STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/29/21 through 10/01/21. 5 of the 31 complaint allegations were substantiated resulting in deficiencies. Event ID# 2OM811.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide wound care daily per physician order to 2 sampled residents. Resident #11 did not receive wound care to a non-pressure chronic left heel ulcer and a non-pressure chronic ulcer of the right midfoot for 2 days. Resident #12 did not receive wound care to an unstageable deep tissue injury (DTI) to the left heel for 1 day. This occurred for 2 of 2 residents sampled for wound care (Resident #11 and Resident #12). The findings included: 1. Resident #11 was admitted to the facility 1/10/20. Diagnoses included peripheral vascular disease (PVD), type 2 diabetes mellitus (DM), non-pressure chronic ulcer of left heel, non-pressure chronic ulcer of midfoot, and	F 684	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F684 1. Address how corrective action will be	10/25/21

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

Electronically Signed | 10/21/2021

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F 684	Continued From page 1 osteomyelitis left ankle and foot, among others. A care plan revised on 8/31/21 documented Resident #11 had actual skin breakdown, potential for further breakdown regarding the diagnoses of PVD and DM and was followed by a wound doctor. Care plan interventions included to treat the wounds as ordered. An annual Minimum Data Set assessment and a Care Area Assessment (CAA), both dated 9/1/21, assessed Resident #11 with clear speech, understood/understands, intact cognition, at risk for changes in skin integrity due to current wounds related to the diagnoses of PVD, current wound/skin problems and received nutrition/hydration to manage skin problems. The CAA documented Resident #11 recently completed antibiotic therapy for osteomyelitis of the left ankle/foot and was followed by a wound doctor (WD) for wounds to his bilateral feet. A Wound Evaluation and Management Summary dated 9/22/21 assessed Resident #11 with wounds to include the following: ·A shear wound of the right lateral foot for a duration of greater than 126 days. The wound measured 1 centimeter (cm) by 0.8 cm by 1 cm, moderate serous exudate (bloody drainage), 80% granulation tissue and 20% muscle and fascia. The wound progress was noted as improved. ·A wound of the left foot for a duration of greater than 130 days. The wound measured 17 cm by 5 cm by 0.3 cm, moderate serous exudate, 20% slough (dead tissue), 30% granulation tissue, 30% muscle, fascia, and bone and 20% skin. The wound progress was noted as improved.	F 684	accomplished for those residents found to have been affected by the deficient practice " Resident #11 and #12: wound care was completed by the nurse and wound physician on 9/29/21. Wound conditions were observed and assessed by the wound physician 9/29/21 during wound rounds. Wound MD was notified of missed treatments and assessed wounds; no new orders given. " Resident #11 was provided with new heel protectors " One on one education provided to responsible charge nurse by both the unit manager and DON on providing wound care per MD orders and shift change reporting. 2. Address how the facility will identify other residents having potential to be affected by the same deficit practice " On 9/29/21, Nurse and wound physician conducted an audit of residents receiving wound care. No other issues were identified. Completed on 9/29/21 " 9/30/21, DON interviewed 100% of residents receiving wound care. 3. Address what Measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur " Licensed nurses will be in-serviced on facility□s policy for wound documentation " All residents receiving wound care are at risk for this deficient practice. " Any Licensed Nurse who is not educated will not be allowed to work until education received. " Any new Licensed Nurses will be	

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F 684	Continued From page 2 A physician (MD) order dated 8/12/21 recorded to apply calcium alginate and border gauze to the right lateral foot daily on day shift. This order was discontinued on 9/27/21. A MD order dated 9/27/21 recorded to apply Betadine and border gauze to the right lateral foot daily on day shift. A MD order dated 9/27/21 recorded to cleanse the left foot/heel with wound cleanser, apply Betadine and Hydrogel, cover with ABD pad (nonsterile highly absorbent pad used for large wounds), and wrap with Kerlix daily on day shift. On 9/29/21, Resident #11 was observed at 11:35 AM in bed on an air mattress. A foam heel protector was observed to his left foot. The foam heel protector was visibly soiled with a red-tinged discharge. A dressing was observed intact to the right lateral foot. The date of the dressing was not visible. An observation occurred on 9/29/21 at 2:42 PM with Resident #11 in his room on an air mattress. A foam heel protector was intact to his left foot and it was visibly soiled to both the interior and exterior with a red-tinged drainage. Nurse #1 removed the foam heel protector and removed a dressing dated 9/26/21 which recorded the initials of Nurse #1. The wound bed and the dressing were both visibly soiled with a red-tinged drainage. During the same observation, the WD removed a dressing to the right lateral foot that was also dated 9/26/21 and recorded the initials of Nurse #1. There was no drainage noted. Nurse #1 stated she provided wound care to Resident #11 on 9/26/21 and that the dressings that were	F 684	educated by Staff Development Nurse or Director of Nursing or designee during orientation process, prior to providing wound care. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustain " Unit manager or designee will complete wound audits to ensure that dressing changes are complete as prescribed by physician. This audit will take place 5x/wk x 4wks, then 3x/wk x 4wks, and then weekly during rounds with wound physician x 4wks. " Unit manager will review any wound concerns during the daily clinical meeting " The results of this audit data will be reported by the Director of Nursing and or Administrator to the Quality Assurance Committee for review and recommendations given in order to assist in ensuring that the facility stays in compliance and if concerns are identified the Quality Assurance Committee will add on additional weeks until compliance is sustained. Once the QA committee determines the problem no longer exist, then the audits will be conducted on a random basis. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed by 10/25/21	

