| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345116 | A. BUILDING _____ B. WING _____ | C 12/13/2021 |

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| CAROLINA PINES AT GREENSBORO, LLC | 109 S HOLDEN RD GREENSBORO, NC 27407 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint survey was conducted 12/05/21 through 12/13/21. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness Event ID # DRCD11 | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification and complaint survey was conducted 12/5/21 through 12/13/21.<br><br>17 of the 48 complaint allegations were substantiated.<br><br>The 2567 and letter were issued January 18, 2022 instead of December 30, 2021. | F 000 | | |
| F 580 SS=E | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the | F 580 | | 1/31/22 |

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

Electronically Signed | 01/27/2022

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| F 580 | Continued From page 1<br>resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, facility Nurse Practitioner, and wound care Nurse Practitioner interview, the facility failed to inform the nurse practitioners that wound care was not completed as ordered (Residents #28, and 32). The facility additionally failed to notify the urologist that Resident #19 ' s recommendations were not implemented. This was evident for 3 of 3 | F 580 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will | |

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| F 580 | Continued From page 2<br>residents reviewed for notification of change.<br><br>Findings included:<br><br>1. Resident #28 was admitted to the facility on 10/14/21 with the diagnosis of dementia.<br><br>Resident #28 ' s admission Minimum Data Set (MDS) dated 10/24/21 documented he had clear speech, understood/understands and had severely impaired cognition. He required total dependence for all activities of daily living (ADL). He had two stage 2 pressure ulcers.<br><br>Resident #28 ' s care plan dated 10/22/21 documented he had an ADL self-care performance deficit and potential for pressure ulcer.<br><br>Resident #28 ' s physician order documented left heel paint DTI with skin prep each day started 10/28/21 and discontinued on 11/24/21.<br><br>Resident #28 ' s physician order documented 11/11/21 right heel stage 2 pressure ulcer (PU) cleanse wound with cleanser, pat dry, apply silver alginate, and place a dry sterile dressing (DSD) each day.<br><br>Resident #28 ' s physician order dated 11/24/21 documented left heel stage 2 PU cleanse wound with cleanser, pat dry, apply medihoney, and apply DSD each day.<br><br>Resident #28 ' s October, November, and December 2021 treatment administration record (TAR) documentation had missing nursing initials for both right and left heel pressure ulcer care for dates: 10/28 - 31/21, 11/1 - 3/21, 11/12/21, | F 580 | take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been.<br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>The facility failed to notify wound nurse practitioner for treatments not completed as ordered on residents #28 and #32.<br>Effective 1/20/2022 the wound nurse practitioner was notified of treatment orders not being completed for resident #28 and #32. The licensed nurse will continue to provide wound treatments as ordered and notify the nurse practitioner and/or physician if treatments not completed as ordered.<br>The facility failed to notify the urologist that residents #19 recommendations were not implemented.<br>Effective 12/17/2021, the licensed nurse notified the urologist of resident #19 catheter and voiding trial not being completed and indwelling Cath was removed as ordered by the physician.<br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Effective 1/20/2022, current residents with indwelling catheters were reviewed to recommendations from the urologist were implemented appropriately in past 30 days. No additional concerns identified.<br>Effective 1/20/2022, the Director of Nursing and/or designee reviewed current residents with pressure ulcer treatments | |

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| F 580 | Continued From page 3<br>11/18/21, 11/19/21, 11/22/21, 11/28/21, 11/29/21 and 12/6/21.<br><br>On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. US #1 stated that there was a nursing staffing shortage and wound care was not always completed as ordered. She stated the Director of Nursing was informed and she had not informed the nurse practitioner.<br><br>On 12/8/21 at 11:00 am an interview was conducted with the facility Nurse Practitioner. He stated that he was not informed that residents ' wound care were not being completed as ordered.<br><br>On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated when Resident #28 ' s pressure ulcers were identified as missed on admission the wound care Nurse Practitioner was informed. The missed wound care information was not provided to the facility or wound care nurse practitioner.<br><br>2. Resident #32 was admitted on 5/7/20 with the diagnosis of vascular dementia.<br><br>Resident #32 ' s quarterly Minimum Data Set (MDS) dated 5/14/21 documented he had 1 stage 4 pressure ulcer and was dependent for all activities of daily living.<br><br>Resident #32 ' s care plan dated 5/14/21 documented problem and interventions for pressure ulcer.<br><br>Resident #32 had a physician order dated 8/3/21 | F 580 | to ensure treatments were completed and documented on the Treatment Administration Record (TAR) per physician orders from 12/20/22 □ 1/19/22. Residents with omissions on the TAR for pressure wound treatments were reported to the physician and wound condition assessed by the licensed nurse. Residents identified wound condition remained unchanged or improved.<br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>Effective 1/20/2022, the Director of Nursing and/or designee will educate current facility and agency licensed nurses on completing and documenting on the TAR pressure wound treatments per physician orders and to notify and the nurse practitioner or physician with omissions and document notification in resident medical record.<br>Effective 1/20/2022, the Director of Nursing and/or designee will educate current facility and agency licensed nurses on reviewing, implementing, and completing urologist recommendations as ordered and to notify the physician or nurse practitioner if recommendations are not followed and document notification in resident medical record.<br>Effective 1/31/2022, any current facility or agency licensed nurses that has not been educated will not be allowed to work until receive education completed. Newly hired facility and agency licensed nurses will receive education during orientation.<br>Indicate how the facility plans to monitor | |

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| F 580 | Continued From page 4<br>left hip clean wound, apply hydrogel to wound bed, apply dry sterile dressing (DSD) each day.<br><br>Resident #32 ' s August 2021 TAR was missing nursing initials wound care completed for dates 8/8/21, 8/11 - 14/21, 8/18 - 20/21, 8/25/21 and 8/27/21.<br><br>Resident #32 ' s September 2021 TAR was missing nursing initials wound care completed for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/27/21, and 9/30/31.<br><br>Resident #32 had a physician order dated 9/16/21 clean the wound, pat dry, apply collagen to wound bed, followed by silver alginate and secure with DSD each day.<br><br>Resident #32 ' s October 2021 TAR was missing nursing initials wound care completed for dates 10/1/21 10/4/21 10/7/21 10/14/21, 10/22/21. Order ended on 10/27/21 no initials for 10/27 - 30/21. Next order was 11/4/21.<br><br>Resident #32 had a physician order dated 11/4/21 cleanse with dakin ' s solution, apply medihoney to wound bed, cover with silver alginate, and cover with DSD each day.<br><br>Resident #32 ' s November 2021 TAR was missing nursing initials care completed for dates 11/5/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/2821 and 11/29/21.<br><br>Resident #32 ' s December 2021 TAR was missing nursing initials care completed for dates 12/1/21 and 12/6/21.<br><br>On 12/7/21 at 12:05 pm an interview was | F 580 | its performance to make sure that solutions are sustained:<br>Director of Nursing and/or designee will audit 5 residents with pressure ulcer treatment orders to ensure treatments are completed per physician orders, if not will review documentation to ensure notification was provided to nurse practitioner or physician 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 4.<br>Director of Nursing and/or designee will review documentation for residents with catheters to ensure urologist was notified if recommendations were not carried out weekly x 12 weeks.<br>The Director of Nursing will report results of these audits will be reviewed with the Quality Assurance Performance Improvement Committee Monthly X 3 and changes will be made to the plan as necessary to maintain compliance with notification of residents□ changes for residents with catheters and pressure wounds. | |

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| F 580 | Continued From page 5 | F 580 | | |

conducted with the Unit Supervisor (US) #1. US #1 stated that there was a nursing staffing shortage and wound care was not always completed as ordered. She stated the Director of Nursing was informed and she had not informed the nurse practitioner.

On 12/13/21 at 4:50 pm an interview was conducted with the wound care Nurse Practitioner. She stated that she was not informed that resident wound care was not completed as ordered.

On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated when Resident #32 pressure ulcers were identified as missed on admission the wound care Nurse Practitioner was informed. The missed wound care information was not provided to the facility or wound care nurse practitioner.

3. Resident #19 admitted to facility on 10/6/21 with diagnosis of urine retention.

An admission Minimum Data Set (MDS) dated 10/11/21 indicated Resident #19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use and bathing. Further review revealed resident had an indwelling urinary catheter.

A review of report of consultation from Urology appointment dated 11/18/21 revealed diagnosis of urinary retention and recommendations to discontinue indwelling catheter for voiding trial,

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| F 580 | Continued From page 6 | F 580 | | |

may replace if unable to void, and please notify urology office if unable to void.

An interview was conducted on 12/5/21 at 1:46 PM with Resident #19 and it was stated there was an order for indwelling catheter to be discontinued after Urology appointment and have a voiding trial done. Resident #19 stated no one had approached them about discontinuing the indwelling catheter and having a voiding trial.

