STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 10/11/22 through 10/13/22. Event ID# JMV411. The following intakes were investigated NC00193847 and NC00193262. 3 of the 3 complaint allegations were not substantiated. However, two deficiencies were found during the complaint investigation.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code a Minimum Data Set (MDS) assessment for pressure ulcer care provided for 1 of 5 resident MDS assessments reviewed (Resident #1). Findings included: Resident #1 was admitted to the facility on 06/03/22 with diagnoses that included, in part: Stage 4 pressure ulcer left ischium (hip), Stage 4 pressure ulcer sacral region, and cerebral infarction (stroke). Review of the physician orders for September 2022 revealed the following orders recorded on the Treatment Administration Record (TAR): 1) Left ischium Stage 4 pressure ulcer-apply wound Vac at 125mmHG (millimeters of Mercury) continuous suction with black foam to left ischial wound. Cleanse ischial wound with wound	F 641	Ayden Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Ayden Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Ayden Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute	11/8/22

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

Electronically Signed | 11/04/2022

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F 641	Continued From page 1 cleanser, allow to sit for 5 minutes, pat dry, then apply wound vac and change every Monday, Wednesday, Friday on day shift and as needed; 2) Sacrum Stage 4 pressure ulcer-Cleanse with wound cleanser, allow to sit for 5 minutes, pat dry, loosely pack wound with silvercel rope, then cover with 4 by 4 gauze or abdominal pad daily on day shift and as needed until healed. Treatments were initialed as administered for both wounds on the TAR during the assessment period. Review of a quarterly Minimum Data Set (MDS) assessment dated 09/12/22 documented Resident #1 had 2 Stage 4 pressure ulcers that were present on admission. The assessment documented she had not received pressure ulcer care during the look back period. In an interview with the Director of Nursing on 10/12/22 at 10:10 AM she stated Resident #1 had (2) stage 4 pressure ulcers that were present on admission and treated at the facility. She explained the MDS assessment of 09/12/22 should have reflected pressure ulcer care was given to Resident #1 during the assessment look back period. She expected all MDS assessments to be accurate. In an interview with Nurse #1 on 10/12/22 at 3:15 PM she stated she had completed the MDS assessment for Resident #1 dated 09/12/22. She acknowledged the assessment should have reflected the resident had received pressure ulcer care during the assessment period.	F 641	Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F641 Accuracy of Assessments On 9/12/22, The Quality Assurance Nurse completed a modification to prior comprehensive assessment for Resident # 1 to reflect accurate coding for pressure ulcer care. On 10/18/22, the MDS consultant initiated an audit of the most recent comprehensive assessment for all current residents to include resident #1. This audit was to ensure the most recent MDS assessment was coded accurately for the residents to include but not limited to coding of pressure ulcer care. The MDS nurse and MDS Consultant completed modifications for all concerns identified during the audit. Audit will be completed by 11/8/22. On 10/19/22 to 10/20/22, the MDS nurse attended a MDS Coding class presented by the Assistant Vice-Present of Reimbursement. Emphasis of the training included MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on how to accurately code assessments based on resident review. All newly hired MDS nurses will be in-serviced during orientation regarding MDS Assessments and Coding. 10% audit of all resident□s most recent	

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F 641	Continued From page 2	F 641	MDS assessments to include resident #1 will be completed by the Facility Consultant and/or MDS Coordinator utilizing the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure the most recent MDS assessment was coded accurately for the residents to include but not limited to coding of pressure ulcer care. The MDS Coordinator and MDS Consultant will address all areas of concern identified during the audit to include completion of resident assessment and/or retraining of the staff. The Administrator will review and initial the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed. The Quality Assurance Nurse will forward the results of MDS Accuracy Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MDS Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Corrective Action Completion Date 11/8/22	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 658		11/8/22

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F 658	Continued From page 3 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document a physician's order for pressure ulcer care for 1 of 1 resident reviewed for pressure ulcer care (Resident #1). Findings included: Resident #1 was admitted to the facility on 06/03/22 with diagnoses that included, in part: Stage 4 pressure ulcer left hip, and Stage 4 pressure ulcer sacral region. Review of a quarterly Minimum Data Set (MDS) assessment dated 09/12/22 documented Resident #1 had intact cognition. She required extensive to dependent assistance with all activities of daily living. She had 2 Stage 4 pressure ulcers that were present on admission. She had not received pressure ulcer care during the assessment look back period. She had received Occupational Therapy on 5 days. She participated in the assessment. Review of a skin assessment for Resident #1 dated 09/08/22 documented a new unstageable pressure ulcer (Pressure Ulcer #5) on her left buttock that measured 1 CM (Centimeter) in Length by 1 CM in width by 0.1 CM in depth. Review of a physician progress note written on 09/08/22 documented: "She does have a new lesion approximately 3 CM in diameter, adjacent to the chronic wound on the sacrum. See treatment notes for details. Treatment nurse did send off wound culture."	F 658	F658 Services to Meet Professional Standards Resident #1 currently does not reside at the facility. On 11/1/22, the Director of Nursing, Quality Assurance Nurse (QA) and Staff Facilitator initiated an audit of all TARs from 10/15/22-11/2/22. This audit is to ensure all treatments were accurately transcribed to the TAR and completed per physician order and that the nurse documented on the TAR following completion of treatment. The Director of Nursing, Quality Assurance nurse and Staff Facilitator will address all concerns identified during the audit to include assessment of the resident, initiating treatment per physician order, notification of the physician of treatment omission/wound status for further recommendations and education of staff. The audit will be completed by 11/8/22. On 10/31/22, the Quality Assurance Nurse and Director of Nursing initiated a 100% skin check on all residents. This audit is to identify any resident with new skin concerns or wounds to ensure all concerns have been properly assessed, treatment initiated as indicated, MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer	

