

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/11/2024
NAME OF PROVIDER OR SUPPLIER MORNING SUN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 WASHINGTON MORNING SUN, IA 52640		
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F 000	INITIAL COMMENTS	F 000			
✓ §	Correction date: <u>May 11th 2024</u> The Morning Sun Care Center is not in compliance with the Code of Federal Regulations (42CFR) Part 483, Subpart B-C following the facility's annual recertification survey with an investigation of complaint #119721 conducted April 8, 2024 to April 11, 2024. Complaint #119721 was not substantiated. Facility census: 23				
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: F 641 Accuracy of Assessments SS=E Based on clinical record review, staff interview, and Resident Assessment Instrument (RAI) Manual review, the facility failed to ensure accurate coding of anticoagulant medication, antiplatelet medication, antibiotic medication, and pressure ulcers on the Minimum Data Set (MDS) assessment for four of twelve residents reviewed for MDS accuracy (Residents #3, #11, #14, and #23). The facility reported a census of 23 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated 3/7/24 identified a Brief	F 641			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Karla Beasley, RN

5/1/2024

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.

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F 641	<p>Continued From page 1</p> <p>Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment, reflected Resident #3 took anticoagulant medication and did not take an antiplatelet medication.</p> <p>The Physician Order dated 8/17/21 documented, Aspirin EC Tablet Delayed Release 81 MG (milligram) with instructions to give 1 tablet by mouth one time a day related to paroxysmal atrial fibrillation (occasional irregular heartbeat in the upper chambers of the heart).</p> <p>Resident #3's March 2024 Medication Administration Record (MAR) lacked administration of an anticoagulant medication, and revealed she took an antiplatelet medication.</p> <p>2. Resident #11's MDS assessment dated 1/18/24 a BIMS score of 14, indicating intact cognition. The assessment reflected Resident #11 took an anticoagulant medication and antiplatelet medication. The assessment lacked documentation Resident #11 received antibiotic medication.</p> <p>The Clinical Physician Orders reviewed on 4/9/24 included the following orders dated:</p> <p>a. 10/11/23 for Methenamine Hippurate Oral Tablet (antibiotic) with instructions to give 1 gram by mouth two times a day for a UTI (urinary tract infection) prophylaxis (prevention).</p> <p>b. Clopidogrel Bisulfate Oral Tablet 75 MG (milligram) with instructions to give 1 tablet by mouth one time a day related to heart failure.</p> <p>Review of Resident #11's Medication Administration Record (MAR) dated January 2024 lacked documentation of receipt of</p>	F 641			

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F 641	<p>Continued From page 2</p> <p>anticoagulant medication. Per Resident #11's MAR, the resident received Methenamine Hippurate twice per day for the month of January and took Clopidogrel Bisulfate daily for the month of January 2024.</p> <p>3. Resident #14's MDS assessment dated 2/27/24 identified a BIMS score of 15, indicating intact cognition. The MDS assessment lacked documentation Resident #14 took anticoagulant medication or antibiotic medication.</p> <p>The Clinical Physician Orders reviewed 4/10/24 at 12:48 PM included the following orders:</p> <p>a. Dated 11/14/23: Apixaban Oral Tablet 5 MG (an anticoagulant medication). Give 1 tablet by mouth 2 times a day related to chronic atrial fibrillation (irregular heartbeat).</p> <p>b. Dated 11/15/23: Doxycycline Hyclate Oral Tablet (antibiotic) 100 MG by mouth in the morning for community acquired PNA (Pneumonia), chronic suppression.</p> <p>Resident #14's February 2024 MAR included the following documentation:</p> <p>a. Apixaban Oral Tablet 5 MG (Apixaban) give 1 tablet by mouth two times a day related to chronic atrial fibrillation.</p> <p>- Documented as administered twice a day.</p> <p>b. Doxycycline Hyclate Oral Tablet (Doxycycline Hyclate) give 100 mg by mouth in the morning for community acquired PNA.</p> <p>- Documented as administered once a day.</p> <p>On 4/11/24 at 12:11 PM, the Director of Nursing (DON) acknowledged the facility followed the RAI (Resident Assessment Instrument) manual. When queried about documentation for Resident #3, the DON explained she only saw the current</p>	F 641			

