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	345336	A. BUILDING ______ B. WING ______	C 03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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F 000	INITIAL COMMENTS The survey team entered the facility on 2/10/21 and an exit conference was held on 2/12/21. Additional information was obtained on 2/16/21, 2/23/21, 3/2/21, and 3/4/21. Therefore, the exit date was changed to 3/4/21. Four of the twelve allegations were substantiated. Immediate Jeopardy was identified at: CFR 483.25 at tag F686 at a scope and severity K The tag F686 consituted Substandard Quality of Care. Immediate Jeopardy began on 1/8/21 and was removed on 2/28/21. A partial extended survey was conducted. 3/31/21 Discussion with CMS resulted in changing f725 G to an H. BW	F 000		
F 641 SS=D	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: Based on record review and staff interview the facility failed to accurately code pressure ulcers and height on the admission Minimum Data Set assessment for 1 (Resident #1) of 8 residents reviewed for accuracy of assessments. Findings included: Resident #1 was admitted to the facility from the hospital on 1/1/2021 and resided there until his	F 641	F641 1.Minimum Data Set (MDS) Assessment for Resident #1 has been modified to accurately code pressure ulcers and height on admission. 2.All residents had the potential to be affected. In house audit completed on the current resident population to validate accurate coding on the MDS for pressure	3/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/18/2021

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.

F 641

Continued From page 1

discharge on 1/27/2021. The resident had a diagnosis of a neurological condition.

The discharge summary from the hospital dated 1/1/2021 revealed Resident #1 had no skin breakdown but was at high risk for pressure injuries. The hospital discharge summary listed the resident as 5 foot 10 inches tall.

The nursing admission observation form check off sheet with skin as one of the categories, dated 1/1/2021 indicated Resident #1 had warm, dry, normal color, normal turgor, and no alterations to his skin.

A Braden scale for predicting pressure sore risk dated 1/1/2021 revealed Resident #1 was at high risk for pressure sores due to completely limited sensory perception, occasionally moist skin, bedfast, completely immobile, adequate nutrition, and a friction problem.

An admission MDS dated 1/8/2021 coded Resident #1 as having no pressure sores and being 5 foot 10 inches tall.

The unit manager (Nurse #1) was interviewed on 2/10/2021 at 1:57 PM, 2/10/2021 at 4:15 PM, and again on 2/12/2021 at 10:50 AM. Nurse #1 stated a nurse aide approached her on 1/08/2021 because Resident #1 had an open area on the left buttock. Nurse #1 stated she observed a "shearing" of the skin of the left buttock on Resident #1. Shearing is a gravity force pushing down on the patient's body with resistance between the patient and the chair or bed. Nurse #1 described the area as a reddened area. Nurse #1 stated she did assess the skin of Resident #1, but she did not document her observations.

F 641

ulcers and height. This audit will be completed by 3/19/21.
3.Education provided to the MDS Nurses on Accuracy of Assessments as it relates to coding pressure ulcers and height by the Regional Clinical Reimbursement Specialist. This education will be completed by 3/22/21. This education will be included in new hire orientation for MDS nurses.
4.Ongoing audits will be completed by the MDS Coordinator or Regional Clinical Reimbursement Specialist for review to ensure accurate coding of pressure ulcers and height. These audits will conducted twice a week for four weeks, 5 audits weekly for four weeks, 5 audits monthly for three months, and then 5 random audits each month for two months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.
5.The Administrator and the MDS Coordinator is responsible for

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F 641	Continued From page 2 Nurse #1 stated she did not know why she did not record any documentation of the skin assessment of Resident #1 on 1/08/2021. Nurse #1 called the resident's physician and obtained orders for treatment. A physician's order was initiated on 1/8/2021 for a treatment of a sheer wound on the left buttock of Resident #1. The order stated the wound was to be cleaned with wound cleanser, patted dry, Medihoney, a medicinal honey with antimicrobial properties, promotes debridement, stimulates wound tissue, and promotes a moist wound bed, applied, covered with foam, and padded well daily. An interview was conducted with the wound care nurse (Nurse #2) on 2/10/2021 at 2:18 PM. Nurse #2 stated Resident #1 was a very tall man who required his bed to be extended due to his height, so his feet would not be pressing on the foot board of the bed. A nutrition risk assessment dated 1/23/2021 completed by the registered dietitian revealed Resident #1 was assessed on 1/1/2021 as being 6 foot 2 inches tall. An interview was conducted on 2/12/2021 at 11:05 AM with the MDS coordinator (Nurse #6) who completed the Admission MDS dated 1/8/2021 for Resident #1. Nurse #6 indicated she looked at all the documentation in the medical record of Resident #1 for the look back period from 1/2/2021 to 1/8/2021. Nurse #6 stated she looked at the hospital discharge summary, physician notes, nursing notes, treatment record, and wound care notes for documentation on how to code the MDS assessments. Nurse #6	F 641	implementing and maintaining the acceptable plan of correction. Corrective action to be completed by March 23,2021.	

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F 641	Continued From page 3 indicated during the look back period there was no documentation Resident #1 had a wound or any skin breakdown. Nurse #6 revealed she did go and speak to Resident #1, but she did not look at his skin or his body. An interview was conducted on 3/4/2021 at 12:37 PM with the interim Director of Nursing. The Director of Nursing stated the MDS nurse can obtain information for the MDS assessments by their own observations or through nursing documentation.	F 641		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, family interview, and physician interview the facility failed to assess a resident and seek medical attention for a change in condition and monitor the blood sugars as ordered by the physician for 1 of 4 residents reviewed for providing care according to professional standards (Resident #9). After the family of Resident #9 called EMS (emergency medical services), Resident #9 was assessed by EMS as having a finger stick blood sugar of 443 mg/dl (Normal 72 to 99 mg/dl) with altered mental status and diabetic symptoms.	F 684	F684 1.Resident #9 is discharged from the facility. 2.All residents had the potential to be affected. In house audit will be completed for the past seven days, on current resident population to validate that blood sugars are being monitored as ordered by the physician and physician notification is made for residents experiencing a change in condition. This audit will be completed by March 19.2021.	3/23/21

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F 684 Continued From page 4

Findings included:

Resident #9 was admitted to the facility on 4/4/2020 with a medical history of diabetic ketoacidosis, end stage renal disease, insulin dependent diabetes mellitus and a seizure disorder. Resident #9 received hemodialysis.

The most recent quarterly Minimum Data Set assessment dated 1/8/2021 coded Resident #9 as having moderately impaired cognition, no moods, no behaviors, and no rejection of care. He required supervision of one person with bed mobility, transfers, and personal hygiene. He required supervision and set up help with dressing and eating. Resident #9 was independent with walking, toilet use, and bathing. He received insulin injections six of the seven days of the assessment period. Resident #9 was coded as receiving dialysis.

The care plan had a problem area dated 1/19/2021 for Cardiovascular and diabetes complications for Resident #9. Some of the approaches were to administer medications as ordered, observe for weakness, monitor blood glucose as ordered, and routine vital signs.

Resident #9 had physician orders initiated on 1/14/2021 for blood sugar monitoring before meals and at bedtime along with administration of insulin on a sliding scale. Documentation on the medication administration record (MAR) revealed Resident #9 received blood sugar monitoring and insulin administration as ordered prior to the evening meal and at bedtime on 1/25/2021.

