. She also confirmed that it was the facility's expectation document who was notified after finding the sore. Record review of facility provided policy titled Skin Integrity Management, dated 2003, revised 10-5-2016, reflected in part: General Guidelines 1. If wound is noted, perform an assessment and initiate a treatment plan as soon as possible. Document in resident's chart, area of change, who you notified, and treatment applied. Record review of facility provided policy titled Pressure Injury: Assessment and Treatment, dated 2003, revised 8-12-2016, reflected in part: Procedure: 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor and circulation to prevent breakdown, injury and infection. 2. Early prevention and/or treatment is essential upon initial nursing assessment of the condition of the skin on admission and whenever a change in skin status occurs. The nurse will determine if prevention and /or treatment of [REDACTED].

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.