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F 641	<p>Continued From page 3</p> <p>medication of aspirin. The DON explained she didn't see anything discontinued during that timeframe on March 7th. When queried about documentation listed above on Resident #11's MDS, the DON explained she received clarification about Methenamine after the fact, and acknowledged it needed to be on the MDS per guidance received. When queried about above findings for Resident #14, the DON explained she saw the same information.</p> <p>Review of the RAI Manual dated October 2023 documented the following:</p> <p>a. Antibiotic: Check to see if the resident received an antibiotic medication at any time during the 7 day look back period (or since admission, entry, or reentry if less than 7 days).</p> <p>b. Do not code antiplatelet medication such as aspirin/extended release, dipyridamole, or clopidogrel as an anticoagulant.</p> <p>4. Resident #23 MDS assessment dated 12/14/23 identified Resident #23 had a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications. The MDS lacked Resident #23's other two pressure ulcers.</p>	F 641			

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F 641	<p>Continued From page 4</p> <p>The Nurse's Admission Assessment dated 12/7/23 at 7:12 PM documented the following skin conditions for Resident #23:</p> <p>a. 3 pressure ulcers with the following measurements:</p> <ul style="list-style-type: none"> - One Stage IV to the sacrum Length measured 3 cm (centimeters) Width measured 2.5 cm with no depth documented. - One Stage II to right thigh (rear) Length measured 2 cm Width measured 1.0 cm No depth documented. - One Stage II to right thigh (rear) Length measured 1.5 cm Width measured 1.0 cm No depth documented. <p>The Narrative Notes had documentation of the following:</p> <p>Resident #23 observed with a sacral decubitus (pressure ulcer) dressing saturated with draining yellow drainage. The ulcer had pink tissue and looked moist. The outer area of the wound appeared yeasty on the skin. Resident #23 had open areas on her right upper back thigh. The note lacked description of the wounds on her right upper back thigh.</p> <p>Resident #23's MDS dated 3/15/24 identified a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer with one unstageable pressure ulcer labeled as facility acquired. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition</p>	F 641			

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F 641	<p>Continued From page 5</p> <p>interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications.</p> <p>The Skin Condition Note labeled late entry on 3/14/24 at 1:30 PM reflected the nurse assessed the sacral (lower back just above the buttock) and gluteal (buttocks) dressings. After cleaning the wounds with wound cleanser, the nurse measured the following:</p> <p>a. Sacral wound: 2.5 cm x 2.5 cm x 1.7 cm; dressing applied of collagen and mepilex</p> <p>b. Right gluteal fold (inner): 1.2 cm x 0.6 cm; dressing of medic honey applied and mepilex</p> <p>c. Right gluteal fold (outer): 1 cm x 0.5 cm; dressing of medi honey and mepilex applied.</p> <p>The Note lacked the label of each measurement (length, width, depth).</p> <p>On 4/8/42 at 9:54 AM Resident #23 sat in her recliner in her room with a pressure reducing cushion in the seat. Resident #23 reported she lived at the facility since December 2023 and had an open area to her bottom on her admission. She wore Prevalon (pressure reduction boots) boots to both feet, an air mattress to her bed which was properly inflated. An indwelling catheter bag hung in a dignity bag below bladder level without tubing touching the floor. She denied pain or discomfort at this time.</p> <p>On 4/10/24 at 9:09 AM Resident #23 sat in her recliner in her room. When the surveyor asked if she could observe her wound care, she reported she would rather not have the surveyor observe. Pressure reducing cushion noted underneath her and she wore Prevalon boots to both feet. The resident refused to allow the surveyor to make observations of the wounds.</p>	F 641			