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just removed were dressings she applied to both wounds on 9/26/21. She stated she could not explain why the dressings had not been changed. Resident #11 stated that he last received wound care to his feet "a couple days ago."

The WD reviewed the medical record for Resident #11 on 9/29/21 at 2:55 PM and confirmed that the wound care orders were for daily dressing changes. The WD assessed each wound and stated the wounds were improving and that she ordered daily dressing changes to control drainage and to meet the goals of wound healing. The WD stated that she wanted the drainage to the left foot well controlled with the dressing changed per order, but even though wound care was not provided on 9/27/21 and 9/28/21, the wounds did not deteriorate.

A telephone interview occurred on 9/30/21 at 2:20 PM with Nurse #2. She stated that she was the 7 AM - 3 PM nurse for Resident #11 on 9/27/21 and 9/28/21. Nurse #2 stated she did not provide wound care to Resident #11's feet on 9/27/21 because she looked at the orders and thought the wound orders to his feet had been discontinued. Nurse #2 further stated she did not provide wound care to the Resident's feet on 9/28/21 because when she went into his room to provide the wound care, he had an incontinent episode and she planned to return to provide wound care to his feet but did not return. Nurse #2 also stated that she did not report this to the oncoming nurse.

A telephone interview occurred with the Unit Manager (UM) on 10/1/21 at 11:04 AM. The UM stated that the charge nurse should provide wound care per order and if the care could not be provided the charge nurse should report off to the

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F 684	Continued From page 4	F 684		

oncoming charge nurse. The UM stated that she routinely ran a report that allowed her to see what wound care had or had not been provided so that she could follow up if any wound care did not get done.

The Director of Nursing (DON) was interviewed on 9/30/21 at 2:30 PM. The interview revealed the MD order should be followed and wound care should be provided daily if that's what the doctor ordered. The DON also stated that if the nurse was interrupted while providing wound care and unable to provide the care, the nurse should report off to the oncoming nurse, and the UM would run a report that would let her see any wound care that still needed to be provided.

2. Resident #12 was admitted to the facility 8/23/21. Diagnoses included an unstageable left heel DTI, and type 2 diabetes mellitus, among others.

An admission weekly skin evaluation dated 8/25/21 documented Resident #12 with an unstageable left heel DTI, that measured 5 centimeters (cm) by 4.7 cm by 0.1 cm.

An admission Minimum Data Set assessment and Care Area assessment, both dated 8/26/21, assessed Resident #12 with adequate hearing, clear speech, understood/understands, intact cognition and admitted with one unstageable DTI with 100% necrotic (dead) tissue to the left heel.

A care plan dated August 2021 identified Resident #12 was at risk for further skin impairment due to a DTI on admission to her left heel. Interventions included to keep skin clean and dry and provide wound care as ordered.

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F 684	Continued From page 5	F 684		

A physician order dated 9/1/21 recorded to cleanse the left heel with wound cleanser, apply Santyl (debridement) and cover with dry dressing daily on day shift.

Resident #12 was observed on 9/29/21 at 11:42 AM in bed on an air mattress. Her feet were observed off-loaded with pillows. A dressing was intact, but the date was not visible. Resident #12 stated that she typically received wound care to her left heel, but that she did not receive wound care on yesterday (9/28/21). Resident #12 stated that the nurse came into her room on 9/28/21 with all the supplies to provide the wound care, but that the nurse got called away and did not come back and so the wound care was not provided.

On 9/29/21 at 1:45 PM, Resident #12 was observed in bed on an air mattress. Her left leg was positioned on a pillow and her left heel was off-loaded. A dressing was intact to her left heel. The dressing was dated 9/27/21 and recorded the initials of Nurse #1. Nurse #1 removed the dressing to the left heel and stated she provided wound care to Resident #12 on 9/27/21. Nurse #1 also stated that the current dressing intact to the Resident's left heel was the dressing Nurse #1 placed on 9/27/21. Nurse #1 further stated that she did not provide wound care to Resident #12 on 9/28/21 because she was off and that she could not explain why the dressing she applied on 9/27/21 was still in place.

