

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

PRINTED: 07/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2021
NAME OF PROVIDER OR SUPPLIER RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 177 S BOX 1489 HAMLET, NC 28345		
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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on site 6/15/21 and 6/16/21 and continued remotely until 6/17/21. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b) (6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# S61U11.	E 000			
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted in conjunction with a complaint investigation 6/15/21 through 6/28/21. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Immediate Jeopardy was identified at: CFR 483.25 at tag F686 at a scope and severity (K). The tag F686 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/14/21 and was removed on 6/24/21. An extended survey was conducted. 5 of the 8 complaint allegations were substantiated resulting in deficiencies.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

07/16/2021

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.

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F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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 reviews, observations, staff and Physician interviews, the facility failed to provide wound care as ordered by the physician to a venous stasis ulcer on the lower extremity (Resident #4). This was for 1 of 4 residents sampled for well-being.</p> <p>The findings included:</p> <p>Resident #4 was originally admitted to the facility on 12/12/13. The cumulative diagnoses included chronic venous hypertension with ulcer of right lower extremity (a condition where there is obstruction in the veins), cerebral infarction (a stroke), diabetes type 2 and peripheral vascular disease (PVD).</p> <p>A review of the annual Minimum Data Set (MDS) assessment dated 3/19/21 indicated Resident #4 had moderately impaired cognition and displayed no behaviors or refusal of care during the 7 day look back period. She required extensive to total assistance with Activities of Daily Living (ADL's) and was coded with 1 venous ulcer present.</p> <p>Resident #4's active care plan, last reviewed</p>	F 684	<p>Richmond Pine Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Richmond Pine Healthcare and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Healthcare and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.</p> <p>F 684 Resident #4 had a venous stasis ulcer on</p>	8/12/21	

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F 684	<p>Continued From page 2</p> <p>4/13/21, revealed a focus area for actual skin integrity impairment: venous stasis ulcer of right lower extremity related to edema and immobility. The interventions included facility skin/wound care protocol.</p> <p>A review of the facility's Wound Ulcer Flowsheet dated 6/4/21 indicated the venous stasis ulcer to Resident #4's right lower leg was healing. There were no wound measurements present.</p> <p>The June 2021 physician orders read to cleanse the right lower extremity with normal saline and pat dry. Apply Calcium Alginate (a wound dressing used for wounds with drainage) to open areas, cover with a dry gauze and secure with a gauze wrap 3 times a week.</p> <p>The June 2021 Treatment Administration Record (TAR) revealed wound care to Resident #4's right lower extremity venous stasis ulcer was not initialed as completed on 6/7/21, 6/9/21 and 6/11/21.</p> <p>The nursing progress notes from 12/1/20 to 6/16/21 were reviewed and indicated Resident #4 had no episodes of refusals of wound care or any type of behaviors.</p> <p>On 6/16/21 at 9:10 AM, an interview was conducted with the Treatment Nurse who explained he was on vacation from the afternoon of 6/4/21 until 6/14/21 and during that time the floor nurses would have completed wound care as needed.</p> <p>A phone interview was completed with the Medical Director on 6/16/21 at 10:05 AM and stated he was unaware the wound care for</p>	F 684	<p>the right lower extremity related to edema and immobility. The facility failed to provide wound care as ordered by the physician. The Treatment Administration Record (TAR) was not initialed as completed on 6/7/21, 6/9/21, and 6/11/21. On June 16, 2021 the ADON assessed Resident #4's venous ulcer on the right lower extremity while observing the dressing change. On June 16, 2021, the ADON notified the physician that treatments were not initialed as completed on 6/7/21, 6/9/21, and 6/11/21, no new orders were received.</p> <p>The recipients who have the potential of suffering/other residents at risk: all residents in the facility, including residents with pressure ulcers, have the potential of suffering from avoidable pressure injury when physicians' orders are not followed, including treatments/ wound dressing changes.</p> <p>June 16, 2021 the treatment nurse and assistant director of nursing (ADON) began auditing TARs of Resident #4's and other residents with wounds. The purpose of the audit was to 1) identify any additional risks related to not following physician orders, 2) treatments not being completed, and 3) treatment completion documented on the TAR. June 23, 2021, the audit was completed by the treatment nurse and ADON. The audit identified wound physician and facility physician orders were not followed for Resident #4 and seven other residents with treatment orders that had treatments not signed on the TARs.</p> <p>June 16, 2021 □ June 23, 2021, the</p>		

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F 684	<p>Continued From page 3</p> <p>Resident #4 had not been completed as ordered on 6/7/21, 6/9/21 and 6/11/21. He added he would have expected the treatments to be completed as ordered even when the treatment nurse was out of the facility or to be notified if there was a reason the wound care could not be completed as ordered.</p> <p>An interview occurred with Nurse #2 on 6/16/21 at 11:25 AM, who was familiar with Resident #4. She was scheduled for the 7:00 AM to 3:00 PM shift on 6/7/21 and 6/9/21. Nurse #2 explained when the treatment nurse was out of the facility the floor nurses were expected to complete wound care as ordered. The June 2021 TAR was reviewed, and stated she was not aware the treatment nurse was out of the facility nor was she informed that she would be responsible to complete wound care for Resident #4 on 6/7/21 or 6/9/21.</p> <p>On 6/16/21 at 11:30 AM, an interview was completed with Nurse #1, who was familiar with Resident #4 and was scheduled for the 7:00 AM to 3:00 PM shift on 6/11/21. Nurse #1 explained when the treatment nurse was out of the facility, the floor nurses were responsible for completing wound care. The June 2021 TAR was reviewed, and Nurse #1 explained she was not aware the treatment nurse was out of the facility nor was she informed that she would be responsible to complete wound care for Resident #4 on 6/11/21. Nurse #1 added she was made aware the treatment nurse was out of the facility the following Monday 6/14/21.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/16/21 at 4:50 PM. The DON explained she was not made aware the treatment</p>	F 684	<p>treatment nurse, with the assistance of the ADON assessed the residents and notified the attending physician/nurse practitioner. No new orders were received from the physician/nurse practitioner.</p> <p>June 16, 2021 the root cause analysis: who <input type="checkbox"/> treatment nurse/all residents; what <input type="checkbox"/> treatments; when <input type="checkbox"/> treatment nurse not at work; where <input type="checkbox"/> resident rooms; why - no coverage; how- created coverage by having 1) a backup treatment nurse, 2) unit manager/weekend supervisor to cover, and 3) nurses trained to complete dressing changes when the treatment nurse is off work.</p> <p>June 16, 2021 <input type="checkbox"/> June 23, 2021, the DON, unit manager, and the staff facilitator provided training to the treatment nurse, registered nurses (RNs), and licensed practical nurses (LPNs) to ensure physician orders for wounds are followed and treatments are completed when a treatment nurse is not available to complete treatments.</p> <p>On June 23, 2021, the education for all RNs and LPNs. The re-education covered:</p> <ol style="list-style-type: none"> 1. Wound Care Manual 2. Nurses, including Treatment Nurse and Nurse #1, are being instructed to provide the physician with all relevant information. Nurses will document relevant information 3. Nurses must follow the facility's policy on wounds/treatments 4. If the resident has to be sent out of the facility for evaluation and/or treatment the DON and/or ADON must notify the 		

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F 684	Continued From page 4 nurse was out of the facility until the afternoon of 6/11/21 and at that time she informed the floor nurses they would be responsible for wound care of their residents until 6/14/21.	F 684	attending physician 5. The DON and/or ADON must be notified of all new wounds, worsening wounds, new wound orders, resident concerns, wound clinic concerns, outside provider concerns The education was completed on 6/23/21 with all staff working; no registered nurse (RN) or licensed practical nurse (LPN) will be allowed to work, including Treatment Nurse and Nurse #1, until the re-education is completed. The re-education is added to the new staff orientation for all RNs, LPNs, and treatment nurses. The facility is not currently utilizing agency staff. On June 23, 2021, the DON, ADON, staff facilitator and unit manager initiated a re-education for all RNs and LPNs. This re-education instructs the RNs and LPNs to enter all treatments completed on TAR. By having treatments completed documented on the TAR, the documents are available for review by the physician, nurse practitioner, and clinical teams. The in-service was completed on June 23, 2021 with all RNs and LPNs working; no RN or LPN will be allowed to work until the re-education is completed. The re-education is added to the new staff orientation for all RNs and LPNs. On June 23, 2021, the assistant director of nursing (ADON), DON, unit manager, and/or staff facilitator began auditing 100% of 1) residents <input type="checkbox"/> current TARs and 2) medical records of current residents with wounds who require dressing changes. The purpose of the audit is to		

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F 684	Continued From page 5	F 684	identify any residents with pressure ulcers who may be at risk if physician orders are not followed. The audit is being completed three times weekly. Results of the audits are being presented and discussed at the Monday <input type="checkbox"/> Friday interdisciplinary team meeting (IDT). Any identified issues are immediately corrected by the auditor to include contacting the physician and notifying the DON if a dressing change is not initiated as completed. The audits will continue three times weekly for three (3) months then, twice weekly for three (3) months. On June 23, 2021, the administrator notified QAPI Committee of the problem of not following physician orders and incomplete documentation. The administrator also notified QAPI Committee of QAPI Committee's role in the plan of correction. The QAPI Committee will review the ongoing in-services and associated signature sheets to ensure completion by current and new staff. Also, QAPI Committee will review audit results monthly for six (6) months for the purpose of trending and making recommendations for performance improvement.		
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	F 686		8/12/21	