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F 641	<p>Continued From page 6</p> <p>In an interview on 4/11/24 at 9:45 AM, the DON reported upon review of Resident #23's admission assessment, She explained she started it on 12/7/23, and documented one Stage IV pressure ulcer to the sacral area. She only remembered that pressure ulcer. It appeared the wound nurse added another entry dated 12/14/23, which identified the resident with 3 pressure ulcers. Upon review of Resident #23's admission MDS, she verified the MDS dated 12/14/23 identified her a Stage IV pressure ulcer. The DON explained reviewing the entry in the progress notes, she had difficulty identifying who added the measurements on the other Stage II pressure ulcers. She recalled she didn't stage pressure ulcers and asked the wound nurse to do so. When asked if Resident #23 developed a second pressure ulcer as the last quarterly MDS now identified her with an unstageable pressure ulcer, she reported Resident #23 did develop a second one, but unsure of the date. There are 2 open areas to the right gluteal. One is a deep tissue injury which was unstageable and that would be facility acquired. The other area to the right gluteal is shearing. Resident #23's had her current pressure ulcers on the sacral and the right gluteal areas.</p> <p>In an interview on 4/11/24 at 10:21 AM, the MDS coordinator upon review of the admission MDS dated 12/14/23, she verified the MDS identified Resident #23 with only one stage IV pressure ulcer with no other ulcers. Upon review of the quarterly MDS dated 3/15/24, she verified the MDS identified Resident #23 now with a facility acquired unstageable deep tissue injury. She based this on review of the last entry of the wound nurse's notes. She did not know what</p>	F 641			

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F 641	Continued From page 7	F 641			
F 656 SS=D	caused the deep tissue injury and verified it was not documented in the nurse's progress notes. 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). (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	F 656			

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F 656	<p>Continued From page 8</p> <p>community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, resident, and staff interviews, the facility failed to develop comprehensive care plans for two of twelve residents reviewed (Residents #14 and #23). The facility identified a census of 23 residents.</p> <p>Findings include:</p> <p>1. Resident #23's MDS dated 3/15/24 identified a BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer with one unstageable pressure ulcer labeled as facility acquired. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications.</p>	F 656			

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F 656	<p>Continued From page 9</p> <p>The Nurse's Admission Assessment dated 12/7/23 at 7:12 PM documented the following skin conditions for Resident #23:</p> <p>a. 3 pressure ulcers with the following measurements:</p> <ul style="list-style-type: none"> - One Stage IV to the sacrum Length measured 3 cm (centimeters) Width measured 2.5 cm with no depth documented. - One Stage II to right thigh (rear) Length measured 2 cm Width measured 1.0 cm No depth documented. - One Stage II to right thigh (rear) Length measured 1.5 cm Width measured 1.0 cm No depth documented. <p>The Narrative Notes had documentation of the following:</p> <p>Resident #23 observed with a sacral decubitus (pressure ulcer) dressing saturated with draining yellow drainage. The ulcer had pink tissue and looked moist. The outer area of the wound appeared yeasty on the skin. Resident #23 had open areas on her right upper back thigh. The note lacked description of the wounds on her right upper back thigh.</p> <p>The Baseline Care Plan dated 12/7/23 lacked Resident #23's problem of pressure ulcers.</p> <p>The Care Plan Focus initiated 12/20/23 and revised 3/26/24 identified Resident #23 had a nutritional risk related to a stage IV sacral pressure ulcer and her diagnosis of multiple sclerosis with a history of protein calorie malnutrition (not enough protein and calories absorbed by her body). The Care Plan lacked interventions to treat, assess, and/or prevent further pressure ulcers.</p> <p>Resident #23's MDS dated 3/15/24 identified a</p>	F 656			

