### Summary Statement of Deficiencies

**F 000 Initial Comments**

An unannounced complaint investigation was conducted from 05/06/21 through 05/07/21. There were 34 allegations investigated and they were all unsubstantiated. Event ID# KOT411.

**F 641 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 record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set assessments to reflect Resident #7 and Resident #5 received dialysis therapy. This was evident for 2 of 2 residents reviewed for dialysis.

The finding included:

1. Resident #7 was admitted to the facility on 09/29/20 with diagnoses that included end stage renal disease which required hemodialysis.

A review of Resident #7's medical record revealed a physician order dated 09/29/20 for hemodialysis three days a week, Monday, Wednesday, and Friday.

A review of Resident #7's significant change Minimum Data Set (MDS) assessment dated 10/05/20 revealed no dialysis was coded.

A review of Resident #7's quarterly MDS assessment dated 01/28/21 revealed no dialysis was coded.

F 641 Accuracy of Assessments

1. A root cause analysis was conducted on 5/7/21 and completed on 5/11/21 to identify the root cause of the two inaccurate Minimum Data Set assessments and to ensure all residents receiving dialysis had accurate coding including resident #7 and all other current residents receiving dialysis. 2 out of 2 of the incorrect Minimum Data Set assessments were corrected by the RN MDS Coordinator on 5/7/2021. The root cause analysis and AD HOC QAPI meeting was led by Administrator with input from Corporate nurse consultant, Director of Nursing, RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wound care nurse, Activity Director, Social Services Director, Therapy Director, and Dietary manager.

The results of the root cause analysis were reviewed by QAPI on 5/10/2021 and incorporated in the plan of correction.

2. All residents have the potential to be affected, therefore 100% of current...
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<th>F 641 Continued From page 1</th>
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<tr>
<td>On 05/07/21 at 4:00 PM an interview was conducted with the MDS Coordinator (MDSC) who confirmed she completed the two inaccurate MDS assessments for Resident #7. The MDSC explained it was an oversight on her part and would submit corrections for the two inaccurate assessments.</td>
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<td>An interview was conducted with the Director of Nursing (DON) on 05/07/21 at 4:33 PM. The DON stated that the MDS painted a picture of the resident and she expected them to be coded accurately.</td>
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<td>An interview was conducted with the Administrator at 5:20 PM on 05/07/21. The Administrator stated her expectation was that the Minimum Data Set assessments were accurately completed.</td>
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<td>2. Resident #5 was admitted to the facility on 11/18/20 with diagnoses that included end stage renal disease that required hemodialysis.</td>
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<td>A review of Resident #5's medical record revealed a physician order dated 11/18/20 that read: hemodialysis three days a week on Monday, Wednesday and Friday.</td>
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<tr>
<td>A review of Resident #5's Minimum Data Set (MDS) assessment dated 11/24/20 revealed there was no dialysis coded. The MDS was completed by MDS Nurse #2.</td>
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<td>An attempt to speak to MDS Nurse #2 was made on 05/07/21 at 2:18 PM without success.</td>
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<tr>
<td>An interview was conducted with the Minimum Data Set Coordinator (MDSC) on 05/07/21 at 5:20 PM. The MDSC confirmed she submitted corrections for the two inaccurate MDS assessments.</td>
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<tr>
<th>F 641</th>
<th>resident assessments were reviewed and audited for accuracy by Director of Nursing, Assistant Director of Nursing, RN MDS Coordinator, and Unit Manager #1 and #2.</th>
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<td>3. The RN MDS Coordinator and all licensed nurse education on assessment accuracy was initiated on 5/7/2021 and completed on 05/11/2021 by Assistant Director of Nursing and Director of Nursing. Any inaccuracy discovered will be immediately addressed and corrected by Director of nursing or Assistant director of nursing to ensure ongoing regulatory compliance.</td>
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<td>4. Assessment audits were initiated on 05/07/2021 and will be completed 4x weekly for 1 month, 1x weekly for 3 months during daily clinical meeting to ensure MDS admission assessment accuracy. Audits will be completed by Director of Nursing, Assistant Director of Nursing, and RN MDS Coordinator Monday through Sunday as required.</td>
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Compliance date of 05/12/2021
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4:00 PM who explained she was one of two MDS nurses who completed the MDS assessments. The MDSC continued to explain that regardless of who completed Resident #5's MDS, the assessment should be an accurate assessment. The MDSC stated that MDS Nurse #2 completed MDS's remotely and could not speak to how she was able to gather the needed information or perform the required interviews to complete the MDS assessment.