Documentation in the nursing progress notes

F 684

3.Education provided to licensed nurses on the Blood Glucose Monitoring Policy. Additional education will be provided to all staff on the Change of Condition Policy. This education will be completed by March 22, 2021. This information will be included in new hire orientation for all staff.
4.Ongoing audits will be completed by the Director of Nursing and/or Assistant Director of Nursing to validate that blood sugars are being monitored as ordered by the physician. Additional audits will be conducted to validate that physician notification is made for residents experiencing a change in condition. These audits will be conducted 5x a week for four weeks, twice weekly for two weeks, weekly for two weeks and monthly for three months. Compliance will be validated during the Clinical Whiteboard meeting held daily Monday through Friday. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.
5.The Administrator and the Director of

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F 684	Continued From page 5 dated 1/26/2021 at 8:00 AM for Resident #9 stated, "[Certified Nursing Assistant] on duty notified nursing staff that resident was unresponsive. This writer responded to his room and checked on the resident. Resident was not his usual self and his CBG (capillary blood glucose) was taken because he is diabetic, and it was 51. He was continuously given a sternum rub in which he was responsive to. He was also given a glucagon 1 mg (milligram) in each deltoid and CBG did go up to 55 and 15 minutes later to 148. Coworkers called 911 services and they did arrive on the scene with action in progress. CBG began to decline to 145 and resident was sent out for safety because he could not swallow and did have a protruding tongue. [Management] aware and [Physician name] was notified." Resident #9 returned to the facility from the hospital on 2/4/2021. The Admission Observation form dated 2/4/2021 at 6:35 PM by the unit manager (Nurse #1) revealed Resident #9 was assessed as alert but sluggish in responses and bowel incontinence since hospitalization due to a new diagnosis of Clostridium difficile. Hospital discharge orders dated 2/4/2021 revealed Resident #9 was to have insulin administered subcutaneously with meals and at bedtime based on a sliding scale of blood glucose monitoring. The physician was to be notified if blood glucose levels dropped below 90 or were above 500. Documentation in a nursing progress note written by Nurse #1 for Resident #9 dated 2/4/2021 at 4:56 PM stated, "Resident arrived at 3:59 PM from [Hospital name]. Resident alert oriented to self and knows some staff members by face and	F 684	Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by March 23,2021.	

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F 684	Continued From page 6	F 684		

name. Resident verbally slow to respond. Resident expressed understanding re: diet, medication changes and ability OOB (out of bed) to wheelchair. Resident with no skin issues with exception of peeling dried skin to sternal area. Appearance of drying burn. No apparent distress."

Nursing progress notes dated 2/4/2021 at 4:03 PM, written by Nurse #1, stated the finger stick blood sugar monitoring frequency for Resident #9 was increased to every 4 hours until further physician orders.

Nurse #1 was interviewed on 2/16/2021 at 10:30 AM. Nurse #1 related she was in communication with the hospital prior to the arrival of Resident #9 coming back to the facility on 2/4/2021. Nurse #1 was told by the hospital nurse of Resident #9 being unresponsive for several days in the hospital and he had declined in cognition. Nurse #1 explained that in the clinical nursing meeting at the facility it was discussed how Resident #9 would need monitoring through out the night due to his blood sugar dropping. Nurse #1 further explained that it was decided in the morning facility clinical meeting, with the administrative nursing staff members, it would be best for the resident to have his blood sugars monitored every 4 hours and an order was obtained from his physician (MD #1). Nurse #1 revealed she had confirmation of the agreement of MD #1 with the blood sugar monitoring of every 4 hours for Resident #9 through a text message. Nurse #1 indicated MD #1 came to the facility twice a week to see his patients but Resident #9 was not in the facility long enough after his arrival from the hospital on the 2/4//2021 for MD #1 to see him.

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F 684	Continued From page 7 Review of the medication orders for Resident #9 revealed the order for blood glucose monitoring/insulin administration was increased on 2/4/2021 from 4 times a day, before meals and at bedtime, to every 4 hours, at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The physician was to be notified if the blood sugar was less than 90 or greater than 500. Resident #9 had an additional order for vital signs to be taken every shift for 72 hours after admission, day and night. Documentation on the MAR from 2/4/2021 at 4:00 PM to 2/7/2021 at 4:00 AM revealed blood sugar monitoring and administration of insulin were completed as ordered when Resident #9 was in the facility and not at dialysis. There were no abnormal blood sugar readings that went beyond the sliding scale for which the physician of Resident #9 would have to be notified during that time period. Documentation on the MAR for 2/7/2021 revealed blood sugar monitoring and administration of insulin was not competed at 8:00 AM and 12:00 PM as ordered. The reasons/comments on the MAR documented by Nurse #4 was, "Resident Unavailable." Documentation on the MAR under vital signs every shift was not completed for Day on 2/7/2021 with the reason/comment being the, "Resident Unavailable." An interview was conducted on 2/10/2021 at 11:02 AM with a family member who was waiting outside the facility to see Resident #9 on 2/7/2021. The family member stated she went to the facility on 2/7/2021 to check on Resident #1 because he had been having episodes of low blood sugars with several hospital visits, and she	F 684		

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F 684	Continued From page 8 was concerned the facility was not monitoring him. The family member stated after the request to see Resident #1 was made, an hour went by and nobody was telling them what was going on. The family member stated her concern grew to the point she called the police to check on the resident. An interview was conducted with NA #8 on 3/4/2021 at 10:41 AM. NA #8 confirmed she was the nurse aide assigned to Resident #9 on 2/7/2021 on the 7:00 AM to 3:00 PM shift. NA #8 stated on the morning of 2/7/2021 Resident #9 was very lethargic and she had to feed him at breakfast. NA #8 revealed she told Nurse #4 several times something was very seriously wrong with Resident #9. NA #8 further revealed it became apparent Nurse #4 was not going to do anything to help Resident #9, so she filled out a Stop and Watch form to protect herself if anything were to happen to Resident #9. A Stop and Watch form is an early warning tool used by the nurse aides to document when they see a change in a resident while caring for them. An interview was conducted with NA #9 on 3/4/2021 at 11:00 AM. NA #9 stated she was a restorative nurse working on the hallway on for which Resident #9 resided on the morning of 2/7/2021. NA #9 stated she saw Resident #9 on 2/7/2021 and described him as looking awful and not his usual self at all. NA #9 revealed Resident #9 was not conscious enough to respond to questions. NA #9 described the resident as having his eyes closed looking weak and lifeless. NA #9 indicated she told Nurse #4 the concern she had for the well being of Resident #9. NA #9 stated Nurse #4 told her it was the "New Normal" for Resident #9.	F 684		

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F 684	Continued From page 9	F 684		

A nursing progress note dated 2/7/2021 written by Nurse #4 at 5:41 PM stated, "Around 1:30 PM family of resident came to facility voicing the need to have a visit with resident. Resident voiced desire to visit but was not able to stay alert long enough to have a visit. Resident would answer questions correctly but needed sternal rubs to maintain alertness. Family members called for a wellness check in which the police officers came to see for themselves and reported back to the family. Daughter requested that resident be sent to ER (emergency room) for evaluation and called EMS (emergency medical services) herself. EMS arrived and exited with resident to [hospital name] at 2:00 PM."