On 12/08/21 at 1:37 PM an interview was conducted with the Director of Nursing (DON), and she stated Resident #19 had refused to have indwelling catheter discontinued after her urology appointment in November 2021 and that is why the voiding trial was not done. DON further stated a voiding trial would be conducted.

On 12/9/21 at 1:24 PM an follow-up interview was conducted with Resident #19, and it was indicated they had not refused to have the indwelling catheter discontinued. Resident #19 stated they had only been asked on 12/8/21 about indwelling catheter being discontinued and the resident communicated to the Nurse they wanted to wait until the morning to have the voiding trial done because of an appointment (12/9/21) and the resident did not want to go to the appointment without it. Resident #19 stated no one had approached them about discontinuing the catheter prior to 12/8/21 or when they returned from the Urologist in November. Resident #19 stated it had not been done and no one had talked about it or the voiding trial, even after it was brought to the facility staff attention.

On 12/9/21 at 3:23 PM an interview was conducted with the Administrator, and it was

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| F 580 | Continued From page 7<br>indicated her expectation was for staff to follow orders as ordered by the physician. | F 580 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature | F 584 | | 1/31/22 |

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| F 584 | Continued From page 8<br>levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, family, resident, and staff interviews the facility failed to maintain an odor free living environment for rooms 205, 213, 218, 223, 224, 226 and in the facility common areas on the 200 hall. The facility additionally failed to maintain clean furniture, bathrooms floors and toilets in rooms 205,220, 222 and 223. This was evident for 9 of 34 rooms observed on the 200 hall.<br><br>Findings included:<br><br>1. Observations of the 200 unit revealed the following:<br><br>a. On 12/05/2021 at 11:30am the 200 hall had a foul urine sewage odor in the common areas<br><br>b. On 12/6/21 at 1:30 pm rooms 201, 205, 212, 213, 218, 223, 224 and 226 and the common areas (this nursing station, dining room and bathroom), had a foul sewage odor.<br><br>c. On 12/7/21 at 9:45 am the 200 hall had a foul urine sewage odor in the common areas (nursing station, both hallway, and dining room).<br><br>d. On 12/7/21 at 9:48 room 205 had a foul urine and sewage odor.<br><br>e. On 12/7/21 at 9:56 am room 212 had a sewage | F 584 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>The facility failed to maintain an odor free living environment for rooms 205, 213, 218, 223, 224, 226 and in the common areas of the 200 hall.<br><br>The facility additionally failed to maintain clean furniture, bathroom floors, and toilets in rooms 205, 220, 222, and 223. This was evident for 9 of the 34 rooms observed on the 200 hall. | |

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| F 584 | Continued From page 9<br>odor.<br><br>f. On 12/7/21 at 10:00 am room 218 had a sewage odor.<br><br>An interview with the resident who resided in room 218 revealed the odor on this hall had been present for years and the resident's are used to the odor. The resident stated the administrator had been working on this for months and when it rained the odor became worse.<br><br>g. On 12/7/21 at 10:23 room 224 was observed with a foul urine and sewage odor in the resident's room and bathroom.<br><br>An interview with the resident who resided in room 224 revealed the odor was sewage and it had been like that for months.<br><br>h. On 12/7/21 at 1:00pm room 201 had a foul sewage odor; there were no residents in room 201.<br><br>I. On 12/8/21 at 5:30 am a strong urine and sewage odor was present in the common areas (nursing station, dining room and bathroom) of the 200 hall.<br><br>j. On 12/8/21 at 10:23 am room 205 had a foul urine odor in the resident's room and bathroom.<br><br>k. On 12/9/21 at 1:00 pm the common areas (nursing station and dining room) on the 200 hall had a strong, foul urine and sewage odor.<br><br>A Family Member (FM) Interview for resident that was residing in room 213 was conducted on 12/07/2021 at 3:00 pm. The FM revealed during | F 584 | Effective 12/13/2021 Regional Environmental Service for Next Level educated housekeeping manger on deep cleaning rooms and common area with return demonstration.<br><br>Effective 12/14/2021 Housekeeping Manger educated staff on deep cleaning rooms and common areas with return demonstration.<br><br>On 12/14/2021 the affected rooms, bathrooms, and common areas were deep cleaned.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>Effective 12/13/2022 100% audit was completed on the 200 hall for odors that included the common areas.<br><br>Effective 12/13/2022 100% audit was completed on all rooms on the 200 hall to evaluate the cleanliness of the furniture, bathrooms, and toilet room.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 12/14/2021 Housekeeping Manger will educate new hires before on deep cleaning rooms and common areas with return demonstration of satisfaction before given an assignment. | |

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| F 584 | Continued From page 10<br>visits with her brother she noted a foul urine and sewage odor in the facility. The FM indicated she had spoken with the Nurses and Administrator about the odor, and it was reported that because the building was old when it rained the backup from the sewage caused the odor in the building. The FM indicated the Administrator told her they were working on this concern. The FM stated that was about 4 months ago, and the odor was still in the facility during her last visit.<br><br>During interview with Nursing Assistant (NA#8) on 12/08/2021 at 6:00am, she indicated she had been working at the facility for about 3 months and did not smell the sewage odor but sometime there was a foul odor when the resident's received early morning care.<br><br>During an interview with Nurse #5 on 12/09/2021 at 4:00pm, Nurse #5 indicated she had worked at the facility for several years and the facility has had an odor. She added the odor was not from the care of the residents but because of the facility being old. Nurse #5 indicated it was an old sewage smell.<br><br>During an interview with Nursing Assistant #11 on 12/9/21 at 4:15 pm who worked on the 200 hall indicated the facility was old, but no odor was present on the 100 hall just the 200 hall had the odor. She indicated it was just a funny smell.<br><br>During an interview with the Maintenance Director on 12/09/2021 at 4:30pm, he indicated he was aware of the odor in the facility, and he had conducted a 100% audit of all the resident rooms and if any issues were identified housekeeping and plumbing would be completed. | F 584 | Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Housekeeping manger and/or designee will audit 5 rooms on the 200 hall 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 4.<br><br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues | |

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During an interview with Administrator on 12/10/2021 at 10:30 am, she indicated had been identified that the plumbing had caused an offensive odor in the residents' rooms and care areas. She stated the Maintenance Director conducted a 100% audit of all resident rooms, bathrooms, shower rooms and common areas. Any areas that had been identified as having an issue would be evaluated by the Maintenance Director and corrective actions would be put into place. She stated nothing about the date of corrective action being completed. If the area needs to be cleaned housekeeping would perform the task, if the odor was identified as a plumbing issue, the Maintenance Director would be responsible for taking care of the problem. Administrator indicated she would contact a vendor for issues with the plumbing that the Maintenance Director was unable to fix. The Administrator indicated staff would be educated on odor control and reporting odors in the facility. She also indicated that the medical director was informed of the odor issues and the issues with the plumbing. The Administrator stated a vendor would be called to evaluate the situation and see what needed to be done to help control the odors in the facility.

2. On 12/6/21 at 10:40 am an observation was done of room #220. The bed frame and rails were noted to have brown soil with food crumbs. The back of the air mattress controller box had visible dust and crumbs. The resident ' s wheelchair had food crumbs accumulated on the frame and on each side of the seat. The bed controller had brown soil. Concurrent interview with the resident: she stated that she noticed the dust and food crumbs. Housekeeping only

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| F 584 | Continued From page 12 | F 584 | | |

cleaned the floor, bathroom, bedside table, and doorknobs. She stated her bed rails, the back of the mattress box, and wheelchair had not been cleaned in a long time.

On 12/6/21 at 11:10 am an observation was done of rooms #205, 222, and 223. Both bathrooms appeared to have brown soil on the floor and toilet. Room #205 had what appeared to be dark urine in the toilet with strong odor and was not flushed. There were numerous brown paper towels on the floor around the toilet and empty urinals. Room #222 had brown paper towels on the toilet seat covered in stool. Room #222 bed A frame and bed controller had visible brown soil. Room #223 bed A had visible brown soil on the bed frame, wheelchair, and bed controller.

On 12/6/21 at 3:55 pm an observation was done of room #s 205, 220, 222, and 223. The rooms remained in the same condition as was observed at 11:10 am this morning.

On 12/9/21 at 12:10 pm an interview was conducted with Housekeeper #1. She stated that the areas cleaned daily in the resident's room were the floors, bathroom, doorknobs, and tray table. Any other surfaces were cleaned when visibly soiled. She stated she had not routinely cleaned the bedside rails or frame, call light, bed and TV remote, or the air mattress pressure device (if one was present). She stated that she had not cleaned the resident's wheelchairs, that was the responsibility of the housekeeping floor tech.