An interview was conducted with the Director of Nursing (DON) on 05/07/21 at 4:33 PM. The DON stated that the MDS painted a picture of the resident and she expected them to be coded accurately.

During an interview with the Administrator on 05/07/21 at 5:20 PM she stated her expectation was that the Minimum Data Sets be accurately coded.

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| Baseline Care Plan

CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning

§483.21(a) Baseline Care Plans

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

The baseline care plan must-

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
null
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ACCORDIUS HEALTH AT WILKESBORO

1000 COLLEGE STREET
WILKESBORO, NC 28697

NAME OF PROVIDER OR SUPPLIER

F 655 Continued From page 4

1. Resident #5 was admitted to the facility on 11/18/20 with diagnoses that included end stage renal disease.

Review of a physician order dated 11/18/20 read, outpatient hemodialysis every Monday, Wednesday, and Friday.

Review of Resident #5’s medical record revealed no baseline care had been developed for the care and treatment required for dialysis.

Review of a comprehensive Minimum Data Set (MDS) dated 11/24/20 revealed the Resident #5 was cognitively intact for daily decision making and required extensive to total assistance with activities of daily living. Dialysis was not checked on this MDS assessment.

Resident #5 was discharged from the facility on 12/04/20.

An interview was conducted with Unit Manager (UM) #1 and #2 on 05/06/21 at 4:41 PM. Both UMs reviewed the schedule and confirmed that Nurse #1 and Nurse #2 worked the day Resident #5 admitted to the facility and should have completed the baseline care plan. The UMs stated that there was an admission checklist that they used for each resident and it listed each assessment that was to be completed by either the hall nurse or one of the UMs and baseline care plans was listed on the checklist. UM #1 stated that generally the hall nurse would greet the resident, get them settled in their room and then complete the admission assessment, complete the baseline care plan, obtain vital signs, and enter a general nurse’s note in the

discharged. An AD HOC QAPI meeting was completed on 5/7/2021 and was led by Administrator with input from Corporate nurse consultant, Director of Nursing, RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wound care nurse, Activity Director, Social Services Director, Rehabilitation Director, and Dietary manager. The results of the root cause analysis were reviewed by QAPI on 05/10/2021 and incorporated in the plan of correction.

2. All residents have the potential to be affected, therefore 100% of the current resident’s baseline care plans were completed and audited for completion accuracy by Director of Nursing, Assistant Director of Nursing, RN MDS Coordinator, and Unit Manager #1 and #2 to ensure ongoing regulatory compliance.

3. All licensed nurses (including RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wound nurse), Dietary manager, Social Services director, Therapy director, and Activity director were educated on the regulatory compliance for baseline care plans. The baseline care plan education began on 5/07/2021 and completed 05/11/2021 and was completed by Director of Nursing, Regional MDS consultant, and Regional Nurse consultant. All new hires will be educated on completing baseline care plans upon hire.

4. Baseline care plan audits were initiated on 5/07/2021 and will be completed 4x weekly for 1 month, 1x weekly for 3 months during daily clinical meeting to ensure regulatory compliance.
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<th>ID/PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 655</td>
<td>Continued From page 5 medical record. UM #2 reviewed Resident #5's medical record and confirmed that no baseline care plan had been developed for Resident #5.</td>
<td>F 655</td>
<td>regarding baseline care plans. Audits will be completed by Director of Nursing, Assistant Director of Nursing, and RN MDS Coordinator Monday through Sunday as required.</td>
<td>Compliance date of 5/12/2021</td>
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An interview was conducted with Nurse #1 on 05/06/21 at 5:01 PM. Nurse #1 confirmed that she worked the unit where Resident #5 resided but could not recall Resident #5 at all. Nurse #1 stated that during the time Resident #5 was admitted the facility was taking multiple admissions and the admission process "was scattered" which meant "basically you did the best you could do." Nurse #1 confirmed that initiating baseline care plan allowed the staff to know how to properly care for the resident. She added that "sometimes I did not get to do any of the assessments." Nurse #1 indicated that if she was working the next day, she would again try to finish any of the admission process that was not complete. Nurse #1 stated that Nurse #2 generally relieved her on third shift, and she would pick up with the admission process and try to complete what had not yet been done. She added that if the baseline care plan were completed, they would be documented in the electronic medical record. Nurse #1 stated that she could not recall Resident #5 nor could she recall completing his baseline care plan but stated "if it is not in his medical record then I did not have time to complete them."