Nurse #4 was interviewed on 2/11/2021 at 12:20 PM. She was working a 7:00 AM to 7:00 PM shift on 2/7/2021. Nurse #4 explained when she arrived the facility was short a nurse and she was asked to be responsible for her one medication cart on a hallway and half of another medication cart for another hallway. Nurse #4 recalled she started to administer medications on the hallway she was most unfamiliar with first. She started on one end of the hallway and worked her way up. Nurse #4 indicated both hallways had residents who needed blood glucose monitoring. She explained she went from resident to resident going up the hallway administering medications and checking blood glucose levels as needed when she came to a diabetic resident. The facility had a lot of room changes recently and she indicated she was not able to get all the blood glucose monitoring done prior to the service of breakfast due to having responsibility for two medication carts. She did check the blood glucose of Resident #9 sometime in between

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F 684	Continued From page 10 breakfast and lunch and she did administer insulin at that time. Nurse #4 did not recall what the blood glucose level of Resident #9 was or how much insulin was administered. She was unaware Resident #9 was back from the hospital at the start of her shift and she was not aware the orders for blood glucose monitoring had switched to every 4 hours for Resident #9. She had not been notified Resident #9 had a level of acuity change after returning from the hospital. If she had known Resident #9 had increased confusion and couldn't even hold his head up, she would have started on his end of the hall. She did not have time to call the physician for Resident #9 because the family called the police and emergency medical services. Nursing assistants on the hallway were monitoring the residents while she was giving medications on the other hallway. Nurse #4 stated a nursing assistant took the vitals of Resident #9 and wrote it down on a piece of paper but due to the computer not working she did not put the vitals into the MAR. Nurse #4 did not check the blood sugar of Resident #9 prior to leaving with EMS. There was no documentation on the MAR of the blood sugar reading for Resident #9 prior to leaving with EMS on 2/7/2021. A nursing progress note dated 2/7/2021 written by Nurse #5 at 2:10 PM stated, "Notified family called police and EMS to facility. Police arrived to building and performed a wellness check. [Responsible Party for Resident #9] requested that resident be sent to ER to be evaluated." Nurse #5 was interviewed on 2/11/2021 at 1:40 PM. She was the nursing supervisor on 2/7/2021 but she had her own 25 patients and a nursing	F 684		

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F 684	Continued From page 11 medication cart she was responsible for. Nurse #5 confirmed she was available to assist other nurses in the facility on 2/7/2021 if an emergency occurred. Nurse #5 recounted the assistant business office manager came to her and told her family members of Resident #9 were at the front door requesting to see him. Nurse #5 explained she asked why Resident #9 could not be brought to the front to see his family. She went to the other hallway to see Resident #9. Nurse #5 related everything happened very quickly because the family of Resident #9 called the police. Nurse #5 further explained she asked Resident #9 if he wanted to see his family and he very slowly acknowledged he did want to see his family. Nurse #4 and herself attempted to get Resident #9 prepared to see his family but he was not his normal self, he was "drifting in and out." He was only aroused with a sternal rub and he was not safe to sit up in a wheel chair. At that point the police arrived in the room and wanted to know what was going on. Nurse #5 indicated the police asked questions of Resident #9 and he slowly responded drifting in and out of consciousness. She and Nurse #4 accompanied the police to the front door to talk to the family of Resident #9. EMS arrived at the front door because they had been called by the family of Resident #9. The family requested Resident #9 be transported to the hospital and the paperwork for his discharge was prepared. Documentation in an emergency medical services report dated 2/7/2021 revealed Resident #9 had a finger stick blood sugar of 443 mg/dl (Normal 72 to 99 mg/dl) with altered mental status with diabetic symptoms. An interview with the Director of Nursing (DON)	F 684		

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F 684	Continued From page 12 was conducted on 2/11/2021 at 2:30 PM. The DON stated it was her expectation that for any change in a resident's condition the resident's physician be notified. The DON stated it was also her expectation physician orders be followed regarding blood glucose monitoring and insulin administration and the nursing staff reach out for help if blood glucose monitoring could not be completed as ordered. An interview was conducted with the physician for Resident #9 (MD #1) on 2/11/2021 at 4:50 PM. MD #1 stated Resident #9 received dialysis services and his blood sugars were "all over the place." MD #1 stated he would never have written an order for blood glucose monitoring for Resident #9 for every 4 hours and did not feel it was necessary to check his blood glucose levels every 4 hours.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		3/23/21

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Based on record reviews, staff interviews, and physician interviews, the facility failed to provide a comprehensive approach to pressure ulcers as evidenced by lack of assessments, lack of documentation, and lack of treatments for 1 or 3 residents reviewed for care and services for pressure ulcers. Resident # 1 was admitted on 1/1/21 with no skin breakdown and was identified on 1/19/21 with an unstageable pressure ulcer to the coccyx, and on 1/20/21 a deep tissue injury to the left heel, left posterior ankle, and left plantar foot.

Immediate Jeopardy began on 1/8/2021 a nurse aide identified an open area on the sacral area and a nurse did not perform a complete assessment until 1/19/21, and at that time it was unstageable. Immediate jeopardy was removed on 2/28/2021 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff education and ensure monitoring systems are in place are effective for the provision of a comprehensive approach to pressure ulcer care. Findings included:

Resident #1 was admitted to the facility from the hospital on 1/1/2021 and resided there until his discharge on 1/27/2021. The resident had a diagnosis of a neurological condition.

The discharge summary from the hospital dated 1/1/2021 revealed Resident #1 had to wear a neck brace continuously, had unremarkable laboratory values except for anemia, and had no skin breakdown but was at high risk for pressure

F 686

F686

1.Resident #1 has been discharged from the facility.

2.A facility wide skin sweep was initiated on 2/26/21 and completed on 2/26/21 by the Signature Care Consultant (SCC), Interim DON, Assistant Directors of Nursing, Wound Care Nurse, and Unit Manager. This was completed to identify any further residents with potential to have been affected. One additional resident was found to have been affected. An audit was completed on 02/26/2021 of all in-house wounds, to ensure a treatment was ordered and in place. No further residents were found to have been affected.

3.Education for all licensed nurses was initiated 2/27/2021 and completed on 2/28/21 by the SCC, Interim DON, and RN Supervisor. Education was on the Skin Observation/Evaluation and Prevention Policy. Education included completing a thorough skin assessment upon admission, completing the Braden assessment, Documentation of new skin alteration findings, MD notification, obtaining a treatment order, family/POA notification, weekly skin assessment, documentation of skin assessments, weekly documentation of pressure ulcer assessments, preventative skin care, completion of wound treatments, wound staging, identifying when a wound is declining and MD notification. Nurse aides and licensed nurses were educated on

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injuries.

The nursing admission observation form check off sheet with skin as one of the categories, dated 1/1/2021 indicated Resident #1 had warm, dry, normal color, normal turgor, and no alterations to his skin.

A Braden scale for predicting pressure sore risk dated 1/1/2021 revealed Resident #1 was at high risk for pressure sores due to completely limited sensory perception, occasionally moist skin, bedfast, completely immobile, adequate nutrition, and a friction problem.

A nutrition risk assessment dated 1/23/2021 revealed Resident #1 was assessed on 1/1/2021 as being 300 pounds and 6 foot 2 inches tall.

Physical therapy notes dated 1/5/2021 stated collaboration was made with the facility social worker, director of nursing, and the unit manager regarding Resident #1 requiring total dependence on care givers for all activities of daily living, the need for an air mattress, as well as the need to establish repositioning schedule every 2 to 3 hours for pressure redistribution and maintenance of skin integrity.