On 12/9/21 at 12:20 pm an interview was conducted with the housekeeping supervisor (HS). HS stated she started a week ago. There

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| F 584 | Continued From page 13<br>were 2 housekeepers scheduled for all days/shift. HS stated when she was hired there was only 1 housekeeper employed and the other 2 housekeepers were hired within the past week. The two new housekeepers needed training. She stated the high touch areas in the resident's room were bathroom, doorknob, bedside table, and dresser. She had not directed the housekeeper to clean the side rails, call light, and TV and bed remotes. The wheelchairs would be scheduled for cleaning by the housekeeping floor tech and wheelchair handles and arm rests were not planned for daily cleaning. The HS stated she was not aware that the bed control and TV remotes, bed rails, wheelchairs, and air mattress pressure device had visible soiling. The HS stated there would a plan to deep clean the rooms which included all the other surfaces not included in daily cleaning. | F 584 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) for opiate medication (Resident #63) for 1 of 24 residents reviewed for MDS.<br><br>Findings Included:<br><br>Resident #63 was admitted to the facility on 7/1/19 and diagnoses included osteoarthritis and pain in right shoulder. | F 641 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers | 1/31/22 |

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| F 641 | Continued From page 14<br>Review of the physician ' s orders for Resident #63 revealed an order dated 11/2/21 for oxycodone (an opioid pain medication) 5-325 three times daily for pain.<br><br>Review of the medication administration record (MAR) for 11/2/21 through 11/22/21 revealed Resident #63 had received oxycodone three times daily.<br><br>A quarterly minimum data set dated 11/22/21 for Resident #63 did not identify the resident had received any opioid medications during the look-back period.<br><br>An interview on 12/10/21 at 9:50 am with the MDS Nurse revealed she had completed the quarterly MDS dated 11/22/21 for Resident #63. She stated she made an error when coding the medication section and she should have coded the resident had received an opioid for 7 days of the look-back period. The MDS Nurse indicated she would do a correction for this MDS.<br><br>An interview on 12/10/21 at 10:05 am with the Administrator revealed she expected resident ' s MDS ' s to be coded correctly according the medications they had received. | F 641 | allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>The facility failed to accurately code the Minimum Data Set for resident #63 by not coding opiate medication.<br><br>The MDS nurse modified resident #63 Comprehensive MDS Assessment to reflect appropriate coding and accuracy for use of an opioid medication on 12/17/2021.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>Effective 1/20/2022 Minimum Data Set Nurses reviewed Comprehensive MDS Assessments submitted for 12/10/21 □ 1/19/22 to ensure accuracy of coding for residents with opiate medications. Identified residents Comprehensive MDS Assessments were modified as appropriate.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022 Regional MDS Consultant educated MDS nurses on | |

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| F 641 | Continued From page 15 | F 641 | accurate coding of residents with opioid medications on the Comprehensive MDS assessment. Newly hired MDS nurses will received education during orientation. The MDS nurse will review residents active medication profile to capture and accurately code residents use of opioid medications.<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Administrator will audit 5 Comprehensive MDS assessments weekly for 12 weeks to ensure residents with opiate medications are coded accurately.<br>The Administrator will report results of audits and review with Quality Assurance Performance Improvement Committee Monthly X 3 and make changes to the plan as necessary to maintain compliance with MDS coding. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as | F 656 | | 1/31/22 |

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| F 656 | Continued From page 16<br>required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, the facility failed to develop a care plan for an actual pressure ulcer (Resident #28) for 1 of 24 residents reviewed for care plan.<br><br>Findings included:<br><br>Resident #28 was admitted to the facility on 10/14/21 with the diagnosis of dementia.<br><br>Nursing admission note dated 10/14/21 | F 656 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers | |

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| F 656 | Continued From page 17<br>documented Resident #28 had a blister on his right foot (heel) and a skin tear on his right buttock. There was not documentation that the left heel was assessed.<br><br>Resident #28 ' s care plan dated 10/22/21 documented he had an ADL self-care performance deficit and potential for pressure ulcer.<br><br>Resident #28 ' s admission Minimum Data Set (MDS) dated 10/24/21 documented he had clear speech, understood/understands and had severely impaired cognition. He required total dependence for all activities of daily living (ADL). He had two stage 2 pressure ulcers.<br><br>On 12/20/21 at 2:30 pm an interview was conducted with the MDS Coordinator. She stated that Resident #28 ' s heel pressure ulcers were missed on admission and a care plan for actual pressure ulcers was not completed.<br><br>On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated Resident #28 had blisters on his heels on admission that were missed, and a care plan was not done. | F 656 | allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>The facility failed to develop care plan for an actual pressure ulcer for resident #28. Effective 12/9/2021, Comprehensive care plan was updated to reflect pressure ulcer for resident #28.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>Effective 1/20/2022 Minimum Data Set Nurses reviewed current residents with pressure ulcers to ensure pressure ulcer is reflected in care plan.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022 Regional MDS Consultant educated MDS nurse and wound nurse on updating care plan to reflect pressure ulcers.<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>MDS Coordinator will audit 5 residents weekly to ensure care plan reflects pressure ulcer for 12 weeks. | |

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| F 656 | Continued From page 18 | F 656 | Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interviews of the staff and nurse practitioner, the facility failed to consistently complete wound care as ordered (Residents #323 and 19) for 2 of 2 sampled residents.<br><br>Findings included:<br>1. Resident #323 was admitted to the facility on 2/9/15 with the diagnoses of heart failure and bullous pemphigus (skin disease).<br>Resident #323 ' s physician progress note date 7/1/21 documented her right foot turned necrotic and family declined surgery (amputation) and decided on comfort measures.<br><br>Resident #323 ' s physician order dated 7/1/21 documented xeroform gauze to the skin tears cover with dry sterile dressing every other day to | F 684 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been.<br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>The licensed nurse failed to consistently | 1/31/22 |

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| F 684 | Continued From page 19<br>the right foot, skin prep and dry sterile dressing each day to left lateral foot, and cleanse with saline, triple antibiotic ointment, wrap with kerlix each day to left leg.<br><br>Resident #323 ' s treatment administration record (TAR) for July 2021 had no initials for wound care documented for left leg wound care missing nursing initials for dates 7/5/21, 7/26/21, 7/29/21, and 7/30/21. Left lateral leg each day order started 7/15/21 was missing nursing initials for dates 7/26/21, 7/29/21, and 7/30/21. Right foot every other day order was missing nursing initials for dates 7/5/21 and 7/29/21.<br><br>Resident #323 ' s significant change Minimum Data Set (MDS) dated 8/24/21 documented decline of the right foot from peripheral arterial disease resulting in gangrene.<br><br>Resident #323 ' s August 2021 TAR no initials for wound care documented for left medial leg for dates 8/6/21, 8/8/21, 8/11-14/21, 8/18 - 20/21, and 8/25 - 27/21. Left leg was missing nursing initials for dates 8/6/21, 8/8/21, 8/11-14/21, 8/18 - 20/21, and 8/25 - 27/21. Right foot was missing nursing initials for dates 8/6/21, 8/8/21, 8/12/21, 8/14/21, 8/18/21, 8/20/21, and 8/26/21.<br><br>Resident #323 ' s September 2021 TAR no initials for wound care documented to left medial leg was missing nursing initials for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/24/21, 9/27/21, and 9/30/21. Left leg was missing nursing initials for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/24/21, 9/2721, and 9/30/21. Right foot was missing nursing initials for dates 9/921, 9/24/21, 9/27/21, and 9/30/21. | F 684 | document completion of wound care treatments as ordered for residents #323 and #19.<br>Effective 12/21/2021, wound care treatments completed and documented on the Treatment Administration Record (TAR) for residents #323 and #19.<br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>Effective 1/20/2022, the Director of Nursing and/or designee monitored current residents with pressure ulcer treatments to ensure treatments were completed and documented per physician orders from 12/20/21 □ 1/20/22. Residents identified with omissions on the TAR were reported to the physician and assessed by the licensed nurse to ensure pressure wound condition had not worsened. Identified resident pressure wounds remained the same or improved.<br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br>Effective 1/20/2022, the Director of Nursing and/or designee will educate current facility and agency licensed nurses on completing and documenting pressure wound treatments on the TAR per physician orders to ensure resident quality of care. Current facility and agency licensed nurses that has not been educated will not be allowed to work until education completed. Newly hired facility and agency licensed nurses will receive education upon hire. The licensed nurse will be responsible for ensuring pressure | |

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| F 684 | Continued From page 20<br>Resident #323 ' s quarterly MDS dated 11/24/21 documented the resident had clear speech, understood/understands. Her cognition was moderately impaired. The active diagnoses were peripheral arterial disease and bullous pemphigus (skin disorder).<br><br>Care plan updated 11/24/21 for right foot decline documented "I have impaired skin integrity of the left lower leg with open areas noted to left leg, right foot and back. Right foot is necrotic."<br><br>On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated that she was responsible for all resident wounds with dressings except minor skin tears. The WCN stated that the Director of Nursing (DON) was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes.<br><br>On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. The US #1 stated that when the wound care nurse was pulled to a nursing assignment, she and the staff were not always informed until later in the day (when residents were up in their wheelchair and declined care) or not at all and wound care was not completed. She stated there was a break-down in communication. US #1 also stated that when a nurse had to cover 1 unit/2 halls with a medication aide, there was not enough time to complete wound care when the wound care nurse was not available. US #1 | F 684 | wound treatments are completed and documented on the TAR as ordered by the physician. The TARs for residents with pressure wounds will be reviewed during daily clinical meeting to provide additional monitoring.<br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br>Director of Nursing and/or designee will audit 5 residents with pressure wound treatment orders to ensure treatments are completed and documented on the TAR per physician orders, 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 4.<br>The Director of Nursing will report results of these audits with the Quality Assurance Performance Improvement Committee Monthly X 3 and make changes to the plan as necessary to ensure resident quality of care. | |

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| F 684 | Continued From page 21 | F 684 | | |

stated that there was a nurse staffing shortage and was aware that wound care was not always completed.