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F 686	<p>Continued From page 6</p> <p>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:</p> <p>Based on record review, observation and interview with the Medical Director, Wound Care doctor, Quality Assurance (QA) Wound Nurse and staff, the facility failed to provide pressure ulcer treatment for more than 6 months and pressure relieving mattress per the Wound Doctor recommendations (Resident #1). In addition, the facility failed to provide pressure ulcer treatment as ordered and failed to ensure pressure relieving mattress was functioning and in correct setting (Residents #2 & #3). This was evident for 3 of 3 sampled residents reviewed for pressure ulcers (Residents #1, #2 & #3). Resident #1, who was high risk for developing pressure ulcers, had developed 6 pressure ulcers (right superior and right posterior leg, left distal posterior and left posterior superior leg, left heel, and right gluteus). Resident #1 was transferred to the hospital on 5/14/21 due to the deterioration of pressure ulcers and infection of the left lower leg pressure ulcers.</p> <p>The immediate jeopardy (IJ) began on 5/14/21 when Resident #1 was transferred to the hospital due to the deterioration of the pressure ulcers and infection to the left lower leg pressure ulcers. Immediate jeopardy was removed on 6/24/21 when the facility submitted an acceptable credible allegation of immediate jeopardy removal. The</p>	F 686	<p>F 686</p> <p>Resident #1 developed a pressure ulcer on his right lower leg and was being followed by the wound clinic. Resident #1 had developed six (6) pressure ulcers- right superior-right posterior leg, left distal-posterior leg, left heel, right gluteus. The wound care physician orders were not followed by the treatment nurse and the facility attending physician wound care orders were not followed as evidence by 1) orders were not correct on the treatment administration records (TARs) and 2) daily treatments were not completed as ordered. In addition, a specialty air mattress, recommended on April 28, 2021, was not placed on</p> <p>Resident #1's bed.</p> <p>June 16, 2021, the assistant director of nursing (ADON) reviewed the wound clinic's orders, assessed Resident #1, and contact the attending physician. The attending physician gave orders for the facility to follow the wound clinic physician's orders. The facility and Treatment Nurse immediately updated the TARs and began following the wound clinic's physician orders. The June 16,</p>		

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F 686	<p>Continued From page 7</p> <p>facility will remain out of compliance with a scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) due to examples #2 & #3, and to ensure monitoring systems put into place are effective related to pressure ulcers.</p> <p>Findings included:</p> <p>1. Resident #1 was originally admitted to the facility on 11/28/17 with multiple diagnoses including loss of movement and sensation of all extremities from an accident.</p> <p>Review of the Norton Scale (used to predict risk of pressure ulcer), Resident #1 was assessed as high risk for development of pressure ulcers on 9/18/20, 3/18/21 and 5/21/21.</p> <p>The 5- day Minimum Data Set (MDS) assessment dated 5/27/21 indicated that Resident #1 had severe cognitive impairment, needed extensive assistance with bed mobility and had no behaviors of rejection of care. The assessment further indicated that the resident has 2 stage 3 pressure ulcers and 2 venous ulcers.</p> <p>Resident #1's care plan for pressure ulcers was reviewed. The care plan problem initiated on 1/26/21 and was reviewed on 5/27/21 revealed "at risk for skin breakdown or development of further pressure ulcers related to incontinence, high risk for pressure ulcers, immobility and total dependence with turning and positioning." The goal was the resident will not develop a pressure ulcer through next review. The approaches included place resident on pressure relieving products such as pressure relieving mattress and</p>	F 686	<p>2021 the maintenance director and central supply clerk placed an air mattress on Resident #1's bed. The facility treatment nurse is now following the wound clinic orders after review and approval of the facility attending physician. The director of nursing (DON), ADON, unit manager, and weekend supervisor set up a back-up plan to ensure wound treatments are completed with the treatment nurse is off work. The facility took additional actions to correct the deficiency through initial audits, root cause analysis, education, and monitoring.</p> <p>June 15, 2021, Resident #2's specialty air mattress was deflated and the machine was not on. June 16, 2021, the nursing assistant (NA) #2 checked the electrical cord of the air mattress and noticed it was not plugged into the wall power outlet. The NA plugged the electrical cord into the power outlet. The treatment nurse checked the machine, ensured the machine was on, and ensured the pressure relieving mattress was functioning properly and in correct setting. The facility took action to correct the deficiency through initial audit, root cause analysis, education, and monitoring.</p> <p>June 2021, Resident #3's TAR was not initialed by a nurse as completed on June 7, 2021. The pressure reducing mattress machine was set at 450 pounds and the resident's weight was 229 pounds on 6/11/2021. On June 16, 2021 the treatment nurse adjusted the setting of the mattress machine. On June 16, 21 the</p>		

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F 686	<p>Continued From page 8</p> <p>chair cushion as appropriate and turn and reposition patient frequently and use draw sheet for turning if needed.</p> <p>The Wound Care Doctor notes revealed that Resident #1 was being followed by the wound clinic weekly for management of his pressure ulcers. The wound doctor notes and the monthly Treatment Administration Records (TARs) were reviewed and revealed that the treatment recommendations from the wound doctor were never followed by the facility for over 6 months (January through June 2021).</p> <p>In January 2021 wound clinic visits (1/7/21, 1/13/21, 1/21/21 and 1/27/21), the notes revealed that Resident #1 had a pressure ulcer on the right posterior leg. The note revealed:</p> <p>1. Right posterior leg ulcer - On 1/7/21 and 1/13/21 visits, the wound doctor had recommended to treat the ulcer with calcium alginate and then wet to dry dressing twice a day, and if unable to do twice a day to call the clinic and speak with the doctor. The measurement of the ulcer on 1/27/21 was 8.7 x 2 x 0.2 centimeter (cm), stage 4. The ulcer was debrided, and on 1/27/21, the treatment recommended was wet to dry dressing twice a day. The treatment provided by the facility was calcium alginate 3 times per week.</p> <p>In February 2021 wound clinic visits (2/10/21, 2/17/21, 2/24/ 21), the notes revealed that Resident #1 had a pressure ulcer on the right posterior leg. The note revealed:</p> <p>1. Right posterior leg ulcer - On 2/17/21 and 2/24/21, the treatment recommendation was to</p>	F 686	<p>mattress setting was 280 pounds. On June 16, 2021 the treatment nurse again checked the mattress setting to ensure it was set at 230 pounds. The facility took action to correct the deficiency through initial audit, root cause analysis, education, and monitoring.</p> <p>The recipients who have the potential of suffering/other residents at risk: all residents in the facility, including residents with pressure ulcers, have the potential of suffering from avoidable pressure injury when physicians' orders are not followed to include not following dressing change orders and not placing air mattresses.</p> <p>June 16, 2021 – June 23, 2021, the ADON, with the assistance of the assistant Treatment Nurse, assessed the residents and notified the attending physician/nurse practitioner. No new orders were received from the physician/nurse practitioner.</p> <p>Initial Audits: June 16, 2021 the ADON began auditing TARs of Resident #1's, Resident #2's, Resident #3's, and other residents with wounds. The purpose of the audit was to 1) identify any additional risks related to not following physician orders, 2) treatments not being completed, and 3) treatment completion documented on the TAR. June 23, 2021, the audit was completed by the treatment nurse and ADON.</p> <p>On June 23, 2021, the ADON audited</p>		

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F 686	<p>Continued From page 9</p> <p>continue wet to dry dressing twice a day and if unable to do twice a day to call the clinic and speak with the doctor. The measurement on 2/24/21 was 2.5 x 1.7 x 0.2 cm, stage 4. The treatment provided by the facility was calcium alginate 3 times per week.</p> <p>In March 2021 wound clinic visits (3/3/21, 3/10/21, 3/17/21, 3/26/21 and 3/31/21), the notes revealed that Resident #1 had a pressure ulcer on the right posterior leg and a new ulcer developed on the right superior leg. The notes revealed:</p> <p>1. Right posterior leg - The 3/3/21 note revealed that the ulcer had increased in size, 17 cm in length over the past week covered with dried blood. The recommendation was to apply Santyl (debriding agent) and then wet to dry dressing at least daily and preferably twice a day. On 3/10/21 visit, the treatment recommendation was to continue Santyl. The treatment provided by the facility was calcium alginate 3 times per week. On 3/12/21, there was an order to change the dressing daily (calcium alginate) from 3 times a week. The TAR did not have nurse's initials on 3/12/21, 3/13/21, 3/14/21, 3/15/21, 3/16/21, 3/17/21, 3/18/21, 3/20/21, 3/21/21, 3/27/21, 3/28/21, 3/30/21 and 3/31/21 to indicate that the treatment was provided. On 3/31/21 visit, the note indicated that the ulcer has 25% necrosis measuring 14.5 x 3.4 x 1.5 cm and recommended to continue Santyl twice a day. This recommendation was not transcribed to the April 2021 TAR.</p> <p>2. Right superior leg - On 3/31/21 note revealed this new ulcer developed measuring 6 x 4.5 x 0.1 cm, stage 2. Recommended treatment was wet to</p>	F 686	<p>100% of 1) residents' current TARs and 2) medical records of current residents with wounds to identify any residents with pressure ulcers who may be at risk if physician orders are not followed. The audit identified wound physician and facility physician orders were not followed for Resident #1 and seven other residents with treatment orders that had treatments not signed on the TARs. There were no other Richmond Pines residents being seen by the wound clinic.</p> <p>June 17, 2021, the treatment nurse checked Resident #2's and Resident #3's specialty mattress to ensure the pressure relieving mattresses were functioning and in correct setting. The mattresses were set appropriately for the residents' needs and their weight.</p> <p>Root Cause Analysis: Who – Treatment Nurse, QA Wound Nurse, floor nurses, Resident #1, #2, #3; What – missed treatments and no air mattress on bed; When – after wound clinic visit and when Treatment Nurse on vacation; Where – at facility in residents' rooms; Why – failure to follow physician orders from wound clinic and from attending physician; How – education, monitoring, quality assurance performance improvement (QAPI) involvement</p> <p>Education: June 16, 2021 – June 23, 2021, the DON, ADON, unit manager, and the staff facilitator provided training to the treatment nurse, RNs, and LPNs to</p>		