An interview with the interim Director of Nursing (DON) was conducted on 2/11/2021 at 3:16 PM. The DON confirmed the air mattress was ordered for Resident #1 as a result of the recommendation of physical therapy. The DON explained all the beds in the facility were pressure redistributing mattresses while Resident #1 obtained a low air loss mattress on 1/7/2021 as evidenced by an invoice with his name on it.

F 686

the importance of frequent turning and repositioning and the importance of ensuring specialty mattresses are size appropriate and notifying the DON if a change is needed. All current agency staff have been educated and all facility new hires and new agency staff will receive education prior to working their first shift. The Director of Nursing and/or Assistant Director of Nursing will be responsible to provide this education and they were informed on 2/28/21.

4.Wound documentation and weekly skin assessments are being completed on every resident. Direct care licensed nurses will complete weekly skin assessments, assess and document the wounds each week, request a treatment for newly identified wounds from the MD, apply the treatments and document on the MAR. The wound nurse will be completing audits to ensure assessments have been completed, treatment orders are received and in place, and that weekly skin assessments are being completed and documented weekly. Ongoing, all wounds will be discussed in the weekly Skin Nutrition At Risk meeting with the RD in attendance.

5.The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by 2/28/2021.

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A nursing progress note dated 1/8/2021 at 12:54 PM written by the MDS (minimum data set) nurse (Nurse #6) and entered as a late entry on 1/13/2021 stated, "Resident (#1) observed on an air mattress."

An admission MDS dated 1/8/2021 coded Resident #1 as having a moderately impaired cognition, no rejection of care, and dependent on two people for all activities of daily living. Resident #1 was coded as having an indwelling catheter and always incontinent of bowel. Resident #1 was coded as having no pressure sores, on a pressure reducing device for the bed, application of ointments other than to feet, and was not on a turning and repositioning schedule.

The unit manager (Nurse #1) was interviewed on 2/10/2021 at 1:57 PM, 2/10/2021 at 4:15 PM, and again on 2/12/2021 at 10:50 AM. Nurse #1 stated a nurse aide approached her on 1/08/2021 because Resident #1 had an open area on the left buttock. Nurse #1 stated she observed a "shearing" of the skin of the left buttock on Resident #1. Shearing is a gravity force pushing down on the patient's body with resistance between the patient and the chair or bed. Nurse #1 described the area as a reddened area. Nurse #1 stated she did assess the skin of Resident #1, but she did not document her observations. Nurse #1 stated she did not know why she did not record any documentation of the skin assessment of Resident #1 on 1/08/2021. Nurse #1 called the resident's physician and obtained orders for treatment.

A physician's order was initiated on 1/8/2021 for a treatment of a sheer wound on the left buttock of Resident #1. The order stated the wound was to

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be cleaned with wound cleanser, patted dry, Medihoney, a medicinal honey with antimicrobial properties, promotes debridement, stimulates wound tissue, and promotes a moist wound bed, applied, covered with foam, and padded well daily.

Review of the treatment administration record (TAR) revealed documentation of ordered treatment to the sheer wound on the left buttock for Resident #1 was initiated on 1/9/2021. The TAR indicated the treatment was not performed as ordered on 1/12/2021, 1/15/2021, 1/16/2021, 1/19/2021, and 1/20/2021.

Documentation on the TAR for treatment for the left buttock of Resident #1 on 1/12/2021 was left blank and no explanation was given. Nurse #8, assigned to provide care on the day shift on 1/12/2021 to Resident #1, was interviewed on 2/23/2021 at 3:26 PM. Nurse #8 stated she did not recall if she did the treatment or if a treatment nurse did the wound care. Nurse #8 did not recall what the wound looked like or who Resident #1 was.

Documentation on the TAR for the treatment for the left buttock of Resident #1 on 1/15/2021 stated under comments the treatment was, "not administered: other." A Medication Aide (Med Aide #1), who signed the TAR on 1/15/2021 for the left buttock treatment, was interviewed on 2/23/2021 at 2:10 PM. Med Aide #1 stated she did not remember what had occurred on 1/15/2021 because she was assigned to give medications to Resident #1 but could not provide wound treatments to residents. Med Aide #1 revealed she signed the TAR as not administered because she could not provide the treatment and

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F 686	Continued From page 17 required the assistance of a nurse. Med Aide did not recall or did not know if a nurse provided the treatment for Resident #1 on 1/15/2021. Documentation on the TAR for the treatment for the left buttock of Resident #1 on 1/16/2021 was left blank and no explanation was given. Nurse #9, assigned to Resident #1 on the day shift on 1/16/21, was interviewed on 2/23/2021 at 3:11 PM. Nurse #9 stated on 1/16/2021 the facility had 2 nurses and one medication aide for the entire building. Nurse #9 indicated she was assigned to care for approximately 85 residents, was able to provide medications, but was unable to perform treatments as required on her shift. Nurse #9 stated she requested the evening shift perform the treatment for Resident #1. Nurse #9 acknowledged she may have performed wound care for Resident #1 on other days, but she did not recall what his wound looked like or what the wound care orders were in January 2021. Nurse #10, the evening shift nurse assigned to Resident #1 on 1/16/2021, was interviewed on 2/23/2021 at 4:24 PM. Nurse #10 revealed she remembered 1/16/2021 very clearly. Nurse #10 stated she recalled giving medications to Resident #1 but was told she tested positive for Covid-19 on her nursing shift and she left the building, not going in any other resident rooms. Nurse #1 stated she did not perform a wound treatment on Resident #1 on 1/16/2021. Documentation on the TAR for the treatment for the left buttock of Resident #1 on 1/19/2021 stated under comments Resident #1 received, "Late Administration: Other comment: patient care." Nurse #11, who signed the TAR on 1/19/21 for the left buttock treatment for Resident #1, was	F 686		

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interviewed on 2/23/2021 at 3:03 PM. Nurse #11 revealed on 1/19/2021 she was assisting the nurse aides with patient care. Nurse #11 stated she did not have time to perform a treatment for Resident #1 and was busy changing the incontinent briefs of other residents. She stated she documented on the TAR for Resident #1 she was doing patient care instead of doing his treatment.

Documentation on the TAR for the treatment for the left buttock of Resident #1 on 1/20/2021 stated under the comments the treatment for Resident #1 was, "Not Administered: Resident Unavailable." Nurse #12, who signed the TAR on 1/20/2021 for the left buttock treatment for Resident #1, did not respond to interview requests.

A care plan was initiated on 1/13/2021 which stated, "[Resident #1] has impaired skin integrity- sheer wound to buttock." The approaches were to analyze the wound(s) to determine pattern/trend; avoid shearing resident's skin during positioning, transferring, and turning; measure and record description of area; monitor and report signs of localized infection; and treat per physician order.

An additional care plan problem area was initiated on 1/13/2021 for Resident #1's risk for pressure ulcers relative to immobility, diagnosis of quadriplegia, and bowel incontinence. The interventions also included turning and repositioning every 2 hours and perform weekly skin assessments.