An interview was conducted with Nurse #2 on 05/06/21 at 5:24 PM. Nurse #2 confirmed that she worked the unit where Resident #5 resided but could not recall the resident at all. She stated that sometimes she got left to complete admissions or the assessments that the other nurses did not get around to completing. Nurse #2 stated that baseline care plan was a part of
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<td>the admission process but generally someone else had already completed them by the she arrived for work. Nurse #2 stated that between herself and Nurse #1 Resident #5 should have had a base line care plan documented in the electronic medical record. She added if it was not in the electronic medical record for some reason the baseline care plans were not completed.</td>
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<td>An interview was conducted with the former Director of Nursing (DON) on 05/07/21 at 11:27 AM. The former DON stated that the admission process even in November 2020 was the same it had always been. There was an admission checklist that included the initiation of base line care plans. She stated that nursing was responsible for completing the admission assessment and baseline care plans. If the UMs were not busy, they could assist with the process. She added that the baseline care plan was an important document because it directed the care of the new resident until the full care plan could be developed. The DON stated once all the items on the checklist were completed it would go through 2 additional reviews to ensure all items including baseline care plans were done. The former DON could not recall specifically if Resident #5's baseline care plans were completed but stated that if they were it would be document in his electronic medical record.</td>
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| | | | An interview was conducted with the DON on 05/07/21 at 4:33 PM. The DON stated that she had only been at the facility for a few weeks. She stated that a nurse needed to initiate a baseline care plan for all new admissions, but she should not recall how soon they should be done. The DON stated that she was not sure who was responsible for completing the baseline care plan.
F 655 Continued From page 7 because she was still very new to the facility. The DON stated she expected a baseline care plan to be initiated for all new admissions especially someone with dialysis since there was very specific things that needed to be monitored.

2. Resident #10 admitted to the facility on 11/24/20 with diagnoses that included: acute/chronic respiratory failure.


Review of the facility daily schedule for 11/24/20 indicated that Nurse #3 was working the unit where Resident #10 resided.

Review of Resident #10's medical revealed no baseline care plan had been developed to address the care and treatment of oxygen.

Review of a Minimum Data Set (MDS) dated 11/30/20 indicated that Resident #10 was cognitively intact for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that oxygen was used during the assessment reference period.

Resident #10 was discharged from the facility on 12/04/20.

An interview was conducted with Unit Manager (UM) #1 and #2 on 05/06/21 at 4:41 PM. The UMs stated that there was an admission checklist that they used for each resident and it listed each assessment that was to be completed by either the hall nurse or one of the UMs and baseline care plans was listed on the checklist. UM #1
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| stated that generally the hall nurse would greet the resident, get them settled in their room and then complete the admission assessment, complete the baseline care plan, obtain vital signs, and enter a general nurse's note in the medical record. UM #2 reviewed Resident #10's medical record and confirmed that no baseline care plan had been developed for Resident #10. An interview was conducted with the former Director of Nursing (DON) on 05/07/21 at 11:27 AM. The former DON stated that the admission process even in November 2020 was the same it had always been. There was an admission checklist that included the initiation of base line care plans. She stated that nursing was responsible for completing the admission assessment and baseline care plans. If the UMs were not busy, they could assist as well with the process. She added that the baseline care plan was an important document because it directed the care of the new resident until the full care plan could be developed. The DON stated once all the items on the checklist were completed it would go through 2 additional reviews to ensure all items including baseline care plans were done. The former DON could not recall specifically if Resident #10's baseline care plans were completed but stated that if they were it would be document in the electronic medical record. An attempt to speak to Nurse #3 was made on 05/07/21 at 3:17 PM and was unsuccessful. An interview was conducted with the DON on 05/07/21 at 4:33 PM. The DON stated that she had only been at the facility for a few weeks. She stated that a nurse needed to initiate a baseline care plan for all new admissions, but she should...
### Summary Statement of Deficiencies

(F 684) Quality of Care

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:

- Based on record review and staff interview the facility failed to complete an initial admission assessment that included a baseline skin assessment for 2 of 10 residents (Resident #5 and Resident #10) reviewed for pressure ulcers.