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F 686	<p>Continued From page 10</p> <p>dry dressing twice a day. The March 2021 TAR did not indicate that treatment was provided to the right superior leg ulcer.</p> <p>In April 2021 wound clinic visits (4/7/21, 4/14/21, 4/21/21, 4/28/21), the notes revealed new ulcers had developed. Resident #1 had 6 pressure ulcers. The notes revealed:</p> <p>1. Right posterior leg - On 4/14/21 note revealed that the ulcer had regressed, now necrotic tissue within the length of the ulcer, approximately 12 cm long contrasted with just a week ago when it was absent. The ulcer was debrided and on 4/14/21 and 4/21/21 visits, had recommended to continue Santyl twice a day. The note on 4/28/21 revealed that the ulcer has regressed with necrotic tissue measuring 15.2 x 5 x 2 cm with tunneling, stage IV. The note revealed that the resident claimed that the facility was not changing the dressing daily. The recommendation was to continue Santyl twice a day and for a specialty mattress to minimize occurrence of pressure ulcers. The treatment provided by the facility was calcium alginate daily instead of Santyl twice a day as recommended. The TAR did not have nurse ' s initials on 4/1/21, 4/3/21, 4/4/21, 4/5/21, 4/10/21, 4/11/21, 4/18/21, 4/20/21, 4/22/21, 4/24/21, 4/25/21, 4/27/21, and 4/29/21) to indicate that the treatment was provided.</p> <p>2. right superior leg - On 4/24/21, the measurement was 2.5 x 0.7 x 0.2 cm, stage 2. The recommended treatment was wet to dry dressing twice a day. This recommendation was not transcribed to the TAR. The April 2021 TARs did not indicate that treatment was provided to the right superior leg ulcer.</p>	F 686	<p>ensure physician orders for wounds are followed and treatments are completed when a treatment nurse is not available to complete treatments.</p> <p>June 23, 2021, the facility administrator and director of nursing (DON) took corrective action with the Treatment Nurse. The administrator and DON met with the treatment nurse for discussion and educated the treatment nurse. The discussion and education included:</p> <ol style="list-style-type: none"> 1. The treatment nurse will follow the physician's orders 2. The treatment nurse/unit manager/hall nurse will submit wound clinic recommendations and orders to the attending physician for approval and physician signatures within 4 hours. The Administrative Nurse on Duty will follow up within 24 hours with physician if no response is received. 3. The treatment nurse will notify the ADON and/or the DON, registered nurses, if the treatment nurse is unable to implement physician orders or wound clinic orders. The ADON and/or the DON will contact the provider 4. The treatment nurse will ensure specialty mattress placement on an at-risk resident's bed, according to physician's orders 5. The QA wound nurse, during monthly visits for six months, will audit and enforce with the treatment nurse that the facility wound protocols are followed, including following physician orders and completing documentation of treatments. Also, the QA wound nurse will audit the wound 		

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F 686	<p>Continued From page 11</p> <p>3. left heel/calcaneus - The note on 4/28/21, this new ulcer developed measuring 0.2 x 0.2 x 0.1 cm, unstageable. The recommended treatment was Silvadene cream. Review of the April 2021 TARs revealed no treatment was provided to the left heel ulcer.</p> <p>4. left distal posterior leg - The note on 4/28/21, this new ulcer developed measuring 2 x 1.8 x 0.1 cm, stage 2. Recommended treatment was Silvadene cream daily and or as needed. The April 2021 TAR did not indicate that treatment was provided to the left distal posterior leg ulcer.</p> <p>5. left posterior superior leg - The 4/28/21 note, this new ulcer developed measuring 2 x 2 x 0.1 cm, stage 4, with large necrotic tissue including eschar. Recommended treatment was Santyl and Silvadene cream. The April 2021 TAR did not indicate that treatment was provided to the left posterior superior leg ulcer.</p> <p>6. Right gluteus/sacrum - The 4/28/21 note, reopened measuring 2.2 x 1.1 x 0.1. cm, stage 2. The recommended treatment was hydrocolloid. The April 2021 TAR did not indicate that treatment was provided to the right gluteus/sacral ulcer.</p> <p>In May 2021 wound clinic visit dated 5/14/21 revealed that Resident #1 had six pressure ulcers and they were deteriorating. The resident was sent to the emergency room (ER). The note revealed:</p> <p>1. Right superior leg - 5/14/21 note revealed the right superior leg ulcer was full thickness with eschar present.</p> <p>2. Right posterior leg - the note on 5/14/21</p>	F 686	<p>clinic recommendations/orders and physician orders verses the TAR to ensure physician orders are being followed. Any audit concern will immediately be reported by the QA wound nurse to the DON/ADON for physician notification.</p> <p>June 23, 2021, the corporate clinical director took corrective action with QA Wound Nurse. The clinical director educated QA Wound Nurse on:</p> <ol style="list-style-type: none"> 1. The treatment nurse will follow the physician's orders 2. The treatment nurse will submit wound clinic recommendations and orders to the attending physician for approval and physician signatures 3. The treatment nurse will notify the ADON and/or the DON, registered nurses, if the treatment nurse is unable to implement physician orders or wound clinic orders. The ADON and/or the DON will contact the provider 4. The treatment nurse will ensure specialty mattress placement on an at-risk resident's bed, according to physician's orders 5. QA Wound Nurse will support the treatment nurse by referencing the wound policy manual <p>On June 23, 2021, the DON, ADON, unit manager, and the staff facilitator provided education for all RNs, LPNs, including Treatment Nurse and Nurse #1. The re-education covered:</p> <ol style="list-style-type: none"> 1. Wound Care Manual 2. Nurses, including Treatment Nurse 		

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F 686	<p>Continued From page 12</p> <p>revealed that the ulcer on the right posterior leg had worsened with necrosis present.</p> <p>3. Left leg (distal posterior) had full thickness covered with eschar and with purulent drainage. Culture was obtained on 5/14/21 visit.</p> <p>4. Left leg (posterior superior) had full thickness covered with eschar and with purulent drainage. Culture was obtained on 5/14/21 visit</p> <p>5. Sacral/right gluteus ulcer - stage 3 (reopened) on 5/14/21 visit</p> <p>6. Left heel/calcaneus - unstageable on 5/14/21 visit</p> <p>The wound doctor note on 5/14/21 revealed that the pressure ulcers had worsened and due to the necrosis on the right posterior leg which were difficult to debride completely at the clinic, an operating room (OR) debridement was indicated. Resident #1 was sent to ER on 5/14/21.</p> <p>The hospital records dated 5/14/21 were reviewed. The records revealed that Resident #1 presented to the emergency room (ER) on 5/14/21 with diffuse wounds to his lower legs and sacral region. He was followed by the wound center who sent him over to the ER for surgical debridement and wound care treatment. He has diffuse stage 2 and 3 ulcers to back of his legs bilaterally and sacral wound. He was alert and oriented to person, place, and time. He was admitted with cellulitis rule out abscess bilateral lower extremities, right more than left, acute on chronic worsening pressure wounds. The left lower extremity pressure wounds were deep into the muscle and fascia. Resident #1 was discharged from the hospital to the facility on 5/21/21 on Clindamycin (oral antibiotic) due to wound infection Methicillin Resistant Staphylococcus Aureus (MRSA) to the left leg</p>	F 686	<p>and Nurse #1, are being instructed to provide the physician with all relevant information. Nurses will document relevant information</p> <p>3. Nurses must follow the facility's policy on wounds/treatments</p> <p>4. If the resident has to be sent out of the facility for evaluation and/or treatment the DON and/or ADON must notify the attending physician</p> <p>5. The DON and/or ADON must be notified of all new wounds, worsening wounds, new wound orders, resident concerns, wound clinic concerns, outside provider concerns</p> <p>The education was completed on June 23, 2021 with all staff working; no registered nurse (RN) or licensed practical nurse (LPN) will be allowed to work, including Treatment Nurse and Nurse #1, until the re-education is completed. The re-education is added to the new staff orientation for all RNs, LPNs, and treatment nurses. The facility is not currently utilizing agency staff.</p> <p>On June 23, 2021, the DON, ADON, unit manager, and the staff facilitator provided education for all certified nursing assistants (CNAs). The re-education covered:</p> <ol style="list-style-type: none"> 1. The nursing assistant's role in preventing pressure ulcers, CNAs are a valuable member of the wound care program team 2. Turning and repositioning helps with blood circulation 3. Bathing and personal hygiene keep 		