An interview was conducted with NA #1 on 2/10/2021 at 11:54 AM. NA #1 stated she worked in the facility on the 7:00 AM to 3:00 PM shift. NA

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F 686	Continued From page 19 #1 indicated she was always able to find assistance to turn and reposition Resident #1 every two hours. NA #1 maintained Resident #1 was turned and repositioned every two hours when he was on her assignment. Review of the medical record revealed no documentation of skin assessments being done on Resident #1 from the date of 1/8/2021 when a shearing wound was identified on the left buttock of Resident #1 until 1/19/2021. The first documentation of a skin/wound assessment for Resident #1 since admission was on 1/19/2021 by the wound care nurse (Nurse #2). Resident #1 was identified as having an unstageable deep tissue pressure ulcer on his coccyx measuring 11 centimeters (cm) in length, 14 cm in width, and a depth unmeasurable on 1/19/2021. A nursing progress note written by Nurse #2 dated 1/20/21 at 3:44 PM stated, "Resident (#1) seen by inhouse wound doctor for sacral wound and left heel. New orders received to begin Santyl to wound, apply Dakin's soak gauze and cover with gauze island [dressing] daily. Left Heel has [deep tissue injury] new order for betadine to affected area and wrap with Kerlix daily. [Responsible party] aware of above new wounds and orders." There was no corresponding wound physician note for Resident #1 dated 1/20/2021. There was no skin assessment on 1/20/2021 of Resident #1's heel to indicate the extent of skin area injured.	F 686		

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The care plan for Resident #1 was updated on 1/20/2021 for the pressure ulcer on the sacrum.

An additional problem area on the care plan was added on 1/20/2021 for a deep tissue injury to the left posterior ankle and left plantar foot relative to immobility and paralysis. This was the first mention in the medical record of Resident #1 having deep tissue injuries to the left posterior ankle and left plantar foot.

There was no wound/skin assessment of the left posterior ankle or the left plantar foot on 1/20/2021 to indicate the extent of the skin area injured. There were no physician orders for the treatment and no documentation on the TAR of any treatment given to the left posterior ankle wound from 1/20/2021 to the resident's discharge on 1/27/2021.

A physician's order was initiated on 1/21/2021 for an unstageable pressure ulcer in the sacral region of Resident #1. The order stated the sacrum was to be cleansed with wound cleanser, wound prep to the peri wound, Santyl applied, covered with Dakin's soaked gauze, covered with ABD (abdominal) pads, and secured with retention tape.

A physician's order was initiated on 1/21/2021 for pressure ulcer monitoring of the sacrum of Resident #1 every shift.

Documentation on the TAR revealed Resident #1 received the treatment for the sacrum as ordered from 1/21/2021 to 1/27/2021.

Documentation on a skin/wound assessment dated 1/21/2021 revealed Resident #1 had a left

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heel pressure area identified. The unstageable deep tissue injury with necrotic tissue was 2.5 cm in length, width of 1 cm, and an unmeasurable depth.

A physician's order was initiated on 1/21/2021 for the left heel of Resident #1. The order stated the left heel was to have Betadine soaked gauze applied and wrapped with Kerlix every day on Monday, Wednesday, and Friday.

A physician's order was initiated on 1/21/2021 for pressure ulcer monitoring of the left heel of Resident #1 every shift.

Documentation on the TAR revealed Resident #1 received the treatment for the left heel as ordered from 1/21/2021 to 1/27/2021.

Documentation on a physician physical medicine consultation report dated 1/21/2021 revealed Resident #1 had a physical medical appointment outside the facility. The recommendations/new orders from the consultation stated a recommendation for a wound referral, a low air loss mattress, turning schedule every two hours, and range of motion exercises to upper and lower extremities daily. Documentation on the report stated, "Sacral decubitus not evaluated."

A nursing progress note dated 1/22/2021 at 2:06 PM, written by the Facility Nurse Consultant read in part, Resident returned from MD appointment on 1/21/21 with the following orders: recommend wound referral, needs low air loss mattress, turning schedule every 2 hours, and recommend [range of motion] upper and lower extremities daily. Attempted to schedule resident an appointment at wound clinic with an appointment

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F 686	Continued From page 22 initially given for 1/29/21 at 11:00 AM. When representative inquired about Covid-19 status of facility, resident appointment was changed to 2/5/21 at 1:00 PM with potential to be changed depending on the Covid-19 status of the facility closer to the appointment date. Until that time, resident will continue to be seen by the facility wound doctor. Resident is already positioned on a low air loss mattress, A turning schedule will be implemented for the resident. Per the rehab manager, the resident will be re-evaluated by PT (physical therapy) and OT (occupational therapy). Responsible party notified of the above recommendations and actions taken. An interview was conducted with Facility Nurse Consultant on 2/10/2021 at 1:53 PM. She stated she was in the facility in January 2021 due to the Director of Nursing leaving her employment with the facility. She reported she conducted an investigation into concerns regarding the development of pressure sores on Resident #1. She stated as a part of her investigation she interviewed staff members who told her Resident #1 had been turned and repositioned every two hours on all shifts. The Facility Nurse Consultant indicated the resident was already on a low air loss mattress and a larger bed had been obtained to accommodate his size and length. She explained Resident #1 required an extension on his bed to accommodate his height. She stated she initiated a form that was posted outside the door of Resident #1 on which the staff members who turned and repositioned Resident #1 had to document when they did this on each shift. The Facility Nurse Consultant revealed she did not know when she initiated this. She stated she felt like the pressure areas were unavoidable for this resident and there was nothing else the facility	F 686		

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F 686	Continued From page 23	F 686		

could have done.

Documentation on a facility skin/wound assessment by Nurse#2 dated 1/27/2021 revealed an additional assessment of the left heel pressure ulcer. The left heel ulcer had increased in size to 3.5 cm in length, 2 cm in width with an unmeasurable depth.

Documentation on a facility skin/wound assessment by Nurse #2 dated 1/27/2021 revealed an initial assessment of a wound on the plantar left bottom foot of Resident #1. It was assessed as 2.5 cm in length, 2 cm in width, and unmeasurable in depth. This was the first documentation of an assessment of the plantar left bottom foot first mentioned on a care plan initiated 1/20/2021.

Documentation on the physician orders revealed treatment orders were initiated on 1/27/2021 for the left plantar foot of Resident #1 with instructions to paint the area and the surrounding tissue with Betadine daily.

The TAR revealed Resident #1 received the treatment for the left plantar foot one time on 1/27/2021 as ordered.

Documentation on an initial evaluation of the wounds of Resident #1 by the telehealth Wound Care Physician (MD #2) dated 1/27/2021 revealed initial assessments of an unstageable sacrum wound, unstageable deep tissue injury of the left posterior ankle, and the unstageable deep tissue injury of the left plantar foot. The left posterior ankle wound was assessed as 3.5 cm in length, 2 cm in width, and unmeasurable in depth. The evaluation of the ankle indicated the

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F 686	Continued From page 24 treatment plan of betadine was to be applied daily. A nursing progress note dated 1/27/2021 at 2:44 PM by Nurse #2 read in part: "Resident (#1) seen by inhouse wound doctor for sacral wound. New orders received to send resident out to emergency department for evaluation for urgent debridement and antibiotic therapy for sacrum. Labs WBC (white blood cell), prealbumin, CRP (c-reactive protein) and ESR (erythrocyte sedimentation rate) all returned with abnormal values. RP aware of above new wounds and orders. Resident dressing changed and prepared for transport." Nurse #2 was interviewed on 2/10/2021 at 2:18 PM and on 2/10/2021 at 4:20 PM. Nurse #2 revealed the wound care nurse for the facility left employment with the facility and the wound care physician was unable to provide services in January 2021. Nurse #2 stated she and a telehealth physician were hired to provide wound care for the facility beginning on 1/1/2021. Nurse #2 explained it took her a couple of weeks to get a system for wound care in place. Nurse #2 stated there was a standing order for weekly skin assessments to be completed for all residents admitted to the facility. Nurse #2 stated on 1/19/2021 and 1/20/2021 she did assessments of the skin of all the residents in the facility so she could get "the full picture" of the wound care required in the facility. She stated she was able to initiate standing orders for any wounds that fit the parameters of the standing wound care orders. Nurse #2 stated when she observed the skin of Resident #1 on 1/19/2021 she knew she would have to obtain orders from the telehealth wound physician because the wound was covered with a	F 686		