The Wound Doctor (WD) assessed the left heel wound for Resident #12 on 9/29/21 at 1:45 PM and stated that Resident #12 had an unstageable left heel DTI with 100% necrotic tissue on admission to the facility. She stated that the

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F 684	Continued From page 6	F 684		

wound started with 100% necrotic tissue, but now the wound bed had approximately 50% necrotic tissue and the rest of the wound bed had healthy tissue. The WD further stated that she ordered daily dressing changes to the left heel DTI and expected the dressing changes to be completed daily.

A telephone interview occurred on 9/30/21 at 2:12 PM with Nurse #2. Nurse #2 stated that she was the 7 AM - 3 PM Nurse for Resident #12 on 9/28/21. Nurse #2 further stated that she gathered the wound supplies towards the end of the shift and went into Resident #12's room on 9/28/21 to provide wound care, but that she got pulled away to another resident's room and did not come back to provide the wound care. Nurse #2 stated that she reported to the oncoming nurse that the wound care had not been provided.

A telephone interview was conducted on 9/30/21 at 4:13 PM with Nurse #3 who stated she arrived to work on 9/28/21 at 5:30 PM, when she arrived, she received report from Nurse #2. Nurse #3 stated that the report she received did not include an update that wound care had not been provided for Resident #12. Nurse #3 stated since she was not aware of this, she also did not provide wound care to Resident #12.

A telephone interview occurred with the Unit Manager (UM) on 10/1/21 at 11:04 AM. The UM stated that the charge nurse should provide wound care per order and if the care could not be provided the charge nurse should report off to the oncoming charge nurse. The UM stated that she routinely ran a report that allowed her to see what wound care had or had not been provided so that she could follow up if any wound care did not get

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F 684	Continued From page 7 done. The Director of Nursing (DON) was interviewed on 9/30/21 at 2:30 PM. The interview revealed the MD order should be followed and wound care should be provided daily if that's what the doctor ordered. The DON also stated that if the nurse was interrupted while providing wound care and unable to provide the care, the nurse should report off to the oncoming nurse, and the UM would run a report that would let her see any wound care that still needed to be provided.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		10/25/21

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 9 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to accurately document the Treatment Administration Record (TAR) for wound care provided to 2 sampled residents reviewed for wound care (Resident #11 and Resident #12). The findings included: 1. Resident #11 was admitted to the facility 1/10/20. Diagnoses included peripheral vascular disease (PVD), type 2 diabetes mellitus (DM), non-pressure chronic ulcer of left heel, non-pressure chronic ulcer of midfoot, and osteomyelitis left ankle and foot, among others. An annual Minimum Data Set dated 9/1/21, assessed Resident #11 with clear speech, understood/understands, and intact cognition. A physician (MD) order dated 9/27/21 recorded to apply Betadine and border gauze to the right lateral foot daily on day shift. A MD order dated 9/27/21 recorded to cleanse the left foot/heel with wound cleanser, apply Betadine and Hydrogel, cover with ABD pad (nonsterile highly absorbent pad used for large wounds), and wrap with Kerlix daily on day shift. The TAR for Resident #11 recorded the initials of Nurse #2 for the wound care to both feet on 9/28/21. An observation occurred on 9/29/21 at 2:42 PM	F 842	F842 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: " Resident #11 and Resident #12 did not have any documentation of wound care being performed. . Wound MD was notified on 09/29/21 of the missed treatments and assessed wounds with no new orders. " Responsible charge nurse was educated on proper wound documentation " TAR was correct to reflect that wound care was not given " Wound MD completed updated documentation on 9/29/21 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: " Residents who receive wound care was audited for completion of documentation and accuracy of documentation. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " Licensed nurses will be educated on facility process for wound documentation by SDC or designee " DON or designee will audit ETAR completion of wound care 5x weekly x 4	