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F 686	<p>Continued From page 13</p> <p>ulcers. The discharge summary indicated to use Dakin's solution to the pressure ulcers.</p> <p>Review of Resident #1's admitting orders on 5/21/21 revealed no treatment orders for the pressure ulcers until 5/27/21. On 6/16/21 at 1:19 PM, Nurse #3 was interviewed. She verified that she readmitted Resident #1 on 5/21/21. She remembered the treatment order from the discharge summary for Dakin's solution, but she forgot to write it down on the admitting orders.</p> <p>The wound clinic visit dated 5/26/21 (after hospitalization) revealed that Resident #1 had six pressure ulcers. The note revealed:</p> <ol style="list-style-type: none"> 1. Right superior leg - Resident #1 claimed that the dressing was not changed by the facility daily. The note dated 5/26/21, stage 3 measuring 3.5 x 4 x 0.2 cm with small necrosis. Recommended treatment on 5/26/21 was Santyl and calcium alginate daily. On 5/27/21, there was an order to apply calcium alginate to ulcer daily and PRN. The May 2021 TAR revealed that there was no treatment provided to the right superior leg ulcer from 5/21/21 through 5/31/21. 2. Right posterior leg - The note dated 5/26/21 revealed stage 4 pressure ulcer measuring 22.5 x 6 x 2 cm with medium amount of necrotic tissue within the wound bed. The recommended treatment was Santyl and calcium alginate daily. On 5/27/21, there was an order to apply calcium alginate to ulcer daily and PRN. The May 2021 TAR revealed that there was no treatment provided to the right posterior leg ulcer from 5/21/21(readmission) through 5/31/21. 3. Right gluteus/sacrum - The note on 5/26/21, 	F 686	<p>the skin clean</p> <ol style="list-style-type: none"> 4. Residents require timely incontinent care to prevent breakdown 5. Residents, especially those with wounds, require hydration for skin elasticity 6. Proper dietary intake and nutrition to provide necessary vitamins for skin health 7. Sometimes additional vitamins and supplements promote healing 8. Notify the hall nurse and/or treatment nurse if the wound dressing is not present on the wound or becomes soiled <p>The in-service was completed on June 23, 2021 with all CNAs working; no CNA will be allowed to work until the education is completed. The education is added to the new staff orientation of CNAs. The facility is not currently utilizing agency staff.</p> <p>On June 23, 2021, the DON, ADON, staff facilitator and unit manager initiated a re-education for all RNs and LPNs. This re-education instructs the RNs and LPNs, including Treatment Nurse and Nurse #1, to enter all treatments completed on TAR. By having treatments completed documented on the TAR, the documents are available for review by the physician, nurse practitioner, and clinical teams. The in-service was completed on June 23, 2021 with all RNs and LPNs working; no RN or LPN will be allowed to work until the re-education is completed, including Treatment Nurse and Nurse #1. The re-education is added to the new staff orientation for all RNs and LPNs.</p>		

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F 686	<p>Continued From page 14</p> <p>revealed a stage 3 pressure ulcer measuring 2.5 x 4.5 x 0.1 cm. Recommended treatment on 5/26/21 was Santyl and calcium alginate daily. There was no treatment ordered for the right gluteus/sacral ulcer. The May 2021 TAR revealed that there was no treatment provided from 5/21/21 through 5/31/21.</p> <p>4. Left heel/calcaneus -The note dated 5/26/21 revealed an unstageable pressure ulcer measuring 5 x 4.5 x 0.4 cm. Recommended treatment on 5/26/21 was Santyl and calcium alginate daily. On 5/27/21, there was an order to apply calcium alginate to the ulcer 3 times per week and PRN. The May 2021 TAR revealed that there was no treatment provided to the left heel ulcer from 5/21/21 through 5/31/21 except on 5/28/21.</p> <p>5. Left distal posterior leg - The note dated 5/26/21 revealed a stage 3 pressure ulcer measuring 3 x 3 x 0.1 cm with medium amount of necrotic tissue including eschar. Recommended treatment on 5/26/21 was Santyl and calcium alginate daily. On 5/27/21 there was an order to apply 4 x 4 gauze to wound bed 3 times per week and PRN. The May 2021 TAR revealed that there was no treatment provided to the left distal posterior leg ulcer from 5/21/21 through 5/31/21 except on 5/28/21.</p> <p>6. Left posterior superior leg - The note dated 5/26/21 revealed a stage 4 pressure ulcer measuring 7 x 2.5 x 0.2 cm with large amount of necrotic tissue. Recommended treatment on 5/26/21 was Santyl and calcium alginate daily. On 5/27/21, there was an order to use 4 x 4 gauze to wound bed 3 times per week and PRN. The May 2021 TAR revealed that there was no</p>	F 686	<p>Process Changes/Monitoring</p> <p>The process of getting the wound clinic recommendations and/or orders to the physician now includes 1) resident returns from the wound clinic with wound clinic recommendation/orders, 2) the wound clinic recommendation/order paperwork is copied by the treatment nurse/unit manager for the DON/ADON to review and the treatment nurse/unit manager/hall nurse scans to the physician, 3) after physician/NP review, the treatment nurse/unit manager/hall nurse will transcribe physician orders onto the TAR, 4) the DON/ADON/unit manager will validate the wound clinic/physician orders are transcribed accurately on the TAR, 5) treatment nurse/hall nurse will provide wound care/treatments as ordered.</p> <p>On June 23, 2021, the DON/ADON initiated weekly rounds with the treatment nurse. The weekly rounds with the treatment nurse include 1) residents seeing outside providers for wound/treatment services and 2) residents receiving treatments in-house only. The weekly rounds audits include verifying that a physician's order is in place and the physician/nurse practitioner is notified with all relevant information provided. Also, the weekly rounds audits cover 1) resident representative notification, 2) if the resident requires outside treatment, and 3) if the DON and/or ADON was notified of wound status, orders, and provider recommendations.</p>		

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F 686	<p>Continued From page 15</p> <p>treatment provided to the left posterior superior ulcer from 5/21/21 through 5/31/21.</p> <p>Resident #1's wound clinic visit dated 6/9/21 revealed that Resident #1 continued to have 6 pressure ulcers.</p> <p>1. Right superior leg - The note dated 6/9/21 revealed a stage 3 pressure ulcer with recommended treatment of wet to dry dressing daily. The June 2021 TAR revealed that there was no treatment provided to the right superior leg ulcer from 6/1/21 through 6/15/21.</p> <p>2. Right posterior leg - The note dated 6/9/21 revealed a stage 4 pressure ulcer measuring 22.5 x 6 x 2 cm with medium necrosis. Recommended treatment was wet to dry dressing. The June 2021 TARs revealed that there was no treatment provided to the right posterior leg ulcer from 6/1/21 through 6/15/21.</p> <p>3. Sacrum/right gluteus - The note dated 6/9/21 revealed a stage 3 pressure ulcer measuring 2.5 x 4.5 x 0.1 cm. Recommended treatment was wet to dry dressing. There was no treatment ordered for the sacral ulcer. The June 2021 TARs revealed that there was no treatment provided to the ulcer from 6/1/21 through 6/15/21 except on 6/4/21 (calcium alginate) and 6/15/21 (calcium alginate).</p> <p>4. Left heel/calcaneus -The note dated 6/9/21 revealed an unstageable pressure ulcer measuring 5 x 4.5 x 0.4 cm. Recommended treatment on 5/26/21 was calcium alginate to wound bed only. The June 2021 TARs revealed that there was no treatment provided to the left heel ulcer from 6/1/21 through 6/15/21 except on</p>	F 686	<p>On June 23, 2021, also during the weekly rounds, the DON/ADON audit the specialty mattresses for proper functioning and correct weight setting.</p> <p>The weekly audits will be completed for six (6) months.</p> <p>The audit results will be forwarded to the Quality Assurance Performance Improvement (QAPI) committee monthly for six (6) months.</p> <p>On June 23, 2021, the administrator notified QAPI Committee of the problem of not following physician orders and incomplete documentation. The administrator also notified QAPI Committee of QAPI Committee's role in the plan of correction.</p> <p>The QAPI Committee will review the ongoing in-services and associated signature sheets to ensure completion by current and new staff.</p> <p>Also, QAPI Committee will review audit results monthly for six (6) months for the purpose of trending and making recommendations for performance improvement.</p>		

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F 686	<p>Continued From page 16</p> <p>6/4/21 (calcium alginate) and 6/9/21 (calcium alginate).</p> <p>5. Left distal posterior leg - The note dated 6/9/21 revealed a stage 3 pressure ulcer measuring 3 x 3 x 0.1 cm with medium amount of necrotic tissue including eschar. Recommended treatment was Santyl and wet to dry dressing. The June 2021 TARs revealed that there was no treatment provided to the left distal posterior leg ulcer from 6/1/21 through 6/15/21 except on 6/4/21 (4 x 4 gauze) and 6/9/21 (4 x 4 gauze).</p> <p>6. Left posterior superior leg -The note dated 6/9/21 revealed a stage 4 pressure ulcer measuring 7 x 2.5 x 0.2 cm with large amount of necrotic tissue. Recommended treatment was Santyl and wet to dry dressing. The June 2021 TARs revealed that there was no treatment provided to the ulcer from 6/1/21 through 6/15/21 except on 6/4/21(4 x 4 gauze) and 6/9/21 (4 x 4 gauze).</p> <p>On 6/15/21 at 9:32 AM, Resident #1 was observed in bed. Both legs were covered with dressing and he was wearing boots on both feet. There was no pressure relieving mattress observed in his bed. When interviewed, he stated that his wound dressings were not changed every day.</p> <p>On 6/15/21 at 3:05 PM, Resident #1 was observed during the dressing change. The treatment Nurse was observed to change the dressing to the pressure ulcers on the right posterior leg, right superior leg, left distal posterior leg, left posterior superior leg, left heel, and sacrum. The pressure ulcers had no necrosis, eschar, or slough except for the ulcers on the left distal posterior leg and left posterior</p>	F 686			