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F 658	Continued From page 4 Review of the physician orders for September 2022 revealed Resident #1 did not have a treatment order for an unstageable pressure ulcer assessed on 09/08/22 until 09/16/22. Record review revealed on 09/16/22 the following physician treatment order was written: Dakins (1/2 strength) solution 0.25% (Sodium Hypochlorite) Apply to left buttocks topically every day shift for wound care; cleanse left buttocks with Dakin's, pat dry, cover with 4 x 4 foam dressing daily and as needed until healed (Start Date 09/16/22). In an interview with the Wound Care Nurse on 10/12/22 at 11:45 AM she stated she knew she worked on 09/02/22 and did not work again until 09/08/22. She recalled when she observed Resident #1's wounds on 09/02/22 she did not have a wound on her left buttock. When she returned on 09/08/22 there was a wound on her left buttock after she had slept in her chair all night. She reported the physician was with her to assess the new wound on 09/08/22. She stated she began to treat the new wound with Dakin's solution to clean it, pat dry and apply a foam 4 x 4 dressing daily. She confirmed on the days she worked between 09/08/22 and 09/16/22 she cleansed the wound daily and applied a dressing but had forgotten to write the physician's order. She had worked on 09/08/22, 09/09/22, 09/14/22, 09/15/22 and 09/16/22. In an interview with Nurse #2 on 10/12/22 at 3:20 PM she stated she had worked as the Treatment Nurse on 09/10/22 and 09/11/22 and had treated Resident #1. She recalled she had noticed Resident #1 had an additional dressing that was	F 658	Flowsheet, incident report completed for any newly identified wounds and care plan updated. No new concerns identified. Audit was completed by 11/1/22. On 11/1/22, the Staff Facilitator initiated an in-service with all nurses regarding (1) Wound Process with emphasis on assessing, initiating treatment and notification of the physician/resident representative for all newly identified skin concerns or changes in wound status (2) Treatments/TAR documentation with emphasis on nurse responsibility to complete treatments in the absence of treatment nurse, signing TAR immediately after completing treatment and notification of the physician if treatment cannot be completed for further instructions. The in-service will be completed by 11/8/22. After 11/8/22 any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Wound Process and TAR Documentation/Treatments The Interdisciplinary Team (IDT) to include Minimum Data Set Nurse, Nurse Supervisor, and Quality Assurance Nurse (QA) will review progress notes for new wounds/skin concerns and new skin alerts 5 times a week x 4 weeks then monthly x 1 month utilizing the Skin Concern/Pressure Ulcer IDT Audit Tool. This audit is to identify new skin concerns to ensure the resident was assessed, treatment initiated per facility	

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F 658	Continued From page 5 not listed on the Treatment Administration Record (TAR). She stated she spoke with the Treatment Nurse on the phone regarding Resident #1's treatments and the Treatment Nurse had given her instructions over the phone to treat the new wound. She confirmed she treated all of Resident #1's wounds during that weekend except for the Wound Vac which was only changed during the week or if needed during off shifts. In an interview with Nurse #3 on 10/13/22 at 10:15 AM she determined she cared for Resident #1 on 09/13/22 after reviewing the TAR for September 2022 and noting she had signed off the treatments for that day. She stated she could not remember particulars about the treatments she had administered that long ago. She stated she worked between 2 or 3 different facilities but if she initialed that she administered a treatment, she did, otherwise she would have documented it not given and documented a reason. She did not recall if she did or did not treat a wound that was not documented on the TAR on 09/13/22 and she did not remember if the Treatment Nurse had or had not given her verbal instructions on how to treat the wound. In an interview with the Director of Nursing on 10/13/22 at 11:50 AM she stated she would expect there to be a physician's order written for any wound treatment being done. She explained if an order was not documented on the TAR, it could cause a wound to be overlooked possibly causing the wound to worsen.	F 658	protocol/physician order, and the order transcribed to the TAR timely. The MDS nurse, nurse supervisor and QA nurse will address all concerns identified during the audit to include assessment of the resident, initiating treatment per facility protocol/physician order, transcribing order to TAR and/or re-training of staff. The Director of Nursing (DON) will review the Skin Audit Tool and Pressure Ulcer Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The IDT team to include Minimum Data Set Nurse, Nurse Supervisor, and Quality Assurance Nurse (QA) will review Not Administered Report 5 times a week x 4 weeks then monthly x 1 month. This audit is to ensure treatments were completed per physician order and that the nurse documented on TAR following treatment. The MDS nurse, nurse supervisor and QA nurse will address all concerns identified during the audit to include completing treatment per physician order, assessment of the resident, notification of the physician for any missed treatments and re-training of staff. The DON will review the Not Administered Report 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will present the findings of the Not Administered Report and the Skin Audit Tool and Pressure Ulcer Audit Tool to the Executive Quality	

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F 658	Continued From page 6	F 658	Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Not Administered Report and the Skin Audit Tool and Pressure Ulcer Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Corrective Action Completion Date 11/8/22	