| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345296 | A. BUILDING _____ B. WING _____ | 04/09/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MARGATE HEALTH AND REHAB CENTER | 540 WAUGH STREET JEFFERSON, NC 28640 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to maintain the veneer of the resident bedroom doors so that the doors were not gouged, chipped or peeling. This was observed on 27 bedroom doors and 5 common room doors located on 5 of 5 halls.<br><br>The findings included:<br><br>During initial tour on 04/06/15 beginning at 9:30 AM, the bedroom doors on the 100, 200, 300 and 500 halls were noted scraped with some having chips and gouges.<br><br>On 04/09/15 at 9:14 AM, an interview with the Maintenance Supervisor (MS) revealed that the facility was in the process of remodeling of the facility in conjunction with the addition which is being built onto the existing building. The MS further stated that about 6 months ago, he conducted a facility wide walk through to determine how many of the doors were damaged and needed to be fixed and or replaced. MS said that he has not heard back from the construction company as to what will be done, either purchasing new doors or covering the existing doors with protective skins. In the meantime, MS stated that he tried to putty the gouges so as not to be hazardous for the residents. | F 253 | F 253<br><br>Specific action taken to correct the deficiency:<br>" Doors listed on 2567 will be ordered by May 17. In the interim Maintenance will sand and patch doors by hall per weekly painting schedule.<br><br>Corrective Action will be accomplished for residents having potential to be affected by:<br>" Doors will be replaced by hall as they arrive. As stated above maintenance will be checking and repairing doors weekly until new doors are completely installed.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:<br>" Maintenance inspect doors routinely x 3 months for signs of further damage<br><br>We will monitor our performance to make sure that solutions are sustained by:<br>" Reporting maintenance findings to the QA committee x 3 months.<br><br>Date of compliance:<br>" Facility will achieve substantial | 5/22/15 |

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

Electronically Signed | 04/30/2015

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| F 253 | Continued From page 1<br><br>On 04/09/15 at 9:20 AM, the Administrator joined in the conversation between the surveyor and the MS. Administrator stated that the need to repair the bedroom doors had been discussed between the facility (which leases the building) and the company that owns the building. Administrator stated that the company that was hired to put on the addition to the facility was going to be responsible for fixing the bedroom doors. Administrator stated that some of the outside doors have been repaired. Once the addition is completed, the construction company will be refinishing the handrails and the nursing station and the resident bedroom doors. Administrator could not provide a plan or timeframe for the bedroom doors to be repaired and stated it had not been decided if the doors were going to be replaced or skinned. He further stated the timeframe of fixing the bedroom doors were out of his hands.<br><br>A more detailed inspection of the facility interior doors was completed by 2 surveyors on 04/09/15 beginning at 9:45 AM and revealed doors with scrapes along the bottom of the doors and chipped and gouged areas on the doors stemming from the edges of the doors where the veneer was breaking away were as follows:<br>*Room 117<br>*Room 118<br>*Shower room on 200 hall<br>*Room 201<br>*Room 207<br>*Room 208<br>*Room 211<br>*Room 214<br>*Day room on the 200 hall<br>*Room 304 | F 253 | compliance by May, 22 2015. | |

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| F 253 | Continued From page 2<br>*Room 306<br>*Room 307<br>*Room 308<br>*Room 310<br>*Room 314<br>*Shower room on 400 hall<br>*Room 405<br>*Room 406<br>*Room 408<br>*Room 410<br>*Room 413<br>*Room 414<br>*Day room on the 400 hall<br>*Dining room on 500 hall<br>*Room 503<br>*Room 504<br>*Room 507<br>*Room 508<br>*Room 509<br>*Room 511<br>*Room 512 and<br>*Room 514. | F 253 | | |
| F 272 SS=E | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns; | F 272 | | 5/22/15 |

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| F 272 | Continued From page 3<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to analyze residents' strengths, weaknesses, and how these affected the residents' functionality in the care area assessments for 13 of 17 sampled residents. (Residents #3, #21, #25, #38, #43, #57, #68, #85, #87, #111, #112, #171, and #172)<br><br>The findings included:<br><br>1. Resident #57 was admitted to the facility on 02/25/15. Her diagnoses included muscle | F 272 | F 272<br>Specific action taken to correct the deficiency:<br>" DON or designee will review for accuracy 10% of CAAs done on a weekly basis x 4 weeks and then monthly x3.<br><br>Corrective Action will be accomplished for residents having potential to be affected by:<br>" IDT Staff in-serviced by DON or designee on MDS accuracy and coding as | |