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

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F 686	<p>Continued From page 17</p> <p>superior leg. The Treatment Nurse was observed to apply calcium alginate to all the pressure ulcers.</p> <p>On 6/16/21 at 9:26 AM, the Treatment Nurse was interviewed. He stated that he worked at the wound clinic in other state as wound care technician few years ago and had no other wound care experience. He reported that he started the role as treatment nurse at the facility in January 2021. He indicated that Resident #1 goes to the wound clinic on a weekly basis for wound care management. The Treatment Nurse indicated that he received the wound clinic notes including the treatment recommendation weekly after each visit. He was responsible for the treatment orders for residents with pressure ulcers and transcribed orders to the TARs. The Treatment Nurse reported that he never followed the treatment as recommended by the wound clinic. He thought that the wet to dry dressing had made the ulcers worst. He also indicated that the wound clinic would debride the ulcers and made them larger in size. He stated that he would consult with the facility ' s Quality Assurance (QA) Wound Nurse if needed. When asked about the specialty mattress, he replied that Resident #1 should have the air mattress long time ago however, the facility did not have available air mattress. He indicated that he did not know that the wound clinic had recommended for a specialty mattress for the resident. The Treatment Nurse also commented that the Medical Director had agreed to use Calcium Alginate to treat Resident #1's ulcers. He also stated that he didn ' t follow the twice a day treatment since the ulcers had improved on 3 times a week dressing change.</p> <p>On 6/16/21 at 9:58 AM, the Wound Care Doctor</p>	F 686			

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F 686	<p>Continued From page 18</p> <p>was interviewed. The Wound Care Doctor stated that Resident #1 was dependent on the staff for bed mobility since he was unable to turn and reposition self. Resident #1 was alert and oriented and able to make his needs known. The resident was being followed at the wound clinic weekly for his ulcers. The Wound Doctor verified that the wounds of Resident #1 were all pressure ulcers. Recommendations for treatment of ulcers were sent to facility and he had emphasized the importance of turning and repositioning and dressing change of twice a day or at least daily. Per review of the facility records, and per resident, the recommended treatments were not followed, and the dressings were not changed at least daily. There was a time when the dressings to his ulcers were dated 2 weeks prior and were dirty with dried fluid surrounding the dressing. He reported that his office staff had a discussion with the facility staff regarding the resident wound care in the past and he tried to contact the attending physician but was unsuccessful. He also stated that he had recommended a specialty mattress in April 2021 but was never provided, this was very important to help wound healing and prevent further skin breakdown given his diagnosis.</p> <p>On 6/16/21 at 10:03 AM, the Medical Director was interviewed. He stated that he was also the attending physician of Resident #1. He stated that he was aware that the resident was referred and was being followed by the wound clinic since they are the expert for wound care. He stated that he expected the facility to follow the treatment as recommended by the wound clinic. He indicated that he had not had any discussion with the treatment nurse regarding wound care for Resident #1. He was never informed that the treatment recommendation from the wound clinic</p>	F 686			

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F 686	<p>Continued From page 19</p> <p>was never followed and he would never tell the staff not to follow the treatment as recommended by the wound doctor.</p> <p>On 6/16/21 at 11:05 AM, the Treatment Nurse was again interviewed. He stated that he was on leave from 6/4/21 through 6/14/21 and the nurses on the floor were responsible for the treatments. He stated that he worked Monday through Friday and was responsible for the wound treatments. He reported that he worked on the floor at times and the nurses were responsible for the treatments. The treatment nurse commented that he didn't know why there were multiple holes on the TARs, which indicated that the treatment was not provided. The Treatment Nurse reported that Resident #1 used to have an air mattress, but he requested to be changed to a regular mattress on 7/9/20.</p> <p>On 6/16/21 at 11:30 AM, Nurse #1 was interviewed. She was assigned to Resident #1 on 6/2/21, 6/6/21, and 6/10/21 when the June 2021 TARs did not have nurse's initial to indicate that treatment was provided to Resident #1's pressure ulcers. Nurse #1 verified that she was assigned to the resident on those dates. She confirmed that she did not provide the treatment on those dates since she was not aware that the treatment nurse was out on leave and she was not informed that she must do the treatment. She commented that it was last week Thursday (6/10/21) or Friday (6/11/21) that she was informed that the treatment nurse was out, and the nurses must do the treatments.</p> <p>On 6/16/21 at 11:40 AM, Nurse #2 was interviewed. She verified that she was assigned to Resident #1 on 6/3/21, 6/7/21, 6/9/21, 6/12/21</p>	F 686			

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F 686	<p>Continued From page 20 and 6/13/21. She reported that she started working at the facility on 4/27/21 and she was not trained or had no experience on wound care. Nurse #2 also stated that she was not aware that the treatment nurse was out, and the nurses had to do the treatments. She was informed that she must do the treatment last week 6/10/21 or 6/11/21 but she did not do the treatment since she was not trained on how to do wound dressing.</p> <p>On 6/16/21 at 12:01 PM, the Director of Nursing (DON) was interviewed. She stated that she was not aware that the treatment recommended by the wound clinic was not followed by the treatment nurse. She expected the treatment nurse to discuss with the Medical Director if unable to follow the recommendation from the wound doctor. The DON further indicated that she had not informed the nurses to do the treatment from 6/4/21 through 6/14/21 since she was not aware that the treatment nurse was on leave. She was made aware that he was on leave end of last week (6/11/21) and she then informed the nurses to do the treatments.</p> <p>On 6/16/21 at 1:35 PM, the facility's supply clerk was interviewed. She stated that she was responsible for ordering the air mattress. She reported that she was not informed to order an air mattress for Resident#1 until 6/3/21 and she had to order the mattress and the pump separately. The mattress was already received but still waiting for the pump.</p> <p>On 6/17/21 at 11:48 AM, the Quality Assurance (QA) Wound Nurse was interviewed. She stated that she was aware that the treatment nurse was not following the treatments as recommended by the wound clinic. She indicated that the wound</p>	F 686			

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F 686	<p>Continued From page 21</p> <p>clinic would debride the ulcers making the wound much larger and would recommend wet to dry dressing which would cause the ulcer to deteriorate. She further reported that the treatment nurse had been in discussion with the Medical Director on a weekly basis and the Medical Director had agreed to use calcium alginate to treat Resident #1's ulcers.</p> <p>The Administrator and the Corporate Nurse Consultant were notified of the immediate jeopardy on 6/23/21 at 12:30 PM. On 6/24/21, the facility provided the following credible allegation of IJ removal:</p> <p>1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the non-compliance</p> <p>The recipient who suffered: Resident #1 developed a pressure ulcer on his right lower leg and was being followed by the wound clinic. What went wrong with Resident #1 ' s wounds: The wound care physician orders were not followed and the facility attending physician wound care orders were not followed as evidenced by 1) orders were not correct on the treatment administration records (TARs) and 2) daily treatments were not completed as ordered. In addition, a specialty air mattress, recommended on April 28, 2021 was not placed on Resident #1 ' s bed until June 16, 2021.</p> <p>The recipients who have the potential of suffering/other residents at risk: all residents in the facility, including residents with pressure ulcers, have the potential of suffering from avoidable pressure injury when physician ' s orders are not followed. On June 23, 2021, the</p>	F 686			

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F 686	<p>Continued From page 22</p> <p>assistant director of nursing (ADON) audited 100% of resident current TARs and medical records of current residents with wounds to identify any residents with pressure ulcers who may be at risk if physician orders are not followed. The audit identified wound physician and facility physician orders were not followed for Resident #1 and seven other residents with treatment orders that had treatments not signed on the TARs. Corrective action: 1) June 16, 2021 - June 23, 2021, the treatment nurse, with the assistance of the RN ADON assessed the residents and notified the attending physician/nurse practitioner. No new orders were received from the physician/nurse practitioner and 2) the DON, unit manager, and the staff facilitator provided training to the treatment nurse, RNs, and LPNs to ensure physician orders for wounds are followed and treatments are completed when a treatment nurse is not available to complete treatments.</p> <p>On June 16, 2021, the Maintenance Director and the Central Supply clerk replaced Resident ' s #1 current mattress with a specialty air mattress.</p> <p>June 23, 2021, an audit was completed by the Treatment Nurse and ADON. The treatment nurse and ADON started auditing on June 16, 2021 after identifying the TARs did not follow physician orders, including treatments not being completed daily as ordered. The purpose of the audit was to 1) identify any additional risks related to physician orders, 2) treatments being completed, and 3) treatment completion documented on the TAR.</p> <p>The process of getting the wound clinic recommendations and/or orders to the physician</p>	F 686			

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F 686	<p>Continued From page 23</p> <p>now includes 1) resident returns from the wound clinic with wound clinic recommendation/orders, 2) the wound clinic recommendation/order paperwork is copied by the treatment nurse/unit manager for the DON/ADON to review and the treatment nurse/unit manager/hall nurse scans to the physician, 3) after physician/NP review, the treatment nurse/unit manager/hall nurse will transcribe physician orders onto the TAR, 4) the DON/ADON/unit manager will validate the wound clinic/physician orders are transcribed accurately on the TAR, 5) treatment nurse/hall nurse will provide wound care/treatments as ordered.</p> <p>January - June 2021, the facility did not follow the physician ' s orders for Resident #1.</p> <ul style="list-style-type: none"> - March 2021, the wound clinic recommended to apply the debriding agent Santyl at least daily but preferably twice a day. On the TAR, the treatment provided was calcium alginate 3 times a week. - March 12, 2021, the physician signed a March 12, 2021 physician order to change dressing treatment daily, calcium alginate. The dressing was not changed daily as ordered. - May 21, 2021, Resident #1 was discharged from the hospital to the facility. May 21, 2021 through May 26, 2021 while at the facility, Resident #1 did not have treatment orders for the pressure ulcers. - On April 28, 2021 the wound clinic recommended a specialty mattress. On June 16, 2021, an air mattress was placed on Resident #1 ' s bed. - April 2021 Treatment Administration Records (TARs) for Resident #1 had multiple holes indicating the treatment was not provided. <p>2. Specify the action the entity will take to alter the process or system failure to prevent a serious</p>	F 686			