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F 656	<p>Continued From page 10</p> <p>BIMS score of 15, indicating intact cognition. Resident #23 required total assistance from staff for all activities of daily living. The MDS included diagnoses of: neurogenic bladder (difficulties with urination), hemiplegia (paralysis of one half of the body) and multiple sclerosis (movement and muscle disorder). The MDS listed Resident #23 as a risk for pressure ulcers/injuries. She had one Stage IV (4) pressure ulcer with one unstageable pressure ulcer labeled as facility acquired. The MDS identified the following skin ulcer treatments of a pressure reducing device for bed, turning/repositioning program, nutrition interventions to manage skin problems, pressure ulcer care, application of non surgical dressings, application of ointments/medications.</p> <p>The Skin Condition Note labeled late entry on 3/14/24 at 1:30 PM reflected the nurse assessed the sacral (lower back just above the buttock) and gluteal (buttocks) dressings. After cleaning the wounds with wound cleanser, the nurse measured the following:</p> <p>a. Sacral wound: 2.5 cm x 2.5 cm x 1.7 cm; dressing applied of collagen and mepilex</p> <p>b. Right gluteal fold (inner): 1.2 cm x 0.6 cm; dressing of medic honey applied and mepilex</p> <p>c. Right gluteal fold (outer): 1 cm x 0.5 cm; dressing of medi honey and mepilex applied.</p> <p>The Note lacked the label of each measurement (length, width, depth).</p> <p>On 4/8/42 at 9:54 AM Resident #23 sat in her recliner in her room with a pressure reducing cushion in the seat. Resident #23 reported she lived at the facility since December 2023 and had an open area to her bottom on her admission. She wore Prevalon (pressure reduction boots) boots to both feet, an air mattress to her bed</p>	F 656			

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F 656	<p>Continued From page 11</p> <p>which was properly inflated. An indwelling catheter bag hung in a dignity bag below bladder level without tubing touching the floor. She denied pain or discomfort at this time.</p> <p>On 4/10/24 at 9:09 AM Resident #23 sat in her recliner in her room. When the surveyor asked if she could observe her wound care, she reported she would rather not have the surveyor observe. Pressure reducing cushion noted underneath her and she wore Prevalon boots to both feet. The resident refused to allow the surveyor to make observations of the wounds.</p> <p>On 4/11/24 at 8:57 AM, Staff A, Registered Nurse reported when a resident admits with an existing pressure ulcer, it should be included on the Baseline Care Plan and on the Comprehensive Care Plan. The MDS Coordinator is responsible for developing the Care Plan. She didn't know when the Care Plans should be completed after admission. Resident #23 did have a Stage IV pressure ulcer to her sacrum on admission. She thought Resident #23 had 2 other areas, but never had any on her legs, but on her bottom. She didn't know if Resident #23 had facility acquired ulcers. The Progress Notes should include the wound measurements, assessments, each week. The wound nurse usually documented them. She worked from 6 PM to 6 AM. The documentation should include measurements, appearance, drainage, treatment, and notification of doctor.</p> <p>The Care Plan should include the following Interventions</p> <ol style="list-style-type: none"> Special mattress Cushion in her wheelchair Pillows to offload her from side to side Reposition frequently from bed to chair, and 	F 656			

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F 656	<p>Continued From page 12</p> <p>chair to bed</p> <p>e. Multivitamin.</p> <p>On 4/11/24 at 9:12 AM, when asked if a resident is admitted with an existing pressure ulcer, should that be addressed on the Baseline Care Plan, Staff B, Licensed Practical Nurse (LPN) responded she didn't know as she didn't do the Care Plans. When asked if pressure ulcers should be addressed on the Comprehensive Care Plan, she said she didn't have any knowledge of that. The MDS coordinator had the responsibility of developing the Care Plan. The MDS Coordinator at the time of Resident #23's admission is the current DON (Director of Nursing). When asked what was the time frame a problem should be identified on the Care Plan after admission, she replied she didn't know. When asked if Resident #23 had any pressure ulcers on admission, she responded Resident #23 had one to her sacral area and another open area to her hip which has healed since her admission. Staff B said any nurse could document on the pressure ulcer, the wound nurse, normally did the measurements, assessments, etc. She didn't know exactly what else should be documented as she didn't assess the wounds, because the RN did.</p> <p>On 4/11/24 at 9:45 AM, the DON explained when a resident admitted to the facility with an existing pressure ulcer, she expected the Baseline Care Plan and the Comprehensive Care Plan to include it. She added the MDS Coordinator is responsible for developing the Care Plan. She expected the Care Plan developed within 48 hours of admission. Common interventions she expected to see on a Care Plan for a resident with pressure ulcers would include: Nutrition</p>	F 656			