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| F 272 | Continued From page 4<br>weakness, lack of coordination, difficulty walking, dementia, late effective cerebral vascular accident and depressive disorder.<br><br>The admission Minimum Data Set (MDS) dated 03/04/15 coded her as sometimes understanding and sometimes being understood, having long and short term memory impairments and moderately impaired cognition, being nonambulatory, needing staff assistance to balance during transitions, requiring extensive assistance with most activities of daily living skills (ADLs), having a fall since admission and receiving diuretics, anticoagulants and antidepressant medications. This MDS dated 03/04/15 noted that the areas that were triggered for assessment included cognitive loss, communication, ADLs, falls, and psychotropic drug use.<br><br>Review of the Care Area Assessments (CAAs) revealed each area included a checklist of items such as diagnoses, but no analysis of Resident #57's strengths, weakness, or how these areas impacted her functionality and her ability to improve or maintain status as follows:<br>a. Cognitive loss: The summary stated Resident #57 was verbal and did well with simple one word or yes and no questions. Her needs were anticipated and med by staff and she had the diagnoses of dementia. The CAA noted a care plan would be developed for cognitive deficits. This was written by the social worker but had no date.<br>b. Communication: The CAA noted she had dementia and depression, was taking the antidepressant medication of Paxil, staff anticipated and met her needs and that she was able to answer yes and no questions, had | F 272 | it relates to care area assessments to ensure future CAA□s are complete.<br><br>Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:<br>" MDS, SS and other IDT members as needed will be re-trained by DON or designee on proper documentation as it relates to CAAs to ensure each checked area, and how it affects the resident, is included in the CAA summary<br><br>We will monitor our performance to make sure that solutions are sustained by:<br>" DON or designee findings will be brought to QA committee x 4 months to ensure compliance.<br><br>Date of compliance:<br>" Facility will achieve substantial compliance by May, 22 2015. | |

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memory impairment, and difficulty finding appropriate words to use during communication. This was written by the MDS nurse on 03/09/15.
c. ADL function: The analysis of findings noted she had generalized weakness, a history of falls, a status post cerebral vascular accident, dementia and staff assisted with ADLs. The analysis also include that she was working with therapy to increase her level of independence.
d. Falls: Other than the family reported she had a history of falling at home, the analysis noted she was at increased falls due to generalized weakness and status post cerebral vascular accident and dementia. The CAA did not mention the fall she had since admission on 02/26/15 or the surrounding circumstances. This was signed by the MDS nurse on 03/09/15.
e. Psychotropic drug use: The analysis of findings simply stated she had a diagnosis of depression and was treated with the medication Paxil. This was signed by the MDS nurse on 03/09/15.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse and social worker who completed the Care Area Assessments (CAA) for Resident #57. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. The social worker stated she had been trained on the job but did not attend any formal MDS training. Neither were aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality.

2. Resident #171 was admitted to the facility on 03/26/15. His diagnoses included after care of a fractured hip, difficulty walking, muscle weakness,

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intellect disability, and psychosis.

The admission Minimum Data Set (MDS) dated 04/02/15 coded him as being cognitively intact (scoring a 12 out of 15 on the brief interview for mental status), requiring extensive assistance for most activities of daily living skills, needing assistance to balance during transitions, receiving antipsychotic medications and plans to discharge home.