The findings included:

1. Resident #5 was admitted to the facility on 11/18/20 with diagnoses that included end stage renal disease.

Review of Resident #5's medical record revealed no admission assessment was completed during Resident #5's stay in the facility. Further review of Resident #5's medical record revealed no skin assessment was completed upon admission to

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**F 655** Continued From page 9

not recall how soon they should be done. The DON stated that she was not sure who was responsible for completing the baseline care plan because she was still very new to the facility. The DON again stated she expected a baseline care plan to be initiated for all new admissions especially someone with that required oxygen.

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**F 684** Quality of Care

1. A root cause analysis was conducted on 5/7/2021 and completed on 05/11/2021 to identify the root cause of the facility error by not completing an initial skin assessment on resident #5 and resident #10. 2 out of 2 residents identified are not current and have discharged. An AD HOC QAPI meeting was completed on 5/7/2021 and was led by Administrator with input from Corporate nurse consultant, Director of Nursing, RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wound care nurse, Activity Director, Social Services Director, Rehabilitation Director, and Dietary manager. The results of the root cause
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345133

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
  C 05/07/2021

NAME OF PROVIDER OR SUPPLIER

ACCORDIUS HEALTH AT WILKESBORO

STREET ADDRESS, CITY, STATE, ZIP CODE

1000 COLLEGE STREET
WILKESBORO, NC 28697

(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE

F 684 Continued From page 10

continued F 684

Review of the facility daily schedule for 11/18/20 revealed that Nurse #1 was working the unit where Resident #5 resided from 7:00 AM to 7:00 PM and Nurse #2 was working that unit from 7:00 PM to 7:00 AM.

Review of a comprehensive Minimum Data Set (MDS) dated 11/24/20 revealed the Resident #5 was cognitively intact for daily decision making and required extensive to total assistance with activities of daily living. The MDS further indicated that the facility did not assess the if Resident #5 was at risk for skin breakdown.

Resident #5 was discharged from the facility on 12/04/20.

An interview was conducted with Unit Manager (UM) #1 and #2 on 05/06/21 at 4:41 PM. Both UMs reviewed the schedule and confirmed that Nurse #1 and Nurse #2 worked the day Resident #5 admitted to the facility and should have completed the admission assessments which included a head to toe skin assessment. UM #1 stated that generally the hall nurse would greet the resident, get them settled in their room and then complete the admission and skin assessment, obtain vital signs, and enter a general nurse's note in the medical record. Um #2 reviewed Resident #5's medical record and confirmed that no admission assessment nor skin assessment had been completed but stated that neither of the UMs could recall Resident #5.

An interview was conducted with Nurse #1 on 05/06/21 at 5:01 PM. Nurse #1 confirmed that she worked the unit where Resident #5 resided

analysis were reviewed by QAPI on 05/10/2021 and incorporated in the plan of correction.

2. All residents have the potential to be affected, therefore 100% of the current resident admission and skin assessments were audited for completion by Director of Nursing, Assistant Director of Nursing, RN MDS Coordinator, and Unit Manager #1 and #2 to ensure ongoing regulatory compliance.

3. All licensed nurses (including RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wound nurse), Dietary manager, Social Services director, Therapy director, and Activity director were educated on the regulatory compliance for completing the resident assessments. The resident assessment education began on 5/07/2021 and completed 05/11/2021 and was completed by Director of Nursing, Regional MDS consultant, and Regional Nurse consultant. All new hires will be educated on completing admission and skin assessments upon hire.

4. Admission assessment audits were initiated on 5/07/2021 and will be completed 4x weekly for 1 month, 1x weekly for 3 months during daily clinical meeting to ensure regulatory compliance regarding resident assessment completion. Audits will be completed by Director of Nursing, Assistant Director of Nursing, and RN MDS Coordinator Monday through Sunday as required.