On 12/8/21 at 11:00 am an interview was conducted with the facility Nurse Practitioner. He stated that he was not aware that residents ' wound care was not being completed as ordered.

On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). The DON was informed by staff that wound care was not always completed due to insufficient staffing.

2. Resident # 19 was admitted to the facility 10/6/21. Cumulative diagnosis included complete amputation at level of below knee and ankle.

An admission Minimum Data Set (MDS) dated 10/11/21 indicated Resident # 19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use, bathing. Skin conditions included a surgical wound that was present on admission.

Resident #19 ' s physicians orders were reviewed. On 10/14/21, there were physician ' s orders to 1. Clean right thigh donor site with wound cleaner, pat dry, apply xeroform sterile gauze followed by dry dressing daily, 2. Paint right below knee amputation (RBKA) surgical site with skin prep daily, 3. Clean left leg graft site with wound cleaner, pat dry, apply Xeroform Sterile

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Gauze to open areas, secure with dry dressings daily.

A care plan dated 10/18/21 revealed Resident #19 had actual impairment to skin integrity of the right knee related to surgical wound. Interventions included maintain or develop clean and intact skin

A review of the treatment record (TAR) for the months of October, November and December 2021 revealed missing nursing initials for treatment to right thigh donor site, for dates: 10/14/21, 10/18/21, 10/22/21, 10/28/21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/5/21, 11/8/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/23/21, 11/26/21, 11/28/21, 11/29/21, 11/30/21, 12/1/21, 12/6/21, to RBKA surgical site for dates: 10/14/21, 10/18/21, 10/28,21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/5/21, 11/8/21, 11/10/21, and to left leg graft site for dates: 10/14/21, 10/18/21, 10/22/21, 10/28/21, 10/30/21, 10/31/21, 11/2/21, 11/3/21, 11/5/21, 11/8/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/23/21, 11/24/21, 12,1/21, 12/6/21. RBKA healed and ordered discontinued on 11/11/2021.

On 12/05/21 at 1:55 PM Resident #19 indicated wound care was not being treated consistently. Resident #19 indicated wounds were getting treated daily then approximately 2 1/2 weeks ago wound care stopped. Resident #19 stated it was reported to Nursing staff wound care was not being done.

An observation of wound care nurse (WCN) perform wound care was conducted on 12/8/21 at 6:51 AM. WCN performed wound care to right thigh donor site and left leg graft site. WCN cleaned both sites with wound cleanser, dried

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with dry gauze, applied skin prep as ordered. Right thigh donor site left open to air and left leg graft site a zinc infused compression sock applied to left leg as ordered. No concerns were identified with wound care provided. Observation of right thigh donor site with healing skin and left leg graft site approximately quarter sized with bloody drainage from site.

On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated she had started her position in July 2021 and was responsible for all resident wounds with dressings except minor skin tears. The WCN stated she was required to carry a phone and be responsible to float into a nurse assignment rotating with 2 other staff when there was not enough staff 7 days a week. The WCN stated when she worked on the weekend, she would have weekday(s) off (which depended on whether she worked both weekend days). The WCN stated when she was not available to provide wound care, the assigned nurse was responsible to provide wound care for that day. The WCN stated that the DON was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN indicated she had not audited the resident TAR for completed wound care. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes.

On 12/14/17 at 3:25 PM, the Director of Nursing was interviewed and stated she expected staff to follow physician orders for wound care.

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| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interviews of the staff, nurse practitioner, and family member, the facility failed to assess and provide wound care for both heel pressure ulcers upon admission which resulted in deep tissue injury and open wounds (Resident #28) and failed to consistently complete pressure ulcer care as ordered (Residents #28, 32 and 19) for 3 of 3 sampled residents.<br><br>Findings included:<br>1. Resident #28 ' s FL2 (cognition and body assessment form) from the hospital dated 10/4/21 provided nursing notes of resident's skin assessment which documented "right heel slightly blistered area of red 5 cm (centimeters) by 4 cm and left heel slightly blistered faint purple 3 x 6 cm."<br><br>Resident #28 was admitted to the facility on | F 686 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The facility failed to assess and provide | 1/31/22 |

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| F 686 | Continued From page 25<br>10/14/21 with diagnosis of dementia.<br><br>Nursing admission note dated 10/14/21 documented Resident #28 had a blister on his right foot (heel) and a skin tear on his right buttock. There was no documentation that the left heel was assessed.<br><br>There were no physician orders for pressure ulcer care and/or pressure relieving interventions implemented on admission documented.<br><br>Resident #28 ' s admission Minimum Data Set (MDS) dated 10/25/21 documented he had clear speech, understood/understands and had severely impaired cognition. He required total dependence for all activities of daily living (ADL). He had two stage 2 pressure ulcers.<br><br>Resident #28 ' s care plan dated 10/22/21 documented he had an ADL self-care performance deficit and potential for pressure ulcer.<br><br>Resident #28 ' s nurses' note dated 10/25/21 documented right and left heels are dark purple, non-blanchable, boggy, with uneven edges. There was a small open area to the sacrum.<br><br>Resident #28 ' s progress note dated 10/25/2021 resident representative stated resident had bilateral breakdown (blister) to heels and sacrum (open area) while in hospital (10/14/21). Note was written by the Director of Nursing.<br><br>Resident #28 ' s progress note dated 10/26/2021 for skin/wound: Foam dressing applied to bilateral heels, old sacral wound and area was cleaned, and dressing applied for added protection. | F 686 | wound care upon admission for resident #28.<br><br>Effective 10/28/2021, wound care orders received and transcribed into electronical medical record for resident #28 who continues to receive treatments as ordered.<br><br>The facility failed to complete pressure ulcer care for residents #28, #32, and #19.<br><br>Effective 12/21/2021, wound care will continue to be provided as ordered for residents #28, #32, and #19.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>Effective 1/20/2022, the Director of Nursing and/or designee reviewed residents admitted from 12/20/21 – 1/19/22 to ensure orders were obtained and transcribed into the electronic medical record to treat pressure ulcers if identified. No additional concerns identified.<br><br>Effective 1/20/2022, the Director of Nursing and/or designee assess current residents with pressure ulcer treatments to ensure treatments were completed per physician orders from 12/20/21 – 1/19/22. The licensed nurse notified physician of residents identified with omissions however, residents wound condition did not worsen as a result. | |

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| F 686 | Continued From page 26<br>Resident representative was informed regarding wounds and the wound care specialist will evaluate tomorrow. Note was written by the Treatment Nurse.<br><br>On 12/20/21 at 3:10 pm an interview was conducted with the Director of Nursing (DON). She stated Resident #28 had blisters on his heels on admission. Only the right heel was documented. FL2 documented by the hospital revealed the resident had slight blister to both heels. The DON stated that there was no documentation or orders for care or pressure relief boots for the heels from admission 10/14/21 until 10/25/21 when the wound care Nurse Practitioner was notified, assessed the resident, and provided orders. The resident ' s blisters had opened and were now stage 2. The DON stated that a blister was considered a stage 2 pressure ulcer. On 10/25/21 the heels were now open, and an order was obtained for treatment. The wound care Nurse Practitioner assessed the heels, and they were documented as deep tissue injury (DTI).<br><br>Resident #28 ' s physician order documented right heel paint DTI with skin prep each day started 10/28/21 and discontinued on 11/11/21.<br><br>Resident #28 ' s physician order documented left heel paint DTI with skin prep each day started 10/28/21 and discontinued on 11/24/21.<br><br>Resident #28 ' s physician order documented 11/11/21 right heel stage 2 pressure ulcer (PU) cleanse wound with cleanser, pat dry, apply silver alginate, and place a dry sterile dressing (DSD) each day. | F 686 | Effective 1/20/2022, the Director of Nursing and/or designee assessed current residents with pressure ulcers to ensure treatments were completed and wounds are healing appropriately.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022, the Director of Nursing and/or designee will educate current facility and agency licensed nurses on completing and documenting pressure ulcer treatment per physician orders and to complete a thorough skin assessment for newly admitted residents and to ensure pressure wound 47 point treatments are promptly received, transcribed and completed as ordered for residents with pressure wounds. Facility and agency licensed nurses that has not been educated will not be allowed to work until education completed. Newly hired facility and agency nurses will receive education during orientation.<br><br>Effective 1/20/2022, the Director of Nursing educated licensed nurse supervisors to assess new admissions for pressure ulcers and to ensure appropriate orders are entered into the residents' electronic medical record. Admissions skin assessments, pressure wound treatment orders and the Treatment Administration Record will be reviewed during morning clinical meeting for additional monitoring to ensure residents | |