Review of the Care Area Assessments (CAAs) revealed each area included a checklist of items such as diagnoses, but no analysis of Resident #171's strengths, weakness, or how these areas impacted his functionality and his ability to improve or maintain status as follows:
a. Cognitive Loss: Notes included the his diagnoses of diabetes, psychosis and intellect disability and the answers that he needed cueing to recall when taking the brief interview for mental status. The analysis of findings stated he was a new admission and family reported he had mild mental retardation. There was no indication as to how this affected him. This was signed by the social worker but was not dated.
b. Communication: The analysis noted he had a diagnoses of decreased mental capacity and psychosis. It noted Resident #171 verbalized and communicated effectively about basic needs. This was signed by the MDS nurse on 04/02/15.
c. ADL function: Notes included he required extensive assistance with mobility due to a left hip fracture he sustained from a fall at home, was receiving therapy, antibiotics for urinary tract infection and pneumonia and had decreased mental capacity and psychosis. This was written and signed by the MDS nurse on 04/02/15.
d. Psychotropic drug use: There were no

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assessment notes, only a checklist. The assessment failed to mention that he had a psychiatric evaluation on 4/3/15 after repeatedly mentioning that he had thoughts that someone wanted to kill him. This was written and signed by MDS nurse 04/06/15.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse and social worker who completed the Care Area Assessments (CAA) for Resident #171. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. The social worker stated she had been trained on the job but did not attend any formal MDS training. Neither were aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality

3. Resident #43 was admitted on 11/22/10 with diagnoses including Alzheimer's disease and anxiety disorder.

Review of the annual Minimum Data Set (MDS) dated 02/16/15 revealed Resident #43 had short and long-term memory loss and moderately impaired cognitive skills for daily decision making. The annual MDS also noted Resident #43 received an antianxiety medication 6 days during the 7 day assessment period.

Review of the Care Area Assessment (CAA) for psychotropic drug use dated 03/02/15 revealed checked items but no analysis of the checked items or any analysis of how they affected the resident's function or what direction the care plan would take. The checked items noted antianxiety medication use with adverse consequences including disturbance of balance, gait, and

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positioning ability and sedation. Content of the note sections included: diagnoses of Alzheimer's with memory deficits. The analysis of findings stated Resident #43 was at risk for adverse side effects of psychotropic drugs due to the use of Buspar (antianxiety medication). Comments under the heading of care plan considerations stated a care plan would be developed to prevent significant adverse side effects of medications.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse who completed the psychotropic drug use Care Area Assessment (CAA) for Resident #43. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. The MDS was not aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality.

4. Resident #112 was admitted on 10/31/12 with diagnoses including cancer and seizure disorder.

Review of the annual Minimum Data Set (MDS) dated 10/18/14 revealed Resident #112 had moderately impaired cognition, was usually understood, and usually understands.

Review of the Care Area Assessments (CAA) dated 11/06/14 revealed checked items but no analysis of the checked items or any analysis of how they affected the resident's function or what direction the care plan would take. Examples were as follows:

a. Cognitive Loss/Dementia was triggered and the checked items noted moderately impaired cognition, decreased ability to make self understood, and a decreased ability to

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understand others. Notes for the mood and behavior section stated when Resident #112 was upset and agitated he had decreased control and could be hard to redirect. Notes for the medical problems section stated Resident #112 had a history of lung cancer with brain metastasis. It was noted Resident #112 wore glasses and had hearing aid devices he ordered and used. The note section for analysis of findings was blank and the note section for care plan considerations stated a care plan would be developed and to see the behavior care plan to address issue.

An interview was conducted with the social worker (SW) on 04/09/15 at 11:44 AM. The SW stated stated she had been trained on the job but did not attend any formal MDS training. The SW confirmed she had completed Resident #112's Cognitive Loss/Dementia CAA summary and stated she would have covered the analysis of the resident's strengths, weaknesses and functionality in her note in the medical record but did not always include this information on the CAA summary.

b. Communication was triggered and the notes under the diseases and conditions stated Resident #112 had a diagnosis of lung cancer with brain metastasis. Hearing impairment was checked as a characteristic of communication and noted he was hard of hearing and used two hearing aides. Decline in cognitive status and increased dependence in activities of daily living were checked as confounding problems and it was noted Resident #112 required supervision with some activities of daily living. The analysis of findings stated Resident #112 had difficulty finding words at times and was able to communicate his needs verbally. A care plan

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consideration was listed as speech therapy as needed and it was noted a care would be developed to promote verbal communication.

An interview with the MDS Coordinator on 04/09/15 at 11:32 AM revealed an MDS consultant came to the facility in October of 2014 and had told the MDS nurses to be sure to write a summary of the resident's strengths, weaknesses, and functionality in the analysis of findings section of the CAA summary. The MDS Coordinator confirmed she had completed Resident #112's Communication CAA summary and should have included an analysis of his strengths, weaknesses, and functionality.