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F 842	Continued From page 10 with Resident #11 in his room on an air mattress. A foam heel protector was intact to his left foot. Nurse #1 removed the foam heel protector and removed a dressing dated 9/26/21 which recorded the initials of Nurse #1. During the same observation, the wound doctor (WD) removed a dressing to the right lateral foot that was also dated 9/26/21. Nurse #1 stated she provided wound care to Resident #11 on 9/26/21 and that the dressings that were just removed were dressings she applied to both wounds on 9/26/21. She stated she could not explain why the dressings had not been changed. Resident #11 stated that he last received wound care to his feet "a couple days ago." A telephone interview occurred on 9/30/21 at 2:20 PM with Nurse #2. She stated that she was the 7 AM - 3 PM nurse for Resident #11 on 9/28/21. Nurse #2 stated she did not provide wound care to the Resident's feet on 9/28/21 because when she went into his room to provide the wound care, he had an incontinent episode and she planned to return to provide wound care to his feet but did not return. Nurse #2 also stated that she documented on the TAR for Resident #11 that wound care was provided on 9/28/21 prior to entering the Resident's room to provide the wound care. Nurse #2 stated that she should not have recorded the wound care was provided before giving the care and since she did that, the oncoming nurse would not know to provide the care. She stated that recording care in the medical record prior to providing the care was a bad habit she needed to break. A telephone interview occurred with the Unit Manager (UM) on 10/1/21 at 11:04 AM. The UM stated that the charge nurse should provide	F 842	weeks, then weekly x 4 weeks, then monthly x 1 " Any Licensed Nurse who is not educated will not be allowed to work until education received on proper wound documentation. " Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: " Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. Once the QA committee determines the problem no longer exist, then the audits will be conducted on a random basis. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed by 10/25/21	

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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 842	Continued From page 11	F 842		

wound care per order and if the care could not be provided the charge nurse should report off to the oncoming charge nurse. The UM stated that care should not be documented until after it is provided. The UM stated that she ran a report that allowed her to see the status of wound care so that she could follow up if any wound care did not get done and if care was documented as provided, but had not actually been done, her report would be inaccurate.

The Director of Nursing (DON) was interviewed on 9/30/21 at 2:30 PM. The DON stated that if the nurse was interrupted while providing wound care and unable to provide the care, the nurse should report off to the oncoming nurse. The DON further stated the medical record should accurately record the care that has been provided.

2. Resident #12 was admitted to the facility 8/23/21. Diagnoses included an unstageable left heel deep tissue injury (DTI), and type 2 diabetes mellitus, among others.

An admission Minimum Data Set assessment dated 8/26/21, assessed Resident #12 with adequate hearing, clear speech, understood/understands and intact cognition.

A physician (MD) order dated 9/1/21 recorded to cleanse the left heel with wound cleanser, apply Santyl (debridement) and cover with dry dressing daily on day shift.

The TAR for Resident #12 recorded the initials of Nurse #2 for the wound care to her left heel on 9/28/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 10/01/2021

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F 842	Continued From page 12	F 842		

Resident #12 was observed on 9/29/21 at 11:42 AM in bed on an air mattress. A dressing was intact to her left heel, but the date was not visible. Resident #12 stated that she typically received wound care to her left heel, but that she did not receive wound care on yesterday (9/28/21). Resident #12 stated that the nurse came into her room on 9/28/21 with all the supplies to provide the wound care, but that the nurse got called away and did not come back and so the wound care was not provided.

On 9/29/21 at 1:45 PM, Resident #12 was observed in bed on an air mattress. A dressing was intact to her left heel. The dressing was dated 9/27/21 and recorded the initials of Nurse #1. Nurse #1 removed the dressing to the left heel and stated she provided wound care to Resident #12 on 9/27/21. Nurse #1 also stated that the current dressing intact to the Resident's left heel was the dressing Nurse #1 placed on 9/27/21. Nurse #1 further stated that she did not provide wound care to Resident #12 on 9/28/21 because she was off and that she could not explain why the dressing she applied on 9/27/21 was still in place.

A telephone interview occurred on 9/30/21 at 2:12 PM with Nurse #2. Nurse #2 stated that she was the 7 AM - 3 PM Nurse for Resident #12 on 9/28/21. Nurse #2 further stated that she gathered the wound supplies towards the end of the shift and went into Resident #12's room on 9/28/21 to provide wound care, but that she got pulled away to another resident's room and did not come back to provide the wound care. She stated that she recorded in the medical record that the wound care had been provided prior to giving the care. Nurse #2 further stated that

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F 842	Continued From page 13	F 842		

recording care in the medical record prior to providing the care was a bad habit she needed to break.

A telephone interview occurred with the Unit Manager (UM) on 10/1/21 at 11:04 AM. The UM stated that the charge nurse should provide wound care per order and if the care could not be provided the charge nurse should report off to the oncoming charge nurse. The UM stated that care should not be documented until after it is provided. The UM stated that she ran a report that allowed her to see the status of wound care so that she could follow up if any wound care did not get done and if care was documented as provided, but had not actually been done, her report would be inaccurate.

The Director of Nursing (DON) was interviewed on 9/30/21 at 2:30 PM. The DON stated that if the nurse was interrupted while providing wound care and unable to provide the care, the nurse should report off to the oncoming nurse. The DON further stated the medical record should accurately record the care that has been provided.