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F 656	<p>Continued From page 13</p> <p>Multivitamin, get the Dietitian, and the physician involved to get orders for extra protein, pressure reducing cushion, mattress, and turn them at least every 2 hours. She expected the nurse to document weekly on the wound. The nurse should measure and document the appearance, notifications completed, any changes, and treatments in a skin note in the progress notes. Resident #23 did have a pressure ulcer to her sacrum on admission, however, she couldn't recall if she had more than one pressure ulcer on admission. Upon review of Resident #23's admission MDS, she verified, she started the admission assessment. It appeared that the wound nurse revised the DON's note. The MDS did identify Resident #23 with one pressure ulcer, however, the wound nurse identified her with 3 pressure ulcers. The DON reported she left the note open for the wound nurse to complete as the DON didn't stage wounds. At the time Resident #23 admitted to the facility, she worked as the MDS coordinator, she thought Resident #23 only had one pressure ulcer to her sacral area. She had 2 open areas to her right gluteal fold, which she didn't believe were pressure ulcers. Resident #24's current pressure ulcer(s) were on the sacral and the right gluteal areas.</p> <p>In an interview on 4/11/24 at 10:21 AM, the MDS Coordinator reported when a resident is admitted with an existing pressure ulcer, the Baseline Care Plan and Comprehensive Care Plan should include it. The MDS is responsible for developing the Care Plan. They should start the Baseline Care Plan within 24 hours after admission. The common interventions she expected to see on a residents' Care Plan with a pressure ulcer would include: frequent repositioning at least every 2 hours, move from bed to chair to wheelchair,</p>	F 656			

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F 656	<p>Continued From page 14</p> <p>restorative care, pressure relieving device on the bed and chair. Treatments as ordered by the physician. Document wound assessments/measurements at least once a week. Upon review of the admission MDS , she verified Resident #23 only had one stage IV pressure ulcer. When asked if Resident #23 developed a second pressure ulcer, she reviewed the first quarterly MDS and verified it identified Resident #23 with one stage IV pressure ulcer and one current unstageable deep tissue injury. The tool used to develop the Care Plan would be the nurse's admission assessment. She couldn't verify if the second open area as a pressure ulcer, however, that it was classified as a deep tissue injury. And she couldn't find documentation of what caused the injury.</p> <p>In an interview on 4/11/24 12:04 PM, the DON provided timeline of Resident #23's wounds and explained the following:</p> <p>a. 12/7/23: Admitted with Stage IV pressure ulcer to the sacrum and 2 stage II pressure ulcers to the right lateral thigh/hip.</p> <p>b. 12/14/23: area to right thigh/hip resolved</p> <p>c. 1/5/24: two new areas to the inner right gluteal fold and to the outer right gluteal fold identified as deep tissue injuries with the cause unknown.</p> <p>The Pressure Ulcer Risk Assessment and Documentation policy reviewed January 2011 instructed the assigned nurse to complete the Admission/Readmission Pressure Ulcer Risk Assessment Tool on new admissions and readmissions. Determine the factors/conditions that place the resident at risk for developing pressure ulcers, list any additional risk factors. Review risk factors and Interventions with the resident and/or responsible party.</p>	F 656			