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| F 686 | Continued From page 27<br>Resident #28 ' s physician order documented left heel stage 2 PU cleanse wound with cleanser, pat dry, apply medihoney, and apply DSD each day.<br><br>Resident #28 ' s October, November, and December 2021 treatment administration record (TAR) documentation had missing nursing initials for both right and left heel pressure ulcer care for dates: 10/28 - 31/21, 11/1 - 3/21, 11/12/21, 11/18/21, 11/19/21, 11/22/21, 11/28/21, 11/29/21 and 12/6/21.<br><br>On 10/27/2021 Resident #28 ' s progress note dated 10/27/21 by Nurse Practitioner wound care specialist documented initial assessment of wounds. Resident had the following wounds: Left heel DTI measures 3.6 x 6 centimeter (cm); Right heel DTI measures 5 x 6.5 cm; Right lateral foot wound measures 3 x 1.2 cm (new). Treatment recommendation was given to paint wounds with skin prep daily followed by dry dressing. Sacral area was resolved with noted scarred tissue.<br><br>On 12/13/21 at 10:30 am an interview was conducted with Resident #28 ' s resident representative/family member. She stated that the resident had acquired a small blister to both of his heels while he was in the hospital. She stated the resident had no dressing on his heels or protection for pressure at the facility. She observed that the blisters opened and got larger and were draining with no dressing in place. She stated that staff placed shoes on the resident ' s feet with open, heel wounds and no dressing. There was drainage in his shoes. She stated that she informed the Administrator that the heels were not being taken care of and he had no | F 686 | receive care and treatment to prevent and heal pressure wounds.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit 5 residents with pressure ulcer treatment orders to ensure treatments are completed per physician orders, 3 X weekly X 4 weeks, weekly X 4 weeks, and Bi-weekly X 4.<br><br>Director of Nursing and/or designee will audit new admission skin assessments and orders to ensure treatments are ordered and transcribed onto the TAR for residents with pressure wounds. Audits will be completed five times weekly x 12 weeks.<br><br>The Director of Nurse will report results of these audits with the Quality Assurance Performance Improvement Committee monthly X 3 and make changes to the plan as necessary to maintain compliance with treatment and services to prevent and heal pressure wounds. | |

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protection to the heels. She stated that the Administrator had the staff place a dressing and boots to prevent pressure. She stated that the staff had not changed the resident ' s dressing. The dressing had an old date (not the day before) and was falling off. She stated after informing the Administrator, the problems got better about 3 weeks after admission.

On 12/7/21 at 11:30 am an interview was conducted with the facility Nurse Practitioner. He stated that if a pressure ulcer was not dressed and provided pressure relief, the fragile tissue would become damaged and increased in size. The ulcer also had the possibility to become infected. He stated he was not aware that Resident #28 ' s pressure ulcer was missed on admission. The facility had used agency nurse staff, they were not familiar with the resident, and could not provide him a resident update.

On 12/7/21 at 12:05 pm an interview was conducted with the Unit Supervisor (US) #1. The US #1 stated that she, the wound care nurse and Infection Preventionist were required to carry a phone for on-call nursing assignment. When there was a nurse call out that could not be filled, one of the three staff were expected to take turns to cover the assignment. The US #1 stated that when the wound care nurse was pulled to a nursing assignment, she and the staff were not always informed until later in the day (when residents were up in their wheelchair and decline care) or not at all and wound care was not completed. She stated there was a break-down in communication. US #1 also stated that when a nurse had to cover 1 unit/2 halls with a medication aide, there was not enough time to

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complete wound care when the wound care nurse was not available. US #1 stated that there was a staffing shortage.

Resident #28 ' s risk meeting note dated 11/18/2021 documented resident reviewed for healing pressure wounds to both feet. Resident was seen by the wound care Nurse Practitioner on 11/17/21 for assessment and treatment recommendation. The Nurse Practitioner documented the resident ' s right lateral foot DTI had resolved. Resident ' s left heel DTI measures 3 x 4.8 cm. Treatment plan for skin prep to wound daily followed by dry dressing. Resident ' s right heel stage 2 pressure wound measures 3 x 2.6 x 0.1cm with 100% granulation and moderate serosanguinous exudate. Treatment continues with silver alginate to wound bed daily secured with dry dressing.

Resident #28 ' s skin/wound note dated 12/2/21 documented the resident was seen by the wound care Nurse Practitioner for assessment and treatment recommendation of wounds to both feet. The Nurse Practitioner ' s assessment documented DTI to left heel is now a stage 2 pressure injury. New treatment order for medihoney to wound bed followed by dry dressing daily. Stage 2 pressure wound to right heel will continue with daily treatment of silver alginate and dry dressing daily. The left heel measured 3 x 4 x 0.1 cm and the right heel measured 2.3 x 1.5 x 0.1cm.

Resident #28 ' s skin/wound note dated 12/8/2021 documented the resident was seen by the wound care Nurse Practitioner today for

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assessment and treatment recommendations. The resident has stage 2 pressure injury to both heels. The left heel wound measured 2 x 1.6 x 0.1cm with 100% granulation tissue and moderate serosanguinous exudate. Treatment continues as, Medihoney to wound bed followed by dry dressing daily. The right heel wound measured 2 x 1.3 x 0.1cm with 100% granulation tissue and moderate serosanguinous Exudate. Treatment continued with medihoney to wound bed followed by silver alginate, secured with dry dressing daily.

On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated that she had started her position in July 2021 and was responsible for all resident wounds with dressings except minor skin tears. The WCN stated she was required to carry a phone and be responsible to float into a nurse assignment rotating with 2 other staff when there was not enough staff 7 days a week. The WCN stated when she worked on the weekend, she would have weekday(s) off (which depended on whether she worked both weekend days). The WCN stated when she was not available to provide wound care, the assigned nurse was responsible to provide wound care for that day. The WCN stated that the DON was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN had not audited the resident TAR for completed wound care. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes.

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On 12/7/21 at 9:35 am an interview was attempted with the wound care Nurse Practitioner. A detailed message was left for return call.

On 12/8/21 at 10:00 am an observation was attempted for Resident #28 ' s pressure ulcer of the heels. The resident declined.

On 12/13/21 at 4:50 pm an interview was conducted with the wound care Nurse Practitioner. She stated that she was not aware that wound care was not completed as ordered. She stated that failing to provide wound care as ordered could cause a set-back for the wound. When exudate (wound drainage) sits on the wound and surrounding skin there can be tissue breakdown and bacterial growth (infection).

2. Resident #32 was admitted on 5/7/20 with the diagnosis of vascular dementia.

Resident #32 ' s quarterly Minimum Data Set (MDS) dated 5/14/21 documented he had 1 stage 4 pressure ulcer and was dependent for all activities of daily living.

Resident #32 ' s care plan dated 5/14/21 documented problem and interventions for pressure ulcer.

Resident #32 ' s wound care note dated 8/17/21 measured the stage 4 left hip at (length x width x depth) 0.3 x 1.3 x 0.1 centimeters (cm).

Resident #32 ' s wound care note dated 8/25/21 measured the stage 4 left hip at 0.3 x 2 x 0.1 cm.

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Resident #32 had a physician order dated 8/3/21 left hip clean wound, apply hydrogel to wound bed, apply dry sterile dressing (DSD) each day.

Resident #32 ' s August 2021 TAR was missing nursing initials wound care completed for dates 8/8/21, 8/11 - 14/21, 8/18 - 20/21, 8/25/21 and 8/27/21.

Resident #32 ' s wound care note dated 9/15/21 measured the stage 4 left hip at 1.6 x 3.5 x 0.2 cm. Surrounding tissue had maceration (skin breakdown from moisture).

Resident #32 ' s progress note dated 9/22/21 measured the stage 4 left hip at 1.2 x 3 x 0.2 cm

Resident #32 ' s September 2021 TAR was missing nursing initials wound care completed for dates 9/6/21, 9/9/21, 9/16/21, 9/20/21, 9/27/21, and 9/30/31.

Resident #32 had a physician order dated 9/16/21 clean the wound, pat dry, apply collagen to wound bed, followed by silver alginate and secure with DSD each day.

Resident #32 ' s progress note dated 10/20/21 measured the stage 4 left hip at 0.7 x 2 x 0.1cm.

Resident #32 ' s October 2021 TAR was missing nursing initials wound care completed for dates 10/1/21 10/4/21 10/7/21 10/14/21, 10/22/21. Order ended on 10/27/21 no initials for 10/27 - 30/21. Next order was 11/4/21.