5. Resident #172 was admitted on 03/17/15 with diagnoses including an unstageable pressure ulcer.

Review of the admission Minimum Data Set (MDS) dated 03/24/15 revealed Resident #172 required extensive assistance with bed mobility and transfer and had an unstageable deep tissue injury. The admission MDS further stated Resident #172 was frequently incontinent of urine and continent of her bowels.

Review of the Care Area Assessment (CAA) for pressure ulcers dated 03/26/15 revealed checked items but no analysis of the checked items or any analysis of how they affected the resident's function or what direction the care plan would take. The checked items on the CAA summary noted an existing pressure ulcer, the need for a pressure relieving or reducing mattress/seat cushion, and noted she required staff assistance to move sufficiently to relieve pressure over any site. The CAA summary checked immobility and

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incontinence as intrinsic risk factors and noted she was assisted with mobility, activities of daily living and was frequently incontinent. Pain was checked as a diagnosis/condition and it was noted Resident #172 was status post hip fracture. Checked items for treatments and other factors included: functional limitation in range of motion, bedfast or wheelchair bound, and devices that could cause pressure. The note section for analysis of findings was blank and and the note section for care plan considerations stated a care plan would be developed to prevent further breakdown and resolve current.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse who completed the pressure ulcer Care Area Assessment (CAA) for Resident #172. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. The MDS was not aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality.

6. Resident #38 was admitted 05/27/05 with diagnoses of chronic obstructive pulmonary disease, osteoporosis and non- Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 01/03/15 revealed Resident #38 was severely cognitively impaired. The MDS further revealed Resident #38 required extensive assistance with transfers and toileting.

Review of the Care Area Assessments (CAA) dated 08/21/14 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected Resident #38's function or what direction the care plan would take. Example as follows:

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Falls was a checklist with the only additional information of being frequently incontinent, dementia, diagnoses of schizophrenia, depression, sees large print and at risk for falls due to history of falls. She has non-skid socks at bedtime, non-skid strips to floor right side of bed, bed in lowest position, pull ups used and 2 person assisted with transfers. This was written by the MDS Coordinator.

An interview was conducted on 04/09/15 at 11:19 AM with the MDS Nurse Coordinator who completed the Care Area Assessments (CAA) for Resident #38. She stated the CAA should contain a summary of how the resident was doing before admission, goals for the resident and expected outcomes. She further stated she had a MDS Nurse Consultant that worked with her in January 2015 and she stressed the importance of the CAA summary.

7. Resident #21 was admitted to the facility on 01/10/15 with diagnoses of hip fracture and history of falls. The admission Minimum Data Set (MDS) dated 01/17/15 revealed Resident #21 had moderately impaired cognition with long and short term memory impairment. The MDS further revealed Resident #21 required extensive assistance with transfers and toileting.

Review of the Care Area Assessments (CAA) dated 01/17/15 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected Resident #21's function or what direction the care plan would take. Example as follows:

Falls was a checklist with the only additional

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information of senility diagnoses of confusion at times, left hip fracture with repair, pain due to hip fracture relieved with as needed pain medication, receiving vitamin D 01/19/15 on Zithromax for congestion. Resident #21 is at risk for falls due to recent fall with hip fracture and repair, use of blood pressure lowering medication and pain medication. She is out of bed to wheelchair and is receiving physical and occupational therapy. This was written by the MDS Coordinator.

An interview was conducted on 04/09/15 at 11:19 AM with the MDS Nurse Coordinator who completed the Care Area Assessments (CAA) for Resident #38. She stated the CAA should contain a summary of how the resident was doing before admission, goals for the resident and expected outcomes. She further stated she had a MDS Nurse Consultant that worked with her in January 2015 and she stressed the importance of the CAA summary.

8. Resident #85 was admitted to the facility on 07/21/14 with diagnoses of non-Alzheimers dementia, anxiety disorder and psychotic disorder. The quarterly Minimum Data Set (MDS) dated 04/01/15 revealed Resident #85 was severely cognitively impaired. The MDS further revealed Resident #85 received antipsychotics and antianxiety 7 days during the 7 day look back period.