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F 686	<p>Continued From page 24</p> <p>adverse outcome from occurring or recurring, and when the action will be complete:</p> <p>June 23, 2021, the facility administrator and director of nursing (DON) took corrective action for the staff involved (Treatment Nurse). The administrator and DON met with the treatment nurse for discussion and educated the treatment nurse. The discussion and education included:</p> <ol style="list-style-type: none"> 1. The treatment nurse will follow the physician ' s orders 2. The treatment nurse/unit manager/hall nurse will submit wound clinic recommendations and orders to the attending physician for approval and physician signatures within 4 hours. The Administrative Nurse on Duty will follow up within 24 hours with physician if no response is received. 3. The treatment nurse will notify the ADON and/or the DON, registered nurses, if the treatment nurse is unable to implement physician orders or wound clinic orders. The ADON and/or the DON will contact the provider 4. The treatment nurse will ensure specialty mattress placement on an at-risk resident ' s bed, according to physician ' s orders 5. The QA wound nurse, during monthly visits for six months, will audit and enforce with the treatment nurse that the facility wound protocols are followed, including following physician orders and completing documentation of treatments. Also, the QA wound nurse will audit the wound clinic recommendations/orders and physician orders verses the TAR to ensure physician orders are being followed. Any audit concern will immediately be reported by the QA wound nurse to the DON/ADON for physician notification. <p>June 23, 2021, the corporate clinical director took corrective action for the QA Wound Nurse. The</p>	F 686			

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F 686	<p>Continued From page 25</p> <p>clinical director educated the QA Wound Nurse on:</p> <p>6. The treatment nurse will follow the physician ' s orders</p> <p>7. The treatment nurse will submit wound clinic recommendations and orders to the attending physician for approval and physician signatures</p> <p>8. The treatment nurse will notify the ADON and/or the DON, registered nurses, if the treatment nurse is unable to implement physician orders or wound clinic orders. The ADON and/or the DON will contact the provider</p> <p>9. The treatment nurse will ensure specialty mattress placement on an at-risk resident ' s bed, according to physician ' s orders</p> <p>10. The QA wound nurse will support the treatment nurse by referencing the wound policy manual</p> <p>June 23, 2021, the facility administrator and director of nursing (DON) pro-actively took corrective action for the staff involved (Nurse #1). The DON educated the hall nurse on:</p> <p>11. The treatment nurse and hall nurse will follow the physician ' s orders</p> <p>12. The treatment nurse and hall nurse will submit wound clinic recommendations and orders to the attending physician for approval and physician signatures</p> <p>13. The treatment nurse and hall will notify the ADON and/or the DON, registered nurses, if the treatment nurse or hall nurse is unable to implement physician orders or wound clinic orders. The ADON and/or the DON will contact the provider</p> <p>14. The treatment nurse and hall nurse will request instruction/assistance, when needed, regarding questions related to wounds/treatments</p> <p>On June 23, 2021, the education for all RNs,</p>	F 686			

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F 686	<p>Continued From page 26</p> <p>LPNs, including Treatment Nurse and Nurse #1. The re-education covered:</p> <ul style="list-style-type: none"> - Wound Care Manual - Nurses, including Treatment Nurse and Nurse #1, are being instructed to provide the physician with all relevant information. Nurses will document relevant information. - Nurses must follow the facility ' s policy on wounds/treatments - If the resident has to be sent out of the facility for evaluation and/or treatment the DON and/or ADON must notify the attending physician. - The DON and/or ADON must be notified of all new wounds, worsening wounds, new wound orders, resident concerns, wound clinic concerns, outside provider concerns - The education was completed on 6/23/21 with all staff working; no registered nurse (RN) or licensed practical nurse (LPN) will be allowed to work, including Treatment Nurse and Nurse #1, until the re-education is completed. The re-education is added to the new staff orientation for all RNs, LPNs, and treatment nurses. The facility is not currently utilizing agency staff. <p>On June 23, 2021, the education for all certified nursing assistants (CNAs). The re-education covered:</p> <ul style="list-style-type: none"> - The nursing assistant ' s role in preventing pressure ulcers, CNAs are a valuable member of the wound care program team - Turning and repositioning helps with blood circulation - Bathing and personal hygiene keep the skin clean - Residents require timely incontinent care to prevent breakdown - Residents, especially those with wounds, require hydration for skin elasticity 	F 686			

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F 686	<p>Continued From page 27</p> <ul style="list-style-type: none"> - Proper dietary intake and nutrition to provide necessary vitamins for skin health - Sometimes additional vitamins and supplements promote healing - Notify the hall nurse and/or treatment nurse if the wound dressing is not present on the wound or becomes soiled <p>The in-service was completed on June 23, 2021 with all CNAs working; no CNA will be allowed to work until the education is completed. The education is added to the new staff orientation of CNAs. The facility is not currently utilizing agency staff.</p> <p>On June 23, 2021, the DON, ADON, staff facilitator and unit manager initiated a re-education for all RNs and LPNs. This re-education instructs the RNs and LPNs, including Treatment Nurse and Nurse #1, to enter all treatments completed on TAR. By having treatments completed documented on the TAR, the documents are available for review by the physician, nurse practitioner, and clinical teams. The in-service was completed on June 23, 2021 with all RNs and LPNs working; no RN or LPN will be allowed to work until the re-education is completed, including Treatment Nurse and Nurse #1. The re-education is added to the new staff orientation for all RNs and LPNs.</p> <p>On June 23, 2021, the DON/ADON initiated weekly rounds with the treatment nurse. The weekly rounds with the treatment nurse include residents seeing outside providers for wound/treatment services. The weekly rounds review includes verifying that a physician 's order is in place and the physician/nurse practitioner is notified with all relevant information provided. Also, the weekly rounds review covers resident</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>representative notification, if the resident required outside treatment, and if the DON and/or ADON was notified of wound status, orders, and provider recommendations.</p> <p>On June 23, 2021, the administrator notified the Quality Assurance Performance Improvement (QAPI) committee of the problem of not following physician orders and incomplete documentation. The administrator also notified the QAPI Committee of QAPI Committee ' s role in the plan of correction.</p> <p>The Administrator is responsible for ensuring this plan is followed.</p> <p>Richmond Pines Healthcare and Rehabilitation Center IJ removal June 24, 2021.</p> <p>The validation of the immediate jeopardy removal plan was conducted on 6/28/21 by the following:</p> <p>Interview and review of the in-service records to ensure nursing staff were educated on pressure ulcer treatments, process of getting the wound clinic recommendations/orders to the medical director/doctor and documentation of treatment provided</p> <p>Interview and review of the in-service records to ensure nursing assistants (NAs) were educated on their role in preventing pressure ulcers</p> <p>Review of the audit completed on Treatment Administration Records (TARs) to ensure treatment orders were transcribed to the TARs, completed, and documented.</p>	F 686			

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F 686	<p>Continued From page 29</p> <p>Observation of residents with pressure ulcer to ensure the air mattress were functioning and in correct setting</p> <p>The facility's date of immediate jeopardy removal of 6/24/21 was validated.</p> <p>2. Resident #2 was admitted to the facility on 2/11/21 with multiple diagnoses including hypertension and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 5/7/21 indicated that Resident #2's cognition was intact, needed extensive assistance with bed mobility and had 2 stage 3 pressure ulcers that were present on admission.</p> <p>Resident #2's care plan for pressure ulcer was reviewed. The care plan problem that was initiated on 2/26/21 was "ulceration or interference with structural integrity of layers of skin caused by pressure related to multiple pressure ulcers to sacrum." The goal was the current ulcers will not worsen thru next review. The approaches included to ensure special mattress was in place.</p> <p>On 6/15/21 at 11:10 AM, Resident #2 was observed with a special mattress in her bed. The air mattress in her bed that was deflated, and the machine was not on.</p> <p>On 6/15/21 at 11:12 AM, Resident #2 was observed during the dressing change. The resident had 2 pressure ulcers, left buttock, and sacrum. The ulcers did not have necrosis, eschar or slough and no signs/symptoms of</p>	F 686			

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

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FORM APPROVED
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F 686	<p>Continued From page 30</p> <p>infection noted. The Treatment Nurse was observed to clean the ulcers with normal saline and calcium alginate was applied and covered with transparent dressing.</p> <p>On 6/16/21 at 8:25 AM, Resident #2 was observed in bed and the air mattress was deflated and the machine was not on.</p> <p>On 6/16/21 at 8:37 AM, Nurse Aide (NA) #2 was interviewed. She stated that she was assigned to Resident #2. NA #2 stated that she didn't know that the resident's air mattress was not on. She reported that she had not been to her room yet this morning. NA #2 checked the electrical cord of the air mattress and noticed that it was not plugged in to the wall power outlet.</p> <p>On 6/16/21 at 8:39 AM, Nurse #1 was interviewed. She stated that she was assigned to Resident #2. She indicated that the treatment nurse was responsible for checking the air mattress to ensure the air mattress was functioning properly.</p> <p>On 6/16/21 at 11:05 AM, the Treatment Nurse was interviewed. He stated that he was responsible for checking the air mattress to ensure it was functioning properly. He indicated that he did not notice the air mattress machine of Resident #2 was not on and the mattress was deflated on 6/15/21 during the dressing change.</p> <p>3a) Resident #3 was admitted to the facility on 9/30/19 with multiple diagnoses that included type 2 diabetes, and a pressure ulcer of the sacral region.</p> <p>Resident #3's active care plan, last reviewed</p>	F 686			