Resident #32 had a physician order dated 11/4/21 cleanse with dakin ' s solution, apply medihoney to wound bed, cover with silver alginate, and

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cover with DSD each day.

Resident #32 ' s progress note dated 11/4/21 measured the stage 4 left hip at 1.2 x 2.5 x 0.2 cm. The wound had moderate drainage.

Resident #32 ' s progress note dated 11/18/21 measured the stage 4 left hip at 0.8 x 2 x 0.2 cm. The wound had moderate drainage.

Resident #32 ' s November 2021 TAR was missing nursing initials care completed for dates 11/5/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/2821 and 11/29/21.

Resident #32 ' s December 2021 TAR was missing nursing initials care completed for dates 12/1/21 and 12/6/21.

On 12/7/21 1:55 pm an interview was conducted with the wound treatment nurse (TN). She stated she started at the facility July 2021 and was responsible for all wounds (except skin tears) Monday through Friday. Nursing staff assigned to a resident with a wound was responsible for care on the weekends and when the TN was absent. She stated that she was responsible to be on call for licensed nursing call outs. She carried a phone and was called 7 days a week, rotating with other staff. The TN stated when she was floated to a nursing staff position, the nursing staff who had residents with wounds were responsible to provide wound care on their shift. The TN stated if she was required to cover a nursing shift on the weekend, she would have day(s) off during the week. The TN noted that on some weekends there were no initials that wound care was completed. The TN stated that she signed the TAR for all the days that she completed wound

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care and did not know why there were multiple blanks for the initial block. TN stated that she never looked back at the TAR to see if wound care was documented as completed. TN had received no communication that care was not completed. TN stated that the DON and Unit Manager communicated to nursing staff when the TN was not available to complete the resident wound care on their assignment. TN stated that she had noted a couple of times in November the date on the resident's wound dressing was not dated the day before. She assumed the care had not been completed and informed the DON. TN could not remember which days the wound dressing had an older date. TN stated she rounded each Wednesday with the wound care Nurse Practitioner.

On 12/7/21 at 3:46 pm an interview was conducted with the Administrator. She stated that the DON, wound treatment nurse, staff development coordinator, and unit manager all were on call/rotate to cover licensed nursing call outs. The four staff rotate. She stated she knew that the treatment nurse carried an on-call phone and was required to be pulled to a nursing assignment any day of the week. She stated that she knew the treatment nurse had weekdays off when required to work on the weekend. The Administrator was informed that since July 2021 to December 2021 there were multiple omissions of nursing signature for wound care treatment not completed on the TAR and that the treatment nurse was interviewed and stated she signed for all the wound care she completed. The Administrator stated that a failure to clean and change the dressing for a wound would cause infection and decline.

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12/8/21 at 10:40 am an observation was done of the resident's sacral decubitus care by the treatment nurse. She followed the order and infection control. There were no concerns observed.

On 12/8/21 at 11:00 am an interview was conducted with the facility Nurse Practitioner. He stated that he was not aware that residents ' wound care was not being completed as ordered. Resident #32 now had a new open area abrasion to his inner thigh due to contracture pressure. He stated that there has been a problem with staffing. There was not enough staff and contract staff do not know the residents. He stated when he would ask a contract nurse for the history of a resident, the nurse would state "I don't know, I have only been here 1 day." He stated that if a resident had not received wound care on average 7 days per month since August 2021 there would be infection and/or wound decline.

On 12/8/21 at 11:10 am an interview was conducted with Unit Supervisor #1. The US was aware that the wound care was not completed as ordered due to staffing shortage and staff getting behind in their work then unable to complete wound care. She stated the treatment nurse (TN) was floated to an assignment and staffing assigned were responsible to perform wound care for that day. Staff was not always informed when the TN was not available and wound care needed to be completed by staff assigned. There was a communication problem/breakdown. She stated that on the second-floor unit when there were 2 medication aides and 1 nurse assigned, there were too many residents that required wound care to be completed by 1 nurse on day shift. She stated nurses work 12 hours and the

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second shift had not completed the wound care and she did not know why. She stated that later in the day she would inform the Director of Nursing (DON) that wound care was not completed when the TN was not available. The DON was not informed of each occurrence. She stated she was not auditing the resident TAR for missed care and had not known how many occurrences per month. The problem had been going on for a couple of months.

3. Resident # 19 was admitted to the facility 10/6/21. Cumulative diagnosis included a stage 3 pressure ulcer to the occipital (back of the head).

An admission Minimum Data Set (MDS) dated 10/11/21 indicated Resident # 19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use, bathing. Skin conditions included a stage 3 pressure ulcer that was present on admission.

Resident #19 ' s physicians orders were reviewed. On 10/14/21, there was a physician ' s order to clean stage 3 occipital head wound with wound cleanser, pat dry, apply Medi honey to open area followed by a dry dressing daily for wound treatment.

A care plan dated 10/18/21 revealed Resident #19 had potential for pressure ulcer development related to immobility. Interventions included administer treatments as ordered and monitor for effectiveness.

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A review of the treatment record (TAR) for the months of October, November and December 2021 revealed missing nursing initials for treatment to occipital head wound for dates as follows: 10/14/21, 10/18/21, 10/22/21, 10/27/21, 10/28/21, 10/30/21, 10/31/21, 11/1/21, 11/2/21, 11/5/21, 11/8/21, 11/10/21, 11/11/21, 11/18/21, 11/19/21, 11/23/21, 11/26/21, 11/28/21, 11/29/21, 11/30/21, 12/1/21, and 12/6/21.

On 12/05/21 at 1:55 PM Resident #19 indicated wound care was not being treated consistently. Resident #19 indicated wound was getting treated daily then approximately 2/12 weeks ago wound care stopped. Resident #19 stated it was reported to Nursing staff wound care was not being done.

An observation of wound care nurse (WCN) perform wound care was conducted on 12/8/21 at 6:51 AM. WCN performed wound care to occipital wound. WCN removed old bandage with date of 12/7/21 with small amount of tan drainage to dressing. WCN cleaned wound with wound cleanser, dried with dry gauze, applied skin prep, and placed a dry dressing to area. No concerns were identified with wound care provided. Observation of occipital wound revealed an approximately nickel sized superficial wound without drainage.

On 12/6/21 at 10:10 am an interview was conducted with the wound care nurse (WCN). The WCN stated she had started her position in July 2021 and was responsible for all resident wounds with dressings except minor skin tears. The WCN stated she was required to carry a phone and be responsible to float into a nurse assignment rotating with 2 other staff when there

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| F 686 | Continued From page 38<br>was not enough staff 7 days a week. The WCN stated when she worked on the weekend, she would have weekday(s) off (which depended on whether she worked both weekend days). The WCN stated when she was not available to provide wound care, the assigned nurse was responsible to provide wound care for that day. The WCN stated that the DON was responsible to inform nursing staff to complete wound care when the WCN was not available. The WCN indicated she had not audited the resident TAR for completed wound care. The WCN stated that she had noticed on a couple of occasions the resident ' s wound dressing date was not the day before, but older (day or two). The WCN stated she informed the DON of the missed dressing changes.<br><br>On 12/14/17 at 3:25 PM, the Director of Nursing was interviewed and stated she expected staff to follow physician orders for pressure ulcer care. | F 686 | | |
| F 690 SS=E | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the | F 690 | | 1/31/22 |

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| F 690 | Continued From page 39<br>resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident, and staff interviews the facility failed to obtain a physician order for the use of an indwelling urinary catheter and failed to follow a urologist order for a voiding trial for one (Resident #19) of one resident reviewed for indwelling urinary catheter use.<br><br>Findings included:<br><br>Resident #19 admitted to facility on 10/6/21 with diagnosis of urine retention.<br>A review of a nursing progress note dated 10/6/21 read in part Resident #19 admitted to facility with an indwelling catheter due to urine retention.<br><br>Resident #19 ' s physicians orders were reviewed | F 690 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to | |

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| F 690 | Continued From page 40<br>and no order for an indwelling catheter was found.<br>An admission Minimum Data Set (MDS) dated 10/11/21 indicated Resident #19 was cognitively intact and required limited assistance with 1-person physical assist with bed mobility, dependent assistance with 2-person physical assist with transfers, dependent assistance with 1-person physical assist with toilet use and bathing. Further review revealed resident had an indwelling urinary catheter.<br><br>A review of report of consultation from Urology appointment dated 11/18/21 revealed diagnosis of urinary retention and recommendations to discontinue indwelling urinary catheter for voiding trial, may replace if unable to void, and please notify urology office if unable to void. Further review of the of the medical record revealed no documentation of the voiding trial.<br><br>An interview was conducted on 12/5/21 at 1:46 PM with Resident #19 and it was stated there was an order for indwelling catheter to be discontinued after Urology appointment. Resident #19 stated no one had approached them about discontinuing the indwelling urinary catheter.<br><br>On 12/08/21 at 7:13 AM an interview was conducted with the Wound Nurse, and she verified Resident #19 had an indwelling catheter. She indicated Resident #19 was admitted to facility with the indwelling urinary catheter and she did not know why the resident did not have an order; however, stated there should be an order for the indwelling urinary catheter.<br><br>On 12/08/21 at 7:17 AM an interview was | F 690 | have been affected by the deficient practice.<br><br>The facility failed to obtain an order to use an indwelling catheter and failed to follow a urologist order for a voiding trial for resident #19.<br><br>Effective 12/17/2021, indwelling catheter was removed per urology recommendations and physician orders.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>Effective 1/20/2022, current residents with indwelling catheters were reviewed to ensure appropriate orders are in the electronic medical record and to ensure that voiding trial was conducted if order was given. The Foley catheter was removed with no problems and resident noted voided with no problems. No additional residents identified with orders or urology recommendations for voiding trials.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022, the Regional Director of Clinical Services educated the Director of Nursing and nurse management on reviewing residents with indwelling catheters to ensure appropriate orders are in the electronic medical record and to | |