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F 686	Continued From page 25 cap of eschar and did not fit in any of the standing orders for wound care. Eschar is dead tissue that fall off from healthy skin. Nurse #2 stated on 1/20/2021 she contacted the wound care physician and he gave her orders for the sacral and left heel deep tissue wounds on Resident #1. Nurse #2 revealed the wound care doctor stated he wanted to initiate wound care orders and order laboratory tests to get a more complete picture of the health of the resident. Nurse #2 stated she initiated the new orders and scheduled Resident #1 to be seen by the telehealth physician on 1/27/2021. Nurse #2 obtained the wound care orders for Resident #1 because from her observation of the wound the treatment needed to change to a different debriding agent. Nurse #2 described the wounds to the wound care MD on 1/20/21. It was not the day set up for a telehealth visit. She obtained orders. Nurse #2 confirmed she obtained a physician's order initiated on 1/21/2021 for an unstageable pressure ulcer in the sacral region of Resident #1. The order stated the sacrum was to be cleansed with wound cleanser, wound prep to the peri wound, Santyl applied, covered with Dakin's soaked gauze, covered with ABD (abdominal) pads, and secured with retention tape. Nurse #2 confirmed she obtained a physician's order initiated on 1/21/2021 for the left heel of Resident #1. The order stated the left heel was to have Betadine soaked gauze applied and wrapped with Kerlix every day on Monday, Wednesday, and Friday. Nurse #2 related she made sure Resident #1 was the first resident to be seen on 1/27/2021 during the telehealth visit by the wound care physician due to the condition of his sacral wound. Nurse #2 stated all laboratory data was faxed to the wound care physician in preparation for the wound care telehealth visit on 1/27/2021 because	F 686		

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F 686	Continued From page 26 of "the state Resident #1 was in." The date 1/27/2021 was the first official wound care assessment day with the telehealth wound care physician for the facility. Nurse #2 stated as soon as the wound care physician saw the wounds of Resident #1, the telehealth visit stopped, EMS (emergency medical services) was called, paperwork was prepared for EMS, and he was sent to the hospital. The telehealth Wound Care Physician (MD #2) was interviewed on 2/12/2021 at 12:11 PM. MD #2 stated he only saw Resident #1 one time on 1/27/2021. MD #2 stated as soon as he saw the pressure wound on the coccyx of Resident #1 on the telehealth visit, he told Nurse #2 to immediately send him to the emergency room. MD #2 stated the laboratory values indicated Resident #1 was in the early stages of sepsis and the wound looked infected. MD #2 stated Resident #1 needed emergency debridement of the wound and he needed intravenous antibiotics immediately. He reported he did not take the time to review the chart of Resident #1 and he knew immediate action needed to be taken by Nurse #2 to get him to the hospital because he was in a life-threatening situation. MD #2 stated weekly skin assessments are the standard in all long-term care facilities so that new areas can be identified and treated immediately. MD #2 stated once a skin breakdown develops it is likely additional areas will form. MD #2 stated skin breakdown must be measured and assessed so risk/benefits of treatment can be determined. MD #2 stated it was hard for him to comment on if the skin breakdown on Resident #1 was avoidable because he did not review the resident's medical chart, but it was his opinion some turning, and repositioning was missed somewhere for this	F 686		

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F 686	Continued From page 27 resident for the pressure area to develop so quickly. Documentation on a hospital record for the 1/27/2021 admission for Resident #1 revealed he was admitted for emergency debridement for a necrotic blackened sacral decubitus with an infection. After debridement the sacral decubitus was assessed as a Stage 4. Resident #1 was started on intravenous antibiotics. The facility interim Director of Nursing (DON) was interviewed on 2/11/2021 at 3:16 PM. The DON stated she was not the DON when Resident #1 was in the facility. The DON acknowledged the facility had no skin assessments for Resident #1 from 1/8/2021 to 1/19/2021. The DON was unsure of the facility policy on skin assessments but acknowledged the facility staff should be checking the resident's skin for breakdown. The primary care physician (MD #1) for Resident #1 was interviewed on 2/11/2021 at 4:50 PM. MD #1 stated he thought the pressure areas developed on Resident #1 due to physician visits outside the facility where he was laying on a stretcher for an extended period, but he could not say for certain what caused the wounds. (Documentation in the nursing notes revealed Resident #1 left the facility for medical appointments on 1/21/2021 and 1/25/2021.) MD #1 stated the facility should have been doing weekly skin assessments from the first day of admission. MD #1 stated the facility obtained an air mattress for the resident and performed turning and repositioning so there was nothing else that could have been done to prevent the pressure ulcers on Resident #1.	F 686		

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F 686	Continued From page 28 The facility Administrator was notified of the immediate jeopardy on 2/26/2021 at 4:30 PM. The facility provided a credible allegation of immediate jeopardy removal: Allegation of Compliance It is alleged that the facility failed to provide ongoing skin assessments for identification and treatment of pressure sores for a resident at high risk for pressure sores. The facility also failed to provide treatment and services for identified pressure areas and/or skin breakdown for Resident #1. 1. The facility identified the deficient practice for Resident #1 on 1/18/2021 and took the following action: A. Investigation was initiated by the Signature Care Consultant (SCC) and Administrator on 1/18/2021. B. Statements were obtained by SCC from staff members who had been taking care of resident #1. C. SCC notified Regional Vice President and Vice President of Clinical Operations on 1/20/2021 of investigation findings. It was decided at this time to temporarily place a hold on new admissions. The admission hold was in place until 2/1/2021. D. A facility wide skin sweep was initiated on 1/19/21 and completed on 1/20/21 by SCC, two LPNs and a RN from sister facilities. E. An audit was completed on 1/21/2021 of all newly identified wounds from the skin sweep completed on 1/20/21 and on all previously identified wounds, by SCC and facility wound nurse, to ensure a treatment was ordered and in place. Resident #1 had new area identified on 1/20/21, left posterior ankle (this is the left heel	F 686		

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F 686	Continued From page 29 wound). There is an order for betadine-soaked gauze wrap with kerlix on 1/21/21 for this wound. The wound on the left plantar foot wasn't identified until 1/27/21. No other missing skin assessments identified. F. Education was completed for licensed nurses by the SCC and Assistant Director of Nursing by 1/28/2021 on the Skin Observation/Evaluation and Prevention Policy. Education included completing a thorough skin assessment upon admission, completing the Braden assessment, Documentation of new skin alteration findings, MD notification, obtaining a treatment order, family/POA notification, weekly skin assessment, documentation of skin assessments, weekly documentation of pressure ulcer assessments, preventative skin care, and completion of wound treatments. Direct care licensed nurses to complete weekly skin assessments, assess and document the wounds each week, request a treatment for newly identified wounds from the MD, apply the treatments and document on the MAR. The wound nurse completed audits to ensue assessments have been completed, treatment orders are received and in place, and that weekly skin assessments are being completed and documented. G. Education completed with licensed nurses and nurse aides by SCC and Assistant Director of Nursing by 1/28/2021 on process for reporting new skin concerns to the physician for a treatment order, and the family/responsible party, per the Skin Observation/Evaluation and Prevention Policy. H. Facility secured a full-time wound nurse, who started on 2/17/2021. I. Starting on 1/21/2021, audits of the following have been conducted weekly by the facility wound nurse, and discussed in the Clinical White Board	F 686		