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F 686	<p>Continued From page 31</p> <p>4/1/21, included a focus area for admitted with pressure ulcer to sacrum and was at risk of developing further pressure areas related to immobility.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 5/6/21 indicated Resident #3 was cognitively intact and displayed no behaviors or refusal of care during the 7 day look back period. She required extensive assistance with Activities of Daily Living (ADL's) and was coded with 1 stage 3 pressure ulcer.</p> <p>The June 2021 physician orders read to cleanse the coccyx wound with normal saline and pat dry. Pack with Calcium Alginate (a wound dressing used for wounds with drainage) and Medihoney (medical grade honey that has antibacterial actions) and cover with a foam dressing 3 times a week.</p> <p>A review of the facility's Wound Ulcer Flowsheet dated 6/4/21 revealed the pressure area to the coccyx measured 1.5 centimeters (cm) in width, 1 cm in length and 0.2 cm in depth and indicated the wound was slow in healing.</p> <p>The June 2021 Treatment Administration Record (TAR) revealed wound care to Resident #3's coccyx pressure ulcer was completed on 6/4/21 and not initialed as completed on 6/7/21.</p> <p>The nursing progress notes from 12/1/20 to 6/16/21 were reviewed and indicated Resident #3 had no episodes of refusals of wound care or any type of behavior.</p> <p>A phone interview was completed with the Medical Director on 6/16/21 at 10:05 AM and</p>	F 686			

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F 686	<p>Continued From page 32</p> <p>stated he was unaware the wound care for Resident #3 had not been completed as ordered on 6/7/21. He added he would have expected the treatment to be completed as ordered even when the Treatment Nurse was out of the facility or to be notified if there was a reason the wound care could not be completed as ordered.</p> <p>An interview occurred with Nurse #4 on 6/16/21 at 11:42 AM, who was familiar with Resident #3. She was scheduled for the 7:00 AM to 3:00 PM shift on 6/7/21 and explained when the treatment nurse was out of the facility the floor nurses were expected to complete wound care as ordered. The June 2021 TAR was reviewed, and stated she was not aware the treatment nurse was out of the facility nor was she informed that she would be responsible to complete wound care for Resident #3 on 6/7/21.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/16/21 at 4:50 PM. The DON explained she was unaware the treatment nurse was out of the facility until the afternoon of 6/11/21 and at that time she informed the floor nurses they would be responsible for wound care of their residents until 6/14/21.</p> <p>3b) Resident #3 was admitted to the facility on 9/30/19 with multiple diagnoses that included type 2 diabetes, and a pressure ulcer of the sacral region.</p> <p>Resident #3's active care plan, last reviewed 4/1/21, included a focus area for admitted with pressure ulcer to the sacrum and was at risk of developing further pressure areas related to immobility. The interventions included an air</p>	F 686			

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F 686	<p>Continued From page 33 mattress to the bed.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 5/6/21 indicated Resident #3 was cognitively intact and displayed no behaviors or refusal of care during the 7 day look back period. She required extensive assistance with Activities of Daily Living (ADL's), was coded with 1 stage 3 pressure ulcer and had a pressure reducing device to the bed.</p> <p>Review of Resident #3's June 2021 physician orders revealed an air mattress to the bed.</p> <p>Resident 3's weight on 6/11/21 was 229 pounds (lbs.).</p> <p>Resident #3's alternating pressure reducing mattress machine was observed on 6/15/21 at 10:25 AM and was set at 450 lbs. The machine had settings from 50 to 450 lbs. and indicated to set according to resident's weight per lbs.</p> <p>On 6/15/21 at 2:45 PM, Resident #3 was observed sitting in the wheelchair at her bedside. The alternating pressure reducing mattress machine was set at 450 lb.</p> <p>The Treatment Nurse was interviewed on 6/16/21 at 10:48 AM, who stated he checked the functionality of the air mattresses daily and was unaware Resident #3's alternating pressure reducing mattress machine being set at 450 lbs. but would check on it.</p> <p>On 6/16/21 at 1:32 PM, Resident #3 was observed sitting up in her wheelchair. The alternating pressure reducing mattress machine was set at 280 lbs.</p>	F 686			

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F 686	Continued From page 34 An interview was conducted with the Director of Nursing (DON) on 6/16/21 at 4:50 PM and indicated she was unaware whose responsibility it was to check the functionality of the air alternating pressure mattresses, but felt it should be done at least daily, most likely by the Treatment Nurse. She further indicated she expected the alternating air mattresses to be set according to the resident's weight for residents with pressure ulcers to promote healing. On 6/16/21 at 5:20 PM, the Treatment Nurse indicated he had checked on Resident #3's alternating air mattress earlier, confirmed it had been set for 450 lbs. and stated he adjusted it. He indicated he was checking the setting of the air mattress daily but was unable to state the last time it was observed. The Treatment Nurse indicated Resident #3's alternating air mattress machine should have been set for 230 lbs. as her weight was 229 lbs. and the machine should have been locked.	F 686			
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, staff and Physician interviews, the facility failed to assess and treat a resident with complaints of pain during wound care (Resident #4). This was	F 697	F 697 Pain Management Resident #4 had a venous stasis ulcer on the right lower extremity related to edema	8/12/21	

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F 697	<p>Continued From page 35 for 1 of 4 residents reviewed for wound care.</p> <p>The findings included:</p> <p>Resident #4 was originally admitted to the facility on 12/12/13. The cumulative diagnoses included chronic venous hypertension with ulcer of right lower extremity (a condition where there is obstruction in the veins), cerebral infarction (a stroke), diabetes type 2 and peripheral vascular disease (PVD).</p> <p>A review of the annual Minimum Data Set (MDS) assessment dated 3/19/21 indicated Resident #4 had moderately impaired cognition and displayed no behaviors or refusal of care during the 7 day look back period. She required extensive to total assistance with Activities of Daily Living (ADL's) and was coded with 1 venous ulcer present. The MDS indicated pain was present occasionally and was rated a 3 out of 10 for severity.</p> <p>A pain assessment was completed by the Assistant Director of Nursing (ADON) on 3/19/21. The assessment indicated Resident #4 verbally self-reported pain occasionally and rated pain level at a 3 out of 10. The pain was noted as not new or of recent onset and was located to the right lower leg. Resident #4 described the pain as aching and medication was marked as relieving the discomfort. The evaluation and intervention section noted the pain level was mild and resident had as needed medication ordered which was effective in relieving pain. The form further indicated there was no nursing action needed based upon the assessment as current pain management was effective in managing Resident #4's pain.</p>	F 697	<p>and immobility. The facility provided wound care on the venous stasis ulcer. The facility failed to assess and treat Resident #4 for pain while the resident had complaints of pain during wound care. On June 16, 2021 the assistant director of nursing (ADON) assessed Resident #4's venous ulcer on the right lower extremity while observing the dressing change. On June 16, 2021, the ADON notified the physician that the as needed (PRN) acetaminophen order needed renewal, the new order for PRN acetaminophen was received. June 16, 2021 a nurse was observed giving Resident #4 two acetaminophen tablets by mouth. Resident #4 accepted the pain medication. Since June 16, 2021, the nurse providing wound care has been offering Resident #4 PRN pain medication prior to performing a dressing change and assessing the resident for pain during the dressing change. The DON, ADON, unit manager, staff facilitator and/or social worker is performing random observations during dressing changes and weekly interview with Resident #4 to ensure Resident #4 is offered pain management, including during dressing changes.</p> <p>All residents in the facility, including residents with pressure ulcers, have the potential of suffering from pain during wound care. The facility must ensure pain management is provided to all residents according to the resident's goals and preferences.</p> <p>June 16, 2021 <input type="checkbox"/> June 23, 2021, the</p>		

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F 697	<p>Continued From page 36</p> <p>A review of the March 2021 physician orders indicated Resident #4 was not ordered anything for discomfort when needed or routinely. There was an order to cleanse the right lower leg with normal saline and pat dry, apply Calcium Alginate (a wound dressing used for wounds with drainage) to the open areas, and cover with dry gauze and wrap with gauze wrap 3 times a week.</p> <p>Resident #4's active care plan, last reviewed 4/13/21, revealed the following focus areas:</p> <ul style="list-style-type: none"> - Peripheral vascular disease related to heart disease. The interventions included to assess for pain and report to physician for possible intervention. -Potential for chronic pain related to CVA (a stroke), complaints of pain, PVD and diabetes. The interventions included to administer pain medications as per physician order and note the effectiveness, document and report complaints and non-verbal signs of pain and observed for signs/symptoms of nonverbal pain such as changes moans, grunting, yelling out, sad expression, crying and report to nurse. - Potential for skin integrity impairment related to history of rashes, history of blister to right great toe, history of abrasion under breasts, history of bruises and fragile skin. The interventions included pain evaluation/assessment as necessary. - Actual skin integrity impairment: venous stasis ulcer of right lower extremity related to edema and immobility. <p>A review of the April 2021 physician orders indicated Resident #4 did not receive a medication for discomfort as needed or routinely. There was an order to cleanse the right lower leg with normal saline and pat dry, apply Calcium</p>	F 697	<p>treatment nurse, with the assistance of the ADON assessed for pain the residents with wound treatment orders and notified the attending physician/nurse practitioner. No new orders were received from the physician/nurse practitioner.</p> <p>June 16, 2021 the root cause analysis: who <input type="checkbox"/> treatment nurse/all residents; what <input type="checkbox"/> pain; when <input type="checkbox"/> nurse performing dressing changes or at other times; where <input type="checkbox"/> resident rooms or where resident is; why <input type="checkbox"/> acute and/or chronic pain; how-follow wound manual and/or recognizing pain by 1) talking with resident, 2) listening to resident, and 3) observing resident's facial expressions.</p> <p>June 16, 2021 <input type="checkbox"/> June 23, 2021, the director of nursing (DON), unit manager, and the staff facilitator provided training to the treatment nurse, registered nurses (RNs), and licensed practical nurses (LPNs) to ensure the Wound Care Manual guidelines are understood. The manual (page A-5) covers Stasis Ulcer Treatment, including Consider pain management with medication review (4). Nurses must ensure that pain management is provided to residents; nurses shall assess and treat residents for pain.</p> <p>On July 8, 2021, the ADON and minimum data set (MDS) nurse audited 100% of 1) residents' current treatment administration records (TARs) and 2) medical records of current residents with wounds to identify any residents with pressure ulcers who may be at risk for</p>		