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| F 690 | Continued From page 41<br>conducted with the Director of Nursing (DON), and she stated Resident #19 should have had an order for the indwelling urinary catheter and she would see what happened.<br><br>A follow up interview was conducted with the DON on 12/08/21 at 1:37 PM and she stated Resident #19 had refused to have indwelling urinary catheter discontinued after her urology appointment in November 2021.<br><br>On 12/9/21 at 1:24 PM an follow-up interview was conducted with Resident #19, and it was indicated they had not refused to have the indwelling urinary catheter discontinued. Resident #19 stated they had only been asked on 12/8/21 about the indwelling urinary catheter being discontinued and the resident communicated to the Nurse they wanted to wait until the morning to have the voiding trial done because of an appointment (12/9/21) and the resident did not want to go to the appointment without it. Resident #19 stated no one had approached them about discontinuing the indwelling urinary catheter prior to 12/8/21 or when they returned from the Urologist in November. Resident #19 stated it had not been done and no one had talked about it, even after it was brought to the facility staff attention.<br><br>On 12/9/21 at 3:23 PM an interview was conducted with the Administrator, and she stated the resident should have had an order for the indwelling urinary catheter on admission. | F 690 | review new orders from the urologist to ensure new orders are implemented as indicated.<br><br>On 01/20/2022, the Director of Nursing providing education to current facility and agency licensed nurses on ensuring residents with catheters have appropriate orders transcribed and that urology recommendations including voiding trials are reviewed, reported to the physician and new orders followed as appropriate.<br><br>Newly hired facility and agency staff will receive education during orientation. The licensed nurse will ensure residents will catheters have accurate physician orders in place and will be responsible for reviewing urology recommendations and reporting to physician with orders transcribed as indicated. The clinical team will review catheter orders and urology recommendations during morning clinical meetings to provide additional monitoring.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit current residents with indwelling catheters to review orders to ensure accuracy weekly x4 weeks, bi-weekly x4 weeks, and monthly x 1 month.<br><br>Director of Nursing and/or designee will audit consults from the urologist to ensure new orders are followed through weekly x4 weeks, bi-weekly x4 weeks, and | |

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| F 690 | Continued From page 42 | F 690 | monthly x 1 month.<br><br>The Director of Nursing will report results of these audits with the Quality Assurance Performance Improvement Committee Monthly X 3 and make changes to the plan as necessary to maintain compliance with care and treatment for residents with catheters. | |
| F 725 SS=G | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge | F 725 | | 1/31/22 |

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| F 725 | Continued From page 43<br>nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interviews of staff, nurse practitioner and family member, the facility failed have sufficient nursing staff to provide wound care as ordered (Residents #28, 32, and 73) for 3 of 3 sampled residents.<br><br>Cross refer:<br>F686: Based on record review, observation and interviews of the staff, nurse practitioner, and family member, the facility failed to assess and provide wound care for both heel pressure ulcers (Resident #28) and failed to consistently complete pressure ulcer care as ordered (Residents #28, 32 and 19) for 3 of 3 sampled residents.<br><br>Findings included:<br><br>On 12/7/21 at 3:46 pm an interview was conducted with the Administrator. She stated that the Director of Nursing (DON), wound treatment nurse, staff development coordinator, and unit manager were all on-call/rotate to cover licensed nursing call outs. She stated she knew that the treatment nurse carried an on-call phone and was required to be pulled to a nursing assignment any day of the week. She stated that she knew the treatment nurse had weekdays off when required to work on the weekend. The Administrator was informed that since June to date there were multiple omissions of nursing initials for wound care treatment on the resident ' s treatment administration record (TAR) and that the treatment nurse was interviewed and stated she signed for all the wound care she completed. | F 725 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to have sufficient nursing staff to provide wound care to residents #28, #32, and #73.<br><br>Effective 1/24/2022 schedules were reviewed for the week to ensure staffing was adequate to provide wound care.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>All residents have the potential to be affected.<br><br>Effective 1/20/2022, current residents with | |

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| F 725 | Continued From page 44<br>The Administrator stated she was not aware that wound care was not completed as ordered.<br><br>On 12/8/21 at 2:10 pm an interview was conducted with the infection preventionist (IP). The IP stated there was a high turnover of nursing staff, she had to wear many hats to cover, and was pulled to a nursing assignment when there was staffing shortage. The facility had hired two new unit managers and was phasing out the assistant director of nursing to help fill the gap. The facility also used agency staff for nursing shortage.<br><br>On 12/8/21 at 3:30 pm an interview was conducted with the Director of Nursing (DON). The DON stated that there was a shortage of nursing staff due to resignations. The facility was using agency staff. When there was a call-out that could not be filled, the wound care nurse, unit supervisor or myself were responsible to cover the assignment. Nursing staff worked 12-hour shifts, and there were 2-day and 2-night shift, full-time nursing positions open. The DON stated that the shortest staffed and hardest to cover was Sunday staffing. | F 725 | treatment orders were assessed to ensure treatments were done as medical doctor ordered.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022, the Regional Director of Clinical Services educated the Director of Nursing and Administrator on providing efficient staffing in the facility to provide wound care to the current residents.<br><br>Effective 1/20/2022, the Administrator educated the staff scheduler on how to calculate nursing hours allotted per day per resident to ensure wound care is provided to the residents as ordered.<br><br>Effective 1/20/2022, the Administrator, Director of Nursing, and Staff scheduler reviewed the current staffing and establish a master schedule to identify openings and ensure recruitment on Indeed posted.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit schedule daily (Monday – Friday) to ensure a staffing is efficient to provide wound care to current residents for 12 weeks. The receptionist and/or designee will audit schedule Saturday and Sunday to ensure a staffing is efficient to provide wound care to current residents for 12 | |

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| F 725 | Continued From page 45 | F 725 | weeks.<br><br>Director of Nursing will bring audits to Quarterly Quality Assurance Meeting. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. | |
| F 727 SS=E | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 7 of 31 days.<br><br>Findings included:<br><br>Review of the nursing staff assignment sheets from 11/5/21 through 12/5/21 revealed the facility | F 727 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following | 1/31/22 |

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| F 727 | Continued From page 46<br>had no documented RN coverage for 11/5/21, 11/6/21, 11/12/21, 11/19/21, 11/22/21, 11/28/2, and 12/4/21. The DON worked an assignment on 11/25/21 from 7:00 pm to 7:00 am documented on the assignment sheet. There were no nurse call outs noted on the 11/25/21 assignment sheet.<br><br>On 12/10/21 at 9:16 AM a telephone interview was conducted with the current DON. She revealed she began her role as DON in July 2021. She stated she had served as a charge nurse only when there was a last-minute call out and other nurse managers have also helped to cover call outs that could not be covered by staff nurses.<br><br>On 12/10/21 at 9:24 AM a telephone interview was conducted with the Administrator. The Administrator stated she had worked at facility since 2/16/21 and the facility was currently using the services of two staffing agencies. She stated she increased staffing levels by one and tried to over staff even when the resident census was decreased. The Administrator indicated the facility had suffered nurse staffing turnover and were challenged with staffing RNs. The Administrator further indicated the average daily census was decreased but greater than 60 residents this year. | F 727 | plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>The facility failed to use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week for 7 out of 31 days. Corrective action is not indicated for these dates.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>Current residents have the potential to be affected by this current deficiency.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022, the Regional Director of Clinical Services educated the Director of Nursing and Administrator on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week per regulations. The Administrator and/or Director of Nursing will review daily nurse schedules to ensure a registered nurse is scheduled at least 8 consecutive | |

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| F 727 | Continued From page 47 | F 727 | hours a day, 7 days a week.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit daily nursing schedule to ensure a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week for 12 weeks.<br><br>The Administrator will report results of these audits with the Quality Assurance Performance<br><br>Improvement Committee Monthly X 3 and make changes to the plan as necessary to maintain compliance with providing a registered nurse 8 consecutive hours a day, 7 days a week. | |
| F 732 SS=B | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides. | F 732 | | 1/31/22 |