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F 686	Continued From page 30 Meeting five times weekly: a. Current orders in chart and same on TAR and are in place. b. Orders are changed as appropriate c. Pressure ulcer treatments are being signed out timely when due d. Wound documentation and weekly skin assessments are being completed on every resident. J. A QAPI meeting was held on 1/20/21 to discuss the above stated plan and request further recommendations. The meeting was attended by the facility administrator, SCC, department heads, nursing administration team and Medical Director. There were no further recommendations. On March 1, 2021 at 1:55 pm, the administrator sent this e-mail to the surveyor: "After careful review of the documentation that we currently have we have not found that we provided the detailed education as outlined in the immediate jeopardy document prior to the entrance of the surveyor on 02/10/2021. As a result, we will be submitting another AOC with an alleged compliance date of 02/28/2021." Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: 1. Resident #1 suffered from the deficient practice and was discharged from the facility on 1/27/2021. K. A facility wide skin sweep was initiated on 2/26/21 and completed on 2/26/21 by the Signature Care Consultant (SCC), Interim DON, Assistant Directors of Nursing, Wound Care Nurse, and Unit Manager. This was completed to identify any further residents with potential to have been affected. One additional resident was	F 686		

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F 686	Continued From page 31 found to have been affected. L. An audit was completed on 02/26/2021 of all in-house wounds, to ensure a treatment was ordered and in place. No further residents were found to have been affected. M. Education for all licensed nurses was initiated 2/27/2021 and completed on 2/28/21 by the SCC, Interim DON, and RN Supervisor. Education was on the Skin Observation/Evaluation and Prevention Policy. Education included completing a thorough skin assessment upon admission, completing the Braden assessment, Documentation of new skin alteration findings, MD notification, obtaining a treatment order, family/POA notification, weekly skin assessment, documentation of skin assessments, weekly documentation of pressure ulcer assessments, preventative skin care, completion of wound treatments, wound staging, identifying when a wound is declining and MD notification. Nurse aides and licensed nurses were educated on the importance of frequent turning and repositioning and the importance of ensuring specialty mattresses are size appropriate and notifying the DON if a change is needed. All current agency staff have been educated and all facility new hires and new agency staff will receive education prior to working their first shift. The Director of Nursing and/or Assistant Director of Nursing will be responsible to provide this education and they were informed on 2/28/21. This was completed 2/28/21. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: N. Wound documentation and weekly skin assessments are being completed on every	F 686		

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F 686	Continued From page 32 resident. Direct care licensed nurses will complete weekly skin assessments, assess and document the wounds each week, request a treatment for newly identified wounds from the MD, apply the treatments and document on the MAR. The wound nurse will be completing audits to ensure assessments have been completed, treatment orders are received and in place, and that weekly skin assessments are being completed and documented. This process began on 1/21/2021 and continues. O. Beginning the week of 3/1/2021, all wounds will be discussed in the weekly Skin Nutrition At Risk meeting with the RD in attendance. Date of IJ removal: 2/28/2021 The credible allegation of IJ removal was verified on 3/4/2021 at 12:15 PM as evidenced by observations, interviews, and record review. Interviews were conducted with licensed nursing staff, to include agency licensed nurses, verifying they received training on admission skin assessment; Braden assessment of wounds; documentation on new skin alteration findings; physician notification; obtaining treatment orders; family/power of attorney notification; weekly skin assessments; weekly documentation of pressure ulcer assessments; preventative skin care; completion of wound treatments; wound staging; identifying a wound decline; turning/repositioning requirements; and importance of ensuring correct mattress/bed size. Interviews were conducted with nurse aides to confirm education was provided on the importance of turning and repositioning residents, notification of nursing staff of new skin issues identified on residents, and importance of ensuring mattress/bed size was appropriate for the resident. Observations	F 686		

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F 686	Continued From page 33 were made of the skin integrity books, containing wound care policies and procedures, at Nursing stations 1 and 2. Documentation was reviewed of the skin sweep, audits of treatment orders and education records for licensed and unlicensed nursing staff. Education records revealed skin care alerts, turning and repositioning requirements, identification of new skin conditions, identification/notification of bed size requirement changes, wound standing orders, wound staging, wound care nurse responsibilities, pressure wound treatment documentation, reporting of skin care changes, skin check expectations, and facility skin care policies and procedures.	F 686		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		3/23/21

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F 725	Continued From page 34	F 725		

(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide sufficient nursing staff to ensure wound care treatments were performed as ordered by a physician for 1 (Resident #1) of 3 residents reviewed for pressure sores. The facility also failed to provide sufficient staff to ensure an assessment was completed, blood sugars were monitored as ordered, and medical attention was sought for a change in condition for 1 (Resident #9) of 3 residents reviewed for the provision of care according to professional standards.

Findings included:

1. A physician's order was initiated on 1/8/2021 for a treatment of a sheer wound on the left buttock of Resident #1. The order stated the wound was to be cleaned with wound cleanser, patted dry, Medihoney, a medicinal honey with antimicrobial properties, promotes debridement, stimulates wound tissue, and promotes a moist wound bed, applied, covered with foam, and padded well daily.

Review of the treatment administration record (TAR) revealed documentation of ordered treatment to the sheer wound on the left buttock for Resident #1 was initiated on 1/9/2021. The TAR indicated the treatment was not performed as ordered on 1/12/2021, 1/15/2021, 1/16/2021,

F725
1.Resident #1 and Resident #9 have been discharged from the facility. The facility will provide sufficient nursing staff to ensure wound treatments are performed as ordered by the physician, blood sugars are monitored as ordered, and that medical attention is sought for changes in condition.
2.All residents have the potential to be affected by the alleged deficient practice.
3.The facility will utilize staffing agencies and continues to recruit nurses to provide sufficient staffing. Nursing staffing will be reviewed daily at the morning meeting, by the CEO, DON and facility scheduler to include days, nights and weekends. Education provided to licensed nurses to contact the administrator and DON if they□re not able to meet the needs of the residents, and follow physicians□ orders, due to staffing.
4.DON, Administrator, and facility scheduler will continue to review staffing schedules, in the morning meeting, to ensure sufficient staffing. The Administrator or designee will interview five random staff 5x a week for four weeks, twice weekly for two weeks, weekly for two weeks and monthly for