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F 697	<p>Continued From page 37</p> <p>Alginate to the open areas, and cover and wrap with dry gauze 3 times a week.</p> <p>The May 2021 physician orders revealed Resident #4 was not ordered any medication for discomfort as needed or routinely. There was an order to cleanse the right lower leg with normal saline and pat dry, apply Calcium Alginate to the open areas, and cover and wrap with dry gauze 3 times a week.</p> <p>A review of the June 2021 physician orders indicated Resident #4 was not ordered anything for discomfort as needed or routinely. There was an order to cleanse the right lower leg with normal saline and pat dry, apply Calcium Alginate to the open areas, and cover and wrap with dry gauze 3 times a week.</p> <p>The June 2021 Medication Administration Record (MAR) revealed Resident #4 had not received any medication for the complaints of discomfort.</p> <p>The nursing progress notes from 12/1/20 to 6/16/21 were reviewed and indicated Resident #4 had no episodes of refusals of wound care or any type of behaviors, was alert and oriented and able to answer yes or no questions.</p> <p>On 6/15/21 at 11:40 AM, wound care observation was completed with the Treatment Nurse. During the removal of the wound dressing Resident #4 began to yell out "it hurts". The treatment nurse continued to remove the dressing and stated, "I know it hurts but I'm almost done".</p> <p>A phone interview was completed with the Medical Director on 6/16/21 at 10:05 AM who stated he was unaware Resident #4 had</p>	F 697	<p>pain. The audit identified two residents, including Resident #4, at risk for pain during skin/wound treatments.</p> <p>July 8, 2021, the facility administrator and DON took corrective action with the Treatment Nurse. The administrator and DON met with the treatment nurse for discussion and educated the treatment nurse. The discussion and education included:</p> <ol style="list-style-type: none"> 1. The treatment nurse will follow the physician's orders, including for PRN pain medication prior to treatment procedures 2. The treatment nurse will notify the ADON and/or the DON, registered nurses, if a resident, including Resident #4, as a wound/treat related pain issue. The ADON and/or the DON will assess the resident and notify the provider. 3. The treatment nurse will ensure specialty mattress placement on an at-risk resident's bed, according to physician's orders to provide additional comfort. 4. The QA wound nurse, during monthly visits for six months, will audit and enforce with the treatment nurse that the facility wound protocols are followed, including stopping a procedure if the resident says/show signs of discomfort. Any audit concern will immediately be reported by the QA wound nurse to the DON/ADON for pain management follow-up. <p>On July 8, 2021, the DON, ADON, unit manager, weekend supervisor, and/or staff facilitator provided education for all RNs and LPNs. The re-education</p>		

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F 697	<p>Continued From page 38</p> <p>consistent complaints of lower leg pain during wound care and would have been expected to be notified of such so the discomfort could be appropriately addressed.</p> <p>On 6/16/21 at 10:15 AM, an interview was conducted with the ADON who was familiar with Resident #4. She explained Resident #4 had expressed discomfort during wound care and had Tylenol available if needed. The ADON was unaware of any type of analgesic provided prior to wound care completion but she would have let the floor nurse know of the pain complaints so Tylenol could be provided.</p> <p>Nurse #4 was interviewed on 6/16/21 at 11:42 AM and confirmed Resident #4 had complaints of discomfort when the dressing to her right lower leg was removed and replaced but often stopped expressing discomfort when the procedure was over. She denied assessing Resident #4 for pain.</p> <p>An interview was completed with Resident #4 on 6/16/21 at 1:36 PM. She denied pain at rest or while sitting in her wheelchair but did experience discomfort during the wound care to her right lower leg which continued for a while after the treatment was completed. Resident #4 was able to express discomfort was sharp during the treatment and achy afterwards. She denied receiving anything for pain prior to or after the wound care.</p> <p>On 6/16/21 at 2:53 PM a nurse was observed giving Resident #4 two Acetaminophen tablets by mouth which the resident readily took.</p> <p>Wound care observation was completed with the Treatment Nurse and ADON on 6/16/21 at 2:56</p>	F 697	<p>covered:</p> <ol style="list-style-type: none"> 1. Wound Care Manual, focused on sections related to pain management 2. Nurses, including Treatment Nurse, are being instructed to provide the physician with all relevant information, including resident pain. Nurses will document relevant information 3. Nurses must follow the facility's policy on wounds/treatments/pain management 4. The DON and/or ADON must be notified of all new wounds, worsening wounds, new wound orders, resident concerns, including resident expression of discomfort/pain <p>The education was completed on July 9, 2021 with all staff working; no RN or licensed LPN will be allowed to work, including Treatment Nurse, until the re-education is completed. The re-education is added to the new staff orientation for all RNs, LPNs, and treatment nurses. The facility is not currently utilizing agency staff.</p> <p>On July 8, 2021, the DON, ADON, unit manager, weekend supervisor, and/or staff facilitator provided education for all certified nursing assistants (CNAs). The re-education included:</p> <ol style="list-style-type: none"> 1. The nursing assistant's role in preventing pressure ulcers, CNAs are a valuable member of the wound care program team 2. Turning and repositioning helps with blood circulation and comfort 3. Residents require timely nurse 		

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(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	
F 697	<p>Continued From page 39</p> <p>PM. The treatment nurse was observed using wound spray to try and loosen the dressing as it was removed. During the wound care Resident #4 was heard repeatedly stating "it hurts, it hurts" or "oooohhh". This was heard while removing the dressing, cleaning the wound, applying new dressing and afterwards while Treatment Nurse was cleaning up supplies.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/16/21 at 4:50 PM. The DON stated if a resident consistently expressed pain during any type of wound care, she would expect the Treatment Nurse or clinical staff to inform the physician to see if pain medication prior to the treatment would be warranted.</p> <p>On 6/16/21 at 5:14 PM an interview occurred with the ADON. The 3/19/21 Pain Assessment Form for Resident #4 was reviewed. The ADON stated she thought Resident #4 had Acetaminophen ordered as needed for discomfort and was an oversight not to follow through. She did confirm she had not notified the physician with the consistent expression of discomfort during wound care by Resident #4.</p> <p>The Treatment Nurse was interviewed on 6/16/21 at 5:20 PM and verified Resident #4 consistently expressed discomfort with wound care to her right lower leg and he failed to notify the physician because Resident #4 would stop complaining when the treatment was completed.</p>	F 697	<p>notification if the resident complains of pain or discomfort</p> <p>4. Residents, especially those with wounds, are at risk of pain</p> <p>The in-service was completed on July 8, 2021 with all CNAs working; no CNA will be allowed to work until the education is completed. The education is added to the new staff orientation of CNAs. The facility is not currently utilizing agency staff.</p> <p>On July 8, 2021, the DON, ADON, staff facilitator and unit manager initiated a re-education for all RNs and LPNs. This re-education instructs the RNs and LPNs to enter all treatments completed on TAR, assessments for pain in the electronic medical record, and medications provided on the MAR. By having pain/medication documentation on the MAR and in the electronic medical record, the documents are available for review by the physician, nurse practitioner, and clinical teams.</p> <p>The in-service was completed on July 9, 2021 with all RNs and LPNs working; no RN or LPN will be allowed to work until the re-education is completed. The re-education is added to the new staff orientation for all RNs and LPNs.</p> <p>On June 23, 2021, the DON/ADON initiated weekly rounds with the treatment nurse. The weekly rounds with the treatment nurse include Resident #4 dressing change observation. The weekly rounds audits include verifying that a physician's order is in place and the physician/nurse practitioner is notified of all pain related information provided.</p>		

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

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F 697	Continued From page 40	F 697	<p>Also, the weekly rounds audits cover 1) resident representative notification, 2) if the resident requested/required pain relieving measure and 3) if the DON and/or ADON was notified of the resident experiencing discomfort. The weekly round audits will be completed for six (6) months. The round audit results will be forwarded to the Quality Assurance Performance Improvement (QAPI) committee monthly for six (6) months.</p> <p>On June 23, 2021, the administrator notified QAPI Committee of the problem of not following physician orders and pain management, including during dressing changes. The administrator also notified QAPI Committee of QAPI Committee's role in the plan of correction.</p> <p>The QAPI Committee will review the ongoing in-services and associated signature sheets to ensure completion by current and new staff. Also, QAPI Committee will review audit results monthly for six (6) months for the purpose of trending and making recommendations for performance improvement.</p>		