Review of the Care Area Assessments (CAA) dated 01/17/15 revealed a checklist but no analysis of the checked items or any analysis of how the checked items affected Resident #85's function or what direction the care plan would take. Example as follows:

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Psychotropic drug use was a checklist with the only additional information of Resident #85 had anxiety and required medication. Will proceed to care plan for anxiety. This was written by MDS Nurse #2.

An interview was conducted on 04/09/15 at 11:19 AM with the MDS Nurse Coordinator. She stated the MDS Nurse #2 that completed the Care Area Assessments (CAA) for Resident #38 no longer worked at the facility. The MDS Nurse Coordinator stated the CAA should contain a summary of how the resident was doing before admission, goals for the resident and expected outcomes. She further stated she had a MDS Nurse Consultant that worked with her in January 2015 and she stressed the importance of the CAA summary.

9. Resident #25 was admitted to the facility 05/03/12. Resident #25's diagnoses included dementia, diabetes, contractured hand, osteoarthritis, osteoporosis and depressive disorder.
MDS assessment dated 02/18/15 recorded that Resident #25 had severely impaired cognition and indicated that Resident #25 required extensive assistance with toileting, transfers and dressing and was incontinent of both bowel and bladder.
Review of the CAA dated 02/18/15 focused on Resident #25's activity of daily living (ADL) functional/rehabilitation status revealed each area included a checklist of items concerning ADL status, potential underlying factors, diagnoses and other pertinent information concerning Resident #25 but no analysis of Resident # 25's strengths and weakness or how these areas

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impacted her functionality or Resident #25's ability to improve or maintain ADL status. Examples as follows:
a. Current ADL status had no blocks checked regarding Resident #25's ADL status and noted only that Resident #25 needs extensive assist on most ADLs.
b. Communication problems and visual problems checked as potential underlying factors related to Resident #25's ADL functional/rehabilitation and accompanied only with the notation that Resident #25 is aphasic, can answer simple questions and identify objects.
c. Limiting factors of mental errors and physical limitations were checked but CAA summary not related to these limiting factors only listed the diagnoses of dementia, right hemiparesis and contractured right hand.
d. CAA dated 02/18/15 indicated by check blocks that Resident #25 is at risk for pressure ulcers and incontinence but noting only that Resident #25's skin is intact, was frequently incontinent and was on a toileting program.
e. CAA concerning Resident #25's analysis of findings related to ADL functional/rehabilitation status communicated only that Resident #25 needs assistance with ADLs, feeds self after set up and propels self in a wheel chair.
f. CAA dated 02/18/15 indicated by a check block that a care plan would be developed concerning Resident #25's ADL functional/rehabilitation status noting only that Resident #25's current abilities will be promoted.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse who completed the CAA for Resident #25. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in

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the CAA summary. She added that she was aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality.

10. Resident #68 was admitted to the facility on 04/26/12. Diagnoses included dementia and a history of transient ischemic attack/stroke.

Resident #68's MDS assessment dated 03/27/15 recorded that Resident #68 had severely impaired cognition, was always incontinent of bowel and bladder and was totally dependent on staff for bed mobility, toileting, transfers and all personal hygiene.

Review of the CAA dated 11/20/14 focused on Resident #68's activity of daily living (ADL) functional/rehabilitation status revealed each area included a checklist of items concerning ADL status, potential underlying factors, diagnoses and other pertinent information concerning Resident #68 but no analysis of Resident # 68's strengths and weakness or how these areas impacted her functionality or Resident #68's ability to improve or maintain ADL status. Examples as follows:
a. Current ADL status had no blocks checked regarding Resident #68's ADL status and noted only that Resident #68 required total assist and that her needs are anticipated and met by staff.
b. All potential underlying factor blocks were unchecked and noted only that Resident #68 is non-verbal and consumed a pureed diet with nectar thick liquids.
c. All remaining fields including lab values, blood sugar and limiting factors on Resident #68's CAA dated 02/18/15 focused on Resident #68's activity of daily living (ADL)

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functional/rehabilitation status were either blank or unchecked except to inform that the resident had a stage two pressure ulcer with the analysis of findings that Resident #68 needed total care and could not ask for her needs to be meet and indicated a care plan would be developed.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse who completed the CAA for Resident #68. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. She added that she was aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality.