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	345336	A. BUILDING ______ B. WING ______	C 03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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F 725	Continued From page 35 1/19/2021, and 1/20/2021. Documentation on the TAR for the treatment for the left buttock of Resident #1 on 1/16/2021 was left blank and no explanation was given. Nurse #9, assigned to Resident #1 on the day shift on 1/16/21, was interviewed on 2/23/2021 at 3:11 PM. Nurse #9 stated on 1/16/2021 the facility had 2 nurses and one medication aide for the entire building. Nurse #9 indicated she was assigned to care for approximately 85 residents, was able to provide medications, but was unable to perform treatments as required on her shift. Nurse #9 stated she requested the evening shift perform the treatment for Resident #1. Nurse #10, the evening shift nurse assigned to Resident #1 on 1/16/2021, was interviewed on 2/23/2021 at 4:24 PM. Nurse #10 revealed she remembered 1/16/2021 very clearly. Nurse #10 stated the facility was short a nurse on 1/16/2021, with only 3 nurses working when 4 nurses were needed. Nurse #10 indicated it was all she could do to get the resident medications administered and she had no time to do any other nursing tasks. Nurse #10 stated she recalled giving medications to Resident #1 but was told she tested positive for Covid-19 on her nursing shift and she left the building, not going in any other resident rooms. Nurse #1 stated she did not perform a wound treatment on Resident #1 on 1/16/2021. Documentation on the TAR for the treatment for the left buttock of Resident #1 on 1/19/2021 stated under comments Resident #1 received, "Late Administration: Other comment: patient care." Nurse #11, who signed the TAR on 1/19/21 for the left buttock treatment for Resident #1, was	F 725	three months to ensure sufficient staffing to safely meet the needs of our residents. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5.The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by March 23,2021.	

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F 725	Continued From page 36 interviewed on 2/23/2021 at 3:03 PM. Nurse #11 revealed on 1/19/2021 she was assisting the nurse aides with patient care. Nurse #11 stated she did not have time to perform a treatment for Resident #1 and was busy changing the incontinent briefs of other residents. She stated she documented on the TAR for Resident #1 she was doing patient care instead of doing his treatment. An interview was conducted with the Interim Director of Nursing on 2/11/2021 at 2:30 PM. The DON stated it was her expectation the nursing staff follow physician orders. The DON indicated it was also her expectation the nurses reach out to who ever is on call if they need help. The DON stated she was on call 24 hours 7 days a week to help at the facility. The DON stated the priority was taking care of the residents in the facility. 2. This tag has been cross referenced to F684. Based on record review, staff interview, family interview, and physician interview the facility failed to assess a resident and seek medical attention for a change in condition and monitor the blood sugars as ordered by the physician for 1 of 4 residents reviewed for providing care according to professional standards (Resident #9). After the family of Resident #9 called EMS (emergency medical services), Resident #9 was assessed by EMS as having a finger stick blood sugar of 443 mg/dl (Normal 72 to 99 mg/dl) with altered mental status and diabetic symptoms.	F 725		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		3/23/21

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F 842	Continued From page 37 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 38 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide accurate documentation of blood sugars and administration of insulin (Resident #9) and accurately document a physician visit (Resident #1) for 2 of 3 residents reviewed for accurate documentation. Findings included: 1. Resident #9 was admitted to the facility on 4/4/2020. He was discharged on 1/26/2021 and readmitted on 2/4/2021 from an acute care hospital. The diagnoses included a medical	F 842	F842 1.Resident #1 and Resident #9 have been discharged from the facility. 2.All residents had the potential to be affected. In house audit completed to validate accurate documentation of blood sugars and insulin administration. Additional audits will be completed to validate accurate documentation of a physicians visit. This audit will be completed by March 19.2021.	

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F 842

Continued From page 39

history of diabetic ketoacidosis, end stage renal disease, insulin dependent diabetes mellitus and a seizure disorder.

Hospital discharge orders dated 2/4/2021 revealed Resident #9 was to have insulin administered subcutaneously with meals and at bedtime based on a sliding scale of blood glucose monitoring. The physician was to be notified if blood glucose levels dropped below 90 or were above 500.

Nursing progress notes dated 2/4/2021 at 4:03 PM, written by Nurse #1, stated the finger stick blood sugar monitoring frequency for Resident #9 was increased to every 4 hours until further physician orders.

Review of the medication orders for Resident #9 revealed the order for blood glucose monitoring/insulin administration was increased on 2/4/2021 from 4 times a day, before meals and at bedtime, to every 4 hours, at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.

Documentation on the MAR for 2/7/2021 revealed blood sugar monitoring and administration of insulin was not documented as completed at 8:00 AM and 12:00 PM as ordered. The reasons/comments on the MAR documented by Nurse #4 was, "Resident Unavailable."

Nurse #4 was interviewed on 2/11/2021 at 12:20 PM. She was working a 7:00 AM to 7:00 PM shift on 2/7/2021. Nurse #4 explained when she arrived the facility was short a nurse and she was asked to be responsible for her one medication cart on a hallway and half of another medication

F 842

3.Education will be provided to the Licensed Nurses on the Blood Glucose Monitoring policy as it relates to accurate documentation of blood sugars and insulin administration. Additional education will be conducted with the Licensed Nurses on Documentation as it relates to accurately documenting a physician visit. This education will be completed by March 22, 2021. This education will be included in new hire orientation for Licensed Nurses.

4.Ongoing audits will be completed by the Director of Nursing and/or Assistant Director of Nursing to validate that blood sugars are being monitored and insulin is administered as ordered by the physician. Additional audits will be conducted to validate that physician visits are accurately documented. These audits will be conducted 5x a week for four weeks, twice weekly for two weeks, weekly for two weeks and monthly for three months. Compliance will be validated during the Clinical Whiteboard meeting held daily Monday through Friday utilizing the Administration Compliance Report and reviewing the Progress Notes. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator,

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F 842	Continued From page 40 cart for another hallway. Nurse #4 recalled she started to administer medications on the hallway she was most unfamiliar with first. She started on one end of the hallway and worked her way up. Nurse #4 indicated both hallways had residents who needed blood glucose monitoring. She explained she went from resident to resident going up the hallway administering medications and checking blood glucose levels as needed when she came to a diabetic resident. The facility had a lot of room changes recently and she indicated she was not able to get all the blood glucose monitoring done prior to the service of breakfast due to having responsibility for two medication carts. She did check the blood glucose of Resident #9 sometime in between breakfast and lunch and she did administer insulin at that time. Nurse #4 did not recall what the blood glucose level of Resident #9 was or how much insulin was administered. She was unaware Resident #9 was back from the hospital at the start of her shift and she was not aware the orders for blood glucose monitoring had switched to every 4 hours for Resident #9. She had not been notified Resident #9 had a level of acuity change after returning from the hospital. If she had known Resident #9 had increased confusion and couldn't even hold his head up, she would have started on his end of the hall. 2. Resident #1 had a nursing progress note dated 1/20/2021 written by Nurse #2 stating in part, "Resident seen by inhouse wound doctor for sacral wound and left heel." There was no corresponding wound physician note for Resident #1 dated 1/20/2021. Nurse #2 was interviewed on 2/10/2021 at 2:18	F 842	MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5.The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by March 23,2021.	

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F 842	Continued From page 41 PM and on 2/10/2021 at 4:20 PM. Nurse #2 stated on 1/20/2021 she contacted the telehealth wound care physician and he gave her orders for the treatments for the sacral wound and left heel of Resident #1. Nurse #2 stated she initiated the new orders and scheduled Resident #1 to be seen by the telehealth physician on 1/27/2021. The telehealth wound care physician (MD #2) was interviewed on 2/12/2021 at 12:11 PM. MD #2 stated he only saw Resident #1 one time on 1/27/2021 for a telehealth visit.	F 842		