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| F 732 | Continued From page 48<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to ensure daily nurse staffing information was posted for two consecutive days in a prominent place readily accessible to residents and visitors.<br><br>Findings included:<br><br>On 12/5/21 at 11:00 AM an initial tour revealed the daily nursing staffing information was dated 12/3/21.<br><br>On 12/5/21 at 1:00 PM an observation of the daily nursing staffing information was still dated 12/3/21. The Director of Nursing (DON) was | F 732 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. | |

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| F 732 | Continued From page 49<br>made aware.<br><br>On 12/5/21 at 1:30 PM an interview was conducted with the DON. She stated the scheduler and the nurse supervisor were responsible for placing the nurse staffing information every morning in the front lobby on the first floor.<br><br>On 12/10/21 at 9:24 AM a telephone interview was conducted with the Administrator. She stated the scheduler was responsible for posting the nurse staffing information on weekdays and the charge nurse that works on the first floor would be responsible for posting on the weekends. The Administrator stated she expected the nurse staffing information to be posted every day of the week. | F 732 | How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>The facility failed to ensure daily nurse staffing information was posted for 2 consecutive days.<br><br>Nursing staff posting was posted upon notification.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>All current residents have the potential to be affected by current deficiency.<br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022, the Director of Nursing and/or designee educated current Staff scheduler to post the nurse staff information daily Monday through Friday and makes changes to the posted schedule throughout the day with changes as necessary and to post projected weekend schedule prior to end of shift Friday. Education was also provided to the licensed nurses on updating the nurse posting after hours and on weekends with changes. The Staff schedule will post nurse staffing in the lobby hall daily Monday through Friday and makes changes as necessary and post projected weekend scheduled prior to end of shift | |

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| F 732 | Continued From page 50 | F 732 | on Fridays. The Director of Nursing or Administrator will post projected weekend staffing on Friday in the absence of the Staff scheduler. The licensed nurse supervisor will make updates/changes to the nurse staffing posting after hours and on weekends. Newly hired licensed nurses and staff schedulers will receive education during orientation.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit nurse staff posting daily to ensure posting is current and accurate. Audits will be completed 5 times a week for 12 weeks.<br><br>The Director of Nursing will report results of these audits with the Quality Assurance Performance Improvement Committee Monthly X 3 and make changes to the plan as necessary to maintain compliance with nurse staff posting. | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and | F 758 | | 1/31/22 |

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| F 758 | Continued From page 51<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by: | F 758 | | |

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| F 758 | Continued From page 52<br>Based on record review, staff, and physician interview the facility failed to obtain documentation for the rationale and duration to extend an as needed (prn) order for a psychotropic medication beyond 14 days. This was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #63).<br><br>Findings Included:<br><br>Resident #63 was admitted to the facility 7/1/19 and diagnoses included bipolar disorder, depression and anxiety.<br><br>A care plan with an initiation date of 8/28/19 for Resident #63 stated the resident used multiple psychoactive medications related to depression, bipolar disorder and insomnia. Interventions included to administer psychotropic medications as ordered by the physician; monitor for side effects and effectiveness every shift.<br><br>Review of the physician ' s orders for Resident #63 identified an order dated 11/16/21 for Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) every 12 hours as needed for anxiety.<br><br>A quarterly minimum data set (MDS) dated 11/22/21 for Resident #63 identified the resident had received antipsychotic, antianxiety and antidepressant medications for 7 days of the look-back period. The resident ' s cognition was intact, and no behaviors were identified.<br><br>Review of a physicians note dated 11/18/21 for Resident #63 revealed medications were reviewed and reconciled and to continue current medications. | F 758 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been.<br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>The facility failed to obtain documentation for the rational and duration to extend an as needed order for a psychotropic medication beyond 14 days for resident #63<br>Effective 12/20/2021, the psychotropic medication was discontinued for resident #63.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br><br>Effective 1/20/2022, current residents with as needed psychotropic medication orders were reviewed for duration and rational if duration longer than 14 days. If as needed psychotropic medication were beyond 14 days medical doctor was called to obtain a rational and/or appropriate stop date. | |

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|---|---|---|---|
| | 345116 | A. BUILDING _____ B. WING _____ | C 12/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CAROLINA PINES AT GREENSBORO, LLC | 109 S HOLDEN RD GREENSBORO, NC 27407 |

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| F 758 | Continued From page 53<br><br>Review of the medication administration record (MAR) for 11/16/21 through 12/8/21 revealed Resident #63 had not received any doses of the as needed Lorazepam.<br><br>An interview on 12/10/21 at 9:40 am with the physician for Resident #63 revealed the as needed Lorazepam order dated 11/16/21 was an oversight. He stated if the regulation for as needed psychotropic medications was limited to 14 days this order should have been re-evaluated within that time frame. The physician explained the resident had multiple psychiatric diagnoses and may need the as needed Lorazepam and he would update the order every 14 days.<br><br>An interview on 12/10/21 at 10:05 am with the Administrator revealed it was her expectation the regulations be followed for as needed psychotropic medications. She added by the 13th day for any as needed orders the physician should re-evaluate the resident to determine if the medication was still needed and write a new order to extend the medications for an additional 14 days. | F 758 | Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 1/20/2022, the Director of Nursing and/or designee will educate current licensed nurses on obtaining 14 days stop date for as needed psychotropic medications from medical doctor and/or rational for a stop date beyond 14 days.<br><br>Effective 1/31/2022, any current License Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone by Director of Nursing and/or designee.<br><br>Effective 1/20/2022, all License Nurses, including Agency staff before their first assignment, will be educated in orientation in person, via phone, and or email by Director of Nursing and/or designee on obtaining 14 day stop date for as needed psychotropic medications from medical doctor and/or rational for a stop date beyond 14 days.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Director of Nursing and/or designee will audit 5 residents with as needed psychotropic medication orders to ensure medication has a stop date of 14 days and/or rational for a stop date beyond 14 days 3 X weekly X 4 weeks, weekly X 4 | |

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| F 758 | Continued From page 54 | F 758 | weeks, and Bi-weekly X 4.<br><br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. | |
| F 921 SS=D | Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)<br><br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, family, resident, and staff interview the facility failed to provide functional running hot water in resident rooms 213, 224 and 226. This was evident for 3 of 34 rooms observed on the 200 hall.<br><br>Findings included:<br><br>1. Observations of the 200 unit revealed the following:<br><br>a. On 12/6/21 at 9:29 am the hot water faucet was not working in room 224. The resident who resided in the room indicated the faucet had not worked in months and the facility was aware of the problem.<br><br>b. On 12/6/21 at 9:35 am the hot water faucet was not working in room 226. The resident who resided in the room reported the faucet hadn ' t worked in over a year. | F 921 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility failed to have sufficient Hot | 1/31/22 |

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| F 921 | Continued From page 55<br><br>c. On 12/8/21 at 4:30 pm rooms 224 and 226 did not have a functional hot water faucet.<br><br>d. On 12/9/21 at 1:00 pm rooms 224 and 226 did not have a functional hot water faucet.<br><br>e. On 12/9/21 at 1:20 pm an observation was made of a family member coming out of room 212 with a pail of hot water and took it into room 213. An interview with the family member on 12/9/21 at 1:25 pm revealed the hot water in room 213 did not get hot and she got hot water out of another room so she could provide care for her family member. The family member added this was something she did every week.<br><br>f. On 12/9/21 at 1:45 pm room 212 did not have a functional hot water faucet.<br><br>During an interview with the Maintenance Director (MD) on 12/09/2021 at 4:00pm he indicated he was not aware of the faucets not working in rooms 224 and 226. The MD stated he would check the water temperature in the identified rooms.<br><br>During an interview with the Administrator on 12/10/2021 at 10:30 am she indicated they had identified plumbing issues and the MD had conducted a 100% audit of the resident rooms, bathrooms, shower rooms and common areas. Any areas that had been identified as having an issue would be evaluated by the Maintenance Director and corrective actions would be put into place. Plumbing issues would be completed by the Maintenance Director. The Administrator indicated she would contact a vendor for issues with the plumbing that the Maintenance Director | F 921 | water for rooms 213, 224, and 226. This was evident for 3 of the 34 rooms observed on the 200 hall.<br><br>On 12/09/2021 the Maintenance Director fixed the none functional hot water faucets for the affected rooms.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>All residents have the potential to be affected.<br><br>Effective 12/10/2021 100% audit was done by Maintenance Director and Administrator on hot water faucets on the 200 hall.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>Effective 12/10/2021 the Maintenance Director was educated on taking water temperatures daily and water temperature regulations to ensure that water is at the appropriate temperature.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>Maintenance director and/or designee will audit schedule daily (Monday  Friday) to ensure water is at appropriate | |

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| F 921 | Continued From page 56<br>was unable to fix. The Administrator did not have any audit tools to review. | F 921 | temperature for 12 weeks.<br>Results of these audits will be reviewed at<br><br>Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>Administrator will review the results of weekly audits to ensure any issues identified are corrected. | |