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F 656	<p>Continued From page 15</p> <p>The assigned nurse will complete the Nursing Admission Assessment which includes factors/conditions that may place a resident at risk for pressure ulcer development. Communicate interventions to appropriate staff. Update the Care Plan and interventions as risk factors change.</p> <p>2. Resident #14's MDS assessment dated 2/27/24 identified a BIMS score of 15, indicating intact cognition.</p> <p>Resident #14's Care Plan lacked long-term antibiotic use.</p> <p>The Clinical Physician Orders reviewed 4/10/24 at 12:48 PM included an order dated 11/15/23 for doxycycline hyclate Oral Tablet (antibiotic) 100 MG by mouth in the morning for community acquired PNA (Pneumonia), chronic suppression.</p> <p>The Physician Order dated 11/15/23 documented the following antibiotic medication for the resident: Doxycycline Hyclate Oral Tablet with instruction to give 100 mg (milligram) by mouth in the morning for community acquired PNA (Pneumonia), chronic suppression.</p> <p>Review of Resident #14's MARs revealed he took Doxycycline in the months of November 2023, December 2023, January 2024, February 2024, March 2024, and April 2023.</p> <p>On 4/11/24 at approximately 10:50 AM when queried if she expected the Care Plan to include prophylactic antibiotics, the MDS Coordinator replied yes. When queried if Resident #14 had this on his Care Plan, MDS Coordinator acknowledged she didn't see it.</p>	F 656			

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F 656	Continued From page 16 On 4/11/24 at 12:09 PM when queried if long term prophylactic antibiotics should be on the Care Plan, the Director of Nursing (DON) acknowledged yes.	F 656			



Plan of Correction in response to the DIA survey completed on 4/11/24.

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited or an admission of the accuracy or truthfulness of any statements, findings, facts, or conclusions that form the basis of the alleged deficiencies. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction Date: 5/11/24

F641 Accuracy of Assessments

The MDS assessment accurately reflects the resident's status.

For the required plan of correction, the facility submits the following:

1. The Center for Medicare/Medicaid Services (CMS) allows modifications of MDS submissions for data entry errors and coding errors for up to the prior 2 years. On April 11th, 2024, the MDS Coordinator submitted modifications to CMS to correct the MDS assessments for residents #3, #11, and #14. On May 2nd, 2024 the MDS Coordinator submitted modifications to CMS to correct the MDS assessments for resident #23.
2. Education was provided to the MDS assessment coordinator on April 11th, 19th, 29th 2024 by a corporate nurse consultant regarding utilization of the reports available on the electronic health record system to facilitate accurate coding and data entrance into the electronic MDS system to ensure assessments accurately reflect the residents' status during the observation period.
3. The Director of Nursing or designee will randomly audit MDS reports monthly for three months to ensure accuracy. The results of the audits will be reviewed as part of our on-going quality assurance process and the frequency of the audits thereafter will be based on outcomes and subsequent recommendations.

F656 Development/Implementation of care plan

The facility develops and implements a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

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For the required plan of correction, the facility submits:

1. To insure that staff members have the information needed to safely care for a new resident and that new residents have an opportunity to communicate their desires and needs for their stay, a baseline care plan should be completed within 48 hours of admission to the facility. A comprehensive care plan is developed within 21 days of admission. Resident #14's care plan was updated on April 11th, 2024, to reflect the nursing care being provided to the resident. Resident #23's care plan was updated on April 11th, 2024 to reflect the nursing care being provided to the resident.
2. The care planning team will receive education regarding the care planning process on May 7th, 2024 at 10:00am via go-to-meeting. The facilities policy/guideline "Baseline Care Plan Guidelines" will be utilized.
3. Through the facility's quality assurance process, the Director of Nursing or designee will audit comprehensive care plans for compliance quarterly at scheduled MDS assessments for 3 months. The frequency of audits thereafter will be based on those outcomes.



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