Compliance date of 5/12/2021
but could not recall Resident #5 at all. Nurse #1 stated that the admission process included the admission assessment and a head to toe skin assessment along with several other assessments. She added that during the time Resident #5 was admitted the facility was taking multiple admissions and the admission process "was scattered" which meant "basically you did the best you could do." Nurse #1 stated that "sometimes I did not get to do any of the assessments." Nurse #1 indicated that if she was working the next day, she would again try to finish any of the admission assessment and skin assessment that had not been complete. Nurse #1 stated that Nurse #2 generally relieved her on third shift, and she would pick up with the admission process and try to complete the admission assessment and skin assessment. She added that if the assessments were completed, they would be documented in the electronic medical record. Nurse #1 stated that she could not recall Resident #5 nor could she recall completing his admission assessment or skin assessment but stated "if it is not in his medical record then I did not have time to complete them."

An interview was conducted with Nurse #2 on 05/06/21 at 5:24 PM. Nurse #2 confirmed that she worked the unit where Resident #5 resided but could not recall the resident at all. Nurse #2 stated that the admission assessment included a head to toe assessment but most of the time that was already completed by the time she arrived at work. She stated that sometimes she got left to complete admissions assessment and skin assessments that the other nurses did not get around to completing. Nurse #2 stated that between herself and Nurse #1 Resident #5
should have had an admission assessment that included a head to toe skin assessment completed on admission and documented in the electronic medical record. She added if it was not in the electronic medical record for some reason the admission assessment and subsequent skin assessment were not completed.

An interview was conducted with the former Director of Nursing (DON) on 05/07/21 at 11:27 AM. She stated that nursing was responsible for completing the admission assessment, head to toe skin assessment, fall risk assessment and several other assessments. If the UMs were not busy, they could also assist as well with the process. The former DON stated that if one shift could not complete the admission assessments then the next shift should be working to complete them as well. The former DON could not recall specifically if Resident #5’s admission assessment and skin assessment was completed but stated that if it was it would be document in his electronic medical record.

An interview was conducted with the DON on 05/07/21 at 4:33 PM. The DON stated that she had only been at the facility for a few weeks. She stated that she expected the nursing staff to complete the required admission assessment and skin assessment immediately after the resident arrived at the facility and document them in the medical record.

2. Resident #10 was admitted to the facility on 11/24/20 with diagnoses that included polyarthritis, hypertension, weakness, dysphagia, and others.

Review of Resident #10’s medical record
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345133

**MULTIPLE CONSTRUCTION B. WING __________________________________**

**Address:**
1000 COLLEGE STREET  
WILKESBORO, NC 28697

**Date Survey Completed:** 05/07/2021

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**Event ID:** KOT411  
**Facility ID:** 923520  
**If continuation sheet:** Page 14 of 15

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F 684 continued:

*revealed no admission assessment was completed during Resident #10's stay in the facility. Further review of Resident #10's medical record revealed no skin assessment was completed upon admission to the facility.*

Review of the facility's daily schedule for 11/24/21 indicated that Nurse #3 was working the unit where Resident #10 resided.

Review of the Minimum Data Set (MDS) dated 11/30/20 indicated that Resident #10 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #10 was at risk for pressure ulcer.

Resident #10 discharged from the facility on 11/30/20.

An interview was conducted with Unit Manager (UM) #1 and #2 on 05/06/21 at 4:41 PM. UM #1 stated that generally the hall nurse would greet the resident, get them settled in their room and then completed the admission and skin assessment, obtain vital signs, and enter a general nurse's note in the medical record. UM #1 and UM #2 stated that the admission assessment and subsequent skin assessment were to be done upon admission and entered into the resident's medical record and if the they were not in the medical record they were not completed.

An interview was conducted with the former Director of Nursing (DON) on 05/07/21 at 11:27 AM. She stated that nursing was responsible for completing the admission assessment, head to toe skin assessment, fall risk assessment and...
An attempt to speak to Nurse #3 was made on 05/07/21 at 3:17 PM and was unsuccessful.

An interview was conducted with the DON on 05/07/21 at 4:33 PM. The DON stated that she had only been at the facility for a few weeks. She stated that she expected the nursing staff to complete the required admission assessment and skin assessment immediately after the resident arrived at the facility and document them in the medical record.

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