STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/5/24 through 8/6/24. Event ID# DYS211. The following intake was investigated: NC00220068. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		8/16/24

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

Electronically Signed | 08/13/2024

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F 842	Continued From page 1 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, Wound Care Physician interview, and record review the facility	F 842	1. Resident #1 treatment is documented on the TAR (treatment administration	

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F 842	Continued From page 2 failed to accurately document treatments on a resident's Treatment Administration Record (TAR) for 1 of 3 residents reviewed for pressure ulcer care. (Resident #1) Findings included: Resident #1 was admitted to the facility on 4/17/24. Her active diagnoses included stage 4 pressure wound of the left heel. Review of Resident #1's wound care physician note dated 6/28/24 revealed the wound care physician documented Resident #1's treatment to her left heel was to be changed to sodium hypochlorite solution (dakins) apply once daily for 30 days: half strength; gauze roll (kerlix) apply once daily. Review of Resident #1's Treatment Administration Record (TAR) revealed from 7/1/24 through 7/12/24 there was no treatment documentation for Resident #1's left heel. During an interview on 8/5/24 at 11:29 AM Treatment Nurse #1 stated on 6/28/24 they had placed ½ dakins wet to dry on the wound per the wound care physician in the room at the time. She stated going forward she knew that the wound was to have ½ dakins wet to dry and that was what she was applying to the wound following 6/28/24. Upon review of the TAR, she stated from 7/1/24 through 7/12/24 there was no documentation of treatment to the left heel. She stated she was in the facility on 7/1/24 through 7/12/24 except for 7/6/24 and 7/7/24. She stated on the days she was here she knew she had placed ½ dakins wet to dry with an island boarder gauze on the left heel as had been discussed with	F 842	record.) 2. All residents with treatment could be affected by this deficiency. A review was completed of the treatment administration record to ensure all residents treatments were documented as ordered by the treatment nurse on 8/8/2024 3. The Director of Nursing or Designee will educate all licensed staff to ensure treatments are documented as ordered by 8/16/2024. 4. Residents□ records with wounds will be reviewed weekly x 4 weeks and then monthly for two months to ensure that treatments are documented as ordered by the provider. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly by the Director of Nursing or Designee for three months for review and, if warranted, further action.	

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F 842	Continued From page 3	F 842		

the wound care physician on 6/28/24. On 7/6/24 and 7/7/24 Treatment Nurse #2 was the weekend treatment nurse and provided wound care, and she could not speak to if she provided treatment to the resident's left heel on those days. She stated she knew there was an order in place on 6/28/24 for the change in treatment to the wound to the heel and she did not know why it had disappeared from their system in July. She stated when he rewrote the order on 7/5/24 it would have replaced the one on 6/28/24 and been in the system and on the Treatment Administration Record. She stated this order had also disappeared from the system. She stated on 7/12/24 when the wound care physician rounded with her again, she noted that there was no order for the left heel wound and it had disappeared from the system. She stated due to this she reentered the order again as the wound care physician had not changed the order on 7/12/24 and that order had stayed in the system.

During an interview on 8/5/24 at 2:56 PM Treatment Nurse #2 stated during the time from 7/1/24 through 7/12/24, she applied ½ dakins wet to dry dressing on Resident #1 as had been discussed with the wound care physician during his rounds on 6/28/24. She stated after the wound care physician finished his rounds each Friday, she and the other treatment nurse would ensure the treatments were correctly entered into their electronic records. She did not know or understand why that order was not showing up in the system as she knew she and Treatment Nurse #1 had placed the order in the record. She stated on 7/6/24 and 7/7/24 she provided dressing change to the left heel with ½ dakins wet to dry as had been discussed with the physician on 6/28/24. She stated she did not know why the

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F 842	Continued From page 4 order was not showing up in the system but knew that was the wound care she provided on those days. During an interview on 8/5/24 at 3:27 PM the Wound Care Physician stated he remembered Resident #1. He further stated on 6/28/24 he did change the wound care to Resident #1's heel to dakins half strength once daily wet to dry dressing with an island boarder gauze and discussed this with both treatment nurses. He stated based on the wound progression on his following visits on 7/5/24 and 7/12/24, it appeared the treatment nurses were applying this new treatment as he had ordered. During an interview on 8/5/24 at 8:02 AM the Director of Nursing stated treatment orders were to be placed on the Treatment Administration Record and the staff were to ensure they documented the treatments they provided accurately.	F 842		