11. Resident #87 was admitted to the facility 01/29/15. Resident #87's diagnoses included difficulty in walking, generalized weakness, lack of coordination, senility and dementia.

Resident #87's MDS assessment dated 02/05/15 recorded that Resident #87 was cognitively intact and indicated that Resident #87 required extensive assistance with bed mobility, transfers, dressing and toileting.

Review of the CAA dated 02/05/15 focused on Resident #87's problem area of pressure ulcers contained an incomplete assessment of Resident #87's impaired skin integrity which did not include a comprehensive description of Resident #87's pressure ulcer. CAA dated 02/05/15 noted only that Resident #87 had a stage 4 pressure ulcer to sacrum with granulation in the wound bed. CAA dated 02/05/15 provided a partial summary of Resident #87's current care related to pressure ulcers but did not provide direction concerning

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monitoring and interventions that may be considered. Examples as follows:
a. Analysis of findings CAA dated 02/05/15 focused on Resident #87's problem area of pressure ulcers indicated that Resident #87 is at risk for increased skin breakdown due to low body weight but does not offer guidance for care planning Resident #87's nutritional requirements.
b. CAA dated 02/05/15 focused on Resident #87's problem area of pressure ulcers noted a risk for increased skin break down due to decreased mobility but does not provided information related to the extent of Resident #87's limitations or offer guidance related to monitoring and improving Resident #87's mobility potential other than to reference Resident #87 is receiving therapy.

On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse who completed the CAA for Resident #87. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. She added that she was aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality.

12. Resident #111 was admitted to the facility on 06/12/13. Resident #111's diagnoses included hemiplegia affecting dominant side and osteoarthritis.

MDS dated 02/13/15 recorded that Resident #111 was severely cognitively impaired and indicated Resident #111 required extensive assistance with bed mobility, transfers, toileting, dressing, bathing and was always incontinent of bowel and bladder.
a. Review of the CAA dated 06/07/14 focused on

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Resident #111's ADL functional/rehabilitation status revealed each area included a checklist of items concerning ADL status, potential underlying factors, diagnoses and other pertinent information concerning Resident #111 but no analysis of Resident # 111's strengths and weakness or how these areas impacted her functionality or Resident #111's ability to improve or maintain ADL status. Examples as follows:

* All blocks related to ADL status unchecked and it is noted only that Resident #87 requires a Hoyer lift for transfers, has paralysis on her right side and can feed herself.
* Incontinence of both bowel and bladder is noted as a potential problem but no monitoring, intervention or toileting program is referenced in the CAA dated 06/07/14 focused on Resident #111's ADL functional/rehabilitation status.
* The analysis of findings informed only that Resident #87 is post cardiovascular accident, blind in right eye, transferred by Hoyer lift and requires extensive assistance but does not offer guidance or assessment related to Resident #87's rehabilitation potential or improving Resident #87's mobility or visual acuity.

b. Review of the CAA dated 06/07/14 focused on Resident #111's use of psychotropic drugs informed that Resident #111 was prescribed antianxiety, antidepressant medication specifying that Resident #111 receives Celexa daily. The analysis of findings assessment concerning psychotropic drug use was limited to the information Resident #111 was alert, seemed a little anxious at times and indicated that Resident #111 had been on antidepressant medication for a long time noting that Resident #111 was free of

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| F 272 | Continued From page 20<br>signs and symptoms associated with the long term use of psychotropic medications. No other information or care plan considerations associated with monitoring changes in cognition, behavior, mood, nutritional status, bowel function, ability to engage in ADLs or the adverse consequences related to the use of psychotropic medications were contained in CAA dated 06/07/14 focused on Resident #111's use of psychotropic drugs. No guidance concerning gradual dose reduction of psychotropic medications was provided in CAA dated 06/07/14 focused on Resident #111's use of psychotropic drugs.<br>On 04/09/15 at 11:19 AM, an interview was conducted with the MDS nurse who completed the CAA for Resident #111. The MDS nurse stated she just started in February and has not had any training in relation to what should be included in the CAA summary. She added that she was aware of the need for a summary analyzing a resident's strengths, weaknesses and functionality. | F 272 | | |